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Orange County Mental Health Services Act

Plan Update FY 2019-2020

OC health CARE AGENCY

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MESSAGE FROM THE AGENCY DIRECTOR

This Mental Health Services Act (MHSA) Annual Plan Update for Fiscal Year (FY) 2019-20 represents an opportunity to review our progress and re-evaluate our current Three-Year MHSA Plan. In the upcoming year we look to enhance our preventative efforts through a time-limited expansion of Prevention and Early Intervention programs and to make significant strides in expanding and improving crisis services through the construction of the Anita Wellness Campus. Through these and other programs, MHSA will continue to transform the Orange County mental health system via the principles of community collaboration; cultural competence; wellness, recovery and resilience; consumer- and family-driven decision-making; integrated service experiences; and increased access for unserved and underserved populations.

Our progress to date would not have been possible without the support and guidance of groups and entities including the Orange County Board of Supervisors; Mental Health Board; MHSA Steering Committee; Community Action Advisory Committee; advocates for unserved and underserved populations; and the multitude of volunteers, County staff and others who have so graciously given their time and expertise to create the successes achieved over the past 14 years. We are also embarking on an exciting public-private partnership with Be Well OC, a coalition of Orange County behavioral health stakeholders including the Health Care Agency (HCA), CalOptima, local hospital systems, and nonprofit, academic and faith-based organizations. This partnership will provide an unparalleled opportunity for us to work together and strive to provide optimal mental health and well-being for Orange County residents through a culturally responsive and inclusive system.

As I review the Annual Plan Update for FY 2019-20, I am pleased with the continued success of many of our programs and am enthusiastic about the plans to expand our system in new and exciting ways. This was truly a collaborative effort between our outstanding community partners and Behavioral Health Services staff, and demonstrates our dedication to improving the lives of the individuals and family members affected by mental illness here in Orange County.

Sincerely,

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

OVERVIEW AND EXECUTIVE SUMMARY

In November 2004, California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA). The Act implemented a 1% state tax on income over $1 million and emphasizes transforming the mental health system to improve the quality of life for individuals living with mental illness and their families. With over 12 years of funding, mental health programs have been tailored to meet the needs of diverse clientele in each county in California. As a result, local communities and their residents are experiencing the benefits of expanded and improved mental health services.

Orange County Behavioral Health Services (BHS) has used a comprehensive stakeholder process to develop local MHSA programs that range from prevention services to crisis residential care. Central to the development and implementation of all programs is the focus on community collaboration; cultural competence; consumer- and family-driven services; service integration for consumers and families; prioritization of serving the unserved and underserved; and a focus on wellness, recovery and resilience.

The current array of services, with an annual budget of $268,562,473 million for FY 2019-20, was developed incrementally, starting with the planning efforts of stakeholders in 2005 and continuing to present day.

The Orange County FY 2019-20 MHSA Annual Plan Update ("Plan Update" or "Update") to the Three-Year Program and Expenditure Plan for Fiscal Years 2017-18 through 2019-20 was approved by the Board of Supervisors on **<INSERT DATE>**. This Update increases funding for all components except Workforce Education and Training, which is maintaining level funding.

Budget Review and "True up" Process

As part of the fiscal review done in preparation for the current Annual Plan Update, BHS engaged in a detailed process of aligning existing program budgets more closely with actual program expenditures from the most recent fiscal year (i.e., FY 2017-18). This budget "true up," which took place during Fall 2018, allowed managers to identify cost savings for programs that could be transferred to cover budget increases and/or implementation costs of other programs within the same component. The most common source of savings was actual or anticipated funds that remained unspent during a program's development and/or implementation phase (e.g., salary savings, reduced number of individuals served, etc.).

MHSA Components and Funding Categories

MHSA funding is broken down into five components that are defined by the Act: Community Services and Supports, Prevention and Early Intervention, Innovation, Workforce Education and Training, and Capital Facilities and Technological Needs. In addition, Community Services and Supports may allocate funds to support MHSA housing. A brief description and the funding level for each of these areas is provided below.

Community Services and Supports Component

Community Services and Supports (CSS) is the largest of all five MHSA components and receives 76% of the Mental Health Services Fund. It supports comprehensive mental health treatment for people of all ages living with serious emotional disturbance (SED) or serious mental illness (SMI). CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration.

In addition to the FY 2018-19 CSS budget adjustments continued into FY 2019-20 for the expansion of programs such as the Crisis Assessment Teams, Children's Full Service Partnerships, and Courtyard Outreach program, other significant changes incorporated into the FY 2019-20 Annual Plan Update include the following:

- Add a new program, Supportive Services for Residents in Permanent Supportive Housing. This program aims to help adults who are living with serious mental illness be successful in their housing placements by providing supportive services as needed.
- Discontinue MHSA funding for Adolescent Dual Diagnosis Residential Treatment. Services will continue and instead be funded through Drug Medi-Cal and Medi-Cal.
- Discontinue MHSA funding for the Mental Health Collaborative Courts – Probation Services program. It was discovered that MHSA funds cannot be used to pay for law enforcement positions, duties or functions. The program will continue to be provided through alternate, non-MHSA funding.

The resulting CSS budget for FY 2019-20 is $174,195,419. Although this amount exceeds anticipated available funds in FY 2019-20, CSS expenditures are anticipated to be within available fund limits but are budgeted at full program costs. This is because historical trends show actual expenditures to be under the annual budget due to various factors, such as unanticipated revenue offsets or cost savings. The Financial Team will monitor and project the revenue and expenditures throughout the fiscal year to ensure funds are not overspent. A full description of each CSS program, including the above changes, is provided in the Community Support and Individual/Family Support sections of this Plan.

Prevention and Early Intervention Component

MHSA dedicates 19% of its allocation to Prevention and Early Intervention (PEI), which is intended to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. HCA recently engaged in an extensive community planning process (described later in this Plan) to identify PEI programs that would receive time-limited funding in order to expend unspent funds carried over from recent prior fiscal years. Some of the significant changes incorporated into the FY 2019-20 Annual Plan Update include the following:

- Continue the Innovation program, Strong Families - Strong Children: Behavioral Health Services for Military Families, with PEI funding
- Fund new and/or expanded services for TAY and young adults at community colleges & universities
- Expand K-12 school-based mental health services
- Fund a new program that will target early childcare providers serving families and young children
- Discontinue the Physical Fitness and Nutrition program as the contracted provider, following re-organization, no longer supports the gym facility

The component expanded funding from the amended FY 2018-19 Plan Update by approximately $5 million for a total component budget of $43,490,187 in FY 2019-20. Consistent with PEI regulations, 64% of total PEI funding is dedicated to serving youth who are under age 26 years. A description of each PEI program is provided in the Community Support and Individual/Family Support sections.

Innovation Component

MHSA designates 5% of a County's allocation to the Innovation component, which specifically and exclusively dedicates funds to trying new approaches that contribute to learning rather than expanding service delivery. Projects are time-limited to a maximum of five years and evaluated for effectiveness and consideration for continued funding through CSS, PEI or other funds. All active projects are described in the Community Support, Individual/Family Support, and Special Projects sections.

In addition, HCA is in various stages of developing new Innovation projects:

- Orange County was recently approved by the MHSOAC to join the Statewide Early Psychosis Learning Health Care Network, a project in which counties will collaborate to standardize the evaluation of early psychosis programs; establish shared learning; and apply identified strategies that will improve participant outcomes,

program impact and cost-effectiveness of local early psychosis programs.

- Orange County is developing a Behavioral Health System Transformation Project proposal, a proof of concept on how best to create a system that will serve individuals in need of behavioral health services, regardless of insurance status or type. The purpose of this project is to determine how Orange County can braid funding sources and work within existing regulations so that the person being served, and not the payment source, remains the center of patient care. This project will also incorporate the development of a dynamic Digital Resource Directory that will allow providers to update their program contact and services information in real-time.

Workforce Education and Training Component

Workforce Education and Training (WET) is intended to increase the mental health services workforce and to improve staff cultural and language competency, and is currently funded through transfers from CSS. WET maintained a level annual budget of $5,150,282 for FY 2019-20, although $65,000 is being transferred to Capital Facilities to support renovations for a facility that will support behavioral health trainings. Thus, the total component budget in FY 2019-20 is $5,085,282. A full description of each program is provided in the System Supports section.

Capital Facilities and Technological Needs Component

The Capital Facilities and Technological Needs (CFTN) component funds a wide range of projects necessary to support the service delivery system and is currently funded through transfers from CSS. A total of $17,645,000 is being transferred to Capital Facilities to fund several projects in FY 2019-20:

- Construction of a building that will house Anita Wellness Campus services
- Renovations for a Crisis Stabilization Unit
- Renovations for a behavioral health training facility
- Completion of renovations for a building used for MHSA services/administration

Housing

Under direction from the Board of Supervisors, a total of $70,500,000 was allocated during the FY 2018-19 community planning process to develop permanent supportive housing. Some funds have been allocated to projects in development and the remaining balance of $30,500,000 is available in FY 2019-20 for Orange County to continue creating permanent housing options for those living with SMI. A description of each project is provided in the Individual/Family Support section of this Plan Update.

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

Orange County Mental Health Services Act (MHSA) Community Stakeholder Process

Orange County Stakeholders

MHSA Steering Committee

Orange County has been utilizing an MHSA Steering Committee since the very first Three-Year Plan was developed. The Steering Committee provides guidance and encourages the HCA to address new ideas or questions that are raised throughout the year. The Steering Committee is made up of approximately 60 members of the community and tasked with fulfilling seven responsibilities:

1. Be fully educated about the status of the MHSA funding availability and requirements, as well as the status of Orange County MHSA program implementation
2. Assist the County with identifying challenges to the development and delivery of MHSA-funded services and make recommendations for strategies to address these challenges
3. Remain informed about current stakeholder meetings and the funding and program recommendations made by members of these groups
4. Review all MHSA funding proposals and provide critical feedback to ensure that funding is allocated to services for identified needs and priorities
5. Make timely, effective decisions that maximize the amount of funding secured by Orange County that preclude Orange County from losing funding for which it is potentially eligible
6. Support the County's ability to meet both State funding requirements and Orange County funding needs
7. Make recommendations regarding future MHSA allocations so funds will be used to provide services for identified needs and priorities

Steering Committee Composition

In 2017 the MHSA Office surveyed members on key demographics and stakeholder characteristics. Approximately 68% of the surveys were returned (39/57) and yielded the following results:

MHSA requires that each County partner with local community members and stakeholders for the purpose of community planning. The Orange County MHSA Steering Committee is composed of stakeholders from each of the following legislated groups and, in most cases, has at least two members representing each category: adults and seniors living with a mental illness; families of children, adults and seniors with a serious mental illness or emotional disturbance; mental health service providers; law enforcement agencies; education; social services agencies; veterans; representatives from veteran organizations; providers of alcohol and drug services; health care organizations; and other important interests. At the current time, the MHSA Steering Committee consists of 55 members of the community. This past year, the MHSA Steering Committee added a representative from each office of the five Board of Supervisors.

In 2017 the MHSA Office provided a survey to all members inquiring about key demographics and stakeholder characteristics. The Office has updated the survey to reflect new members of the MHSA Steering Committee's demographic representation.

Geographical Representation: In 2017, 37 responded that the activities they participate in are county-wide (more than one city).

Age Groups: In 2017, 44% of the members responded that they were adults between the ages of 26-59; 49% of the members were adults ages 60 and older; 7% declined to state their age. Currently there are no Transitional Age Youth (TAY) members participating in the Steering Committee: one of the past members now falls into the adults category and the other left the Steering Committee to pursue a higher education degree.

Race/Ethnicity: Currently the majority of members identify as White/Caucasian (47%). Members also identify as Asian/Pacific Islander (16%), Latino (15%), Other Race/Ethnicity (14.5%), and Black/African American (7%).

Languages (members could select multiple): In 2017, the majority of members said they speak English (87%), the second highest percentage said they speak Spanish (21%). In addition, members speak Vietnamese (8%), Farsi (3%), some selected a language not on the list (8%) and some declined to state (3%).

A new survey to update the Steering Committee composition will be sent out prior to the new MHSA Three Year Plan for FY 2020-21 through FY 2022-23.

Community Action Advisory Committee

The MHSA Community Action Advisory Committee (CAAC) is a group of 15 individuals who are living with a mental health condition or who have a family member living with a mental health condition. The group meets on a monthly basis to discuss MHSA-related programs,

review program outcomes and make recommendations to the MHSA Steering Committee on program/service needs and gaps from the consumer/family member perspective. A member of CAAC sits on the MHSA Steering Committee and provides updates on behalf of CAAC, related to community needs, funding ideas/requests, and any other issue related to consumers and family members.

MHSA Planning Process for the FY 2019-20 Annual Plan Update

The MHSA Community Planning Process began shortly after the start of the fiscal year in July, 2018. The MHSA Coordination Office notified community stakeholders of a Public Forum/Public Comment period in place of the July MHSA Steering Committee. The MHSA Coordination office notified the community stakeholders that the focus of the Public Forum would be for Prevention and Early Intervention (PEI) funding, as the HCA was aware of $22 million in one-time, available PEI funding. During the Public Forum/Public Comment, the MHSA Office heard from 63 community stakeholders. All comments were reviewed and the perceived needs/gaps were grouped together by similar program type for the PEI division to review while putting together workgroups to discuss programs and funding.

Children's PEI Programs	23 comments
Early Intervention Support for Older Adults	17 comments
Veteran Socialization	5 comments
Underserved Populations	4 comments
Criminal Justice	2 comments
Miscellaneous	13 comments

Community Engagement Meetings (CEMS)

At the direction of the Orange County Board of Supervisors, the MHSA Office hosted 7 community engagement meetings (three provider and four community member) in three different cities in July and August. In order to make the meetings accessible to as many interested parties as possible, the meetings were held in Fullerton (north), Santa Ana (central) and Mission Viejo (south). Each of the seven meetings were run the same way, breaking the participants into different table groups and asking each table to identify their top 5 service area priorities in Behavioral Health (this included areas not necessarily covered by MHSA). Each table was given a list of the different Behavioral Health Service (BHS) areas, as well as the different topics and issues associated with it:

	Service Area	Examples/Definition
1	**Prevention**	Examples: violence prevention, suicide prevention, stigma reduction, community mental health education, etc.
2	**Provider Training in Behavioral Health Topics/ Issues**	Examples: Trainings on Evidence Based Practices, EMDR, DBT, Culturally Competency in the workforce.
3	**Crisis Prevention**	Examples: hotlines, etc.
4	**Crisis Assessment**	Examples: mobile crisis assessment teams, crisis stabilization units that assess and discharge to outpatient services or a higher level of care in under 24 hours, etc.
5	**Crisis Treatment**	Examples: short-term crisis stabilization services provided in the home; short-term crisis residential programs, etc.
6	**Substance Use Education**	Examples: relapse prevention, life skills, healthy relationship.
7	**Substance Use Disorder (SUD) Clinic-Based Outpatient Services**	Co-occurring substance use and mental health outpatient services should be captured in numbers 11 and 12 below.
8	**SUD Residential Treatment**	Examples: SUD-focused Residential Treatment, Co-Occurring SUD/Mental Health Residential Treatment, etc.
9	**SUD Maintenance/ Recovery Support Services**	Examples: programs focused on maintaining sobriety
10	**Navigation Services/ Access and Linkage to Treatment**	Refers to services designed to help individuals navigate the County Behavioral Health System, or to improve linkage/engagement in County Behavioral Health programs. Examples: Outreach and Engagement, OC Links, etc.

	Service Area	Examples/Definition
11	**Behavioral Health Clinic-Based Outpatient Services**	Refers to mental/behavioral health/co-occurring services primarily provided in Clinic settings.
12	**Mobile Behavioral Health Outpatient Services**	Refers to mental/behavioral health/co-occurring services provided out in the field/community.
13	**School-Based Mental Health Services**	Mental Health Services provide at campuses – all grades – through college.
14	**Parent/Family Education Services**	Examples: Parenting, maternal wellness, family strengthening.
15	**Transportation**	
16	**Housing**	Specifically for individuals diagnosed with a serious mental illness.
17	**Services for those living in Supportive Housing**	Specifically for individuals diagnosed with a serious mental illness.
18	**Employment/Educational/ Vocational Support**	
19	**LPS Conservatorship Support**	Refers to support and resources for families of adult children on an LPS conservatorship.
20	**Peer/Family Support**	Supportive services provided to consumers and/ or family members by those who have lived-experience with mental/behavioral health recovery.
21	**Other (please specify)**	Examples: peer support, family support, parent/ youth partner support.

The top 5 areas identified by each table of participants were then tallied, resulting in the group's overall Service Area priorities (n= 5-7 per meeting, depending on ties). Each identified Service Area was posted on a large sheet and hung on the wall, and participants were given the opportunity to list the specific programs, services and/or target populations they believed to have unmet needs within an identified Service Area. The MHSA staff then facilitated a discussion with meeting participants to gain a clearer understanding of the group's identified needs and gaps by Service Area.

Across all seven Community Engagement Meetings, a total of 121 individuals participated: 93 provider stakeholders and 38 community stakeholders. The MSHA Office presented the findings at the October 15, 2018 MHSA Steering Committee meeting, the results of which are summarized, in part, below.

COMMUNITY

Service Priority Area	North	Central	South	North	Central	South
Prevention	●	●	●		●	●
School-Based Mental Health	●	●	●			●
Clinic-Based Outpatient	●		●	●	●	
Housing		●	●	●		●
Crisis Assessment & Treatment	●		●		●	●
SUD Services	●		●	●		
Navigation / Access & Linkage		●				
Employ. / Educ. / Voc. Support		●				
Peer / Family Support		●			●	

Of note, the 2 Community meetings held in Santa Ana and the Community Meeting held at a CAAC meeting were combined for the Central Community information.

Prevention and Early Intervention Community Planning Workshops

Following both the MHSA Public Forum and the Behavioral Health Community Engagement Meetings, the Prevention and Early Intervention Division hosted a series of workgroups to take a more in-depth look at the prior needs and gaps in the service priority areas brought forth by community stakeholders. Four planning meetings were held and each focused on a different age/service area, and a fifth meeting was held to review the findings.

August 14, 2018	Family Support Programs, programs serving families with children birth to age 8
August 21, 2018	Focusing on school-based programs, children/youth 9-16
August 29, 2018	Focusing on adult and older adult programs
September 11, 2018	Transitional Age Youth
September 25, 2018	Recap and concluding discussions on needs and prioritization

A total of 121 members of the community, including representatives from more than 45 local service providers, participated in the PEI Community Planning Workshops. The meetings were conducted similarly to the Community Engagement Meetings, with small groups working to identify priorities and needs/gaps among the given age group/program group. Each group reported out after a discussion period and the groups collectively synthesized their ideas, which are summarized to the right:

Identified PEI Community Planning Process (CPP) Needs	
1.	Increased awareness/improved navigation of the Behavioral Health System
2.	Systematic screenings for mental illness
3.	Training for individuals, families and providers
4.	Implementation and/or expansion of peer support models
5.	Time-limited expansion of existing direct services
6.	Time-limited funding of new services
7.	Targeted stigma reduction programs
8.	Additional supports to remove barriers to access/training

At the September 25, 2018 meeting, PEI Management presented a set of recommendations for new and/or expanded PEI services aimed to address the identified needs and gaps.

In October and November 2018, the HCA presented a consolidated summary of the priority areas and community needs identified across the Community Engagement Meetings and PEI Community Planning Workshops to the MHSA Steering Committee, the Orange County Mental Health Board, and the Orange County Drug and Alcohol Advisory Board.

PEI CPP Identified Needs		Community Engagement Priorities								
		Prevention	School Based Mental Health	Clinic-Based Outpatient	Housing	Crisis Assessment & Treatment	SUD Services	Navigation Access & Linkage	Employment Education Vocational Support	Peer and Family Support
1.	Increased awareness - improved navigation of the BHS	●				●		●		
2.	Systematic screenings for mental illness	●								
3.	Training for individuals, families and providers		●							
4.	Implementation and/or expansion of peer support models	●				●				●
5.	Time-limited expansion of existing direct services									
6.	Time-limited funding of new services	●						●		
7.	Targeted stigma reduction programs	●								
8.	Additional supports to remove barriers to access/training					●				

Finally, at the November 26, 2018 MHSA Steering Committee meeting, the PEI division presented a set of nine recommendations on how to allocate available, unspent PEI funds carried over from recent fiscal years:

1.	Allocate funding for an early childhood mental health program targeting early childcare providers serving families and children
2.	Allocate funding to expand school-based services to better address mental health needs, K-12
3.	Allocate funding to expand existing Gang Prevention Services
4.	Allocate funding to implement services for TAY and young adults at community colleges and universities
5.	Allocate funding to expand existing services for isolated older adults
6.	Allocate funding to provide a variety of behavioral health community trainings
7.	Allocate funding to expand outreach to cultural and linguistic populations that continue to be underserved
8.	Allocate funding to existing Community Mental Health Education Events to Reduce Stigma
9.	Allocate funding to expand services for Veterans

The current MHSA Annual Plan Update for FY 2019-20 marks the first of three-to-four years in which unspent, available carryover funds will be used to implement the above time-limited recommendations.

Public Hearing and Approval by the Board of Supervisors

The MHSA Plan Update FY 2019-20 was completed, reviewed and approved by the BHS Director and posted to the Orange County MHSA website on March 22, 2019 for a 30-day review by the public. At the close the of the public comment period the MHSA Office and BHS Managers responded to all substantive public comments. The Plan, with the additional comments and responses, was submitted to the Mental Health Board, and on May 5, 2019 the Mental Health Board (MHB) held a Public Forum at the Brea Community Center to hear from the community on HCA's implementation of MHSA. The Public Hearing was advertised through a posting with the Clerk of the Board and emails to the Community Action Advisory Committee, members of the MHSA Steering Committee, and interested community members who have asked to be notified of meetings and events from MHSA. In addition, the Public Hearing was posted on the County-wide Board of Supervisors Event Calendar, promoted through the Health Care Agency's social media applications (Twitter, Facebook), and advertised in local newspapers in all the threshold languages. At the hearing, BHS Management reviewed the highlighted changes to the Plan and individuals from MHSA programs provided testimonials to the positive impact MHSA services have had on their lives. At the conclusion of the Public Hearing, the Chair of the Mental Health Board led a discussion among the members and called for a vote to approve the MHB's recommendation of the Plan. The plan was approved with one abstention. After receiving formal recommendation by the Mental Health Board, the MHSA Plan Update FY for 2019-20 was brought before the Orange County Board of Supervisors and approved at the regularly scheduled meeting held on May 21, 2019. At the same meeting, the Board of Supervisors also approved an amendment to increase the amount of Supportive Services for Residents in Permanent Supportive Housing program to $5 million for 12 months.

ORANGE COUNTY DEMOGRAPHICS

Orange County is the third most populous county and second most densely populated county in California.	It is home to a little over 3 million (3,190,400) people (Census, v2017), up almost 6% from 2010.
The County's population is comprised of four major racial/ethnic groups:	■ Whites (41%), Hispanics (34%), Asian/Pacific Islanders (21%) and Blacks/African Americans (2%). ■ 30% of residents are born outside the U.S. (Census, 2013-2017).
Currently, Orange County has five threshold languages (Spanish, Vietnamese, Korean, Farsi and Arabic).	According to Orange County's Healthier Together (2019), English is spoken at home by 54% of the population four years and older, followed by Spanish (26%) and Asian/Pacific Islander languages (14%).
22% of the County's population was under age 18 and 14% were 65 or older (Census, v2017).	The percentage of the population ages 65 and older is expected to increase over the next 20 years. As the percentage of seniors grows, the need for mental and physical health care is expected to rise.
Approximately 6% (120,558) of the civilian population 18 and older are veterans (Census, 2013-2017).	In one study of OC veterans (OC Veterans Initiative), half of post-9/11 veterans interviewed did not have full-time employment, 18% reported being homeless in the previous year, and nearly half screened positive for posttraumatic stress disorder (PTSD) and/or depression.
Orange County is home to an emerging Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning population.	The California Health Interview Survey estimates that 4.5% of Orange County residents identify as gay, lesbian, homosexual, or bisexual (2017).
The County has a well-educated population, with 85% of residents ages 25 years and older having graduated from high school and 39% having earned a bachelor's degree or higher.	This is slightly higher than the state average of 82% having graduated high school and 32% having earned a bachelor's degree or higher (Census, 2013-2017).
Since 2007, Orange County has consistently had the highest Cost of Living Index compared to neighboring areas. Although Orange County's cost of living for groceries, utilities, transportation and miscellaneous items tends to rank in the middle among similar jurisdictions, high housing costs make Orange County a very expensive place to live.	■ $81,851: Median household income (2013-2017). ■ $1,693: Median Gross Rent (Census 2013-2017) ■ $620,500: Median House Price (Census 2013-2017). ■ 5.3%: Unemployment Rate (OC Healthier Together, 2019) ■ 11.5%: Individuals below Poverty Level (Census 2013-2017).

MHSOAC Regulations Implementation

In Fall 2016, after receiving input from a number of community stakeholders statewide, the Mental Health Services Oversight and Accountability Commission (MHSOAC) voted to approve a new set of regulations governing PEI and Innovation programs. The regulations were amended in July 2018 and define and/or delineate the following for both components:

- Reporting requirements, including expenditure reports, program and evaluation reports to be submitted to the MHSOAC, etc.
- Program evaluation guidelines, including that evaluations are culturally competent and, depending on the type of program, measure one of more the following:
  - For PEI: reduction in prolonged suffering; changes in attitudes, knowledge or behaviors; number of referrals and linkages; duration of untreated mental illness; timeliness of access to care; etc. Relevant outcomes are described within the program descriptions contained in this Plan.
  - For INN: the intended mental health outcomes of the project as they relate to the risk of, manifestation of, and/or recovery from mental illness; improvement of the mental health system; the primary purpose of the project (described below); the impact of any new and/or changed elements as compared to established mental health practices.
- Reporting guidelines for program/project changes, including:
  - For PEI, substantial changes to a Program, Strategy or target population; the resulting impact on the intended outcomes and evaluation; and stakeholder involvement in those changes.
  - For INN: substantial changes to the primary purpose and/or to the practice/approach the project is piloting; increases in the originally approved Innovation budget; and/or a decision to terminate the project prior to the planned end date due to unforeseen legal, ethical or other risk-related reasons.

PEI-Specific Regulations

In addition, there are certain regulations specific to PEI programs:

- General requirements for services, including the age ranges to be served, minimum percent funding allocated to programs serving children and TAY, etc.
- General component requirements, including the minimum number and type of PEI programs that each County shall include in its plan, etc., which are described in more detail below.
- Strategies for program design and implementation, including that programs help create access and linkage to treatment, improve timely access to mental health services, and be non-stigmatizing and non-discriminatory, etc., which is described in more detail below.
- Use of effective methods in bringing about intended program outcomes, including evidence-based practices, promising practices, and/or community- and/or practice-based standards, etc., which are described within each program description.

Required PEI Programs

Per the Regulations, counties not classified as small must include at least one PEI program in each of five category types, and have the option of offering a sixth type. Orange County offers all six types, with some combining two types into one program as permitted by the regulations. The required programs, along with their accompanying Orange County PEI programs, are listed on the next page.

Prevention

Activities that reduce risk factors for developing a potentially serious mental illness and build protective factors with the goal of promoting mental health

OC Programs:

- Children's Support & Parenting Program
- Family Support Services
- School-Based Stress Management Services
- Parent Education Services
- School-Based Mental Health Services
- School-Based Behavioral Health Intervention and Supports
- School Readiness / Connect the Tots
- Gang Prevention Services
- Violence Prevention Education
- Warmline
- Training in Physical Fitness & Nutrition
- Outreach and Engagement Collaborative
- Expand K-12 school-based mental health services
- Services for TAY & young adults at community colleges & universities
- Early childhood mental health programs targeting early childcare providers serving families & children

Early Intervention

Treatment/services that promote recovery and functioning for a mental illness early in its emergence

OC Programs:

- Community Counseling & Supportive Services
- School Readiness / Connect The Tots
- OC ACCEPT
- 1st Onset of Psychiatric Illness - OCCREW
- OC Parent Wellness
- School-Based Behavioral Health Intervention and Supports - Early Intervention Services
- School-Based Mental Health Services
- Stress Free Families
- Survivor Support Services
- College Veterans Program
- OC4 Vets
- Early Intervention Services for Older Adults
- Strong Families Strong Children: Behavioral Health Services for Military Families

Access and Linkage to Treatment

Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable

OC Programs:

- Information and Referral/OC Links
- BHS Outreach & Engagement Services

Stigma and Discrimination Reduction Program

Activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase accesptance, dignity and inclusion

OC Programs:

- Mental Health Community Educational Events
- Statewide Projects

Outreach for Increasing Recognition of Early Signs of Mental Illness

Process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness

OC Programs:

- Crisis Prevention Hotline
- Expand K-12 school-based mental health services
- Early childhood mental health programs targeting early childcare providers serving families & children
- Training, Assessment and Coordination Services
- Services for TAY & young adults at community colleges & universities

Suicide Prevention Program

Activities that aim to prevent suicide as a consequence of mental illness

OC Programs:

- Crisis Prevention Hotline
- Statewide Projects

Required PEI Service Strategies

In addition to including the above program types, every PEI program must include the following strategies:

Access and Linkage to Treatment

Strategies for linking individuals who are living with SED or SMI to an appropriate and higher level of care

Improve Timely Access to Mental Health Services for Underserved Populations

Strategies designed to overcome barriers and improve timely access to services for underserved populations

Non-Stigmatizing and Non-Discriminatory

Strategies to reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive

Orange County is continuing to bring its PEI program descriptions, data collection and reporting into compliance with the new Regulations, particularly with regard to:

- assessment of the duration an individual's mental illness remained untreated
- collection of the full demographic categories in County-operated programs as the electronic health record still needs to be modified
- process to un-duplicate demographic data counts when complete personally identifying information is not available in/across programs within a fiscal year
- length of time from when (1) a written referral to a higher level of mental health service is provided to individuals living with serious mental illness/serious emotional disturbance and (2) when that person attends the first appointment
- collection of all data elements required for Outreach for Increasing Recognition of Early Signs of Mental Illness programs

To address the above issues, the County continues to work on modifying its own Electronic Health Record and on developing and coordinating standardized data collection procedures across County-operated and County-contracted programs, and will report on its progress in these and other areas in future Annual Plan Updates. Other required PEI Three-Year Report elements are contained within this Plan Update.

Innovation-Specific Regulations

The MHSOAC also established regulations specific to Innovation projects, including:

- A County may expend Innovation funds on a specific project only after receiving approval from the MHSOAC
- Innovation projects must do one of the following:
  - ☐ Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention
  - ☐ Make a change to an existing practice in the field of mental health, including but not limited to, application to a new population
  - ☐ Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings
- Innovation projects must select one of the following purposes:
  - ☐ Increase access to mental health services to underserved groups
  - ☐ Increase the quality of mental health services, including measureable outcomes
  - ☐ Promote interagency and community collaboration related to mental health services or supports or outcomes
  - ☐ Increase access to mental health services

These elements are described in each INN project description contained within this Plan Update.

Community Support

Prevention

Community Support programs are specially designed to reach large groups of people. They aim to strengthen the resilience and wellness of a community as a whole, by providing information, training and skill-building around mental health.

PREVENTION

Similar to preventative care in the medical system which seeks to prevent disease, prevention programs in the behavioral health system strive to prevent the development of serious emotional or behavioral disorders or mental illness in at-risk individuals. These programs achieve this through large-scale, population-based efforts designed to reduce risk factors or stressors, build protective factors and skills, and/or increase resilience. Prior to the MHSA, preventative mental health services were not widely available due to financial barriers or the focus of community mental health systems on treating existing mental health problems. Now through the MHSA, efforts can be specifically devoted to promoting mental health and wellness, increasing awareness of available mental health services and resources, and decreasing stigma. There are three service areas in this category, each with a slightly different prevention focus:

- Community Events and Services
- School-Related Services
- Community Training

These program types and the services they provide are described in more detail in the sections that follow.

COMMUNITY EVENTS AND SERVICES

Prevention programs in the Community Events and Services area are large-scale events hosted in Orange County. These events use multi-media platforms to inform the community at large about mental health and to reduce stigma. Orange County currently funds two such program through PEI: Mental Health Community Education Events and Statewide Projects.

Prevention: Community Events and Services	Annual Budgeted Funds in FY 2019-20
Mental Health Community Education Events (PEI)	$881,000
Statewide Projects (PEI)	$900,000

Mental Health Community Education Events (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics
2-95	At-Risk	Field	All Community Members

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, and Khmer.

Target Population and Program Characteristics

The Mental Health Community Education Events program hosts mental health-related educational and artistic events that are open to individuals of all ages living in Orange County. The events take place several times throughout the year at different locations across the county. A time-limited Request for Application (RFA) is periodically released to the community inviting individuals and organizations to submit proposals for events. Examples of events that have qualified for funding include art workshops and exhibits, multi-cultural musical and dance performances, and other related activities.

Services

Participants are invited to attend an event and use a visual arts medium to express their thoughts and feelings about mental illness and stigma. Their artwork is then displayed at a community location that is open to the public. While each hosted event is different, they all provide consistent messaging aimed at educating the public on mental illness, the stigma surrounding mental illness and the mental health resources available in their communities. The events also seek to educate the public about the abilities and experiences of those living with a behavioral health issue and to instill self-confidence and hope in people living with mental illness and their family members.

Several community-based stigma reduction events took place in FY 2017-18.

A collaborative of community agencies held a series of workshop events using the arts to promote Drawing Out the Stigma in multi-ethnic communities. Participants were encouraged to express their thoughts and feelings about stigma and mental illness through visual arts such as painting as well as collaborative arts such as creating a mural or quilt. These events were followed by a month-long Community Art Exhibit to showcase the artistic expressions from these community-based workshops. The art exhibit also provided the community an opportunity to have a dialogue about mental health and the stigma associated with it. The workshops and the art exhibits culminated in a large-scale, multi-ethnic arts festival which featured cultural performances and music by participants, many of whom had experienced mental illness themselves. In addition to multi-ethnic foods, the festival also featured the art work by each of the collaborative, community based agencies. The event served as a platform for meaningful interactions between consumers and attendees.

Another set of stigma art events focused primarily on Orange County's Latino community included: 1) La Vida a Todo Color (Life in Full Color), a series of interactive art workshops for monolingual, low-income Latino/Latina children, youth and older adults who may be at risk of developing mental health conditions or are currently experiencing mental health conditions; and 2) Kids Against Stigma Art Fair Ventana de Desahogo (Window of Relief), a talent show of performance art by youth and young adult artists who have experienced various types of mental health conditions. The event was organized to raise awareness and highlight the resilience of the participants.

Strategies to Promote Recovery/Resilience

The program encourages participants and their family members to attend and participate in stigma reduction activities in their community. Recovery is promoted by tapping into participants' creative energy and encouraging their self-expression to reduce feelings of self-stigma, shame and isolation. The events also work towards reducing stigma and promoting inclusion within the community at large.

Strategies to Increase Timely Access to Services for Underserved Populations

The program is designed to be inclusive of those living with mental illness, as well as those who have loved ones living with mental illness. Community partners who specialize in working

with underserved cultural populations are involved to improve community members' access to the events. By hosting local activities, the program also provides an opportunity for these partner agencies to interact with residents living with mental illness, thereby encouraging them to seek the agencies' services in the future.

Strategies to Reduce Stigma and Discrimination

The program hosts events that are available to all Orange County residents and are sensitive and responsive to participants' backgrounds. Care is taken to host events in communities of underserved populations where stigma is particularly prevalent. The art displays attempt to educate the surrounding community and dispel misperceptions associated with mental illness. This strategy is employed because art is capable of transcending socioeconomic status, ethnicity, culture, language, mental illness and other such 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 mental illness to define themselves by their abilities rather than their disabilities.

Challenges, Barriers and Solutions in Progress

The challenges encountered by the Mental Health Community Educational Events program in FY 2017-18 were primarily related to planning and coordination. Many providers are not always aware of the complex logistical aspect of providing these services, and while they may

have wonderfully creative ideas, providers are often unable to plan for challenges in marketing, recruiting and/or engaging participants. To assist with these challenges, HCA staff provides technical assistance to the providers during the early stages of the project.

Community Impact

The program has provided services to more than 20,800 individuals since its inception in FY 2012-13. Feedback from participants and attendees indicates that the arts remain one of the greatest assets in empowering and educating the community while raising awareness and understanding of mental health issues.

Statewide Projects (PEI)

Program Serves	Symptom Severity				Location of Services				Population Characteristics							
0+	At-Risk	Early Onset	Mild-Moderate	Severe	Home	Field	School	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Medical	Students

The program provides services in English, Spanish, and Vietnamese.

Target Population and Program Characteristics

Statewide Projects serves the Orange County community-at -large through participation in the following CalMHSA sponsored initiatives:

- Suicide Prevention: These activities include social marketing and training 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.

- 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 underserved racial and ethnic communities about mental health.

- Student Mental Health: These activities are designed to change school climates and campus environments by promoting mental health and engaging students in kindergarten through higher education. Technical assistance and social media campaigns aimed at increasing awareness and engaging the local community are also provided.

Services

Orange County takes part in a statewide campaign known as Each Mind Matters (www.eachmindmatters.org) to promote the initiatives through a variety of activities and events tailored to the needs of local communities. The campaign is also available in Spanish (i.e., "Sana Mente").

During FY 2017-18, 77,490 Each Mind Matters materials were distributed and during FY 2016-17, 53,400 of these materials were distributed throughout Orange County to increase awareness of mental health and suicide prevention and decrease associated stigma and discrimination. Examples of the Each Mind Matters materials include promotional items such as green ribbons and wrist bands and educational materials such as the "Mental Health Support Guide" in English, Spanish, Korean and Vietnamese; "Be True and Be You Mental Health Guide" for LGBTQ+ youth; "Aging and LGBT

Mental Health Support Guide"; Latinx LGBTQ + Immigrant Youth Provider Fact Sheet; Tool kits for Suicide Prevention, Stigma and MentalHealth Awareness; Tip Sheets for Suicide Prevention including "Say This –Not That," "How do I talk to my teenager about suicide", Suicide Prevention at the Workplace, Talking Points for Counties: Recent Celebrity Deaths, "OC Links Talking Cards: How to Initiate a Conversation About Mental Health," and "Know the Signs/El Suicidio Es Prevenible."

Various mental health awareness activities were also hosted by community partners throughout the county. Some of these included arts and crafts displays; workshops and presentations in schools, universities, shelters, Family Resource Centers, parks, older adult community centers, juvenile hall, Orange County Courts, police departments, hospitals, wellness centers, residential treatment facilities and recovery homes; and a resource fair at the Mexican Consulate Office.

High school and college students in Orange County also had the opportunity to participate in "Directing Change," a statewide video competition that focuses on reducing stigma and preventing suicide. Youth who learn about suicide prevention and mental health create public service announcements that are used to educate the broader community. The Directing Change program received a total of 740 submissions, 134 of which were from Orange County. A total of 342 Orange County youth participated in the film contest. In the regional competition, three Orange County films were selected as winners in the categories of "Mental Health Matters" (i.e., "First Steps," "I Am, and "Behind the Pictures"). Three films were selected as winners in the "Suicide Prevention" category (i.e., "Dear Friend," "Don't Be Afraid to Ask" and "I Am"). One film was selected as winner in the category of Through the Lens of Culture (i.e. "Proud to Be Me"). View the 2018 winning films here.

Statewide Projects also provided 16 local agencies, including schools and organizations, outreach materials, training and technical assistance on stigma reduction, suicide prevention and/or student mental health. These included:

- Provided Kognito online mental health and suicide prevention trainings for 13,573 faculty, staff and students at eight community colleges;
- Trained two staff members at a community-based agency providing services to the Latino community in Orange County to be online "Directing Change" judges;
- Presented at the NAMI California annual conference on CalMHSA's resources and process for developing culturally and linguistically appropriate materials and community- defined practices for mental health education and suicide prevention;
- Provided Mental Health Outreach at three college campuses for various events including the Suicide Prevention Walk of Hope;
- Prepared a detailed report for the Health Care Agency on existing suicide prevention efforts in the community and unmet needs in Orange County. Conducted 38 interviews with 45 Stakeholders to gather information;
- Provided ongoing technical assistance to Orange County Department of Education staff regarding Assembly Bill 2246; and six total consultations to two college campuses' Active Minds Chapters. These student-led chapters engage in capacity building, training, educational programming (i.e., "Send Silence Packing," etc.) and local community engagement through student-led programs on mental health topics and campus outreach:
- Compiled a comprehensive list of suicide prevention resources tailored for older adults;
- Provided numerous webinars and technical assistance emails on a range of topics along with practical tools. Topics covered included suicide prevention, Mental Health Awareness Month Toolkits, Self-Care and Coping with Crisis, Means Restrictions, Strategies to collaborate with Native Communities;
- Provided data and infographics regarding mental illness and suicide-related information in Orange County;
- Created a SanaMente radio and digital media Public Service Announcement, "Take Care" (Cuidate), targeting the Spanish-speaking community between the ages 25-29.

Strategies to Promote Recovery/Resilience

Statewide Projects, through its multi-faceted approach, promotes recovery and resilience within Orange County as a whole by providing information and resources to prevent suicide, combat stigma and foster healthy, supportive communities.

Strategies to Improve Timely Access to Services for Underserved Populations

The program uses state and county-wide social marketing campaigns and websites to educate the public about mental illness and increase access to mental health services. In Orange County, program staff organized a month-long Each Mind Matters mental health awareness campaign in May 2018. The campaign events took place in a number of different community locations and were designed to initiate conversations about the stigma surrounding mental health conditions, engage youth in stigma reduction and art activities, provide resources and well- ness tips, create awareness for community members and support strategies to link individuals to needed services in a timely manner. An Orange County calendar was also created to highlight these and other community partners' mental health activities. (See http://www.ochealthinfo.com/bhs/about/pi/mhm)

In addition, Statewide Projects funded mini-grants for various Orange County agencies to create new outreach materials and social marketing campaigns designed to improve timely access of their services by those in need. Participating agencies included various local high schools and colleges, the LGBT Center of Orange County, NAMI Orange County, Active Minds and Viet-CARE California.

Strategies to Reduce Stigma and Discrimination

Consistent with Statewide Projects' initiatives, strategies to reduce stigma and discrimination related to mental illness are central to the campaign materials, events and training. The message and materials are tailored to be culturally and linguistically appropriate and designed to reach Orange County residents of all ages, including students in kindergarten through college.

Challenges, Barriers and Solutions in Progress

To mitigate the impact of limited resources and reach a larger geographic area, the program successfully collaborated with community partners to build a network that expanded the program's reach in Orange County. County staff, community partners, local advocates and those with lived experience, came together to carry out the Each Mind Matters movement.

Community Impact

The reach of Each Mind Matters continues to grow in Orange County, with an increasing number of individuals, agencies and organizations participating in the campaign each year. RAND Corporation has evaluated the statewide PEI Project and identified that 50% of Californians were exposed to the campaign "Know the Signs," and additionally, the "Know the Signs" campaign was rated by experts to be aligned with best practices and as one of the best media campaigns on the subject; since the counties began pooling funds through CALMHSA in 2011, 15% more Californians exposed to Each Mind Matters seek help for mental health challenges; 87% of students who were involved with the Directing Change Student video contest, increased their understanding of mental illness and suicide after participating in Directing Change. (www.directingchange.org).

A student filmmaker who created the film "Dear Friend" for the Directing Change video contest shared this note, "While writing our script, we did a lot of research on what the best things were to say when you fear your friend is thinking about suicide. While working together on this film, we were able to open up to each other about our own struggles with depression and have good dialogue together based off of our work."

SCHOOL-RELATED SERVICES

A key location for prevention efforts is in local schools. Orange County currently funds several school-related prevention programs through the PEI component, and all but one (School Readiness/Connect the Tots) is located on school campuses. These programs and services are described in more detail below.

Prevention: School-Related Services	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
School-Based Behavioral Health Intervention and Supports – Prevention (PEI)	40,500	$3,408,589	$84
Violence Prevention Education (PEI)	14,500	$1,352,651	$93
School-Based Stress Management Services (PEI)	3,500	$155,000	$44
School-Based Mental Health Services (PEI)*	2,800	$2,315,236	$827
School Readiness/Connect the Tots (PEI)	1,900	$2,800,000	$1,474
Gang Prevention Services: Gang Reduction Intervention Partnership (PEI)	400	$403,100	$1,008
Education and Behavioral Health Support Services for TAY and Young Adults (PEI)	TBD	$500,000	TBD
K-12 School-Based Mental Health Services Expansion (PEI)	TBD	$925,000	TBD

* The numbers for School-Based Mental Health Services are the total figures that include the Early Intervention track described in the Early Intervention Outpatient section.

School-Based Behavioral Health Intervention and Support (PEI)

Target Population and Program Characteristics

Program Serves	Symptom Severity	Location of Services	Population Characteristics		
	At-Risk	 School	 Parents	 Families	 Teachers/ School Personnel

The program provides services in English, Spanish.

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

Services

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

1. Classroom prevention is a classroom-based approach that utilizes an evidence-based curriculum with learning modules that focus on key learning objectives such as self-concept, life-skills, positive decision making and respect.
2. Students exhibiting higher-level problem behaviors are provided student-based interventions, which utilize smaller student groups that focus on specific areas of concern such as bullying, anger management, conflict resolution, drug prevention and/or self-esteem.
3. Finally, students who require more intensive services than what is provided in classrooms or small group workshops and who display symptoms indicative of higher level needs receive Tier Three, Family Intervention. This tier provides early intervention services for at risk families and focuses on family skill-building designed to improve family communication, relationships, bonding and connectedness.

Strategies to Improve Timely Access to Underserved Populations

The school setting generally allows for a large number of students to benefit from prevention and early intervention services, and SBBHIS targets schools with the highest need of prevention services. The program provides direct services in the classroom, which allows students to receive lessons in their current learning environment. This approach reduces classroom disruption and encourages student comfort and compliance. Serving students in the classroom also assists with reaching those students in the classroom, which assists in reaching those who may be more difficult to reach outside of school hours.

Strategies to Reduce Stigma and Discrimination

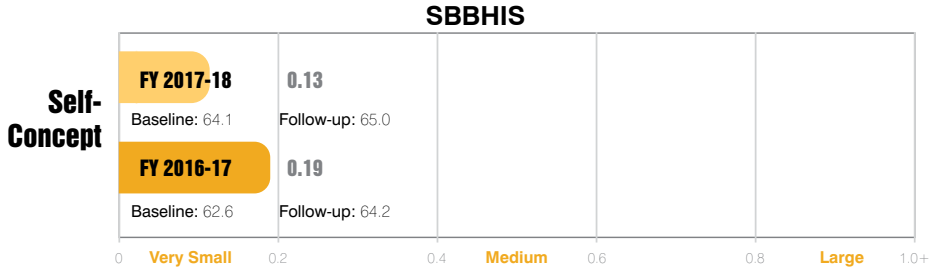
The program strives to make services available to students and parents in participating schools and to provide services that are sensitive and responsive to participants' backgrounds. The program also employs bilingual staff to meet the program's multicultural and language needs.

Outcomes[1]

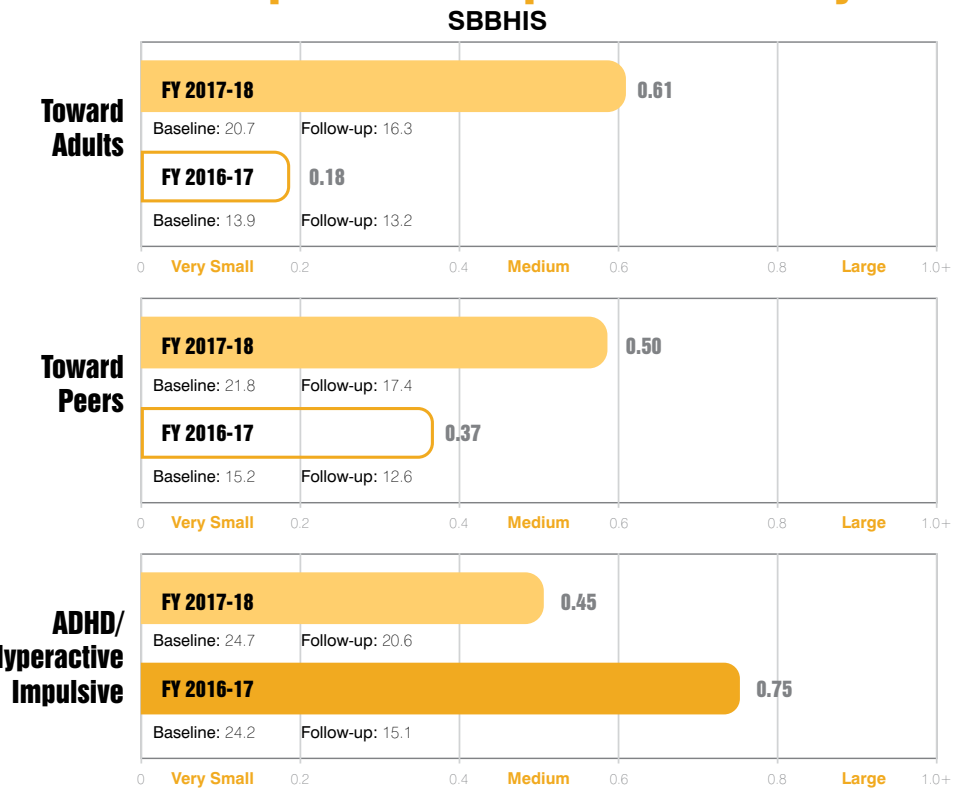
During FY 2017-18, a total of 26,358 participants were served, including 21,869 students, 3,500 parents/guardians, 995 school staff and 228 family members in 34 schools across 8 school districts. This is comparable to the number served in 2016-17, in which a total of 26,924 participants were served, including 24,242 students, 1,590 parents/guardians, 914 school staff and 178 family members in 30 schools across 7 school districts. To assess the program's effectiveness in reducing prolonged suffering, positive self-concept for Tier 2 participants (FY 2017-18: 507; FY 2016-17: 544) and disruptive behaviors for Tier 3 participants (FY 2017-18: 66; FY 2016-17: 32) were assessed between intake (baseline) and program exit. The program's evaluation strategy utilizes assessment tools that are appropriate both for the various ages of the population served as well as school climate and culture.

Data for Tier 2 indicate gains in both years. Based on a measure adapted from the Self-Concept Scale (maximum score=80), students in Tier 2 in 2017-18 started with a slightly higher baseline score compared to students in 2016-17, meaning students in FY16-17 were less confident at baseline. On follow-up, observed gains were slightly smaller in FY 2017-18 relative to follow-up scores when compared to 2016-17. Although there is a slightly larger effect size in 2016 for overall impact between the two years, both groups of students ended very close in terms of their final scores on self-concept at the conclusion of the program indicating that when looking at aggregate data, participants still maintained positive self-concept.

Tier 2: Impact on Self-Concept by FY



Tier 3: Impact on Disruptive Behavior by FY



[1] *Due to technical challenges and issues related to measure sensitivity and validity, Tier 1 data are not presented for FY 2016-17. HCA is working with the provider on identifying an appropriate performance outcome measure, and those results, when available, will be presented in future plan updates.*

In FY 2017-18 parents in Tier 3 reported at baseline that their children displayed more frequent disruptive behavior towards both adults and peers than at baseline in FY 2016-17. Nevertheless, substantive decreases in disruptive behaviors and thus larger effect sizes were generated in FY 2017-18 than in FY 2016-17. In FY 2017-18, the program made changes in the program structure to increase Tier 3 participation and as a result, the program was able to serve many more students than in FY 2016-17. The reorganization also better aligned Tier 2 and Tier 3, allowing for more appropriate participants at each level. This resulted in the higher baseline at intake and a stronger impact and effect size in services for FY 2017-18.

Challenges, Barriers and Solutions in Progress

Implementing services within a school setting is a complex and multifaceted process that involves coordination and decision-making at all levels of school administration. As a result, obtaining an official Memorandum of Understanding (MOU) from each school district can be a time consuming process and, consequently, access into schools may be delayed. Other notable challenges faced when providing services at schools include changes in class size and limited availability of classroom time. Strategies have been developed to streamline the process of recruiting and partnering with schools. Rapport building and relationship strengthening with administrators have been key to providing service delivery in a streamlined manner.

School Based Behavioral Health Intervention and Supports

The program has been successful in implementing the three tiers of services. In FY 2017-18, four additional schools and one additional district was served. PEI conducted a community planning process in FY 2018-19 for time-limited unspent carryover funds and as a result, the existing services were expanded and one additional service provider was added. The service expansion was made to include services to 20 additional schools in Orange County with an emphasis in on South Orange County schools which also includes a parent partner component that serves parents in the home setting. As a result, the program will serve a total of 60 schools.

Community Impact

The program continues to build capacity in the community through collaboration with community partners and school districts. More than 101,200 students, 6,550 parents/caregivers and 4,156 schools' staff have participated since program inception.

Reference Notes

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

2 ***Behaviors-Adult:***
FY 2017-18: Baseline M=20.7, SD=13.6; Follow-up M=16.3 SD=19.9 t(66)=4.46, p<.001, Cohen's d=0.61
FY 2016-17: Baseline M=13.9, SD = 6.0; Follow-up M=13.2, SD=4.3; t(28) = 0.90, p=<.382, Cohen's d=0.18

Behaviors-Peers:
FY 2017-18: Baseline M=21.8, SD=14.8; Follow-up M=17.4, SD=12.3, t(66)=3.96, p<.001, Cohen's d=0.50
FY 2016-17: Baseline M=15.2, SD =9.3; Follow-up M=12.6, SD=6.3; t(32)=1.90, p=.06, Cohen's d=0.37

ADHD/Hyperactive/Impulsive:
FY 2017-18, Baseline M=24.7, SD=15.0; Follow-up M= 20.6, SD=12.7, t(65)=3.53, p<.001, Cohen's d=0.45
FY 2016-17, Baseline M=24.2, SD = 16.5; Follow-up M=15.1, SD=10.6; t(22) =3.30, p<.01, Cohen's d=0.75

Violence Prevention Education (PEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics			
6-15	At-Risk	Early Onset	School	Parents	Families	Students	School Staff

The program provides services in English, Spanish, Vietnamese, Farsi, and Korean.

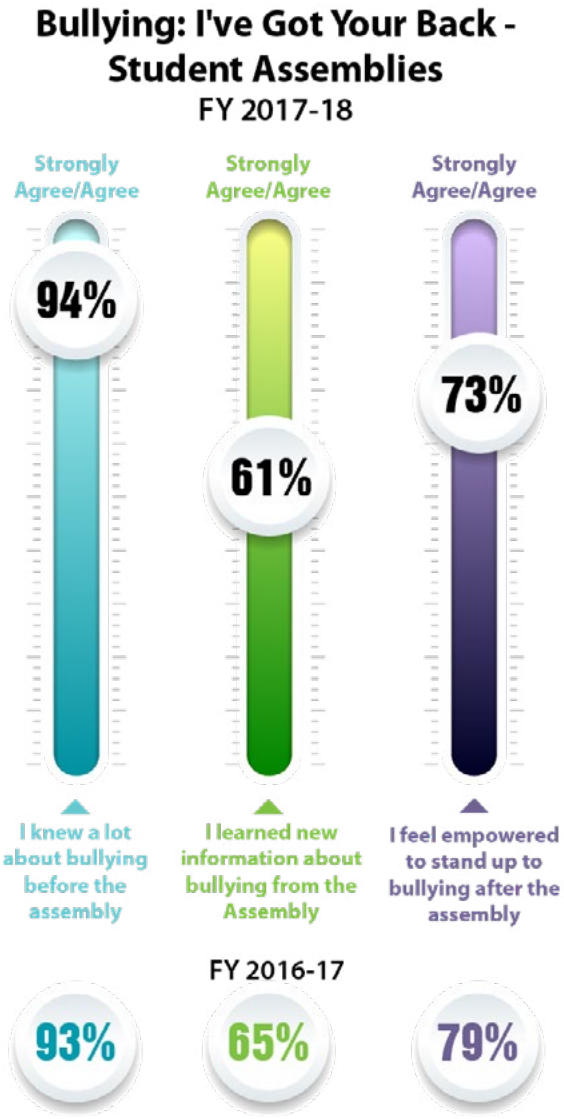
Target Population and Program Characteristics

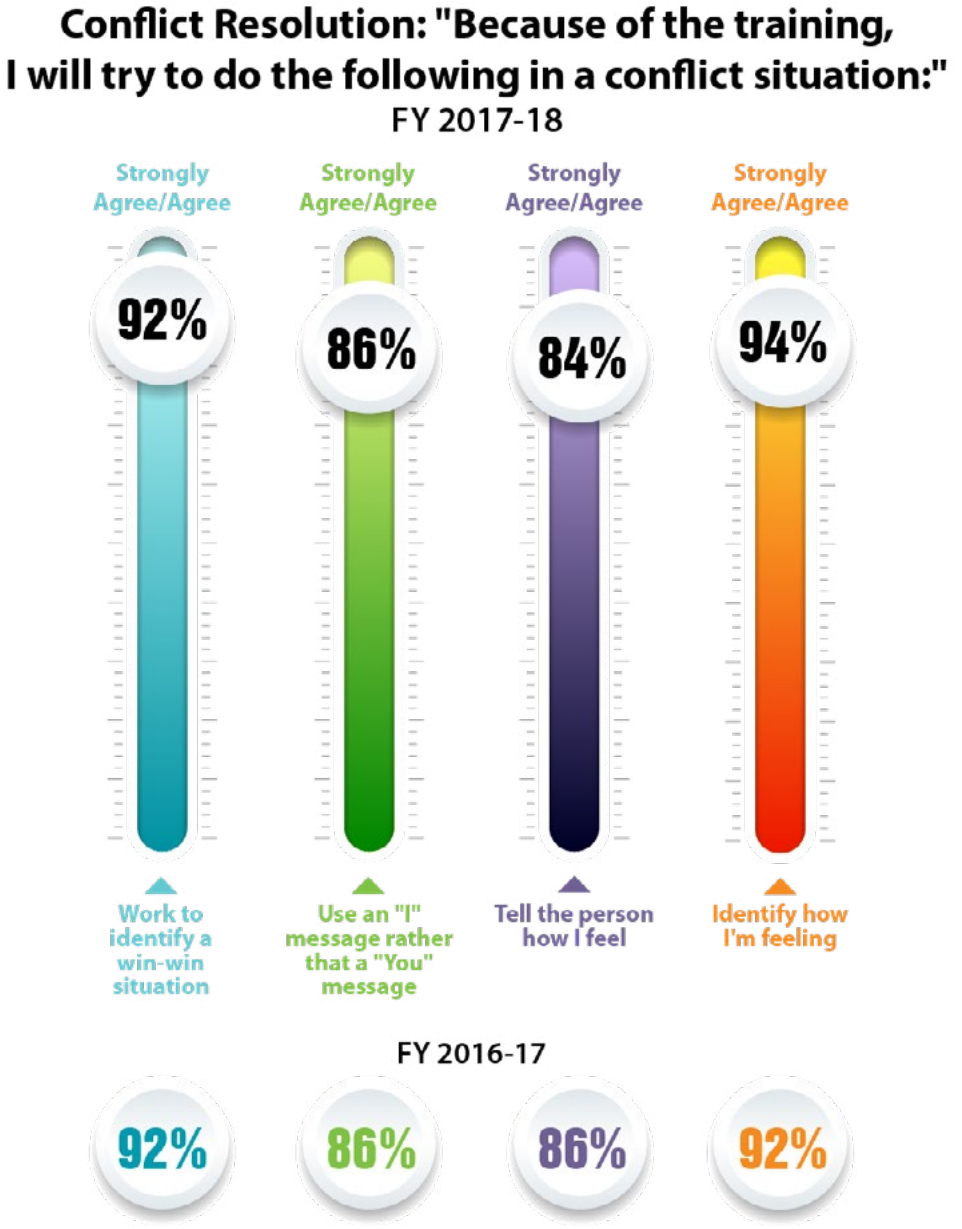
The Violence Prevention Education (VPE) program consists of five distinct tracks, each aimed at reducing a different aspect of violence and/or its impact in schools, local neighborhoods and/or families. The target audience for the different programs includes students, parents and school staff at participating elementary, middle and high schools throughout Orange County, as well as other community sites such as domestic violence shelters.

Services/Impact

The program has five different tracks designed to promote violence prevention. Three of the tracks are structured as educational/ informational presentations. The fourth is a crisis team network that responds to schools and other community locations that have experienced a crisis event and the fifth is Threat Assessment Violence Prevention Response training, a new component added for FY 2018-19. Each track uses an evidence-based or practice-based evidence standard geared toward the specific focus being covered, and fidelity to the Evidence-Based Practice (EBP) model is maintained by providing staff with periodic refresher trainings to ensure appropriate implementation. Each track and its associated learning impact are described in more detail on the following pages.

Bullying: This track provides education for students, staff, administrators and parents on bullying and cyber-bullying prevention. It is composed of two components: (1) anti-bullying presentations conducted at school site assemblies in an effort to impact the overall school climate by reducing and/ or preventing bullying; and (2) a traditional classroom-based curriculum focused on combating cyber-bullying. In FY 2017-18, the majority of respondents agreed or strongly agreed that they knew or learned about bullying and felt empowered to stand up to bullying behavior after having attended a student assembly.





Conflict Resolution: The Conflict Resolu- tion track supports students and parents by providing after school workshops, training and skill-building activities for teachers. The teachers, in turn, work to develop conflict resolution and peer mediation skills in their students. The overwhelming majority of participants agreed or strongly agreed with various statements reflecting their commitment to engage in the healthy/ adaptive behaviors promoted during the workshop. Starting in FY 2018-19, this track was modified to focus more on restor- ative prac- tices programming which is an evidence-based practice that will provide trauma informed educational sessions and trainings to emphasize positive character, conflict resolution, rite of passage, decision making and coping skills.

Strategies to Promote Recovery/Resilience

School-based activities are designed to promote resilience by encouraging a positive school climate. The various tracks work to reduce risk factors such as bullying and harassment and to develop protective factors such as conflict resolution skills. In addition, the Crisis Response Network facilitates recovery through the support and resources provided immediately in the aftermath of a crisis.

Strategies to Increase Timely Access to Services for Underserved Populations

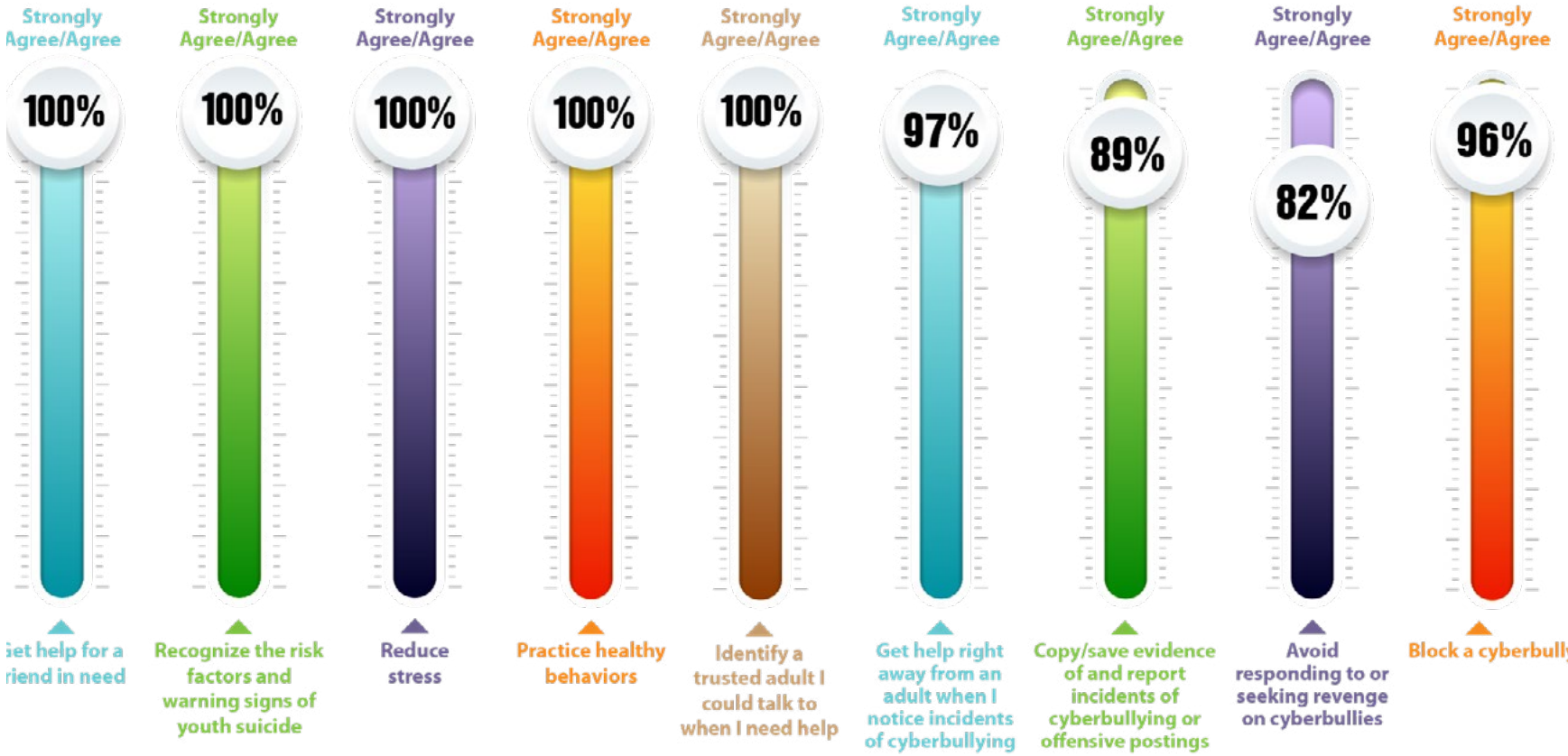
The Violence Prevention Education program promotes timely access to its services by providing them directly in school sites. Programming is open and available to all schools and districts in Orange County, including nontraditional school sites; charter, access and private schools; and after-school programs. Presentations and informational campaigns generally target the entire student body which includes those who may not be able to be reached outside of the school site. Safe From The Start also provides services at other Orange County locations such as domestic violence shelters and alternative living sites, and the Crisis Response Network will respond anywhere needed in Orange County.

Strategies to Reduce Stigma and Discrimination

VPE presentations and materials are linguistically and culturally appropriate and available for all Orange County residents. VPE also uses trained professionals, school staff and peers to facili- tate participant engagement and learning. The tracks utilize various methodologies to maximize the program's impact within different populations and to provide services that are sensitive and responsive to participants' backgrounds.

Crisis Response Network: After today's presentation, I will try to do the following:

FY 2017-18

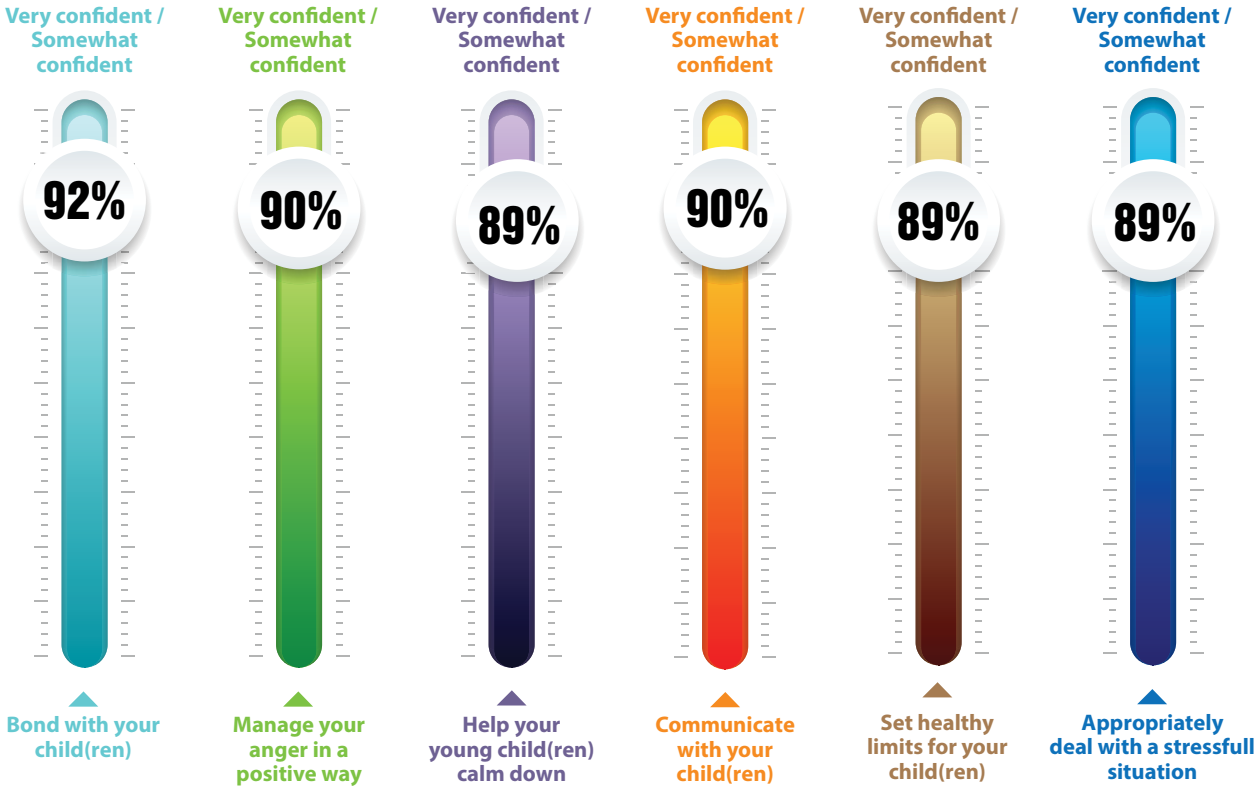


FY 2016-17

Crisis Response Network: The Crisis Response Network coordinates and manages a roster of trained crisis responders who are ready to mobilize and assist a school or community in times of emergency, need or threat. Responders are trained in Crisis Incident Stress Management. The Network also uses of crisis dogs to assist students reduce stress and tension associated with trauma and to provide emotional support. This track also conducts assemblies on cyberbullying in schools.

Percent of Parents Rating Confident by Item - Safe From the Start

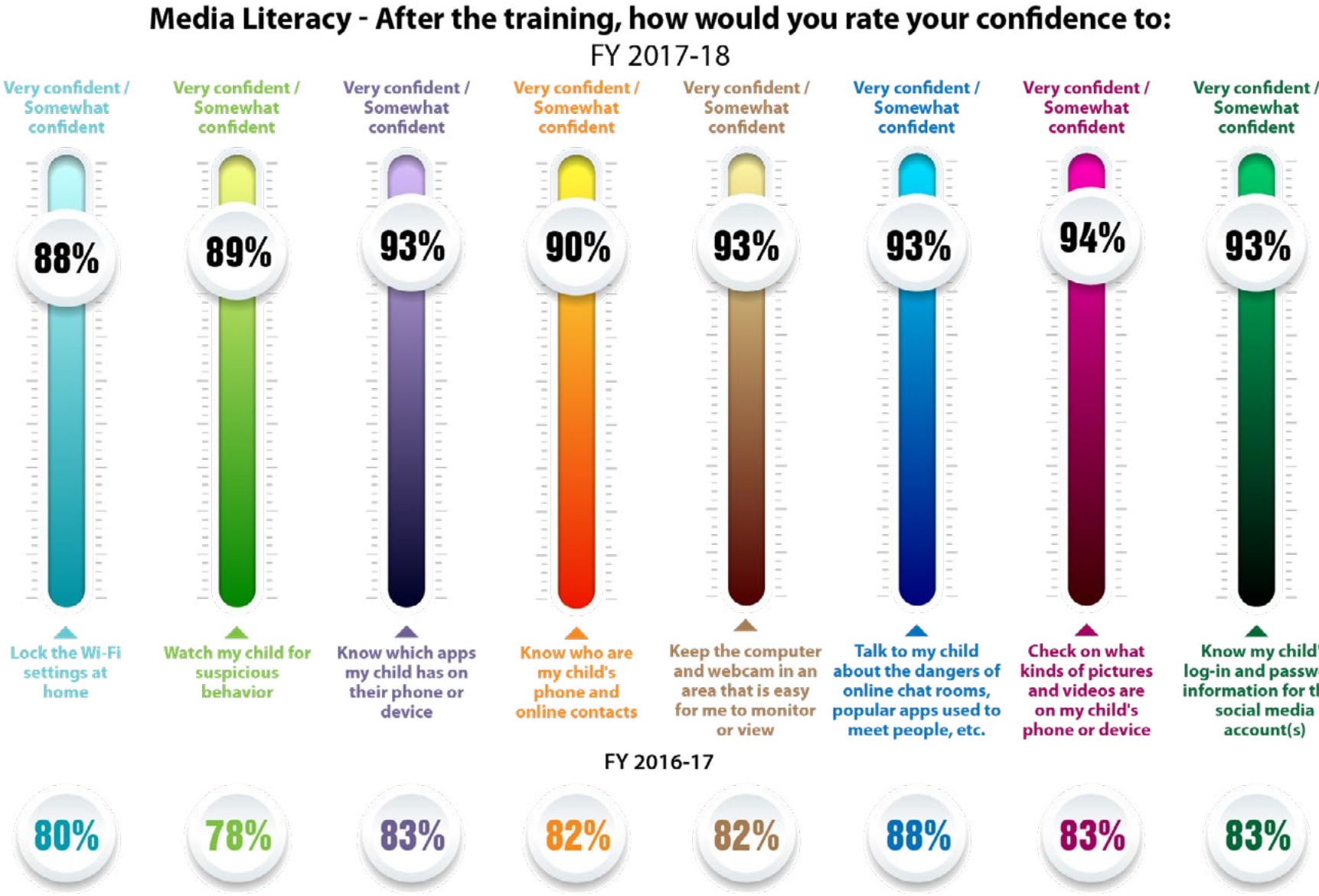
FY 2017-18 (n=659)



FY 2016-17 (n=567)

70% | 65% | 68% | 69% | 67% | 66%

Safe From The Start: Safe From The Start provides parents with essential knowledge regarding the brain development of young children. More specifically, this track disseminates scientific research on how children's exposure to violence, whether through direct physical contact or as a witness, can impact their neurological development which may then, in turn, compromise their cognitive, social and emotional development. Safe From The Start presenta- tions are provided to parents at school during and after school hours and also at shelters where they are presented as a three-part series. The overwhelming majority of participants reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training.



Media Literacy – The Media Literacy track provides presentations for students, parents and school staff in an effort to reduce students' use of digital media in digital harassment, cyber-bullying, bullying and exploitation. Following the presentations, participants reported feeling confident in their ability to take steps aimed at decreasing use of digital media to engage in digital children's risk for digital harassment, bullying and/or exploitation.

Challenges, Barriers and Solutions in Progress

The program has found the need to adjust service delivery by focusing on new or modified curricula and/or approaches that serve students and parents in a larger group setting. This has resulted in trainings that are often held in one assembly rather than across multiple classroom sessions in an effort to meet the changing scheduling needs of participating schools and districts.

Community Impact

The program has served 44,633 students, 3,585 parents, and 1,124 teachers/staff in FY 2017-18. The program has provided services to more than 157,866 students, 27,460 parents, and 7,238 schools staff since its inception in August 2013, with the goal of reducing violence and its impact in schools, neighborhoods and families. The program has had a strong impact in local communities by increasing awareness about the risks posed by violence and bullying, providing support in times of crisis, and creating educational opportunities for students, staff, parents and Orange County residents.

School Readiness / Connect the Tots (PEI)

Program Serves	Symptom Severity			Location of Services					Population Characteristics							
																
0-8	At-Risk	Early Onset	Mild-Moderate	Home	Field	School	Workplace	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring Medical	Students

The program provides services in English, Spanish, Vietnamese, Korean, Arabic and Farsi.

Target Population and Program Characteristics

School Readiness/Connect the Tots serves families with children ages 0-8 years who are exhibiting behavioral problems that put them at increased risk of developing mental illness (as determined by behavioral and socio-emotional screening tools) and of school failure. These families often face issues related to crowded living conditions, neighborhoods affected by gangs and drugs, a history of violence in the family, and history of separation from loved ones. Many of the families served are also monolingual (i.e., Spanish and Vietnamese).

Services

The program, which was expanded during FY 2018-19 provides prevention and early intervention services aimed at reducing risk factors for emotional disturbance in young children, promoting school readiness and preparing them for academic success. Services include child and family needs assessments, parent education/training and coaching, case manage- ment, and referral and linkage to community resources. Triple P techniques are used to provide parenting education, training and coaching.

Strategies to Promote Recovery/Resilience

By identifying risk factors and intervening early, the program promotes resilience through resources and supports that are best matched to the child's and family's needs. These often include strategies to promote self-care, appropriate bonding and positive communication. By providing assessments and services in the home, program staff also observe and identify young children's needs in the environment in which they are occurring. Completing parenting training curriculum directly in the families' homes also increases the chances of parents successfully implementing the techniques learned.

Strategies to Increase Timely Access to Services for Underserved Populations

Providers are utilizing Early Development Index (EDI) data to outreach to families for screening and assessment strategically. Timely access to services is facilitated by clinicians who meet with participants wherever the parent would like to meet, whether in the home or in the community. Thus, there are no barriers regarding transportation or childcare. Moreover, by seeing participants in their homes, program staff has the opportunity to see and work with the entire family rather than only those who are able or willing to attend appointments scheduled in a traditional clinic setting.

Program staff also works with the parents to identify appropriate referrals for ongoing services and support as they prepare to discharge from the program. Staff often facilitate connections by providing a "warm hand-off" such as completing and forwarding a referral form (after the Authorization to Disclose is signed by the participant's parent) or directly assisting the parent with a phone call to the new agency. Compared to FY 2016-17, a total of 873 children and 1,130 parents were served during FY 2017-18, and 861 children and 1,035 parents in FY 2016-17. In FY 2017-18, School Readiness/Connect the Tots provided 820 referrals and 318 linkages to special needs and disability services; behavioral health outpatient, prevention, and early intervention programs; information and referral resources; family support services; recreation activities; and basic needs (i.e., donated items). By comparison, School Readiness/Connect the Tots provided 478 referrals and 204 linkages during FY 2016-17 to similar referral and linkage categories.

Strategies to Reduce Stigma and Discrimination

The program strives to make services available to all Orange County residents and to be sensitive and responsive to participants' backgrounds. Staff helps educate participants on behav-

Impact on Parental Self-Efficacy by FY

School Readiness/Connect the Tots

ioral health issues and normalize experiences when appropriate in an effort to decrease stigma associated with help-seeking.

Outcomes

During FY 2017-18, a total of 873 children and 1,130 parents were served. This is comparable to the number served during FY 2016-17, in which a total of 861 children and 1,035 parents were served. Parents were administered the Parenting Children and Adolescents Scale-Self-Efficacy (PARCA-SE) at baseline and follow-up to assess for changes in overall parenting self-efficacy, support of good behavior, limit setting, and proactive parenting to help prevent the development of serious emotional disturbance in children living in at-risk environments. The PARCA-SE is culturally sensitive, as it has been validated for use among diverse racial and ethnic groups (i.e., White, Hispanic, Black, Native American, Asian, Native Hawaiian, Biracial, or Other), and is available in multiple threshold languages.

Results from FY 2017-18 for PARCA-SE data show that School Readiness/Connect the Tots services made large impacts on parents' overall self-efficacy, support of good behavior, limit setting, and proactive parenting. By comparison, the impact was moderate for all domains listed during FY 2016-17. Together, these findings demonstrate an increased impact of these services on parental self-efficacy across the two fiscal years. It is hypothesized that because services were expanded and offered to families in greatest need from all regions of the county during FY 2017-18 (as opposed to contracted services being restricted to the South region in FY 2016-17), families most willing to commit and engage in services across all regions likely participated and benefited from these services in the most recent fiscal year. HCA will continue to explore this and other hypotheses for the increased impact between fiscal years.

Challenges, Barriers and Solutions in Progress

The EDI data indicated that there were several areas of high need that were not covered by existing School Readiness services/CTT services. Therefore, for FY 2018-19, services were expanded with an additional provider to create a School Readiness collaborative to cover all Orange County. Additionally, PEI revamped the service delivery model to create a continuum of services where School Readiness services would focus mainly on screening and assessment and short term parenting sessions. CTT services were redesigned to accept referrals solely from the School Readiness collaborative to serve those indicating higher assessed needs and/or needed longer term parenting services.

Community Impact

The program has provided services to thousands of participants since its inception in July 2011. Staff regularly work with school and Head Start personnel, physicians and nurses to connect families to services. By helping prepare children to participate in a classroom setting, the program works to decrease the potential for school failure, which can be a risk factor for the development of mental illness.

[1]Reference Notes

Supporting Good Behavior:
2017-18, Baseline M=6.0, SD=0.9; Follow-Up M=6.6, SD=0.5; t(298)=-12.65, p<.001, Cohen's d=0.80
2016-17, Baseline M=5.8, SD=1.1; Follow-up M=6.2, SD=0.8; t(334)=-7.97, p<.001; Cohen's d=0.45

Setting Limits:
2017-18, Baseline M=5.2, SD=1.3; Follow-Up M=6.4, SD=0.7; t(298)=-17.57, p<.001, Cohen's d=1.11
2016-17, Baseline M=5.1, SD=1.3; Follow-up M=5.8, SD=1.0; t(334)=-11.28, p<.001; Cohen's d=0.63

Proactive Parenting:
2017-18, Baseline M=5.3, SD=1.3; Follow-Up M=6.5, SD=0.7; t(298)=-17.65, p<.001, Cohen's d=1.13
2016-17, Baseline M=5.1, SD=1.4; Follow-up M=5.9, SD=1.0; t(334)=-11.62, p<.001; Cohen's d=0.66

Overall Score:
2017-18, Baseline M=5.5, SD=1.1; Follow-up M=6.5, SD=0.6; t(298)=-18.49, p<.001, Cohen's d=1.18
2016-17, Baseline M=5.3, SD=1.1; Follow-up M=5.9, SD=0.9; t(334)=-11.86, p<.001; Cohen's d=0.67

School-Based Stress Management Services (PEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics	
					
6 - 17	At-Risk	Early Onset	School	Students	Staff/Providers/ Workforce

The program provides services in English.

Target Population and Program Characteristics

School-Based Stress Management Services (SBSMS) provides training to teachers (Kindergarten through 12th grade) as a way to support students' well-being, academic performance and socioemotional growth. The program is open to Orange County teachers from private, public and non-public schools. Two teachers per school can receive training, and teachers are selected for training based on their ability to meet the program's attendance requirements.

Services

This prevention program strives to reduce the risk of mental illness resulting from unhealthy coping strategies among youth by building protective factors. To achieve this, teachers attend trainings where they learn a variety of resilience, stress management and self-awareness strategies and how to incorporate them in their classrooms. Skills taught include breathing, cognitive reframing and other relaxation practices. Teachers are also taught to recognize the signs and symptoms of stress and its impact on the mind, body, learning and socioemotional development. The curriculum is promoted as a "tool-box" from which teachers may select age-appropriate and culturally-sensitive strategies.

The program also includes a component where a staff member observes teachers implementing the various mindfulness techniques in the classroom and follows-up with a debriefing session. This provides teachers the ability to adjust their techniques based on the feedback provided.

Strategies to Promote Recovery/Resilience

School-Based Stress Management Services promotes resilience by educating teachers and, indirectly, their students, on how to recognize and manage stress in healthy, adaptive ways. The strategies taught through the program promote well-being, mind-body awareness and socio-emotional development.

Strategies to Increase Timely Access to Services for Underserved Populations

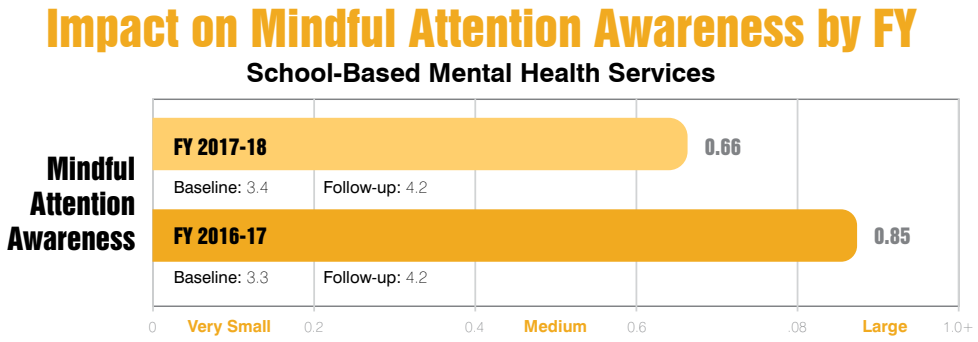
By providing stress management and mindfulness techniques directly in the classroom when they are needed, the program provides immediate access to its services that bypasses barriers such as transportation, child care, scheduling conflicts and/or stigma that may be encountered with more traditional services.

Strategies to Reduce Stigma and Discrimination

The program strives to make its services available to students and teachers in participating schools and to provide services that are sensitive and responsive to participants' backgrounds. The program also specifically trains teachers to use practices that incorporate culturally-sensitive considerations so that the program is inclusive for students from diverse backgrounds. Implementing the program directly in classrooms expands its reach to a large number of students who might not otherwise access mental health services provided in more traditional settings.

Outcomes

In FY 2017-18, the program reached 77 teachers who taught 4,094 students in 29 schools across 18 school districts. In FY 2016-17, the program reached 64 teachers who taught 3,033 students in 27 schools across 14 school districts. Teachers were administered the Mindful Attention Awareness Scale at baseline, every three months and at discharge (FY 2017-18: n=77, FY 2016-17: n=64). Teachers reported similar gains in mindful attention awareness in both years as a result of the training. These gains produced medium and large effect sizes over two years of tracking. Student increases in self-awareness are anecdotal but suggest strongly that students employ the breathing and mindfulness skills taught by participating teachers.



Challenges, Barriers and Solutions in Progress

Due to the inherent nature of a classroom setting, time constraints can impact conditions ideal for implementing the mindfulness techniques, particularly for secondary teachers. In FY 2016-17, the program had fewer high school teachers recruited for training than anticipated, resulting in fewer secondary students being served the first year. The program is working to create a balance between the number of elementary teachers and secondary teachers who are trained in order to better meet the needs of the Orange County learning community.

Community Impact

The program has already provided services to more than 7,191 students and 141 teachers since its recent inception in October 2016 and initial outcomes indicate that the program is having a positive effect in Orange County classrooms.

Reference Notes

Mindful Attention Awareness:
2017-18, Baseline M=3.4, SD= 0.8; Follow-up M= 4.2, SD=0.7, t(76) =-5.77, p<.001; Cohen's d=-0.66
2016-17, Baseline M=3.3, SD=0.8; Follow-up M=4.2, SD=0.6; t(64)=-6.74, p<.001; Cohen's d=-0.85

School-Based Mental Health Services – Prevention Track (PEI)

Program Serves	Symptom Severity	Location of Services	Population Characteristics	
11-15	At-Risk	School	Parents	Students

The program provides services in English and Spanish.

Target Population and Program Characteristics

The prevention track of School-Based Mental Health Services (SBMHS) works with students who are transitioning between elementary and middle school or between middle and high school and their parents. The program conducts outreach to local schools and districts to identify interest in program services. The early intervention track, which provides outpatient services to individuals, is described in the Outpatient Services section.

Services

The SBMHS prevention track utilizes a classroom-based curriculum to provide psychoeducation to students on topics such as healthy relationships, appropriate communication of feelings, bullying, mental health symptoms and substance use. The instruction is designed to increase resilience and build protective factors as students transition to a new school setting. Parent sessions are offered at schools in the evening to update parents on the topics their children are learning in class, share facts about addiction and the different classes of substances that are commonly abused and teach families how to manage stress and stay connected despite busy schedules. The curriculum is facilitated by clinicians and seeks to engage students through the use of slide presentations, online videos and interactive classroom activities.

Strategies to Promote Recovery/Resilience

To help promote recovery and resilience among students, their social networks are engaged to create a supportive environment. The program creates buy-in from school partners and families by helping them understand that increased participation in the program promotes resilience, which can help prevent problems later in life.

Strategies to Increase Timely Access to Services for Underserved Populations

SBMHS encourages access by providing services on campus, which reduces potential barriers related to transportation, scheduling and/or reluctance to seek services in traditional mental health setting.

Strategies to Reduce Stigma and Discrimination

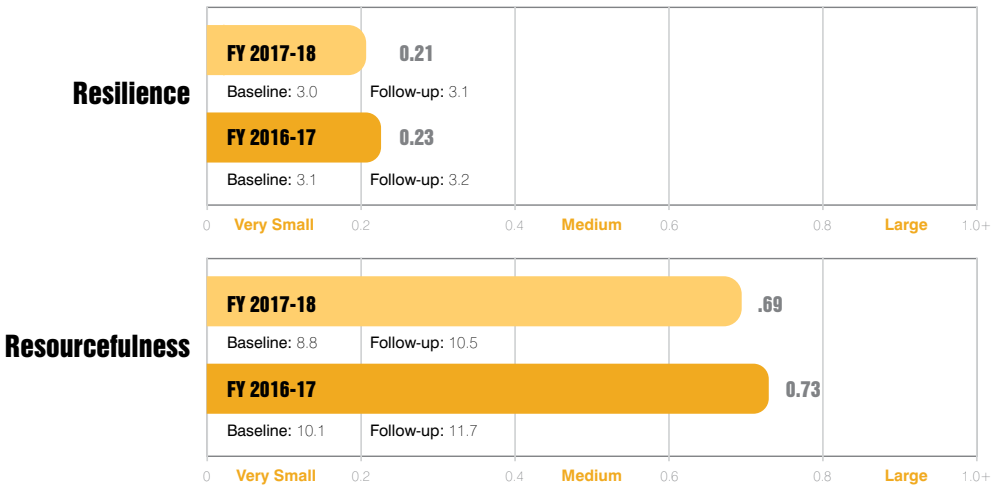
SBMHS reduces stigma through a two-fold process. First, by providing presentations on mental health and wellness to students and parents, SBMHS works directly to counter stigma and misperceptions that may exist within the community. Second, by delivering the classroom-based psychoeducation on campus, students and parents may be more willing to access services because there is less stigma associated with events hosted at schools compared to those provided in traditional mental health settings.

Outcomes

The program served 2,182 students in FY 2017-18. In FY 2016-17, the prevention track served 2,039 students. This track is intended to provide students with coping skills that will allow them to address any existing behavioral health problems more effectively. The program aims to measure reductions in or prevention of prolonged suffering through the YOQ® 30.2. In 2017-18, 404 participants completed both the baseline and follow-up. Of the 404 with paired assessments, 81% reported a healthy or reliably improved level of distress at follow-up, thus demonstrating that SBMHS was associated with preventing symptoms

Impact on Youth Protective Factors by FY

School-Based Mental Health Services



of mental illness from becoming severe and disabling for the majority of individuals receiving program services.

Intake and follow-up surveys were completed by 875 students in 2017-18, and 1,726 students in 2016-17. The program appeared to have a medium-to-large impact on increasing resilience and a small impact on increasing resilience across both fiscal years. Thus, the program appears to be associated with increasing protective factors among students, particularly with regard to resilience.

Challenges, Barriers and Solutions in Progress

In FY 2017-18 the two tracks, which had been operating as separate programs, were merged. The merger allows for greater flexibility in meeting the needs of local school districts by increasing the number of staff available to provide both prevention and early intervention services. One of the challenges faced during FY 2017-18, which impacted the number of participants served, was that existing partnered sites made changes to their core curriculum that resulted in a pause of SBMHS prevention services at these sites. Once these sites worked out the scheduling of the required core curriculum, SBMHS prevention services were re-integrated back into school programming. This pause allowed for staff providing the prevention services to assist in the schools by providing the early intervention services because of staff vacancies. In addition, some of the partner school sites opted for Alcohol and Drug curriculum instead, further lowering the number of students served. The program continues to reach out to new schools and school districts for expanding the reach of the program.

Community Impact

SBMHS collaborates with school districts throughout Orange County to provide its prevention services and is currently providing early Intervention services in two large school districts. Through these efforts, the program has reached more than 18,000 participants since its inception in July 2015. Program staff also receive regular in-service training on topics and resources available to the communities they serve in order to best meet the needs of the students and their families.

Reference Notes

Youth Survey Resilience:
2017-18, Baseline M=3.0, SD= 0.6; Follow-Up M=3.1, SD=0.6, t(874)=-20.48, p<.001, p<.001; Cohen's d=0.21
2016-17, Baseline M=3.1, SD=0.5; Follow-Up M=3.2, SD=0.5; t(1726)=-9.69, p<.001, p<.001; Cohen's d=0.23

Resourcefulness:
2017-18, Baseline M=8.8, SD= 2.8; Follow-Up M= 10.5, SD=2.7, t(874) = -20.48, p<.001; Cohen's d=0.69
2016-17, Baseline M=10.1, SD=2.4; Follow Up M=11.7, SD=2.1; t (1724) = -30.25, p<.001; Cohen's d=0.73

Gang Prevention Services (PEI)

Program Serves	Symptom Severity	Location of Services			Population Characteristics	
9-15	At-Risk	Field	School	Hospitals	Parents	Students

The program provides services in English and Spanish.

Target Population and Program Characteristics

Gang Prevention Services (GPS) is a school-based collaboration with the Gang Reduction Intervention Partnership (GRIP) operated by the Orange County District Attorney's Office in conjunction with the Probation Department, local Police Departments and school staff.

GPS provides case management to 4th through 8th grade youth who display signs of being at risk for gang activity which, in turn, places them at an increased risk of violence and of developing mental health conditions, particularly those that are trauma-related. Schools are selected to participate in the program by the Orange County District Attorney's Office and the Orange County Probation Department based on high levels of truancy, discipline issues and gang proximity. The program also focuses on being inclusive of all high-risk youth regardless of their familial affiliations to gang activity or behavior.

Services

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

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

Strategies to Promote Recovery/Resilience

The program promotes resilience by providing psychoeducation and case management aimed at building adaptive coping and positive decision-making skills in at-risk youth. For youth receiving case management, wraparound activities such as soccer camps, homework clubs and incentive events encourage and motivate youth to reach their goals. GPS staff also works with parents to help them find ways to support their child and increase the transfer of skills learned in the classroom to home and other environments.

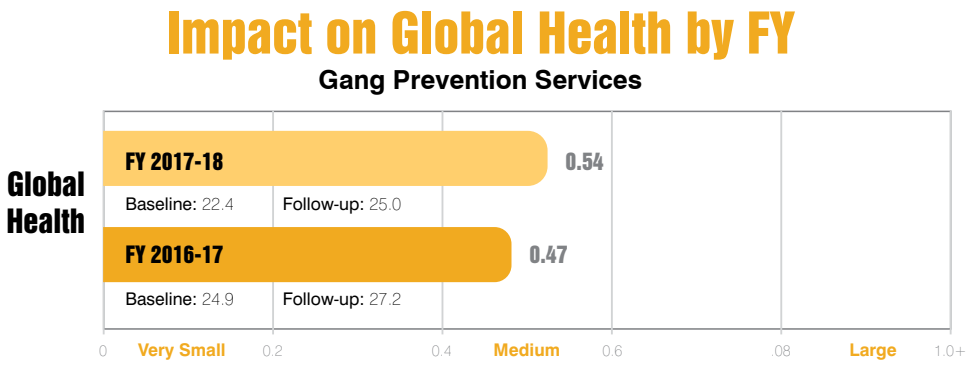
Strategies to Increase Timely Access to Services for Underserved Populations

GPS improves access to its services by identifying schools with the highest levels of truancy, discipline issues and gang proximity and then co-locating its program on those campuses. This school-based approach is particularly helpful for students and their parents/caregivers who might otherwise be isolated when not in the school setting. GPS also has staff who are bilingual in English and Spanish to facilitate engagement in the program by the target population.

For youth and families in need of additional services and supports, the program also refers them to community resources. The program provided 1,360 referrals and 1,050 linkages in 2017-18, which is considerably more than the 866 referrals and 634 linkages provided in FY 2016-17. The program primarily referred and linked individuals to counseling services, adult literacy programs, housing and food assistance, medical care, school supplies, and enrichment activities.

Strategies to Reduce Stigma and Discrimination

The program strives to provide services that are linguistically and culturally appropriate and enlists the help of trained professionals, school staff, law enforcement and local celebrities to encourage participation in its program activities. These individuals present a positive role model and motivate the parents and students to feel empowered to participate in the behavior contracts.



Outcomes

A total of 427 students in 39 schools across 11 districts were served in FY 2017-18, and 426 students in 34 schools across 8 districts were served in FY 2016-17. To measure the extent to which the program increased the protective factor of health and well-being, students completed the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. The change in scores between baseline and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students served. In FY 2017-18 and FY 2016-17, the program was associated with moderate gains in global health. Additionally, 82% students increased attendance; 76% decreased truancy and 75% decreased curfew violations.

Challenges, Barriers and Solutions in Progress

In GPS, case managers are constantly encouraging parents to engage with their child by facilitating the establishment of positive social support networks. This is accomplished by creating an open environment with other parents, the school and local law enforcement. The program assists with this coordination by offering parents opportunities to be involved as greeters at their child's school and by encouraging an environment of rapport building with law enforcement. This is an innovative strategy as many communities are often intimidated by law enforcement officials. Youth and their families also meet regularly with case managers to resolve and overcome challenges related to truancy or other school-related behavioral issues in an effort to deter future gang involvement.

Community Impact

GPS has provided services to more than 3,931 students and parents since its inception in August 2013. Through its case management services, the program has encouraged youth to avoid high-risk behavior and be more involved in positive decision-making. The program has also strengthened relationships with the community by partnering with organizations and businesses such as the Los Angeles Angels of Anaheim. Through these collaborations, agencies are able to educate and motivate students and to serve as mentors for future career possibilities. The Californian State Association of Counties, which highlights effective and innovative prevention and intervention programs across California, selected GPS for this honor in 2014. The GPS program continues to receive awards for working with Orange County schools on gang suppression, interventions for at-risk students, gang information forums and parent/faculty education.

Reference Notes

[1] ***PROMIS Global Health 7:***
FY 2017-18: Baseline M=22.4 SD=3.0; Follow-up M=25.0, SD=3.92; t(338)=-9.85, p<.001; Cohen's d=-0.54
FY 2016-17: Baseline M=24.9, SD=4.3; Follow-up M=27.2, SD=4.1; t(100)=-9.46, p<.001; Cohen's d=-0.47

Education and Behavioral Health Support Services for Transitional Age Youth (TAY) and Young Adults (PEI)

Target Population and Program Characteristics

The transition from adolescent to young adulthood brings numerous challenges for all youth, and particularly so for those with who are at risk or are exhibiting early signs of emotional and/or behavioral health concerns. The goal of these services is to support the resilience and recovery of TAY who are 16-25 years old, including those who are in traditional educational settings and those not in these settings. TAY, including those in the foster care system are particularly vulnerable as these individuals often "age out" of programs traditionally offered at schools and other child-serving behavioral and social service programs resulting in a gap or loss of services.

Services

The Education and Behavioral Health Support Services for TAY and young adults are new services for FY 2019-20 that seek to specifically support and engage TAY and reduce the risk of mental health conditions from becoming worse. Services will seek to promote resilience in these youth by building on protective factors and addressing the risk factors. The program will collaborate with schools, college campuses, LGBTQ alliances, social services agencies and community based organizations. Service delivery will adopt a peer-to-peer model and utilize evidence-based best practices that will be culturally and linguistically responsive. Services will include outreach, education, stigma reduction, and suicide prevention activities for high risk TAY. Targeted outreach will occur to identify and engage TAY who are LGBTQ, men of color, women, veterans and homeless, TAY who are transitioning out of the foster care system, TAY who are transitioning into college and TAY who are not engaged in school settings.

K-12 School-Based Mental Health Services Expansion (PEI)

Target Population and Program Characteristics

With 28 school districts in Orange County with varying levels of resources and need, better equipping schools in the early identification of a mental health condition and intervening as soon as possible is the ultimate goal of this service expansion.

Services

These new services will seek to implement strategies and services that have the largest impact across K-12 school districts in Orange County utilizing evidenced-based prevention strategies serving teachers, parents/caregivers, and students. Services will include large scale trauma-informed teacher and staff training for identifying the early warning signs of mental illness, learning how to communicate and effectively engage students who are struggling and understanding how to access resources. Similarly, educational trainings will be made available to parents, caregivers and families to support early identification and access. Services will include cost effective peer-support models for students, parents and families in further supporting those most in need of support. In addition, services will include school-based suicide prevention and stigma reduction campaigns and activities to further extend the reach. Finally, services will include educational and networking forums for schools and school districts to further learn from each other, including about resources and efforts that are successful and making a difference.

COMMUNITY TRAINING

Prevention: Community Training	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Religious Leaders Behavioral Health Training Services (INN)*	Transition to existing training programs	N/A	N/A
Training, Assessment and Coordination Services (PEI)	N/A	$700,000	N/A
Early Childhood Mental Health Program (PEI)	TBD	$400,000	TBD

** Project coming to an end.*

As part of its Prevention services, Community Training programs provide mental health trainings throughout Orange County. The training offered through this service area differs from that offered through the Workforce Education and Training service area in that the former focuses on serving community members, agencies, partners and providers, and the latter generally focuses on serving County-operated and County-contracted providers. Orange County currently has two community-focused training programs – one funded through Innovation and the other through PEI, which are described below.

Religious Leaders Behavioral Health Training Services (INN)

Target Population and Program Characteristics

The Religious Leaders Behavioral Health Training Services project serves religious leaders and community members of all faiths in Orange County.

Services

The project is designed to increase access to needed behavioral health services by utilizing a train-the-trainer model that provides basic behavioral health skills training to religious leaders. Project staff (i.e., training coordinators) conducts outreach at various places of worship located throughout Orange County to recruit and enroll religious leaders into an 8-hour train-the-trainer course. Trained religious leaders, in turn, provide a 4-hour basic behavioral health skills training to their congregants and community members. Training content for the religious leaders and community members includes culturally competent information and open discussion about the impact of culture and religious beliefs on mental illness and recovery; the cultural impact of stigma; cultural barriers to accessing treatment; cultural variations in defining mental health; and spirituality as a protective factor to address stigma and the effect on their community. All trainings are provided in a group setting and offered at various locations throughout Orange County.

The Religious Leaders Behavioral Health Training Services project was approved by the Mental Health Services Oversight and Accountability Commission on April 24, 2014. The primary purpose is to increase access to mental health services, with the 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.

This project was approved by the Mental Health Services Oversight and Accountability Commission on April 24, 2014. The primary purpose of this project is to increase access to mental health services, with the 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. The project was implemented July 1, 2015. Innovation funds for this project will end June 30, 2020. Successful components of the training model will continue to be provided, as needed, through existing BHS training programs.

Strategies to Promote Recovery/Resilience

Culturally specific information is integrated into the training materials to raise awareness about mental illness within different ethnic communities, identify barriers to seeking help, and provide strategies to support individuals experiencing symptoms of mental illness. A section of the 8-hour train-the-trainer curriculum focuses on the recovery model and identifies the various sources of support during an individual's recovery process (i.e., religious leaders, cultural healers, healthcare providers, family members, etc.).

Strategies to Improve Timely Access to Services for Underserved Populations

This training offers a promising new strategy to improve timely access to behavioral health care, as many community members seek guidance from their pastors and religious leaders during crisis, especially among ethnic communities. A portion of the train-the-trainer curriculum for religious leaders focuses on the County and community behavioral health resources available for individuals struggling with symptoms of mental illness. The religious leaders, in turn, impart

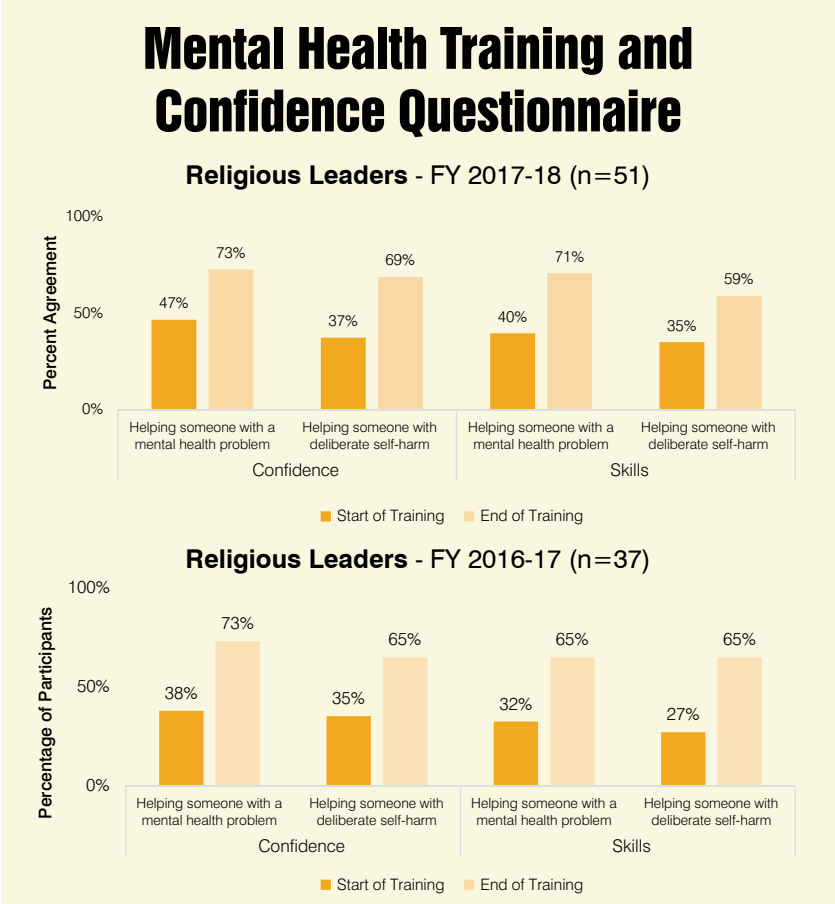
their knowledge of these resources to community members, thus serving as a gateway to behavioral health services. The training not only raises awareness about available resources, but also provides religious leaders with the knowledge and ability to better support their community members during a mental health crisis.

Strategies to Reduce Stigma and Discrimination

An essential portion of the curriculum is devoted to defining stigma, discussing its impact on individuals and their families, and identifying strategies to reduce stigma. Interactive group discussions and activities are integrated throughout the trainings to engage participants in active discussion about the definition and impact of stigma.

Outcomes

In FYs 2016-17 and 2017-18, religious leaders completed a County-created Mental Health Training and Confidence Questionnaire before and after receiving the 8-hour training. The questionnaire asked religious leaders to rate the degree to which they felt comfortable and had the skills to help someone with a mental health problem or with thoughts/behaviors of self-harm. Results suggest that religious leaders enrolled in the project felt more confident to help those with a mental health diagnosis after participating in the trainings.



Religious leaders also completed the Knowledge, Attitudes, and Beliefs about Mental Health survey before and after each training. However, project staff noted challenges in the phrasing, interpretation and meaning of questions. It was determined that this outcome measure was not adequately capturing perceptions about mental health. As a result, the measure was discontinued and replaced with the Beliefs and Attitudes about Mental Health survey. Outcomes for this survey will be reported in future Plan Updates.

Challenges, Barriers and Solutions in Progress

During FY 2017-18, the project continued to encounter challenges identified in previous years. The most significant challenge continues to be the time commitment required of religious leaders to not only attend the 8-hour train-the-trainer course, but also facilitate a 4-hour training on their own. Despite a significant change to the curriculum content and length of trainings, religious leaders continued to express difficulty in committing to these trainings. To address this challenge, project staff continued to provide increased support to religious leaders to reduce their time spent in planning and preparation for their 4-hour trainings. Community trainings also continued to be offered at various sites with attending the training. Finally, the project experienced challenges engaging specific communities, including African American, Vietnamese, Buddhist, Jewish, Latter Day Saints and LGBTIQ. They have also had difficulties in expanding their trainings to include the Christian, Baha'i and Zoroastrian religious communities within south Orange County. In an effort to improve engagement, project staff have expanded outreach activities and are working on building key relationships to help reach these target populations.

Community Impact

This project has trained 156 religious leaders and 1,632 community members since its inception in July 2015. Upon completing the 8-hour train-the- trainer course, religious leaders were asked a series of questions to elaborate on their experience of the training. In general, religious leaders felt the training provided sufficient information about behavioral health resources, presented a helpful overview of different types of mental illness, and offered support strategies that could be useful in assisting community members. Religious leaders also expressed a better understanding of the terminology used to discuss mental illness and the triggers associated with different conditions.

Training, Assessment and Coordination Services (PEI)

Target Population and Program Characteristics

The Training, Assessment and Coordination Services program serves the PEI priority populations, their family members and any community member working with these priority populations such as first responders, probation officers and teachers. The PEI priority populations, as originally defined by the California Department of Mental Health, include trauma-exposed individuals, individuals experiencing onset of serious mental illness, underserved cultural populations, and children and youth in stressed families who are at-risk of school failure and/or juvenile justice involvement.

Services

The program is designed to provide a variety of behavioral health-related trainings and supports to better understand, identify and address the potential mental health needs of the PEI priority populations and to help these populations access and utilize local community mental health resources. Included in the program are trainings and incident responses provided by the Behavioral Health Services Disaster Response (BHSDR) Team, which included Psychological First Aid (PFA) training and Critical Incident Stress Management (CISM) group and one-on-one debrief- ings, grief-related education and self-care education.

Responses. There were 26 requests for BHSDR services that reached 256 individuals during the FY 2017 – 2018 and 18 requests that reached 185 individuals in FY 2016-17. Services included the following interventions: Psychological First Aid (PFA), Critical Incident Stress Management (CISM) group debriefings, CISM one-on-one debriefings, CISM briefings and education on grief, stress reactions and self-care.

Trainings. Thirty-three trainings were provided to 499 individuals in FY 2017- 2018. Fifty-three trainings were provided to 1,354 individuals in FY 2016 – 2017. Primarily Psychological First Aid (PFA) and Disaster Preparedness for Disaster Service Workers (DSW), the mandatory training for all Behavioral Health Services (BHS) employees was provided. Additionally, Vicarious Trauma: Impact and Skills to Help You Cope, a two hour CEU approved course, continued to be provided to BHS staff as well as BHS contract providers.

Strategies to Promote Recovery/Resilience

The training content is specifically tailored to foster recovery and resilience in the target popula- tion being served. This can include providing crisis management, self-care skill building, and/or grief education and resources. In addition, they are designed to better inform and/or prepare a wide range of community providers and potential first responders on how to identify behavioral health conditions in all age groups, how to assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively, and how to increase their knowl- edge regarding accessing behavioral health services.

Strategies to Improve Timely Access to Services

An assessment was completed to assess the County's training needs. This process involved representation from all of the PEI priority populations, including family members and providers working with these populations. Some of the needs and strategies identified included: providing more trainings in south county; providing trainings in Vietnamese, Korean and Farsi; and providing on-going technical assistance after a training to reinforce learning. In addition, the increased need for culturally-nuanced mental health awareness training, coupled with infor- mation for accessing services, was identified.

Strategies to Reduce Stigma and Discrimination

Consistent with one of the identified areas of concern in the needs assessment, trainings will specifically address the stigma and discrimination faced by those living with mental illness and those seeking services.

Outcomes

The findings from the PEI Training Needs Assessment continue to be implemented with new trainings being offered this year.

Challenges, Barriers and Solutions in Progress

A variety of strategies are being implemented to implement training services out in the community in a timely manner. They include: building training components into existing programs and/or contracting out new services.

Community Impact

During February 2018 – May 2018, BHSDR also played a large role in providing services for the Flood Control Channel (FCC) transition. BHSDR staff were called upon to join BHS Outreach and Engagement in providing various services to the population including, but not limited to, providing motel vouchers, assessing former residents of the FCC and referring and linking FCC residents to various needed services. BHSDR staff worked countless hours on the project and contributed to the success of the mission.

Early Childhood Mental Health Program (PEI)

Target Population and Program Characteristics

Children exhibiting problematic behaviors in preschool are expelled at three times the rate of school children in K-12 grades. To address this issue as well as the needs of other early childcare settings, the Early Childhood Mental Health Program is a new program for early childcare providers serving young children, particularly those who exhibit problematic behaviors and are at the risk of mental illness.

Services

Services will utilize a Promotion/Prevention/Early Intervention continuum that supports the effective management of challenging behaviors of infants and preschool children and supports a healthy social emotional development. Services will be designed to: 1) build capacity within the early education setting, and the family through education, coaching and support services, 2) identify and link families and children needing more intense supports and clinical services. Service delivery will adopt a collaborative approach across systems of education and care and utilize evidence-based best practices that will be culturally and linguistically responsive. Services will include outreach, staff training and on-site mental health consultations for early childcare providers, parent education and family support, screening/assessment and linkages to services. In the short-term, program outcomes will include: 1) an increase in knowledge of early childhood providers regarding identification of children's mental health needs and available resources, 2) a reduction in children's problem behaviors and in the long-term program outcomes will demonstrate reduced child expulsion and improvements in children's social and emotional development as reflected in improved Early Development Index social emotional data.

Individual/Family Support

Navigation/Access and Linkage to Treatment/Services

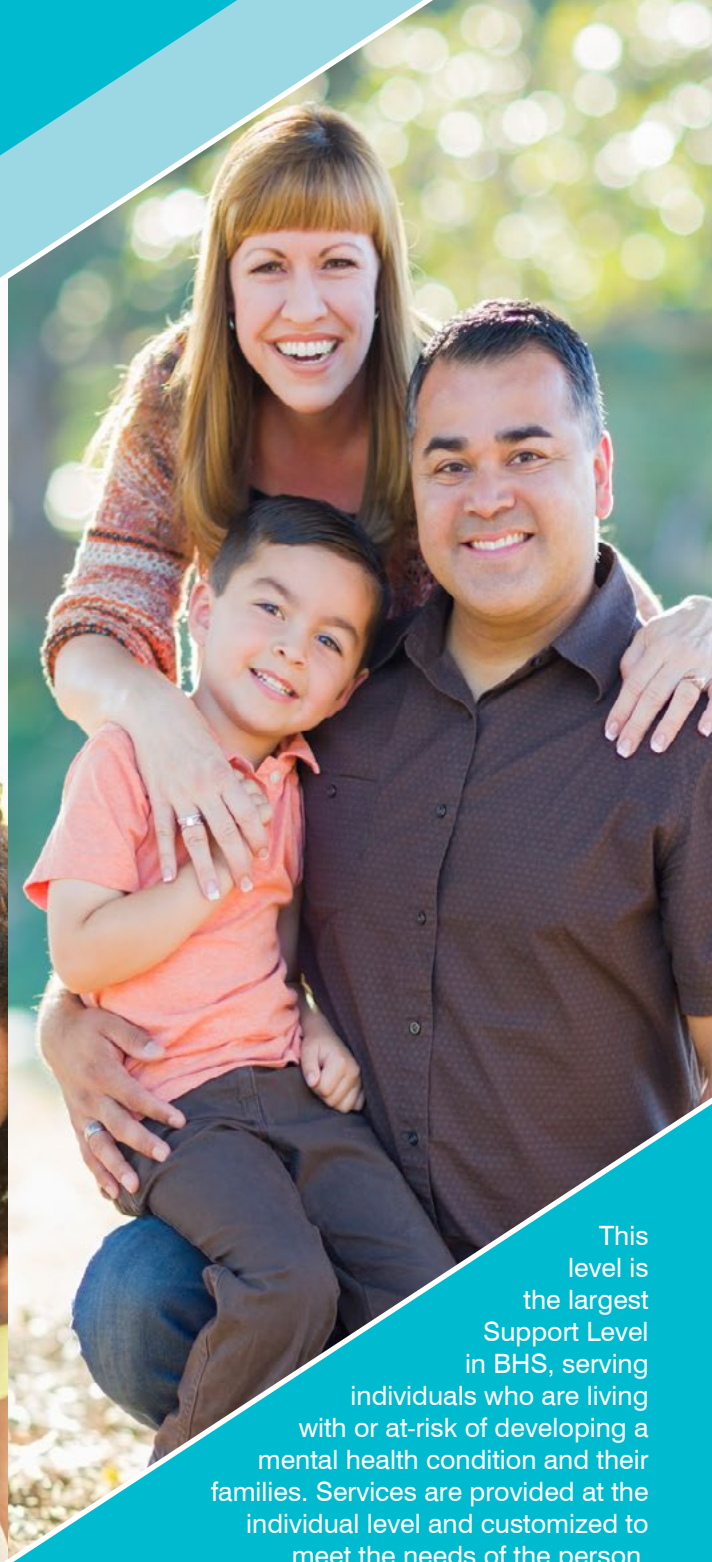
Crisis Services

Residential Treatment

MHSA Outpatient Treatment

Recovery and Supportive Services

Supportive Housing



This level is the largest Support Level in BHS, serving individuals who are living with or at-risk of developing a mental health condition and their families. Services are provided at the individual level and customized to meet the needs of the person.

NAVIGATION/ACCESS AND LINKAGE TO SERVICES

Programs that fall within the Navigation/Access and Linkage to Treatment/Services function are designed to link individuals of all ages who are living with a mental health condition to an appropriate level of care. In addition, for a program in this service function to meet the MHSOAC PEI Regulations criteria, these types of programs and/or program strategies must provide written referrals and be designed to link individuals who are living with SED or SMI to the most appropriate higher level of care.

Orange County offers several programs that fulfill this broad service function. The majority of the programs are funded by CSS and tailored to meet the needs of specific unserved populations living with SMI or SPMI (i.e. individuals who are homeless, discharging from jail or a hospital, etc.). The remaining two programs in this section are funded by PEI and serve the broader Orange County community needing assistance with navigating and/or accessing the County behavioral health system of care, regardless of the level of their behavioral health need (i.e., at-risk through severe). In addition, the Crisis Assessment Teams (described in the Crisis Services section) provide access and linkage to treatment for individuals with SED/SMI who are experiencing an acute crisis.

Navigation / Access and Linkage to Treatment/Services	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Information and Referral/OC Links (PEI)	13,800	$1,000,000	$72
Outreach & Engagement Collaborative (PEI)	3,625 (combined engaged participants)	$3,385,711	$2,259 (combined engaged participants)
BHS Outreach and Engagement (CSS/PEI)		$2,569,933 (CSS) $2,232,523 (PEI)	
Multi-Service Center – Courtyard Program (CSS)	10,000 Contacts	$900,000	$90 per contact
Recovery Centers/Recovery Clinic Services/ Recovery Open Access (CSS) *	3,500	$8,458,531	$2,417
Assisted Outpatient Treatment (CSS) ** Access and Linkage Team	909 calls; 562 referrals;	$845,400 Access and Linkage	$1,504 (per referral)
CHS Jail to Community Re-Entry (CSS)	TBD	$2,600,000	TBD

* *The Recovery Centers/Recovery Clinic Services/Recovery Open Access figures include numbers for all three programs. Recovery Centers/Recovery Clinic Services is described in Outpatient Services.*

** *The Assisted Outpatient Treatment total budget for both the Assessment and Linkage Team and the AOT Full Service Partnership is $5,015,841. The numbers reported above reflect the AOT Access and Linkage Team only.*

Information and Referral/OC Links (PEI)

Program Serves	Symptom Severity				Location of Services	Population Characteristics										
																
	At-Risk	Early Onset	Mild-Moderate	Severe	Telephone/ Internet	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Students	Criminal Justice	Staff/ Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic and Telecommunications Device for the Deaf (TDD) number for hearing impaired.

Target Population and Program Characteristics

OC Links is a Behavioral Health Services (BHS) Information and Referral Line that serves anyone seeking information or linkage to any of the BHS programs. Because the Navigators who staff the line are clinicians, they are able to work with callers experiencing any level of behavioral health issue.

Services

Serving as the single access point for the HCA/BHS System of Care, OC Links provides telephone and internet chat-based support for any Orange County resident seeking HCA behavioral health services. Trained Navigators provide screening, information and referral and linkage directly to BHS programs that best meet the needs of callers. Navigators make every attempt to connect callers directly to services while they are still on the line. Once the caller is scheduled for their first appointment, the Navigator offers a follow-up call within the next 1-2 days to ensure a linkage has occurred.

OC Links operates from 8 a.m. to 6 p.m., Monday through Friday. During these hours, callers may access navigation services through a toll-free phone number (855-OC-Links or 855-625-4657) or a Live Chat option available on the OC Links web page (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).

Strategies to Promote Recovery/Resilience

OC Links provides trained navigators who are consumer-centered and focused on reducing barriers to client engagement in services. Navigators use recovery principles and techniques such as motivational interviewing to help engage individuals in their recovery journey.

Strategies to Increase Timely Access to Services for Underserved Populations

To increase awareness and usage of OC Links services among unserved and underserved populations in Orange County, various advertising strategies in multiple languages have been used. For example, OC Links displays its information and phone number on rotation every day at the Civic Center Plaza message board; has advertised on Public Access Cable Television Community Resource displays; and has posted advertisements on Facebook and Twitter that direct people to the OC Links website where they can obtain information and connect to Live Chat with the Navigators. Information cards in all of the threshold languages are also handed out at many locations throughout the county, including schools, colleges, community organizations, businesses, court houses, libraries and resource fairs.

Once an individual connects with OC Links, they can work with a Navigator who speaks English, Spanish, Vietnamese, Korean, Arabic or Farsi. The program also has access to a language line translation service to meet the language needs of any caller and offers a Telecommunications Device for the Deaf (TDD) number (714-834-2332) for hard of hearing callers. OC Links

responded to 17,509 callers in FY 2017-18 and provided 15,018 referrals over the phone that resulted in 4,782 linkages. This was a slight increase from the 14,152 callers in FY 2016-17 who were provided 16,798 referrals over the phone that resulted in 4,456 linkages. Across both fiscal years, the top linkage categories were outpatient mental health and substance use programs (all ages) and prevention and early intervention services.

Strategies to Reduce Stigma and Discrimination

OC Links has continually prioritized cultural competence in all aspects of the program. Clinicians hired are bilingual/bicultural (see grid) and regularly provide outreach trainings on OC Links and the HCA BHS system of care at community agencies, religious organizations, apartment complexes and resource fairs that have a specific cultural focus in their threshold language. Staff also provides trainings to the general community at community events, resource fairs, and to law enforcement hundreds of times per year. With this increased presence in the community, OC Links hopes to reduce the stigma and discrimination attached to those attempting to reach out for behavioral health services.

Due to their bicultural background and training, each Navigator is also able to match callers to the service or program that best meets their cultural needs. Many callers have remarked that having a Navigator who speaks their language has reduced the amount of stigma they felt when reaching out for mental health or substance use services.

Challenges, Barriers and Solutions in Progress

Increasing community awareness about OC Links and the services available through the County is a constant challenge that must continually be addressed. In order to better educate the public about OC Links on an on-going basis, a short video about the program was created and placed on the HCA website. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County BHS.

Community Impact

The program has responded to more than 62,500 participants since opening in Fall 2013. OC Links serves Orange County residents by helping callers navigate a large and complex system of care and linking them to the County and/or County-contracted services best suited to meet their behavioral health needs.

Outreach and Engagement (PEI/CSS)

Outreach and Engagement (O&E) Collaborative (PEI)

Program Serves	Symptom Severity			Location of Services
				
	At-Risk	Early Onset	Mild-Moderate	Field

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Japanese, Mandarin, Taiwanese, Khmer, Hmong and Samoan.

BHS Outreach and Engagement (O&E) and County Operated (CSS/DEI)

Program Serves	Symptom Severity		Location of Services	Population Characteristics						
										
	Mild-Moderate	Severe	Field	Parents	Families	LGBTIQ	Veterans	Homeless/ At-Risk	Co-Occurring SUD	Co-Occurring Medical

The program provides services in Spanish, Vietnamese, Farsi, Korean and Arabic.

Target Population and Program Characteristics

Outreach and Engagement (O&E) provides field-based access and linkage to treatment and/or support services for unserved and underserved individuals of all ages living in Orange County. Orange County currently has two O&E programs, each with a specific focus. Both programs work with individuals experiencing a range of symptom severity, with the BHS program specializing in working with those who are homeless or at-risk of homelessness and who have had difficulty engaging in mental health services on their own. In addition, the PEI-funded O&E Collaborative works with individuals who have had life experiences that make them at-risk of developing behavioral health conditions but are hard to reach in traditional ways because of cultural, linguistic or economic barriers. O&E staff from both programs identifies participants through street outreach and referrals from community members and/or providers.

Services

The O&E programs work to identify those in need of mental health services, collaborate with them to determine the services that will best meet their mental health needs and work to engage them in these on-going services. To promote awareness of, and increase referrals to, their services, the programs perform outreach at community events and locations likely to be frequented by individuals the programs intend to serve and/or the providers that work with them in non-mental health capacities (i.e., health fairs, community festivals, door-to-door outreach, etc. for the O&E Collaborative; street outreach, homeless service provider locations, etc. for BHS O&E). Staff then screen individuals in the community or over the phone to determine what is needed based upon an established level of risk, and provide program-specific linkage strategies described in more detail below.

O&E Collaborative's Linkage Strategies: Participants screened by the collaborative are assigned to one of three levels based on their degree of risk both of developing a mental illness and/or of not engaging in needed services:

- Level I is for individuals identified as at-risk or mild risk who are provided referrals for services and able to access them independently.
- Level II is for individuals identified as mild to moderate risk who have a mental health issue and/or barriers to accessing services that require additional engagement efforts.
- Level III is for individuals identified as moderate to high risk who have a mental health issue and/or barriers to accessing services that require intensive engagement efforts.

Staff work to overcome any identified barriers for individuals in Levels II and III by offering educational and skill-building workshops and presentations, support groups, and individual interventions such as crisis intervention, needs assessment, life

coaching, individual skill development and wellness/case management. In addition, participants in the highest level of risk are provided appropriate clinical intervention such as mental health counseling and clinical case management until they are able to be linked to on-going care.

BHS O&E's Linkage Strategies: BHS strategies include developing personalized action plans to decrease barriers to accessing services and evidence-based Seeking Safety psycho-educational 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 providing assistance with scheduling appointments, providing transportation to services, addressing barriers and offering ongoing follow-up.

Strategies to Promote Recovery/Resilience

The O&E programs work to build protective factors and developmental assets that, in turn, reduce the vulnerability of the people served. Individuals may have previously experienced trauma or, particularly among the homeless population, are currently experiencing daily trauma and struggling to meet their basic needs, leaving them feeling disenfranchised or stigmatized. In order to engage individuals successfully, staff integrates a strength-based approach that works with individuals in their current stage of recovery and acknowledges and builds upon their existing coping skills. They also use harm reduction techniques, provide unconditional positive regard and offer supportive services while working to link individuals to treatment.

Strategies to Increase Timely Access to Services for Underserved Populations

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

Providing services out in the community allows O&E to reach those who would not normally access services due to being isolated because of cultural, linguistic, socioeconomic or transportation reasons. The staff adapts its outreach efforts to match the needs of different sub-populations, cultures or county regional areas. This allows staff to become experts in particular locations which then allows them to build trust and rapport with individuals more readily. The O&E programs also provide toll-free numbers to further increase access.

The O&E programs' primary goal is to increase individuals' willingness to enroll in needed services and facilitate linkage to appointments in as timely a manner as possible. Therefore all services focus on making referrals and linkages. Staff stay up to date on available resources, network and collaborate with other providers, assist with decreasing barriers to accessing services as they are identified, and provide transportation and warm handoffs to ensure linkage to on-going care. The O&E Collaborative provided 19,500 referrals resulting in 7,932 linkages in FY 2017-18, and 22,424 referrals resulting in 8,407 linkages in 2016-17 to services such as health education, disease prevention, wellness and physical fitness; PEI programs; adult education services; family support services; and behavioral health outpatient services. BHS O&E provided 8,696 referrals resulting in 2,399 linkages in 2017-18, and 9,225 referrals resulting in 2,576 linkages in 2016-17 to services such as mental health and substance use outpatient and intensive outpatient programs; housing support services; and medical services.

Strategies to Reduce Stigma and Discrimination

Due to the stigma associated with mental illness that can run deep within diverse communities, the O&E programs recruit diverse staff and volunteers who are knowledgeable about the communities they serve. The programs follow the premise that it is not enough for staff to speak the language, but they also need to know the religious and cultural nuances and the traditions of that particular community. Partnering with community agencies that come into regular contact with the target population also helps the programs gain the trust of a community. These strategies allow program staff to establish relationships with participants and their families which, in turn, reduces stigma related to seeking mental health services.

Challenges, Barriers and Solutions in Progress

For many Orange County residents who go unserved, one key barrier to seeking services is transportation. O&E removes this obstacle by bringing information and services such as case management and counseling directly to participants wherever they are in the community.

Lack of affordable housing also continues to be a barrier, especially for the homeless, and the programs continue to collaborate with agencies to improve access to affordable housing opportunities. In the past, linking individuals to mental health services was challenging when they were uninsured, underinsured or had other barriers to accessing services (e.g., transportation, meeting program eligibility criteria, etc.). With the addition of short-term counseling services, the O&E Collaborative can now fill this gap.

To address some participants' reluctance to provide personal information or enroll in engagement services, the programs have reached out to work with trusted community agencies/organizations. Through these partnerships, O&E staff has demonstrated the ability to follow through on commitments to address participants' needs and assisted individuals with accessing referrals, thereby building trust and rapport with participants. Once rapport and some success in linking to resources have been established, participants have been more receptive to engaging in on-going services.

Community Impact

O&E is firmly rooted in Orange County with strong collaborations with various community based organizations, school districts, law enforcement, churches, physician groups, parent groups, housing providers, outreach teams, older adult programs, other behavioral health programs and other providers of basic needs. The programs have reached individuals of all ages from multiple cultures throughout Orange County and have helped them access needed behavioral health and supportive services.

Over time, these collaborations have enabled stronger community partnerships that allowed providers to leverage existing resources and make mental health and wellness a priority. The Outreach and Engagement Services has impacted the community by allowing for more avenues to educate the community about mental health and navigating the system better. Ultimately, in the long-term each of these partners is working towards a common goal of integrating mental health and wellness into their regular operations that impacts policy and make a systems change.

The BHS O&E team were the recipients of the 2017 Steve Ambriz Team Excellence Award

The Multi-Service Center Courtyard Program (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
18+	Severe	Field	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Students	Criminal Justice

The program provides services in Spanish, Vietnamese, Farsi and Korean.

Target Population and Program Characteristics

The Multi-Service Center (MSC) Courtyard program serves residents ages 18 years or older who are living at the Courtyard homeless shelter in Santa Ana and have a serious and persistent mental illness and/or co-occurring substance use disorder. The mobile outreach team from the Multi-Service Center operates at the Courtyard shelter seven days a week to link individuals to mental health and/or substance use services, including detoxification.

Services

Courtyard 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. In coordination with BHS O&E staff operating at The Courtyard during traditional business hours, MSC outreach workers facilitate linkage to the most appropriate services for each individual (i.e., case management, outpatient mental health, medical appointments, housing, employment, SSI/SSDI and other 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.

Strategies to Increase Timely Access to Services for Underserved Populations

To improve access to its services, the Courtyard outreach team is available 7 days a week and operates during evening hours. The staff is bilingual/bicultural and a language translation service is available when needed. In addition, the team is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals into services. In FY 2017-18, the Courtyard Outreach made 8,194 contacts, 786 referrals and 577 linkages. In FY 2016-17, the program made 7,431 contacts, 896 referrals and 642 linkages.

Strategies to Reduce Stigma and Discrimination

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

Challenges, Barriers and Solutions in Progress

The MSC Courtyard program strives to build stronger partnerships with the collaborative agencies and community groups focused on integrating the residents at the Courtyard into permanent housing. Communication among community partners is not only necessary but ideal to meet the immediate needs of the residents. The program has an on-site Outreach Lead to act as the liaison with these other agencies. The Lead also provides additional support to the team by attending meetings with the collaborative and ensuring that outcomes data are collected properly and presented in a timely manner.

Community Impact

The Courtyard mobile outreach team collaborates with a variety of human services and non-profit providers to help residents 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 the Courtyard residents, the Courtyard mobile outreach team is part of a shared goal to help break the cycle of homelessness among those living with serious mental illness.

Recovery Open Access (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics					
18+	Severe	Outpatienet Clinic	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in Spanish, Vietnamese, and Khmer.

Target Population and Program Characteristics

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 urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail or are currently enrolled in outpatient BHS services and have an urgent medication need that cannot wait until their next scheduled appointment. These individuals are at-risk of further hospitalization or incarceration if not linked to behavioral health services quickly.

Services

Recovery Open Access serves two key functions: (1) it links adults with serious and persistent illness to on-going, appropriate behavioral health services and (2) it provides access to short-term integrated behavioral health services (i.e., brief assessments, case management, crisis counseling and intervention services, 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 on-going care.

Strategies to Promote Recovery/Resilience

By providing timely access to needed care, including mediation support, Recovery Open Access allows individuals to move forward in their recovery instead of hitting roadblocks to their care.

Strategies to Increase Timely Access to Services for Underserved Populations

Individuals in the program face issues related to transportation, difficulty navigating the behavioral health system, management of their symptoms, and/or degree of insight into their mental health issues. As described above, Recovery Open Access improves access to care by expediting urgent care needs and by facilitating quicker and smoother linkages to behavioral health treatment for those discharging from inpatient and jail settings. Recovery Open Access has made significant progress linking individuals to ongoing care within 30 days of discharge, making 1,014 linkages in FY 2017-18 compared to 591 linkages made in FY 2016-17.

Strategies to Reduce Stigma and Discrimination

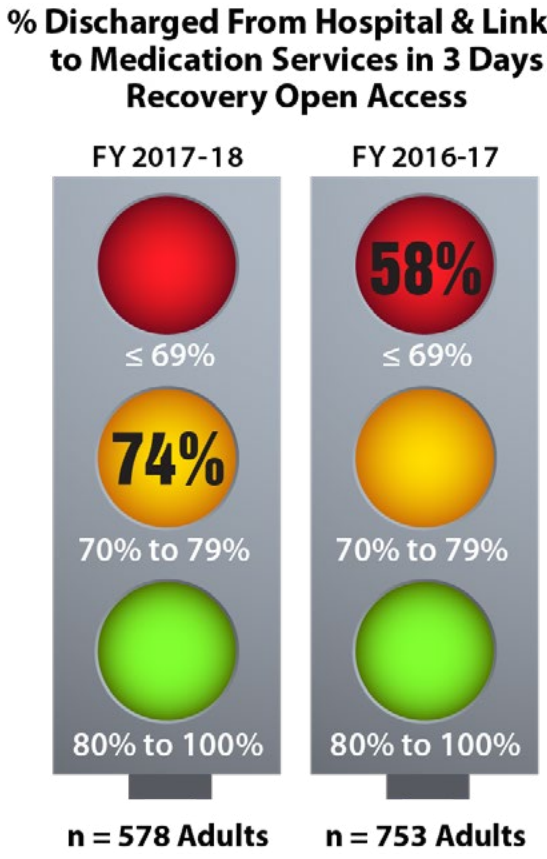
All clinicians and peer workers are trained yearly in cultural competency, which reviews the concepts of culture, race, ethnicity, diversity, stigma and self-stigma. The training also demonstrates the influence of unconscious thought on a person's judgment as it relates to stereotyping and racism. Through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

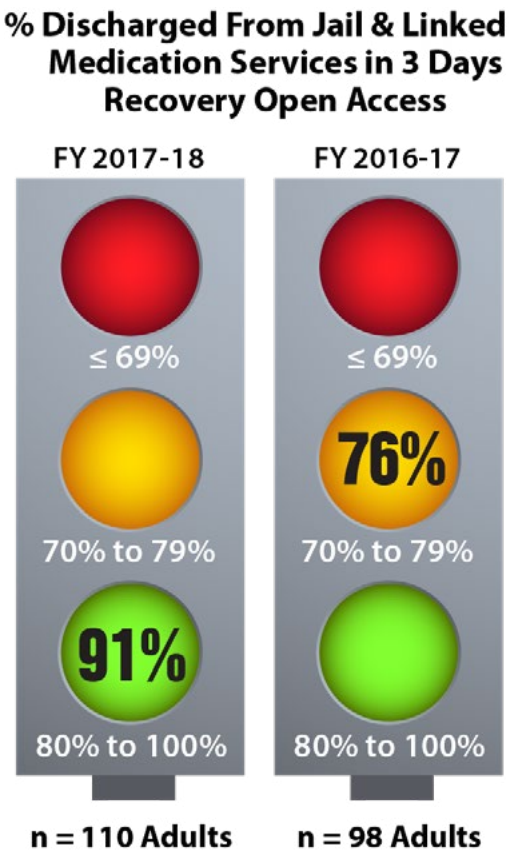
Outcomes

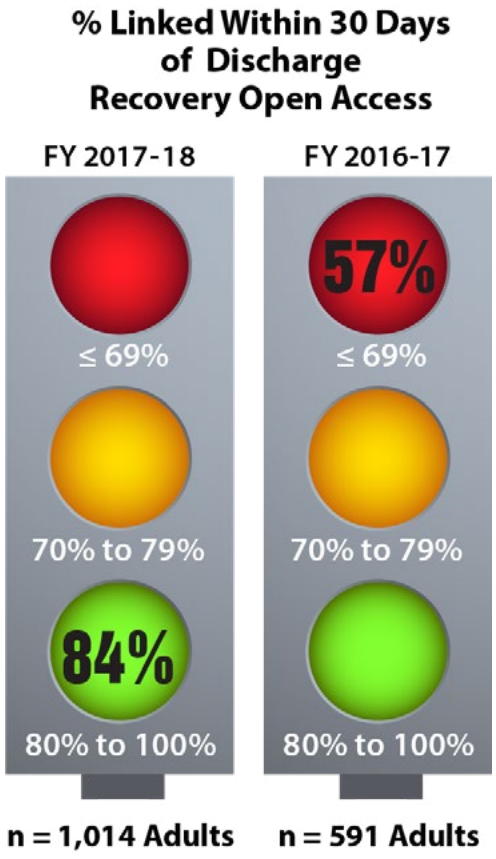
Recovery Open Access served 1,762 adults in FY 2017-18, up from 1,357 adults served in FY 2016-17. Performance of the program was measured by whether the program met or exceeded the following targets:

- 80% of adults discharged from a hospital and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of adults discharged from jail and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of all adults admitted to Recovery Open Access are linked to ongoing care within 30 days

The program made considerable progress toward meeting its targets in FY 2017-18 after not meeting any of its goals in FY 2016-17. Program expectations for scheduling appointments with the Open Access psychiatrist, receiving medication and receiving on-going care were clarified with staff at the end of FY 2016-17, which greatly improved the timeliness with which staff achieved all three linkage goals in FY 2017-18.







Challenges, Barriers and Solutions in Progress

Recovery Open Access relocated the south county site to Costa Mesa in August 2017 to improve access for people who live in south county and to decrease the workflow at the north county site, which had become unmanageable. The program has more peer positions to engage consumers and their family members with the goal of improving the ability to help link them to their appointments. To address challenges related to missed appointments, the program has implemented care managers to do more dedicated follow-up and linkage support for individuals (i.e., accompanying to appointments, home visits, engage in additional follow-up with those who don't link with the provider).

Community Impact

Recovery Open Access has provided services to more than 3,478 individuals since its inception through end of FY 2017-18. The program collaborates with a variety of community partners including: hospitals, jails, homeless shelters, substance abuse programs, community health clinics, mental health clinics, OC Probation and Orange County Social Services Agency (SSA) to help individuals receive needed behavioral health care.

Assisted Outpatient Treatment: Assessment and Linkage Team (CSS)

Target Population and Program Characteristics

Program Serves	Symptom Severity	Location of Services	Population Characteristics				
18+	Severe	Anywhere	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in Spanish, and Vietnamese.

Assisted Outpatient Treatment (AOT) is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis. In Orange County, AOT accomplishes this through a two-pronged approach: (1) an expanded and specialized referral, assessment and linkage process combined with (2) civil court involvement, whereby a judge may direct participation in outpatient treatment. The former services are provided by the AOT Assessment and Linkage Team (ALT), which engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system. Legislative requirements of AOT and ALT services are described in more detail below and the AOT FSP is described in the Full Service Partnerships section of this Plan.

In accordance with California Assembly Bill 1421 (AB 1421) (also known as "Laura's Law"), the following criteria must be met for a person to qualify for AOT:

1. Adult is 18 years or older and suffering from a serious mental health illness;
2. A clinical determination is made that the person is unlikely to survive safely in the community without supervision;
3. A history of lack of compliance with treatment for mental illness, in that at least one of the following is true:
    a. The person must have two or more psychiatric hospitalizations in the past 36 months (or been placed on the acute mental health unit in jail) or;
    b. The person has had one or more serious acts or threats of violence in the past 48 months;
4. The person has been offered an opportunity to participate in a treatment plan and continues to fail to engage in treatment;
5. The person's condition is substantially deteriorating;

6. It is likely the person will benefit from assisted outpatient treatment;
7. Assisted outpatient treatment is necessary to prevent relapse or deterioration that would be likely to result in grave disability or serious harm to self or others and;
8. Participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.

Per the legislation, the following individuals (also known as "qualified requestors") may refer a person for an AOT evaluation: (1) immediate family members such as a parent, sibling, spouse or adult children of the person; (2) adults residing with the person; (3) the director of any public or private agency, treatment facility, licensed residential care facility or hospital in which the person is a resident or patient; (4) a licensed mental health professional treating the individual; or (5) a peace officer, parole or probation officer supervising the individual.

AOT participants are typically homeless or at-risk of homelessness, incarcerated or hospitalized, and have a history of non-compliance with treatment as a result of the severity of their mental illness and lack of awareness of their condition. In addition, AOT participants often have co-occurring substance use issues and physical health problems.

Services

The AOT ALT evaluates people referred to the program to determine whether they qualify for AOT, engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system. Orange County has established a toll free number (1 (855) 422-1421) for the general community to call for more information about the AOT program and for qualified requestors to make AOT referrals.

Upon receiving a referral from a qualified requestor, the AOT ALT connects with the requestor to gather additional information about the referral, including identifying information about the requestor and the referred individual; information about their circumstances; and the reason(s) for the AOT referral. When an AOT candidate appears to meet criteria for AOT but refuses voluntary services, a licensed clinical psychologist from the team meets with the candidate, reviews their records, and conducts a psychological assessment to determine if they meet AOT criteria. If the AOT candidate continues to meet criteria and refuses voluntary services, they may be ordered by the court to participate in the AOT FSP (for more information about AOT FSP, please refer to the Full Service Partnership section of this Plan). Despite a court order to participate, however, the judge cannot impose involuntary treatment should a participant fail to comply because AOT in Orange County has been implemented with MHSA funds which can only be used for voluntary services.

Strategies to Promote Recovery/Resilience

The AOT program takes a consumer-focused and recovery-oriented approach to treatment. Program staff work with participants "where they are at," build rapport, identify their goals, hopes and dreams and then tailor treatment based on the participant's unique goals, needs, strengths and stage of recovery.

Strategies to Improve Timely Access to Services for Underserved Populations

There are many issues that may keep individuals from seeking AOT services including: limited insight into the mental illness that results in non-compliance with treatment; homelessness or risk of homelessness; history of incarceration; difficulty finding permanent housing; lack of transportation; limited income and limited support. The ALT works to overcome these barriers by engaging in frequent contact with the participant through visits to their home, hospital, correctional facility or any place the participant is known to be. These contacts focus on building therapeutic relationships that facilitate trust, linkage to services and, ultimately, treatment adherence. Transportation support is also provided for participants as needed. In addition, the program has access to all languages through the use of a contracted interpreter service provider in order to minimize any potential language barriers.

During FY 2017-18, the program received 488 new referrals and provided services to a total of 589 individuals. All eligible AOT individuals who were available for assessment were successfully linked to appropriate mental health services (n=226). Of those linked to services, an overwhelming majority accepted services voluntarily (n=155), thus demonstrating the team's success in working with this marginalized and unserved population.

Strategies for Reducing Stigma and Discrimination

The AOT program recognizes the importance of reducing stigma and discrimination in order to help individuals with mental illness access and accept services. One of the strategies used by the AOT ALT is to provide presentations and training at hospitals, police departments and various community meetings to help raise awareness about mental health issues and about the services that are available.

Challenges, Barriers and Solutions in Progress

One of the challenges for the program is misinformation about what AOT can and cannot do for individuals being referred and served in Orange County. Because Orange County implemented AOT with MHSA funds, services must remain voluntary; the judge cannot order medication administration for those who refuse to take prescribed psychotropic medications, for example. The program is working to increase presentations at hospitals, police departments, jails, clinics and community-based organizations to increase community awareness and understanding about AOT and its implementation specifically in Orange County.

Another challenge the program continues to face is being able to locate individuals consistently when they are released from jail and are homeless. The AOT ALT continues to work with the jails to link individuals to services upon release to try and reduce the number who are lost to follow-up due to homelessness.

Community Impact

Through FY 2017-18, the AOT ALT has provided services to 1,440 individuals since its inception in October 2014 and continues to receive a high volume of referrals through the toll-free number (approximately 30 to 45 each month). In addition to providing assessment and linkages services to eligible individuals, the team also provides the community with information about AOT in Orange County. The program responded to 303 calls in FY 2017-18 and 582 informational calls in FY 2016-17.

CHS Jail to Community Re-Entry (CSS)

Program Serves	Symptom Severity	Location of Services	Population Characteristics
18+	Moderate-Severe	Correctional Facilities	Criminal Justice

The program provides services in English and TBD.

Target Population and Program Characteristics

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

Services

This program will use a comprehensive approach to discharge planning and re-entry linkage services for inmates with mental illness at all five County jail facilities. Discharge planning services will be conducted while individuals are still in custody and will include thorough risk-needs-responsivity (RNR) assessments, re-entry groups aimed at identifying possible barriers to successful re-entry and developing tailored discharge plans. Services will also include facilitation of linkage to a range of services upon release, such as counseling, medication support, housing and transportation. Connections with family and other support systems such as forensic peer support mentors will also be facilitated. JCRP staff will work in collaboration with other stakeholders, including the Orange County Sheriff's Department, Orange County Probation Department, Orange County Public Defender, Social Services Agency, Regional Center of Orange County, Orange County Housing Authority and other ancillary agencies to identify gaps in service delivery and solidify linkages with external stakeholders for a smooth transition from jail to community.

Strategies to Promote Recovery/Resilience

This program will offer intensive mental health case management aimed at bridging the gap between mental health services provided while in custody and the treatment and support services needed upon release from custody.

Strategies to Increase Timely Access to Services for Underserved Populations

Timely access to JCRP services will be provided by beginning the comprehensive discharge planning while the individual is still in custody.

Strategies to Reduce Stigma and Discrimination

These strategies will be further developed as the program is implemented and will be reported in future Plan updates.

Outcomes

Because this program is in its start-up phase and in the process of hiring staff, outcomes are not yet available.

CRISIS SERVICES

Orange County has a comprehensive array of Crisis Services that operate 24/7 and are designed to support individuals of all ages who are experiencing a behavioral health emergency. These programs include a Crisis Prevention Hotline, mobile Crisis Assessment Teams, and crisis support services provided either in the home or a residential setting. Their goal is (1) to provide access to structured clinical support – either directly or through linkages – so that the person may continue living safely in the community, when appropriate, or (2) to facilitate admission to a psychiatric hospital when a higher level of care is warranted.

Crisis Services	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Crisis Prevention Hotline (PEI)	7,000	$392,533	$56
Children's CAT (CSS)	4,250	$2,864,032	$674
TAY/Adult CAT/PERT (CSS)	5,396	$5,971,826	$1,107
Crisis Stabilization Units (CSS)	6,570	$4,150,000	$632
Children's In-Home Crisis Stabilization (CSS)	400	$1,085,480	$2,714
TAY/Adult In-Home Crisis Stabilization (CSS)	245	$1,500,000	$6,122
Children's Crisis Residential Program (CSS)	208	$2,988,248	$14,367
TAY Crisis Residential Program (CSS)	96	$1,491,368	$15,535
Adult Crisis Residential Program (CSS)	739	$3,251,229	$4,399

Crisis Prevention Hotline (PEI)

Program Serves	Symptom Severity		Location of Services	
0+	Mild-Moderate	Severe	Via Telephone	Internet Chat

The program provides services in English, Spanish, Deaf/Hard of Hearing (text) and other languages using language line.

Target Population and Program Characteristics

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention telephone/text/chat service. It is available to individuals who are experiencing a crisis and/or suicidal thoughts or are concerned about a loved one attempting suicide and wanting to call the hotline for assistance.

Services

Program counselors provide immediate, confidential over-the-phone/text/chat assistance and initiate and assist in active rescues when necessary. In addition, for individuals who have given their consent, counselors conduct follow-up calls to ensure continued safety. This extended care model provides a stronger safety net and reduces the likelihood of attempts and emergency room visits.

The hotline uses the Applied Suicide Intervention Skills Training (ASIST) as its method to prevent suicide. The program has also expanded its services to be inclusive of friends and family members who have been impacted by a loved one's suicide. Callers who are not experiencing a crisis are triaged and offered access to the WarmLine or other appropriate resources.

The Crisis Prevention Hotline program also works to educate the wider Orange County community on the signs of serious depression and suicidal ideation, myths associated with

talking about suicide, strategies on how to listen to and aid someone in distress, and promotion of the crisis line and its services. Staff provides this information through community outreach, education and information tables at events and speaking engagements.

Strategies to Promote Recovery/Resilience

Clinicians work with the individual in crisis and/or their family member to identify previously successful coping strategies or currently available supports and resources. They also make timely referrals to needed services and supports in order to facilitate crisis stabilization.

Strategies to Improve Timely Access to Services for Underserved Populations

The 24-hour availability of the Crisis Prevention Hotline, as well as the availability of text/chat, allows individuals to access services at any time, wherever they are, in the manner most comfort- able for them. Program staff provide services both in English and Spanish and volunteers who speak other languages are utilized whenever available. The language line is used when callers speak languages not available through staff or volunteers on site. In addition, the Deaf/ Hard-of-Hearing population can access services without having to wait for an interpreter by utilizing crisis texting services.

Services are publicized through Orange County's OC Links, County and contracted provider websites, the state's Each Mind Matters website and outreach to schools, hospitals, provider sites and the community at large.

Strategies to Reduce Stigma and Discrimination

To promote use of the Crisis Prevention Hotline within unserved and underserved populations, the program utilizes California Mental Health Services Act Authority's (CalMHSA) culturally appropriate materials to target underserved monolingual communities (i.e., Vietnamese and Farsi-speaking). The anonymity of the hotline also facilitates accessing of crisis services by individuals who might otherwise not seek help because of the stigma associated with mental illness. In addition, the hotline collaborates with partner organizations to conduct outreach, reduce stigma and provide education in a manner consistent with the values and perspectives of the community they are trying to engage.

Outcomes

Corresponding to its increased outreach efforts, the hotline saw a 35% increase in usage in FY 2017-18 (i.e., 9,200 unduplicated callers, 11,607 calls), compared to FY 2016-17 (i.e., 6,807 unduplicated callers, 8,475 calls).

To assess the program's effectiveness in reducing prolonged suffering, callers were asked to complete their Self-Rated Intent (SRI) on a 5-point scale at the beginning and end of the call. Risk of suicidal behavior was rated low if a caller reported their suicidal intent as a score of 1 or 2, medium if they reported a score of 3, and high if they reported a 4 or 5. A score that moved to a lower risk category by the end of the call or remained in the low risk category for the duration of the call suggests that services effectively decreased suicidal intent. The proportion of high risk callers fell from 23% to 8% in FY 2018-17 and 27% to 7% in FY 2016-17 by the end of the call. Thus, Crisis Prevention Hotline counselors helped reduce suicidal intent and prevented the worsening of crisis symptoms.

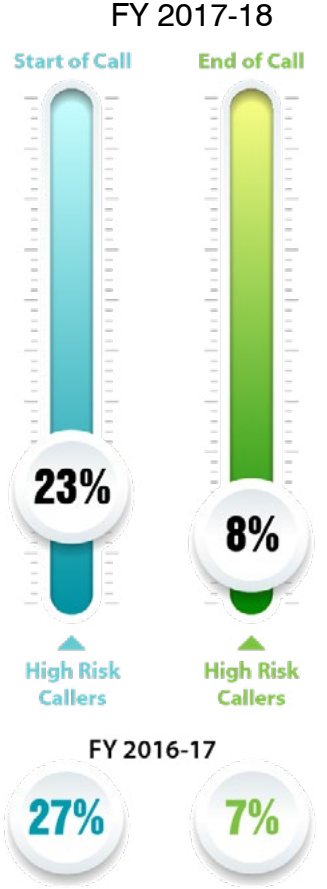
Challenges, Barriers and Solutions in Progress

The hotline has seen a steady increase in calls over the past several years which exceed the current staffing capacity of the hotline. The MHSA Steering Committee recently voted to approve adding funds to the program to address this growing need.

Community Impact

Since program inception in 2010 through June 2018, the Crisis Prevention Hotline has answered a total of 60,921 calls.

Percent High Risk Callers at Call Start and End by FY



Crisis Assessment Teams/Psychiatric Emergency Response Teams (CSS)

Children's CAT

Program Serves	Symptom Severity		Location of Services						Typical Population Characteristics					
0-17	Mild-Moderate	Severe	Home	School	Hospital and ER	Police Station	Group Homes	Field	Families	Parents	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish and Vietnamese.

TAY and Adult CAT/PERT

Program Serves	Symptom Severity		Location of Services						Typical Population Characteristics					
18+	Mild-Moderate	Severe	Home	Workplace	Outpatient Clinics	Hospital and ER	Residential	Field	Families	Parents	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Khmer Tagalog and Mandarin.

Target Population and Program Characteristics

The Crisis Assessment Teams (CAT) provide mobile crisis assessment and response throughout Orange County for individuals of all ages 24 hours a day, 7 days a week, 365 days a year. There are currently 27 children's CAT clinicians and 45 TAY/Adult clinicians who respond to calls from anyone in the community and dispatch to anywhere in Orange County. The TAY/Adult team hired 5 out of 8 of the expansion positions this year.

Psychiatric Emergency Response Teams (PERT) are specialized units comprised of behavioral health clinicians from the TAY/Adult CAT who ride along with police officers. PERT clinicians partner with 16 agencies 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 and Westminster during shifts designated by each participating department.

Services

CAT is a multi-disciplinary program that provides prompt response to anywhere in the county when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training to conduct evaluations and risk assessments that are geared to the individual's age and developmental level and involve interviews with collateral sources such as parents, guard-

ians, family members, law enforcement, emergency department staff and school personnel. Clinicians link individuals to an appropriate level of care to ensure their safety, which may involve initiating an involuntary hospitalization. They also conduct follow-up contacts with individuals and/or their parents/guardians to provide information and referrals and to encourage linkage to on-going behavioral health services that may help reduce the need for future crisis interventions.

PERT clinicians have established strong partnerships with numerous local law enforcement agencies throughout Orange County. They ride along with police officers on designated shifts and promptly respond to calls involving individuals with behavioral health needs. During these calls clinicians conduct risk assessments, initiate involuntary hospitalizations as necessary and provide appropriate care and linkages to resources in a dignified manner. In addition to assisting individuals in accessing needed behavioral health services, PERT educates police on behavioral health issues and provides officers with tools that allow them to assist individuals living with behavioral health issues more effectively.

Strategies to Promote Recovery/Resilience

During the assessment, clinicians work with the individual in crisis and/or their family members to identify previously successful coping strategies, as well as any available supports and resources. Clinicians also work to make timely referrals and linkages to facilitate recovery and prevent the need for future crisis services.

Strategies to Improve Timely Access to Services for Underserved Populations

The Children's and TAY/Adult teams serve the entire County of Orange and strive to improve timely access to their services in a number of ways. First, the teams advertise their services on the Internet and at community events and accept referrals 24/7 from anyone in the community through a toll-free number. In an effort to encourage utilization by underserved populations, CAT clinicians also conduct trainings and outreach throughout the county to increase recognition of the signs of behavioral health crisis and address any associated misperceptions about mental health. The teams also provide a mobile response to overcome any transportation barriers on the part of the people they serve and strive to arrive within one hour of receiving the referral and within 30 minutes from the time the clinician dispatches. Finally, the teams have bilingual/bicultural staff with the capacity to provide services in many languages (see grids). In addition to working with those in crisis, bilingual/bicultural clinicians work with family members to provide information and culturally appropriate referrals to ensure that individuals and their families receive services in a timely manner.

Both teams have noted a steady increase in calls over the past several years, particularly as homelessness has persisted and passage of AB 2246 required all school districts to have a suicide prevention response in place for students in grades 7 through 12. With requests for services coming from families, hospitals, schools, caregivers, law enforcement, social services, treatment providers and the general community at ever increasing rates, CAT and PERT continue to expand their teams to provide better geographic coverage across Orange County and maintain a timely response. Nevertheless, it has proved challenging to keep up with demand, particularly for Children's CAT.

Strategies to Reduce Stigma and Discrimination

CAT/PERT continues to place priority on hiring bilingual and bicultural staff. Staff also attend cultural diversity workshops so that they may conduct evaluations in a sensitive manner and offer culturally appropriate service referrals. In addition, PERT provides law enforcement with information and tools to help officers more effectively assist individuals who are experiencing a behavioral health crisis. The success of these law enforcement/behavioral health partnerships has resulted in a more compassionate response in the community.

Outcomes

The Children's team conducted 3,786 evaluations in FY 2017-18 and 3,039 evaluations in FY2016-17. The TAY/Adult team conducted 4,553 evaluations in FY 2017-18 and 4,568 evaluations in FY 2016-17.

The program is evaluated by 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. TAY/Adult CAT/PERT met its goal with a dispatch-to-arrival rate of 82% in FY 2017-18 and 79% in FY 2016-17. Although the Children's team missed its target over the past two years with a 51% and 56% response rate in FY 2017-18 and FY 2016-17, respectively, in both years the average dispatch-to-arrival time was still close to target (i.e., 34 minutes in FY 2017-18, 32 minutes in FY 2016-17).

The Children's CAT team has identified potential factors contributing to why the response time has fallen short of the goal. The program receives a majority of calls in the late afternoon and early evening hours when school ends for the day and parents are arriving home. This coincides with high peak traffic times on local freeways resulting in longer drives. The team is currently examining the number of calls from areas that are farthest from the office location to identify ways to address response time, especially during high traffic times. Additionally, while the program is centrally located in Orange County, staff must walk to an off-site parking

lot to get to their cars, thereby increasing response time by approximately 5 minutes. With the program moving to a new location with on-site parking in March 2019, HCA will monitor whether this change helps improve dispatch-to-arrival times.

In addition to dispatch-to-arrival times, the teams examine the rate at which individuals are psychiatrically hospitalized as a way of monitoring the severity of the presenting problems experienced by the individuals served and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals continued to be hospitalized less than half the time (40% and 44% in FY 2017-18 and FY 2016-17, respectively, for children; 45% and 48% in FY 2017-18 and FY 2016-17, respectively, for TAY/adults). The program has continued to note a larger number of individuals living with co-occurring disorders who are under the influence of alcohol or other substances at the time of evaluation, which can elevate their risk and level of care needs, thereby limiting placement options.

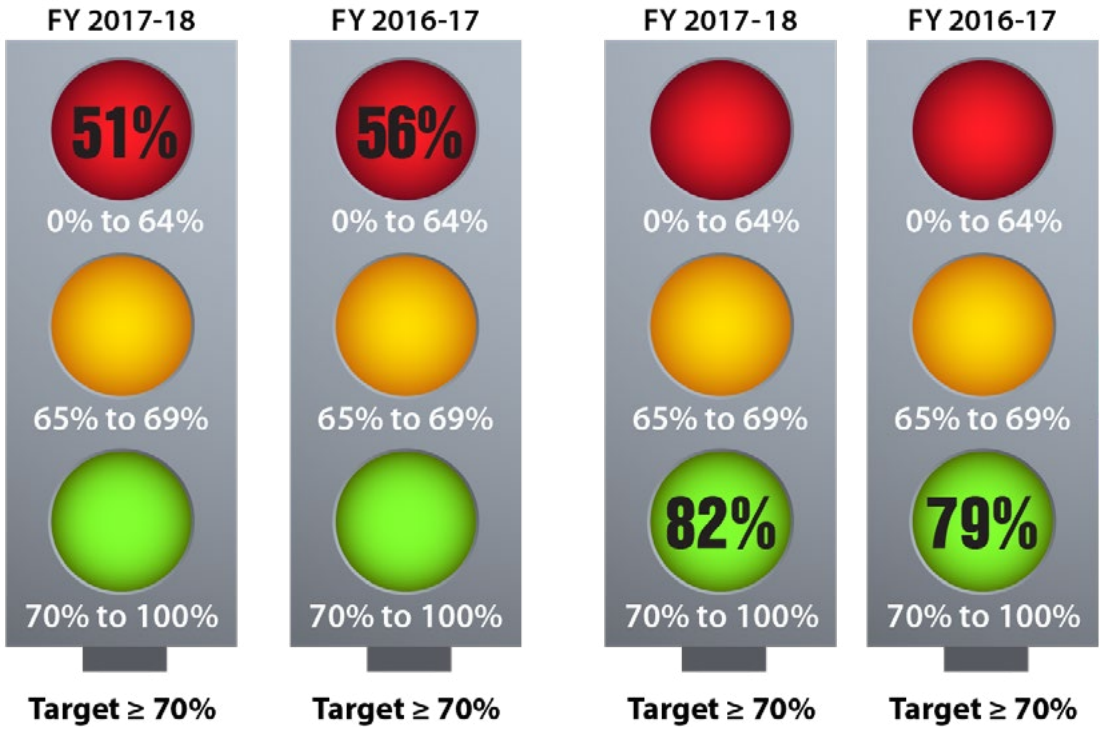
Challenges, Barriers and Solutions in Progress

While the increasing calls from law enforcement, schools and the community are ultimately a reflection of the programs' positive impact in Orange County, this growing demand nevertheless poses challenges. As PERT continues to expand, the TAY/Adult program experiences decreased staffing due to the transition of CAT staff to the new PERT teams. To accommodate increasing call volume, both the Children's and TAY/Adult teams have increased the number of positions, however hiring clinicians remains difficult due to the undesirability of certain shifts in a 24/7 program. Hiring bilingual staff is even more difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. Due to the nature of the service type being provided, turnover for these positions is higher than in others areas of HCA. HCA is trying to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift.

Community Impact

Since their inception in January 2003 through June 2018, the crisis teams have responded to calls for more than 24,600 children and 32,800 TAY/Adults. The teams have been successful in safely linking individuals who are experiencing behavioral health crises to appropriate levels of care that are less restrictive, costly and more recovery-oriented than inpatient psychiatric hospitalization, hospital emergency department visits and incarceration. Feedback from law enforcement regarding having PERT clinicians in the field with officers has also been overwhelmingly positive and helped incorporate a more compassionate response when law enforcement interact with individuals experiencing behavioral health crises.

Dispatch-to-Arrival Rate in 30 Minutes or Less by FY



Crisis Stabilization Units (CSS)

Program Serves	Symptom Severity			Location of Services	Typical Population Characteristics					
13+	At-Risk	Mild-Moderate	Severe	TBD	Families	Parents	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Students

The program will provide services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic, and other languages as needed through use of language line services.

Target Population and Program Characteristics

Although HCA operates a County-operated Crisis Stabilization Unit (CSU) for adults using non-MHSA funds, Orange County stakeholders identified a need to dedicate MHSA funding for additional CSUs that would meet increasing demand for services and expand the age range of those served. Similar to the existing program, the MHSA CSUs will provide the community with a 24-hour/7-day a week service for individuals who are experiencing a psychiatric crisis requiring emergent behavioral health stabilization that cannot wait until a regularly scheduled appointment. The program will serve Orange County residents ages 13 and older, the majority of whom may be on a 72-hour civil detention for psychiatric evaluation due to danger to self, others or grave disability resulting from a behavioral health disorder (i.e., Welfare and Institutions Code 5150/5585). The CSUs will be able to be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement officers and others in the community who believe an individual has an emergent behavioral health need. Currently, the County has an approved contract with one provider and is in various stages of ongoing negotiations with three other providers.

Services

The primary goals for the County-contracted CSUs will be to provide timely voluntary and involuntary crisis stabilization services for individuals who cannot wait for a regularly scheduled appointment with their behavioral health care provider; a viable alternative to costly inpatient hospitalization that utilizes the most dignified and least restrictive referral options whenever possible and appropriate; and an appropriate option for individuals whose default presentation would otherwise be to hospital emergency departments.

Services, which are not to exceed 23 hours and 59 minutes, will include psychiatric evaluation, basic medical services, nursing assessment, medication services, crisis intervention, collateral history, and referral and linkage to the appropriate level of continuing care. Clinicians will also provide individual therapy, brief intensive services, motivational interviewing and short-term group therapy modalities including psycho-education, cognitive behavioral therapy and self-soothing therapy techniques. Topics may include, but are not limited to, building a wellness toolbox or resource list; symptom monitoring; identifying triggers and early warning signs of symptoms; identifying a crisis plan; and building a Wellness Recovery Action Plan (WRAP). Services will also include substance use disorder treatment for individuals who have co-occurring substance use disorders.

Strategies to Promote Recovery/Resilience

CSUs will promote recovery and resilience in many ways. All services will be provided in an environment that is compatible with, and supportive of, the recovery model and trauma-informed care principles. Services will be tailored to the unique strengths of each individual and focus on taking personal responsibility for managing one's recovery. The CSUs will also employ peer recovery specialists who will provide support and assist individuals in their recovery by supporting self-sufficiency and encouraging engagement in meaningful life activities and relationships. Peers will be encouraged to share their stories of recovery to help provide hope to participants and their families that recovery is possible.

Strategies to Improve Timely Access to Services for Underserved Populations

People who are experiencing a crisis may be unable or unwilling to seek out services due to lack of transportation or other resources, homelessness, stigma, fear of the "system" or unknown, and cultural issues. HCA has secured a contract with one provider and is in various stages of ongoing negotiations with three potential contractors in order to expand crisis stabilization services throughout Orange County to address some of these access issues. In addition, they will operate 24/7 so that individuals in crisis can access

the services at any time. To meet the needs of Orange County's diverse population, the CSUs will hire staff who are bilingual/ bicultural in all threshold languages and the language line will be utilized to accommodate individuals who speak languages other than those spoken by staff.

Strategies to Reduce Stigma and Discrimination

Contractors will be required to hire and retain bilingual/bicultural staff whenever possible, as well as recruit, hire and train individuals who are in recovery. Contractors will also provide cultural competency trainings, provide literature in multiple languages and formats, and enhance accessibility and sensitivity for individuals who are living with physical challenges.

Outcomes

Because the MHSA-funded CSUs are not currently implemented, outcomes are not yet available.

In-Home Crisis Stabilization (CSS)

Children's IHCS

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
0-17	Severe	Home	Hospital	Field	Families	Parents	Medical	Homeless/ at-Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic, and other language as needed through use of language line services.

TAY/Adult IHCS

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics						
18+	Severe	Home	Hospital	Field	Families	Parents	Veteran	Medical	Homeless/ at-Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, and Arabic, and other languages as needed through use of language line services.

Target Population and Program Characteristics

In-Home Crisis Stabilization (IHCS) programs consist of family stabilization teams including clinicians and staff with lived experience who 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 avoiding such placements if provided appropriate support. The teams operate 24/7 and individuals are referred by County behavioral health clinicians and emergency department personnel.

Services

Individuals and families/identified support networks are typically referred to IHCS after a clinician has evaluated an individual for possible hospitalization and determined that, while they do not meet criteria for hospitalization, they and their family/identified support network would benefit from supportive services. The evaluator then calls the crisis stabilization team to the site of the evaluation, and the team immediately works with the individual and family/identified support network to develop a stabilization plan. After triggers have been identified and a safety plan is in place, in-home appointments are made for the next day. The IHCS team utilizes strategies such as crisis intervention, assessment, short-term individual

therapy, collateral services and case management to help the individual and/or family/identified support network establish a treatment plan, develop coping strategies and ultimately transition to ongoing support. Length of stay in both the Children's and the Adult/TAY program is usually three weeks but can extend up to six weeks based on clinical need and the amount of time it takes before an individual can be linked to long-term services. All IHCS services are mobile and, whenever possible, provided in the home, at the identified residence of individuals who are experiencing homelessness, and/or in any setting that the individual or family/identified support network feels comfortable.

Strategies to Promote Recovery/Resilience

Peer specialists are key members of the IHCS teams and their stories of lived experience, recovery and resilience serve as a source of hope and inspiration for the individual participants and their families/identified support network who are in the midst of a crisis. Services are strength-based and tailored to the needs of the individual and family/identified support network, and families/significant others are encouraged to be active participants in the recovery process, which allows them to develop confidence in their ability to handle future challenges successfully.

Strategies to Improve Timely Access to Services for Underserved Populations

The IHCS team responds within two hours to the setting where the behavioral health crisis was initially discovered, which allows the team to establish rapport with the individual and family/identified support network and increase their likelihood of engaging in services. All services are provided in the home or any other locations in which the individual and family/identified support network feel the most comfortable. The program also hires bilingual/bicultural staff who speak multiple languages (see grid), and the language line and/or interpretation services are available when staff who speak the language of a participant or family member/significant other are not available.

Strategies to Reduce Stigma and Discrimination

Peers, youth and parent partners help decrease stigma by serving as positive role models and providing hope for the individual and their family/identified support network that recovery is possible. Staff participate in various cultural competency trainings so that they can communicate and interact with individuals in ways that respect and value the family's/support network's world view.

Outcomes

The Children's team served 672 children's/families in FY 2017-18 and 404 in FY 2016-17. The goal is to maintain a psychiatric hospitalization rate that is 25% or less during the time the youth was enrolled in the program through 60 days post-discharge, which the program met with a hospitalization rate of 6% in FY 2017-18 and 12% in FY 2016-17.

The Adult/TAY IHCS program began providing services in August 2018 and outcomes will be reported in future plans.

Challenges, Barriers and Solutions in Progress

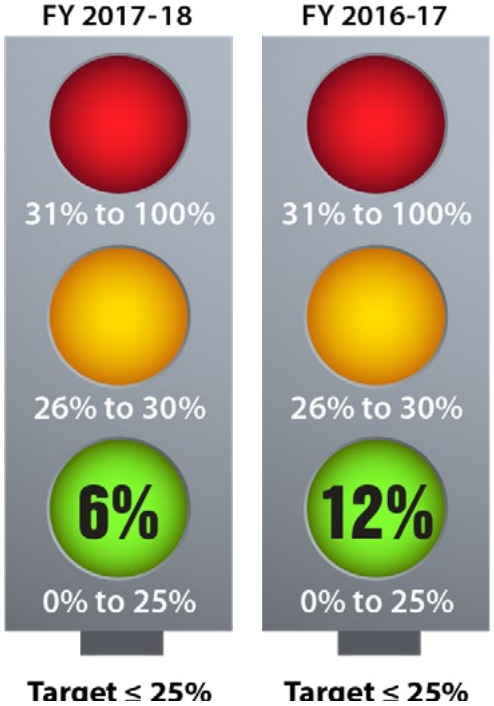
A challenge for the Children's program has been identifying an effective way to streamline the referral process so that interventions can be implemented quickly enough to help the child avoid being placed in a more restrictive setting. The County and provider have worked diligently to establish effective communication between referral sources and the in-home team, which has resulted in youth being seen in a more timely manner and safely provided services in the community.

Community Impact

There have been more than 3,000 admissions to the Children's program since its inception in 2006. The program collaborates with referring agencies, behavioral health programs, schools and emergency departments, and will collaborate with the crisis stabilization units (CSUs) once established. 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 behavioral health crisis and their families/support networks.

Hospitalization Rate - Up to 60 Days Following Discharge by FY

Childrens In Home Crisis Stablization



Crisis Residential Programs (CSS)

The Crisis Residential Programs (CRPs) are highly structured, voluntary residential programs that focus on promoting resilience and recovery. Individuals are referred to a CRP if they are in a behavioral health crisis and have been evaluated for psychiatric hospitalization, do not meet criteria for inpatient hospitalization, and they and/or their family is experiencing considerable stress. For children, an additional criterion is that respite would benefit the child/youth and the family. The programs are voluntary and serve anyone in Orange County who meet eligibility requirements. In addition, individuals must be referred by hospitals, CAT/PERT or County or County-contracted behavioral health (i.e., programs do not accept walk-ins, self-referrals).

Target Populations and Program Characteristics

Children's Crisis Residential

Program Serves	Symptom Severity				Location of Services	Typical Population Characteristics			
									
	At-Risk	Early Onset	Mild-Moderate	Severe	Residential	LGBTIQ	Homeless/at-Risk	Co-Occurring SUD	Students

The program provides services in English, Spanish, Vietnamese, Korean, Farsi, Arabic, and American Sign Language (ASL) and other language as needed through use of language line services.

The Children's CRP serves children between the ages of 12 and 17 who are experiencing a behavioral health crisis and their families. Many of the children have a history of serious emotional disturbance and are experiencing significant family conflict and/or are at-risk of hospitalization or out-of-home placement. The Children's CRP provides services at three sites (Laguna Beach, Huntington Beach and Tustin) with a total of 16 beds. The program generally lasts for three weeks, although children can remain in treatment for up to six weeks if needed.

TAY Crisis Residential

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics		
						
	Mild-Moderate	Severe	Residential	LGBTIQ	Veteran	Co-Occurring SUD

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Combodian and Mandarin.

The TAY CRP serves young adults ages 18-25, many of whom have experienced multiple traumas characterized by violence, are homeless or at-risk of homelessness, have co-occurring substance use issues and/or receive little family support. TAY CRP currently has one facility with six beds in Costa Mesa. Like the Children's program, TAY CRP is designed to be three weeks long although youth may remain in treatment for up to six weeks if needed. In addition, TAY who would benefit from a longer-term structured environment may be referred to the Social Rehabilitation Program (SRP; see Residential Treatment).

Adult Crisis Residential

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics		
						
	Mild-Moderate	Severe	Residential	LGBTIQ	Veteran	Co-Occurring SUD

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Khmer and Mandarin.

The Adult CRP serves adults ages 18 and older who are County residents, diagnosed with a behavioral health disorder, may have a co-occurring substance use disorder, and may be at-risk of psychiatric hospitalization. The individual must be in crisis and willing to engage in voluntary crisis residential services. The Adult CRP provides services at three sites (Orange, Mission Viejo, Anaheim) with a total of 27 beds. Stays in the Adult CRP last, an average, seven to 14 days.

Services

The CRPs emulate a home-like environment in which intensive and structured psychosocial recovery services are offered. Depending on the individual's age and their or their family'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; 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 abuse education and treatment services for people who have co-occurring conditions.

To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other on-going behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual). The Children's CRP also offers a weekly graduate drop-in group.

Strategies to Promote Recovery/Resilience

The CRPs are person-centered and recovery oriented. Services focus on empowering individuals to take responsibility for themselves by giving them choices in their daily activities and helping them develop independent living skills. Each individual admitted to a Crisis Residential Program has a comprehensive service plan that meets the individual's needs, and specifies the goals to be achieved for discharge. To integrate the individual back into the community effectively, discharge planning starts upon admission. In the Children's program, opportunities are provided throughout the day to develop protective factors, practice emotion self-regulation, and develop supportive peer, staff and family relationships. In the TAY CRP, participants, when ready, present their own case for increased independence to the treatment team as a way to prepare for a lower level of care. In the adult program, the CRP provides a healthy alternative to psychiatric hospitalization in a therapeutic home-like environment for people experiencing an acute behavioral health episode.

Strategies to Improve Timely Access to Services for Underserved Populations

The CRPs hire bilingual/bicultural staff who speak multiple languages (see grid). The language line and/or interpretation services are also available when staff who speak the language of a participant or family member is not available. In addition, central to each participant's treatment plan is connection to on-going services and stable supports. Case management and close coordination with partner programs help ensure that participants are linked to appropriate, available resources in the county.

Although family involvement is critical to the success of the Children's CRP, family members may experience transportation difficulties, work/school schedule conflicts and child care issues that create barriers to participation. To address these challenges and improve families' access to services, programs are located throughout Orange County, counseling sessions accommodate family members' work and school schedules, and program staff provide transportation assistance.

To meet the needs of adults throughout the county, an additional six-bed Adult CRP opened in Anaheim in May 2018 to continue to expand short- term crisis residential services.

Strategies to Reduce Stigma and Discrimination

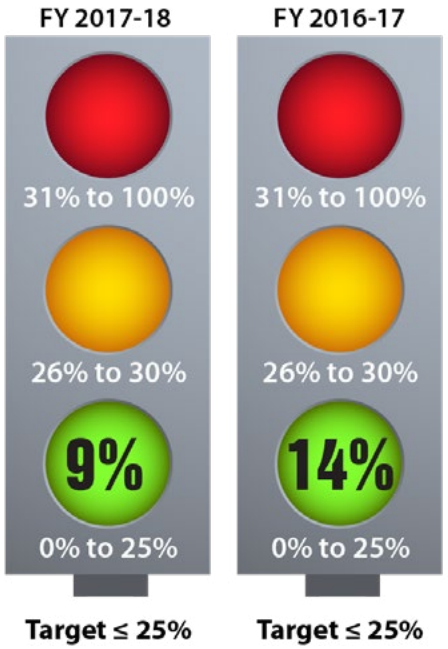
CRPs provide a welcoming, home-like environment that meets individuals and families where they are at in their recovery. The TAY and Adult programs also provide transgender individuals with a choice regarding the room assignment with which they most identify or prefer (i.e., male, female, private). The programs strive to provide a physically and emotionally safe environment, free of judgment to all participants so they can focus on their recovery.

Outcomes

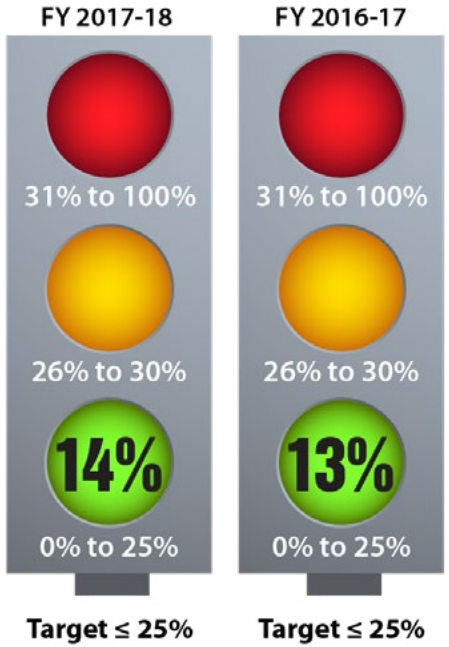
In FY 2017-18, there were 277 admissions to the Children's program, 64 to the TAY program and 626 to the adult program. In FY 2016-17, there 243 admissions to the Children's program, 60 to the TAY program and 426 to the adult program. The goal of the CRPs is to minimize discharges before the person has achieved an adequate degree of stabilization. For the Children's and TAY programs, this is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the youth is enrolled in the program through 60 days post-discharge. Both programs met this goal with hospitalization rates ranging from 9%-14% across the two fiscal years. Because the length of stay is substantially shorter in the Adult CRP compared to the Children's and TAY programs, its target is a hospitalization rate of less than 5% within 48 hours of discharge. The Adult CRP met its goal in both fiscal years as 1% of adults in FY 2017-18 and no adults in FY 2016-17 were hospitalized within this time frame.

Hospitalization Rate – Up to 60 Days Following Discharge by FY

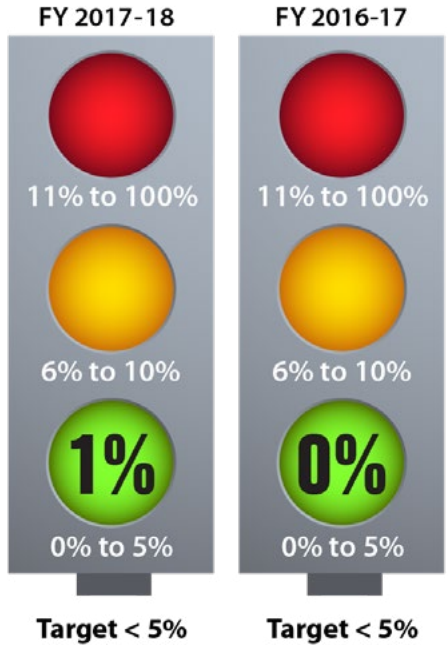
Children's Crisis Residential Program



TAY Crisis Residential Program



Hospitalization Rate - Up to 48 Hours Following Discharge by FY Adult Crisis Residential Program



The Adult CRP also tracks the percentage of individuals served who achieved crisis stabilization while in the program and were discharged to a less restrictive level of care such as an outpatient clinic, Full Service Partnership or private psychiatrist/therapist. The target goal established by management is a 90% discharge rate to a lower level of care, which was exceeded during FY 2017-18 (93%) and FY 2016-17 (98%).

Challenges, Barriers and Solutions in Progress

An ongoing, primary challenge has been the increased demand for Crisis Residential services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and anticipates a proposed solution within FY 2019-20 that will help address barriers that older adults may have encountered when accessing crisis residential services.

The TAY CRP continues to face challenges with the lack of stable housing available when youth are ready for a lower level of care.

Community Impact

Since inception, the CRPs have assisted 1,493 children, 1,550 TAY and 3,205 adults with intensive services provided in a therapeutic, home-like environment. The programs reduce admissions to local emergency departments and provide a strengths-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

To facilitate access into their programs, as well as linkage to on-going services upon discharge, the CRPs work closely with the County Crisis Stabilization Unit, County and County-contracted outpatient clinics, Full Service Partnerships, Programs of Assertive Community Treatment, Older Adult Services, Recovery Services/Centers and other County-contracted programs.

RESIDENTIAL TREATMENT

Residential Treatment programs provide 24-hour care in a residential setting for individuals whose behavioral health treatment needs exceed the capacity of outpatient programs. Orange County currently funds three residential programs through MHSA/CSS, each with a specific focus. Two are targeted to serve Transitional Age Youth (TAY) with specific residential care needs. The remaining program serves adults and older adults with co-occurring mental health and substance use disorders. The programs, which are all voluntary, are described in more detail below.

Residential Treatment	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
TAY Social Rehabilitation Program (CSS)	See TAY CRP numbers on page 61		
Youth Core Services Short-Term Residential Therapeutic Programs (CSS)*	700	$5,370,000	$7,671
Co-Occurring Mental Health and Substance Use Disorders Residential Treatment – AOABH (CSS)	TBD	$500,000	TBD

* *The budget for Youth Core Services is the total figure that includes both the Short-Term Residential Therapeutic Programs and outpatient services described in the Intensive Outpatient section.*

Transitional Age Youth Social Rehabilitation Program

Program Serves	Symptom Severity		Location of Services		Typical Population Characteristics			
								
18 - 25	Mild-Moderate	Severe	Anywhere	**Residential**	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean and Arabic.

Target Population and Program Characteristics

The TAY Social Rehabilitation Program (SRP) is a six-bed facility that provides structured and supervised housing for youth between the ages of 18 and 25 who are living with serious mental illness and may have a co-occurring substance use disorder. TAY are referred to the SRP if they would benefit from a high level of supervision provided by a residential program but do not need as intense a placement as Crisis Residential or psychiatric hospitalization. Youth are typically experiencing significant family conflict, are homeless or at-risk of being homeless, unserved or underserved, or transitioning out of the juvenile justice or foster care system. Placements typically range from two to six months.

The SRP primarily accepts referrals from FSPs. The SRP also serves as a step-down level of care for those who are ready to discharge from the TAY Crisis Residential Program (CRP; see program description under Crisis Services), but would still benefit from a residential placement. Many of the youth referred to this program have difficulty in living situations like room and boards or sober living homes where they have primary responsibility for structuring their own time. All TAY who enter the SRP are already linked with an FSP. The program does not admit individuals who are registered as a sex offender, conserved or diabetic.

Services

The SRP places an emphasis on personal growth and helps prepare youth for returning to the community and living more independently. Services include safe and stable shelter, food, medication assistance, case management, individual and group therapy, and coaching to develop basic living skills. Some of the evidence-based

therapeutic interventions used include Seeking Safety, Trauma-Focused Cognitive Behavioral Therapy and Motivational Interviewing. Linkage to ongoing community mental health services and other supports such as assistance with employment and school enrollment are also integral parts of this program.

Strategies to Promote Recovery/Resilience

The SRP staff and clinical team provide 24-hour support and emphasize personal growth to help prepare youth for returning to the community and living more independently. As mentioned above, these youth can have difficulty with conforming to program expectations, so the SRP provides opportunities to learn new behaviors by breaking them down into smaller, achievable units and giving the encouragement for accomplishing each part before integrating the behaviors into a whole response.

Strategies to Improve Timely Access to Services for Underserved Populations

Central to each TAY's treatment plan is the connection to services or stable supports, which will allow appropriate transition into the community when their time at SRP is complete. Case management services and close coordination with Full Service Partnership programs ensure the TAY benefits from the full range of resources available to them.

Strategies to Reduce Stigma and Discrimination

By helping youth learn tasks that the great majority of their same-aged peers can accomplish, the program enhances self-esteem and assists them in integrating with their peers.

Outcomes

Of the 21 TAY served during FY 2017-18 and 26 served during FY 2016-17, a total of 10 and 8, respectively, were referred directly to the SRP and included in the analysis here. The remaining youth transferred between the Crisis Residential and Social Rehabilitation Programs and are included in the TAY CRP since they had required a higher level of care at some point during their placement. Similar to the CRP, the TAY SRP strives to maintain a psychiatric hospitalization rate of 25% or less during the time the youth is enrolled through 60 days post-discharge. This goal was met in FY 2017-18 and FY 2016-17, with 5% TAY in FY 2017-18 and none of the TAY in FY 2016-17 requiring a hospitalization during this timeframe.

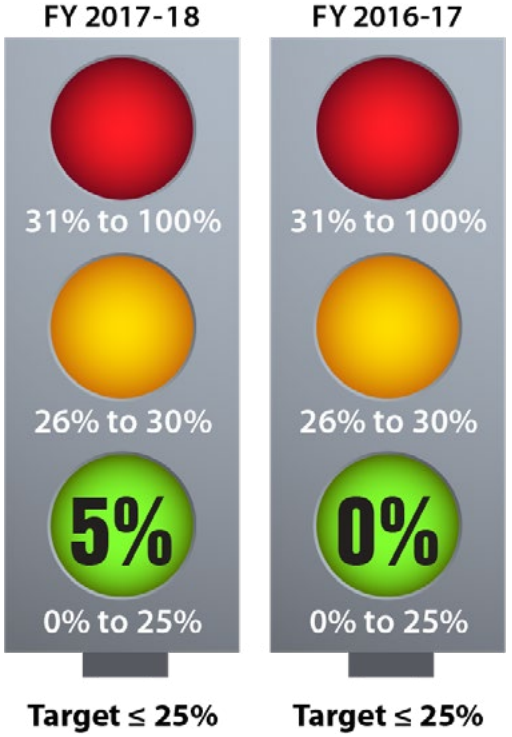
Challenges, Barriers and Solutions in Progress

It can be difficult to design a structured program that simultaneously supports and encourages independence. When youth are away from the program, substance use can be problematic even in a flexible harm reduction model. Every attempt is made to empower youth, encouraging their exercise of voice and choice by having participants make as many decisions as possible about food, outings and house rules. The program also includes as much psychoeducation on substance-related issues as can be useful within a population that is at a developmentally appropriate stage to test limits.

Community Impact

The program has provided services to 212 TAY since its inception in September 2009. The program provides an alternative to hospitalization by providing a safe, therapeutic environment that is the first step toward independent living. Youth are also enrolled in FSPs to further assist with their transition to less restrictive levels of care.

Hospitalizations Up to 60 Days Following Discharge by FY



Youth Core Services – Short-Term Residential Therapeutic Programs

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics							
0-21	Severe	Residential	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Medical	Students

The program provides services in English and TBD as contracts are awarded.

Target Population and Program Characteristics

Starting in FY 2017-18, the Youth Core Services – Short-Term Residential Therapeutic Programs (STRTPs) was established to serve foster youth from birth up to age 21 who need the highest level of behavioral health care in a trauma-informed residential setting. HCA estimates that 150 of the youth served in Youth Core Services will be served in the STRTPs. Residential costs will be paid through the foster care system and HCA will contract with the STRTPs to provide MediCal Specialty Mental Health Services to address the mental health needs of wards and dependents placed under the Senate Bill 403 mandate. All referrals to the program will be made by Child Welfare or Probation with approval from the Interagency Placement Committee (IPC), which includes staff from Child Welfare, Probation and HCA. HCA is currently working to establish its initial contracts for the STRTPs and an interagency STRTP workgroup is collaborating with different providers that will meet the needs of this population.

Services

Per state legislation, foster youth can stay in an STRTP up to six months before transitioning to a less restrictive, more family-like setting. While in the placement, the STRTP will provide an integrated program of specialized and intensive behavioral health services and supervision that includes 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, STRTPs are required to provide EBPs that meet the needs of its specific population. Thus, the specific treatment interventions will vary among the providers. In addition, the legislation requires that all providers must provide trauma-informed and culturally relevant core services that include:

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

Strategies to Promote Recovery/Resilience

Due to the extensive histories of trauma experienced by the youth referred to this program, STRTP providers will foster recovery and resilience by creating a space that provides physical and emotional safety for the children. Providers will sensitively conduct screenings and assessments to identify the trauma-related reactions and risk of the children and youth they serve. Assessments will also factor in how the children's developmental stage and cultural considerations intersect with their trauma experiences and use this information to connect children with appropriate evidence-based treatments that will: (1) address their trauma and other behavioral health symptoms, and (2) help them form positive supportive relationships. Providers will also educate caregivers on how their own trauma histories may be impacting their current behavior and relationships, particularly with their children, and will help adults develop skills and tools to support their children in recovery.

Finally, the STRTP model recognizes that those who work with trauma-exposed individuals can

be affected, and programs are encouraged to educate and support staff on how to address these impacts so that they can continue to support the children and families with whom they work. Staff are also expected to partner with youth, families and the other agencies with which they interact (i.e., child welfare, mental health, law enforcement, legal, medical, educational, etc.) so that they are working collaboratively and one system is not 'undoing' the work of another.

Strategies to Improve Timely Access to Services for Underserved Populations

The state has outlined an emergency admission procedure to provide this level of care when it is the only viable alternative. All "pre-placement" activities occur once a youth is placed in the program in order to facilitate timely access to its services. If criteria are subsequently determined not to be met, alterna- tive placements are arranged. The program will also provide services in Spanish, Vietnamese and other languages through staff who are bicultural/bilingual.

Strategies to Reduce Stigma and Discrimination

Staff hired to work at a STRTP will receive on-going and inten- sive training in child development, cultural and gender iden- tity issues and severe trauma. This training will help provide staff with evidence-supported skills and strategies to offer a safe environment that respects the backgrounds and histo- ries of the youth and families and to collaborate with them to identify services and supports that best meets their needs.

Outcomes

The program has not yet been implemented so there are no outcomes to report at this time.

Adult Co-Occurring Mental Health & Substance Use Disorders Residential Treatment

The Co-Occurring Mental Health and Substance Use Disorders Residential Treatment programs ("Co-Occurring") serve individuals living with both types of behavioral health conditions in structured residential settings that provide 24/7 care. Historically Orange County has contracted with traditional residential treatment providers that focus on substance use disorders (SUD). Over the years, it became increasingly apparent that some individuals in these programs had serious mental health conditions that fell outside the scope of practice of the existing providers. Thus, programs were designed to address the specialized needs of this population. Orange County currently has one such program for adults funded through CSS. Beginning in FY 2019-20, CSS will no longer fund co-occurring residential treatment services for adolescents. Services will continue to be provided but will instead be funded through Drug Medi-Cal.

Target Populations and Program Characteristics

Adult Co-Occurring

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics				
							
	Severe	Residential	LGBTIQ	Veteran	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese and TBD.

The Adult Co-Occurring Residential program will serve individuals who are diagnosed with serious and persistent mental illness (SPMI) and a concurrent SUD. Qualifying TAY over the age of 18 will also be able to participate.

Although the contract for the Adult program was awarded by the Board of Supervisors in August 2017, the provider has experienced challenges securing a site. Current plans are to establish this program at the Anita Wellness Campus once construction is completed.

Services

The Co-Occurring Residential Program will provide 24/7 care for adults in a structured setting. Recognizing that sustained rates of recovery can be significant when mental health and substance abuse treatment are integrated, the program will incorporate individual and group therapy and other services identified during the contracting process.

Outcomes

Because the Adult Co-Occurring program has not yet been established, no outcomes are available at this time.

OUTPATIENT SERVICES

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

- Early Intervention Outpatient
- Clinic-Based Outpatient Mental Health
- Integrated Outpatient Care
- Intensive Outpatient
- Outpatient Recovery
- Specialized Outpatient/Interagency Collaborations

These program types and the services they provide are described in more detail in the sections that follow.

EARLY INTERVENTION OUTPATIENT

The first subcategory of outpatient services is the early intervention programs. These programs serve individuals of all ages who are experiencing mild to moderate mental health symptoms and most specialize in serving a traditionally underserved group such as Veterans and military-connected families or the lesbian, gay bisexual, transgender community. Consistent with a key MHSA aim of preventing symptoms of mental illness from becoming severe and disabling, Early Intervention Outpatient Services are designed to create a system of first-help and deliver services in the community to encourage access to their programs. These programs are funded by PEI and are described below according to the target populations they are designed to serve.

Early Intervention Outpatient	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Short-Term Treatment: Community Counseling and Supportive Services (PEI)	700	$1,986,136	$2,837
Suicide Prevention/ Postvention: Survivor Support Services (PEI)	130	$343,693	$2,644
Veterans Services: College Veterans Program (PEI)	100	$400,000	$4,000
OC4Vets (PEI)	180	$1,295,957	$7,200
Strong Families-Strong Children: Behavioral Health Services for Military Families (INN-PEI)	150	$1,000,000	$6,667
LGBTIQ Services: OC ACCEPT (PEI)	150	$550,000	$3,667
Early Onset: 1st Onset of Psychiatric Illness (OC CREW; PEI)	70	$1,500,000	$21,429
Early Intervention Services for Older Adults (PEI)	600	$2,469,500	$4,116
Family Services: OC Parent Wellness (PEI)	700	$1,713,072	$2,447

Early Intervention Outpatient	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
School-Based Outpatient: School-Based Health Intervention and Support – Early Intervention Services (PEI)	16	$440,000	$27,500
School-Based Mental Health Services (PEI)	2,800	$2,315,236	$827

Short-Term Treatment

Early Intervention – Short-Term Treatment programs provide outpatient behavioral health treatment for those who are experiencing mild to moderate symptoms of a behavioral health condition or who are at-risk of developing a mental health condition. Individuals in this type of service tend to be enrolled for about six months and do not necessarily have a specialized need supported by other Early Intervention Outpatient programs (i.e., Veterans, Early Onset, Family Services, etc.). Orange County currently has one Early Intervention – Short-Term Treatment program that is funded by PEI.

Community Counseling and Supportive Services (PEI)

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics							
0+	At-Risk	Early Onset	Mild-Moderate	Outpatient Clinic	Satellite Locations	Parents	LGBTIQ	Veteran	Homeless/ at-Risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Korean, Arabic, and ASL.

Target Population and Program Characteristics

The target population for Community Counseling and Supportive Services (CCSS) includes Orange County residents of all age groups 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. The majority of enrolled participants are un-insured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. The program is designed to treat the early symptoms of depression, anxiety, alcohol and/or drug use, violence and Post Traumatic Stress Disorder (PTSD). The early onset of mental illness is determined through referrals and screening. Participants are referred to the program by family resource centers, medical offices and emergency departments within the local community. The program also receives referrals from County-operated and County-contracted programs.

Services

CCSS provides face-to-face individual counseling and groups (i.e., psychoeducational, skill building and insight oriented), case management, and referral and linkage to community services. Psychiatric medication support and behavioral health nurse wellness evaluations are also provided for participants. Clinicians utilize evidence-based practices such as Eye Movement Desensitization Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants.

Strategies to Promote Recovery/ Resilience

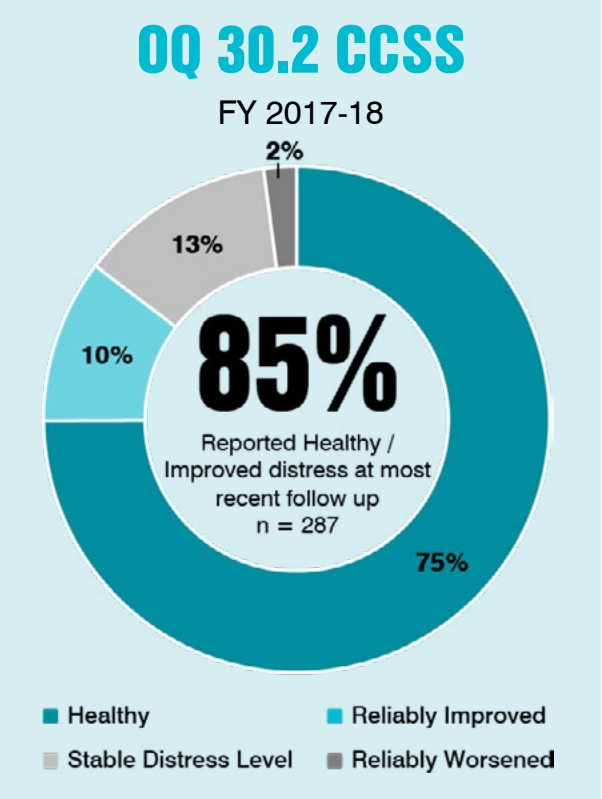
Clinicians use various strategies such as mindfulness practices, strengths-based approaches and motivational interviewing to reinforce and strengthen resilience in participants. Enrolled participants are engaged in individualized care planning to promote positive change. The clinic promotes recov-

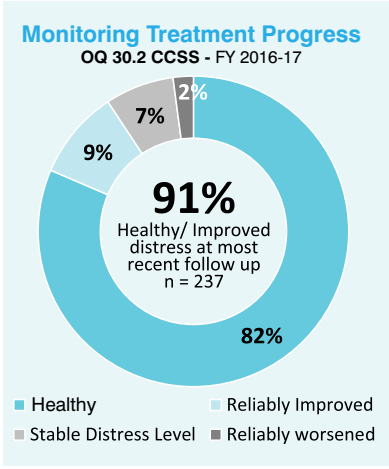
ery by creating an open, warm and safe place to receive care and individualized services.

Strategies to Improve Timely Access to Underserved Populations

Program participants experience barriers to engaging in services such as lack of childcare or transportation, an inability to take time off work to make counseling appointments during business hours, conflicting family priorities, financial burden, substance use, lack of a support system and mental health stigma. To overcome these barriers, program staff participate in various outreach events in Orange County and through community presentations to de-stigmatize and break down barriers to mental health services. The program also offers evening hours, onsite childcare and bus vouchers for those without a reliable means of transportation. In addition, the program provides bilingual/bicultural staff in the threshold languages to work with non-English speaking participants. The program also partners with community agencies to provide services to highly marginalized populations such as Middle Eastern and North African refugees via "satellite" locations to improve timely access to its services. The program also partners with community agencies to provide services to highly marginalized populations such as the Middle Eastern and North African refugee and the Deaf and Hard of Hearing communities via "satellite" locations to improve timely access to services. Finally, in FY 2018-19, the program has co-located a clinician with the Sheriff's School Mobile Assessment Resource Team (SMART) to provide comprehensive assessment of identified student at-risk.

For participants exiting the program, CCSS provides referrals to appropriate community services and resources in order to promote and sustain recovery. The program provided 298 referrals and 156 linkages in FY 2017-18 and 328 referrals and 157 linkages in FY 2016-17. The program primarily makes referrals and linkages to behavioral health services, legal services and advocacy and health care benefits.





Strategies to Reduce Stigma and Discrimination

CCSS serves all eligible Orange County residents regardless of citizenship status. The program employs bilingual and bicultural staff to provide services in a culturally sensitive manner. As mentioned above, it has also partnered with community agencies that work with unserved populations who might be reluctant or unwilling to seek out treatment at a behavioral health clinic but will engage in services in non-behavioral health settings.

Outcomes

CCSS served a total of 492 participants during FY 2017-18 (29 children, 87 TAY, 357 adults and 19 older adults) and 467 participants in FY 2016-17 (34 children, 73 TAY, 344 adults and 16 older adults). Individuals completed an age-appropriate form of the OQ 30.2 at intake, every three months of program participation and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. This measure reflects cultural competence as it is available in all threshold languages and contains a wide range of symptoms, including somatic symptoms, which may be experienced and/ or reported by people from different cultural backgrounds.

Of the 492 participants who were served In FY 2017-18, 287 completed the OQ 30.2 at intake and at least one follow-up. In FY 2016-17, 237 of the 467 individuals served had completed both a baseline and follow up assessment. Across both fiscal years, the overwhelming majority reported mental health distress levels that were either in the healthy/non-distressed range (FY 2017-18: 75%, FY 2016-17: 82%) or were reliably improved (FY 2017-

18: 10%, FY 2016-17: 9%) at the most recent follow-up. Thus, CCSS services were associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with a meaningful reduction in suffering among those who had reported clinical- ly elevated distress levels upon entering the program.

Challenges, Barriers and Solutions in Progress

In FY 2017-18, the program implemented a new Intake Coordinator role to assist with better identifying individuals experiencing mild and moderate symptoms and with referring participants with a higher level of need to another resource. Subsequently, the program has been more effective in triaging referred participants to the most appropriate level of care and is now tracking these non-enrolled participants who are linked to other services. This has resulted in fewer individuals enrolled than anticipated and the program is continuing to outreach and create new partnerships so that they may reach and serve greater numbers of eligible participants. The program has also filled several vacancies throughout the year, positioning itself to meet community need.

Community Impact

CCSS has provided services to more than 1,315 participants since its inception in May 2015. It also collaborates with a community based organization (CBO) to provide services to the Arabic speaking community and collaborates with another CBO to provide services to the deaf and hard-of-hearing comnmunity. In addition, the program gives presentations to community partners as requested, to promote awareness and utilization of its services for unserved and underserved populations with mental health needs.

Suicide Prevention/Postvention Survivor Support Services

Another subset of the Early Intervention Outpatient programs specializes in suicide prevention and/or postvention therapeutic interventions for at-risk populations. Orange County currently funds one program through PEI that specializes in these services, although it should be noted that all programs are able to respond to and/or serve any individual expressing suicidal statements and/or behaviors.

Survivor Support Services (PEI)

Program Serves	Symptom Severity				Location of Services	
0+	At-Risk	Early Onset	Mild-Moderate	Severe	Field	Community-Based

The program provides services in English, Spanish, Farsi, Korean and Arabic.

Target Population and Program Characteristics

Orange County's contracted PEI program, Survivor Support Services, serves two groups of individuals within this service function: (1) those who have recently experienced the loss of someone to suicide and (2) those who have attempted suicide and may be suffering from depression. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by partner agencies.

Services

Survivors After Suicide. For children, adolescents and adults who are coping with the loss of someone to suicide, the program provides time-limited individual counseling. Short-term bereavement counseling can also be provided to a family to improve their functioning and communication after the loss of a family member.

In addition to counseling, the program offers bereavement groups in two different formats. 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 type of group for survivors after suicide are drop-in bereavement groups designed to help those who are receiving individual counseling and program alumni to continue the healing process in the months and years following their losses.

Survivors of Suicide Attempts. The program offers closed groups that provide a safe, non-judgmental place for people who have survived a suicide attempt to talk about the feelings that led them to attempt suicide. The goal of this group is to support

their recovery and to provide them with skills for coping with deep hurt. The program also provides these individuals with culturally appropriate follow-up care and education. The program uses Applied Suicide Intervention Skills Training (ASIST), which is a practice-based evidence standard, to guide program services for these individuals.

Community Training. The program employs, per the PEI regulations, a strategy to increase recognition of early signs of mental illness. More specifically, the program trains first responders in ASIST and safeTalk so that they are better able to recognize the early warning signs of suicide, depression and/or other types of mental illness and respond appropriately. Audiences include nurses, physicians, teachers and school personnel, law enforcement and other Orange County community members. In FY 2017-18, the program provided 70 trainings and reached 2,015 community members, including 64 first responders. In FY 2016-17, the program provided 59 trainings that reached 315 potential first responders.

Strategies to Promote Recovery/Resilience

The program promotes recovery and resilience by offering a broad range of services for those affected by suicide so that interventions can be tailored to meet participants where they are in the grieving process and provide them with needed support and resources. The support groups also encourage the continued use of adaptive coping skills and the resources provided after participants discharge from the program.

Strategies to Improve Timely Access to Services for Underserved Populations

Situated near five major freeways, the program is located centrally in Orange County and is accessible from anywhere in the Southern California area to help minimize transportation barriers. Community partners provide counseling and support groups in different parts of Orange County to assist with minimizing both transportation and cultural barriers to treatment. Support groups and counseling are also provided in the threshold languages.

Because of the stigma associated with suicide and mental illness, survivors become ready to engage in services at different stages after their loss, which does not always coincide with when they are referred to the program. Staff remains steadfast, patient and ready to provide treatment at any time the survivor is ready for support. If a survivor does not begin services directly after the referral, staff continues to reach out and periodically re-assess readiness for services. For those nearing completion of services, the program also provides referrals to ongoing services to help survivors maintain their recovery. The program provided 692 referrals and 220 linkages to mental health services in FY 2017-18, and 471 referrals and 226 linkages in FY 2016-17. HCA is currently exploring factors that may underlie the difference in referral rate across the two years.

Finally, to increase awareness of, and timely access to its services among underserved populations, the program provides suicide awareness, suicide prevention and program information throughout Orange County. Staff and community partners present at community events, cultural events and fairs, schools, parent and family education events, religious organizations, colleges and other settings in many of the threshold languages, including Spanish, Korean, Arabic and Farsi. The program provided 110 of these types of outreach activities in FY 2017-18 and 192 in FY 2016-17. The decrease between fiscal years was due to staffing shortages that have since been addressed.

Strategies to Reduce Stigma and Discrimination

The County strives to make its programs available to all Orange County residents and provide services that are sensitive and responsive to participants' cultures and needs. The way in which individuals cope with loss varies across cultures, religions and age groups and staff are respectful of these differences. Services are carefully designed to take into account the sensitive nature of loss and differences in the grieving process. For example, non-traditional marketing approaches were used for the Spanish-speaking survivors. Instead of using the more traditional term "support group," which has stigma associated with it in this population, staff referred to their services as "workshops." This approach was so successful that community partners are now utilizing it to overcome cultural barriers and stigma.

Outcomes

In FY 2017-18, the program served 109 individuals in its closed groups, 64 in its open groups, and 559 in individual counseling services. In FY 2016-17, the program served 94 individuals in its closed groups, 59 in its open groups and 511 in individual counseling services.

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

Survivors After Suicide. Individuals reported on their grief over losing someone to suicide on the Grief Experiences Questionnaire (GEQ; FY 2017-18: n=22; FY 2016-17: n=20). Participants reported small to moderate decreases on overall and specific expressions of grief in FY 2017-18, and small to large decreases in FY 2016-17. Thus, services were generally as-

Impact on Symptoms of Grief by FY

Survivor Support Services

sociated with a meaningful lessening of grief following the loss of a loved one to suicide. Given the small sample sizes, however, it cannot yet be determined whether differences across fiscal years reflect a change in the impact of services, the nature of the individuals served or other factors, and the HCA will continue to monitor the program's outcomes.

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

Challenges, Barriers and Solutions in Progress

Stigma regarding suicide continues to be a barrier to seeking services. Program has redirected staff to conduct more outreach and presentations to address this barrier. In response to observations that community partners still encounter difficulty referring people from underserved populations to the program, Survivor Support Services has increased its availability in Spanish and Korean and has formed workshops for survivors of suicide loss that include an additional psychoeducational focus that addresses misperceptions and stigma related to mental illness and suicide. Due to their positive experience with these groups, some Spanish-speaking survivors have transitioned to individual supportive counseling. To improve linkage to the Survivors of Suicide Attempts groups, the program has begun to work with juvenile hall and continued to work with hospital emergency departments and wellness centers to engage individuals who have attempted suicide.

Community Impact

The program has provided services to more than 867 since its inception in August 2010. One of the key components of the program's success is its collaboration with community partners and agencies that serve ethnic communities. This partnership promotes awareness, breaks down stigma related to mental health and educates communities about available resources.

Reference Notes

Somatic Reactions:
FY 2017-18: Baseline M=13.4, SD=5.0; Follow-up M=12.1, SD=3.6; t(21)=1.47, p=.16; Cohen's d=0.33
FY 2016-17: Baseline M=11.5, SD=4.2; Follow-up M=9.5, SD=2.7; t(19)=3.23, p<.01; Cohen's d=0.84

General Grief Reaction:
FY 2017-18: Baseline M=15.0, SD=4.1; Follow-up M=13.5, SD=3.6; t(21)=1.75, p=.10; Cohen's d=0.38
FY 2016-17: Baseline M=13.1, SD=4.4; Follow-up M=11.7, SD=4.3; t(19)=2.01, p<.05; Cohen's d=0.47

Search for Explanation:
FY 2017-18: Baseline M=17.0, SD=4.8; Follow-up M=14.2, SD=5.1; t(21)=2.77, p<.05; Cohen's d=0.59
FY 2016-17: Baseline M=15.0, SD=3.5; Follow-up M=12.6, SD=3.7; t(19)=2.70, p<.05; Cohen's d=0.60

Loss of Social Support:
FY 2017-18: Baseline M=13.1, SD=5.6; Follow-up M=11.3, SD=3.8; t(21)=1.46, p=.16; Cohen's d=0.41
FY 2016-17: Baseline M=11.6, SD=4.3; Follow-up M=11.1, SD=4.0; t(19)=0.55, p=.59; Cohen's d=0.12

Stigmatization:
FY 2017-18: Baseline M=12.9, SD=5.4; Follow-up M=10.9, SD=4.8; t(21)=1.67, p=.11; Cohen's d=0.36
FY 2016-17: Baseline M=11.2, SD=4.8; Follow-up M=9.0, SD=4.0; t(19)=3.05, p<.01; Cohen's d=0.70

Guilt:
FY 2017-18: Baseline M=16.7, SD=4.9; Follow-up M=14.6, SD=4.7; t(21)=1.81, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=14.5, SD=4.5; Follow-up M=12.1, SD=3.4; t(19)=2.55, p<.05; Cohen's d=0.58

Responsibility:
FY 2017-18: Baseline M=13.9, SD=4.8; Follow-up M=12.0, SD=4.7; t(21)=1.84, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=10.1, SD=3.4; Follow-up M=9.1, SD=2.9; t(19)=1.65, p=.12; Cohen's d=0.37

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

Rejection:
FY 2017-18: Baseline M=14.7, SD=5.8; Follow-up M=13.2, SD=5.6; t(21)=1.51, p=.15; Cohen's d=0.32
FY 2016-17: Baseline M=11.8, SD=4.8; Follow-up M=11.1, SD=4.6; t(19)=0.89, p=.39; Cohen's d=0.20

Self-Destructive Behavior:
FY 2017-18: Baseline M=10.5, SD=4.2; Follow-up M=9.6, SD=3.7; t(21)=1.34, p=.19; Cohen's d=0.29
FY 2016-17: Baseline M=8.0, SD=3.5; Follow-up M=8.1, SD=3.1; t(19)=-0.17, p=.87; Cohen's d=0.04

Unique Reactions:
FY 2017-18: Baseline M=13.4, SD=3.5; Follow-up M=12.0, SD=3.9; t(21)=2.00, p=.06; Cohen's d=0.43
FY 2016-17: Baseline M=12.8, SD=2.6; Follow-up M=10.5, SD=2.7; t(19)=4.92, p<.001; Cohen's d=1.10

Overall Score
FY 2017-18: Baseline M=154.8, SD=38.4; Follow-up M=136.3, SD=33.6; t(21)=2.16, p<.05; Cohen's d=0.46
FY 2016-17: Baseline M=132.6, SD=32.6; Follow-up M=116.7, SD=30.7; t(19)=3.28, p<.01; Cohen's d=0.74

Veterans Early Intervention Outpatient Services

Early Intervention Outpatient Services for Veterans provides outpatient services to Orange County Veterans and/or military-connected families who are experiencing, or are at-risk of developing, mild to moderate mental health symptoms. The HCA currently funds three outpatient programs specifically geared towards Veterans and their families through PEI and INN.

College Veterans Program – Early Intervention Services (PEI)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
										
	At-Risk	Field	School	County Veteran Service Office	LGBTIQ	Veteran	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English.

Target Population and Program Characteristics

The College Veterans Program – Early Intervention Services provides services to military veterans and their family members who are enrolled at local college campuses. Participants served in this program tend to be between the ages of 22-57 years and, due to unique issues and challenges related to the transition from active military duty to civilian and student life, are at-risk of developing mental health conditions and/or of experiencing school failure. Student veterans are self-referred or referred by campus staff or faculty to this PEI program, which was established to meet a need identified by community stakeholders during the MHSA community planning process.

Services

The College Veterans Program places counselors who understand military culture in Orange County community colleges to help veterans navigate available support services and resources. Services include behavioral health screening and assessment to determine whether further evaluation and/or referrals to behavioral health services are needed, individualized case management, brief counseling, and referrals and linkages to appropriate community resources. Services are provided using evidence-based and best practices such as motivational interviewing. Through this program, participants also have access to appointments with a Behavioral Health Services clinician who is a veteran and can understand the unique issues and challenges faced by veterans transitioning to civilian and student life. These services are provided with the goal of helping them succeed at college by reducing their school failure or dropout rates and by reintegrating them into the community and their families.

Strategies to Promote Recovery/Resilience

College Veterans Program utilizes a master's level clinician who is also military-connected with lived experience. Utilizing a person-centered and strength-based approach, the interventions work to address barriers to recovery or access to care and promote resiliency through encouraging healthy choices and positive coping mechanisms. The clinician is located on-site at the assigned campuses and is purposefully incorporated into the student health center or veteran resource center.

Strategies to Increase Timely Access to Services for Underserved Populations

Many participants have limited resources, such as limited or lack of transportation, housing, financial stability or support, adequate employment and/or daycare. Some participants, particularly with their military-connected background, may also hold cultural beliefs that deter them from asking for help. To address these barriers, the program is co-located on campus because there is far less stigma associated with school settings compared to mental health settings.

Clinicians also provide referrals to community-based services and supports as participant needs are identified. Once a referral is made, the clinician follows up with the participant to ensure they attended the first appointment. If a linkage did not occur, the clinician engages the veteran in discussions about the appropriateness of and their desire for change. The program provided 249 referrals that resulted in 10 linkages in FY2017-18, which is lower than the 133 referrals that resulted in 83 linkages in FY 2016-17. Participants most fre-

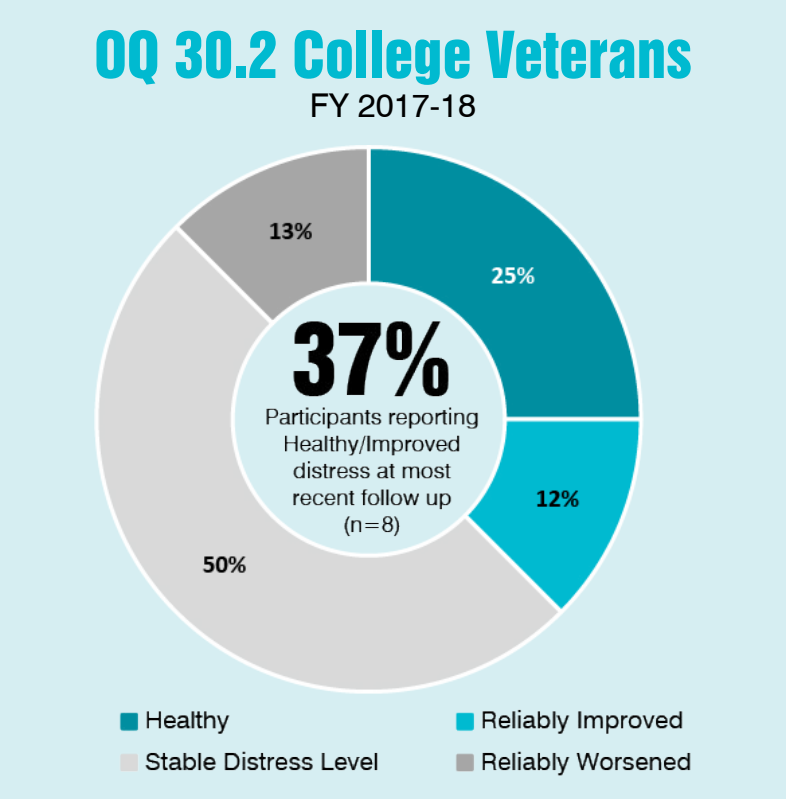
quently connected with transportation services; food and nutrition assistance; housing resources and advocacy; employment services and resources; adult education services; legal services and advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs; health care services; health education, disease prevention, wellness, and physical fitness; special needs and disability services; and veteran entitlement programs.

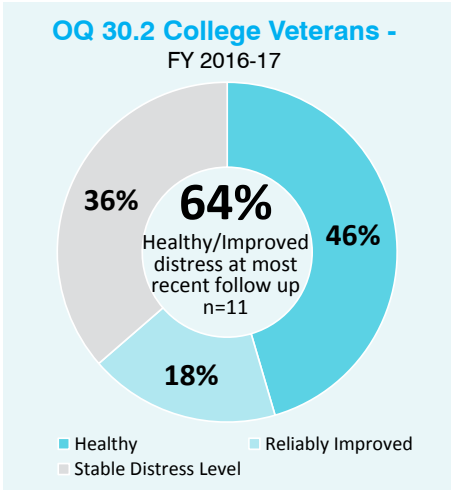
Strategies to Reduce Stigma and Discrimination

The program is staffed by military service members or veterans who can address the unique needs of student veterans, including the stigma associated with seeking behavioral health services and how those services might impact Veterans Administration (VA) benefits or be reported to the VA. The on-campus clinician provides frequent education to staff and faculty about ways to engage military-connected students with a culturally competent approach.

Outcomes

The College Veterans program served a total of 14 participants in FY 2017-18 and 27 participants in FY 2016-17. The program intended to administer the OQ 30.2 at intake, every three months and at discharge, and compare scores to the measure's clinical benchmarks. Due to implementation issues the measure was only administered at intake and discharge and paired measures were only available for 8 individuals in FY 2017-18 and 11 individuals in FY 2016-17. Among these, 37% in FY 2017-18 and 64% in FY 2016-17 reported healthy or reliably improved levels of distress at the time of discharge. While the findings demonstrate that the program prevented symptoms of mental distress from becoming severe and disabling for this small subset of participants, it is unclear whether this pattern of results is generalizable to the larger population of student-veterans served. Thus, the program is engaging in a two-fold process regarding its performance outcomes. First, it is working to improve its completion rate of the outcome measure and, second, it is working with program staff on how to utilize the OQ as a tool that can help inform clinical care.





Challenges, Barriers and Solutions in Progress

As mentioned above, the program continues to experience significant issues related to the collection of its performance outcome measure, which is currently being addressed. In addition, the program has had limited visibility due to the current staffing pattern (i.e., only one staff dedicated to the program). With the support of the MHSA Steering committee and HCA Administration, the program will convert from County-operated to County-contracted with expanded funding. It is believed these two changes will help improve the program's ability to engage more student veterans and their family members

Community Impact

The program has provided services to more than 94 participants since its inception in October 2011. The program works with many local veteran organizations, such as the Veterans Service Office (VSO), Veteran's Affairs, and Veterans Resource Centers at local community colleges in order to best meet the needs of Orange County's Veterans. It is also implementing changes with the hopes of expanding its reach and serving larger numbers of student-Veterans in Orange County.

OC4Vets (PEI)

Program Serves	Symptom Severity		Location of Services				Typical Population Characteristics				
18+	At-Risk	Early Onset	Home	Field	Courts	County Operations Center	Foster Youth	Families	LGBTIQ	Veterans	Homeless/ at-Risk

The program provides services in English, Spanish, Farsi, Korean and Arabic.

Target Population and Program Characteristics

OC4Vets serves Orange County veterans and their 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. OC4Vets is co-located with the Veterans Service Office (VSO). A VSO claims officer completes a referral to OC4Vets for those veterans or family members in need of behavioral health services. Referrals may also be self-referral or from other agencies working with veterans. This program was originally an Innovation project that was continued with PEI funding due to its demonstrated success.

Services

Program services include case management, behavioral health screening and assessment, employment and housing supportive services, referral and linkage to community resources, outreach and engagement activities and community trainings. Culturally competent, skilled therapists utilize evidence-based practices such as cognitive behavioral therapy and motivational interviewing when providing clinical interventions. One clinician is also trained in EMDR to serve veterans who are experiencing trauma.

In addition, the program is staffed with Peer Navigators who are veterans and, through their shared military experience, can provide support and navigation of the healthcare system to participants. Veterans who are involved in legal proceedings with Family Court, Military Diversion or Veterans Treatment Court are also provided clinical case management to support and advocate for veterans to seek behavioral health treatment in lieu of permanent consequences such as jail or a restraining order.

Strategies to Promote Recovery/Resilience

OC4Vets works from a strength-based approach incorporating recovery principles by using motivational interviewing, developing person-centered and individualized care plans and focusing on the veteran's strengths.

Strategies to Improve Timely Access to Services for Underserved Populations

Participants face issues such as lack of transportation, daycare and/or permanent housing, as well as stigma related to mental health. The program works to overcome these barriers to its services by providing them at locations where veterans and their families are already accessing other services or critical supports (i.e., using appointments with the claims officer as a gateway to addressing behavioral health issues). To encourage continued use of services, the program offers case management, behavioral health screening and assessment, and outreach and engagement activities. Staff also conduct community trainings on how to engage or work with veterans, thus helping agencies or other providers understand military/veteran culture and increasing their awareness about County services available for veterans.

Program staff also works with participants to link them to various community resources. The program provided 110 referrals resulting in 69 linkages in FY 2017-18, and 363 referrals resulting in 216 linkages in 2016-17, to housing resources and advocacy; behavioral health outpatient services; employment services and resources; veteran entitlement programs; transportation services; PEI programs; financial assistance; legal services and advocacy; food and nutrition assistance; entitlement programs; health care services; behavioral health crisis response; financial services; health care benefits; senior services; health education, disease prevention, wellness, and physical fitness; recreation; and family support services.

Strategies to Reduce Stigma and Discrimination

The program works to decrease stigma associated with seeking behavioral health services by staffing the program

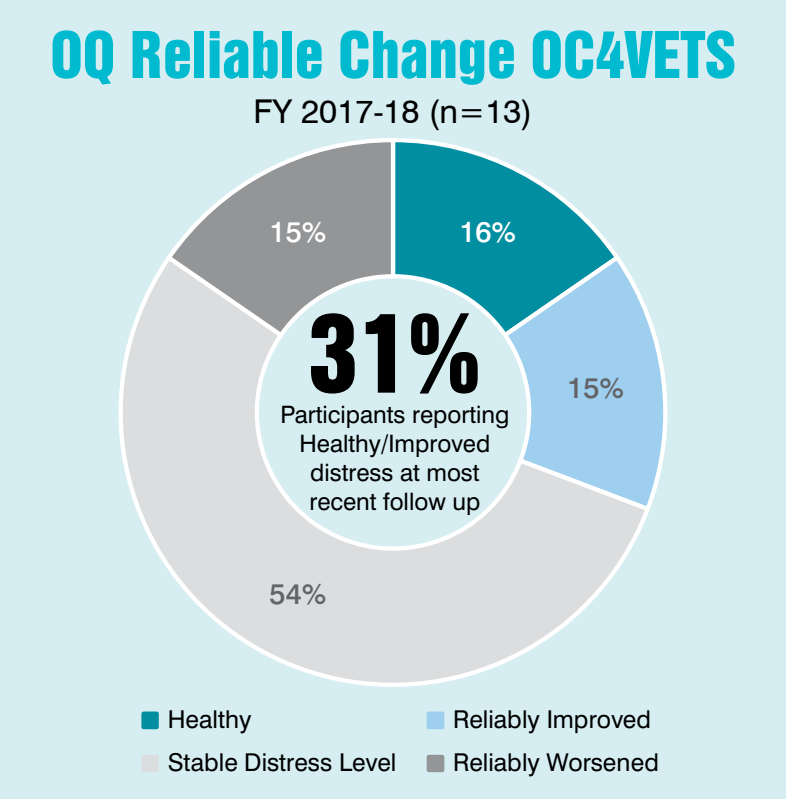
with military service members, veterans and peer navigators who can address the unique needs of veterans.

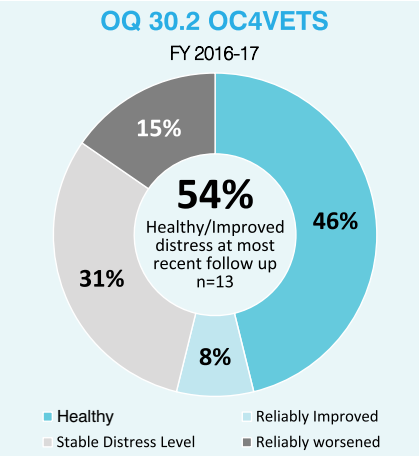
Outcomes

OC4Vets served a total of 60 participants during FY 2017-18 and 139 participants during FY 2016-17. As with the College Veterans program, the program experienced administration issues with the outcome measure (OQ 30.2) and paired measures were only available for 13 individuals in both FY 2017-18 and FY 2016-17. Approximately one-third to one-half of participants reported healthy or reliably improved distress levels at follow-up in 2017-18 and 2016-17, respectively. The program is also working with staff to improve its outcome measure completion rate so that it can determine whether these results are unique to this particular subsample of participants or whether this pattern is reflective of the overall Veteran population served by OC4Vets.

Challenges, Barriers and Solutions in Progress

OC4Vets transitioned from Innovation funding to PEI funding in February 2016 and the program was not fully staffed during this changeover. In order to improve continuity of care for participants through a more robust workforce, full-time peer navigators were hired, replacing part-time navigators. Unfortunately, one clinician position still remains vacant, directly affecting the program's ability to reach full ca- pacity. The program is also working to improve its OQ administration proce- dures and its use as a clinical tool.





Community Impact

The program has provided services to more than 720 participants since its inception, first as an Innovation project and then as a PEI program. The program has developed strong collaborations with a number of agencies that serve Orange County's veteran population, includ- ing the Veteran's Service Office with OCCR, Workforce Investment Office with OCCR, Office on Aging, Veterans Affairs Administration, Orange County Superior Courts and Orange County Family Court.

Strong Families-Strong Children: Behavioral Health Services for Military Families (INN to PEI)

Program Serves	Symptom Severity			Location of Services			Typical Population Characteristics		
									
	At-Risk	Mild-Moderate	Severe	Home	Field	Outpatient Clinic	Parents	Families	Veteran

The program provides services in Spanish.

Target Population and Program Characteristics

Strong Families-Strong Children (SFSC): Behavioral Health Services for Military Families serves all members in the military family, including veterans, service members, spouses, partners and children. The goals of this project are to improve family functioning, communication and overall well-being. Eligible participants may self-refer or be referred by behavioral health providers throughout Orange County.

Services

The SFSC project is designed to increase access to military-connected families. It utilizes 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. Clinicians provide short-term individual and family therapy to address the impact of traumatic events and experiences on children and family members. Peer navigators provide one-on-one peer support, case management, and referrals and linkages to community resources. Additional project services include outreach and engagement, screening and assessment to encourage appropriate referrals to and enrollment in program services; workshops and educational support groups for families; and counseling using the Families Overcoming Under Stress (FOCUS) program, which is an evidence-based practice derived from research on military-related risk and protective factors that aims to improve parent-child well-being and family functioning.

This project was approved by the Mental Health Services Oversight and Accountability Commission on April 24, 2014. The primary purpose is to increase access to mental health services to underserved groups, with the 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. The SFSC project was implemented July 1, 2015. Innovation funds for this project will end on June 30, 2020. Based on demonstrated effectiveness (reported below), the program will be continued through Prevention and Early Intervention funding beginning July 1, 2019.

Strategies to Promote Recovery/Resilience

The SFSC project is based on a peer-to-peer model, utilizing individuals with experience and knowledge of military culture to promote recovery and resilience. Peer navigators promote family resilience by helping participants manage their mental health, improve family functioning, strengthen their relationships with others and build support networks, all of which are critical to recovery The goal of this project is to empower family members to be proactive in the management of their own recovery, as well as within the family structure. Services are inclusive of the entire family unit, which allows for more effective family communication, functioning and support. Furthermore, enhancing the veteran's support system by strengthening the family unit reinforces the important role family provides in the veteran/ active member's recovery process.

Strategies to Improve Timely Access to Services for Underserved Populations

In order to meet the complex needs of military families, a collaboration of non-profit organizations was established to form the Strong Families, Strong Children Collaborative(SFSC) – A Partnership to Support Veteran and Military Families. Peer navigators established strong relationships with community agencies serving veterans in an effort to bridge the gap in services and better link their participants to appropriate resources. Many of the agencies have acknowledged the peer navigators' commitment to the project and their participants, highlighting their passion for helping military-connected families. Peer navigators provided in-home and community-based services to increase timely access to services and address barriers related to transportation services.

In FY 2017-18, the program provided 278 referrals and 157 linkages. This is a respectable increase from FY 2016-17, in

which the program provided 217 referrals and 106 linkages. As peer navigators became more familiar with local agencies, they were able to provide the most appropriate referrals, thereby improving the ability to link families to services. Peer navigators connected families to a wide range of resources, including basic needs (i.e., food, clothing), housing, mentalhealth, early intervention services, domestic violence prevention, legal services, financial services, employment services and education benefits.

Housing and mental health services were the two highest needs identified for military families referred into the SFSC program. In FY 2017-18, 44 families who experienced homelessness or were at-risk of homelessness successfully accessed housing services. This is a slight increase from FY 2016-17, in which 38 families successfully accessed housing services. In addition, the comprehensive family assessment enabled SFSC staff to identify and address underlying conditions that contribute to housing challenges, such as frequent or prolonged unemployment, mental health issues related to PTSD or TBI and family tensions. In FY 2017-18, 60% of families who presented with housing concerns or issues also accessed mental health services.

Strategies to Reduce Stigma and Discrimination

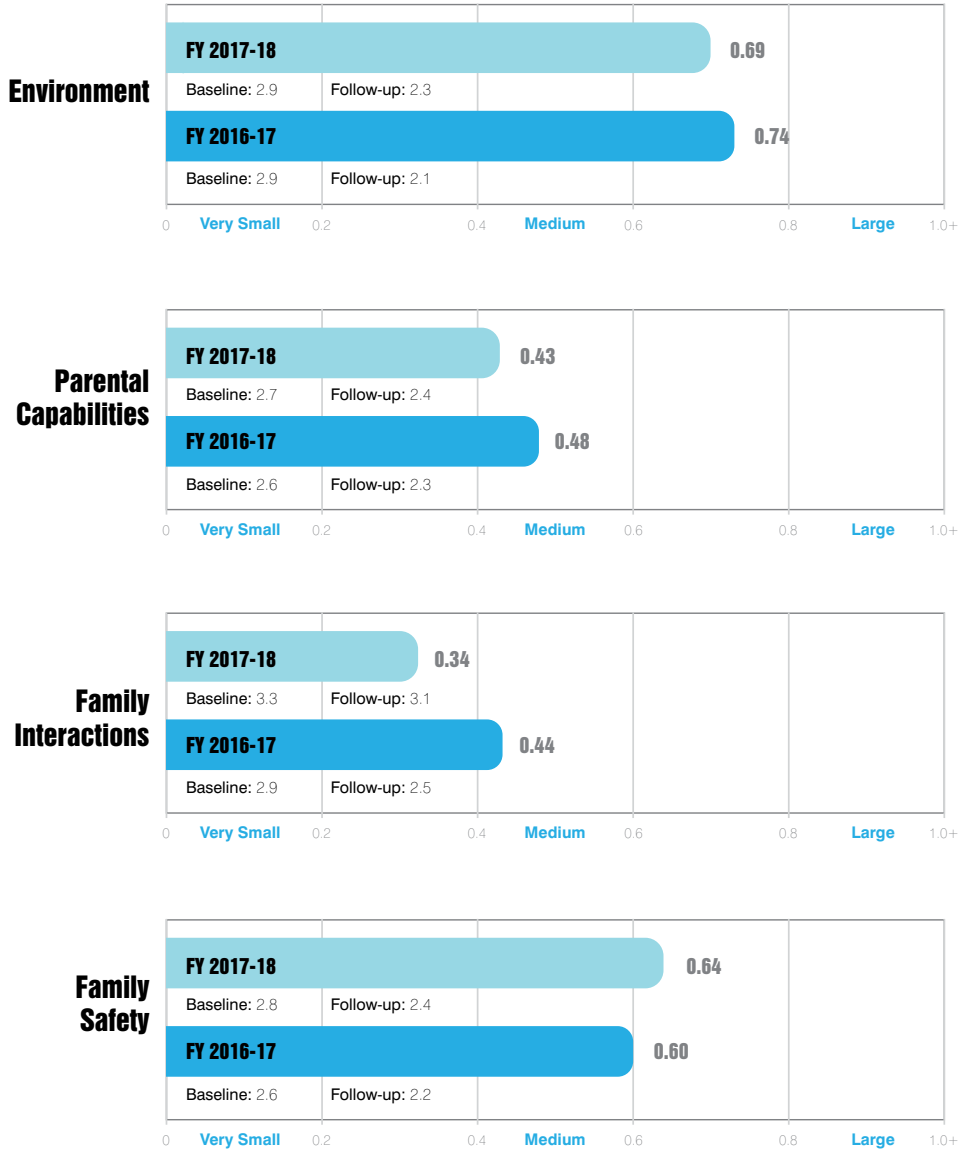
The peer-to-peer model has been successful in establishing a safe and trusting relationship between the peer navigator and military family members. Their experience and knowledge of military culture allows peer navigators to broach the sensitive topic of mental health with veterans and service members. Peer navigator support reduces risk and improves recovery of military-connected family members. Their presence in each of the three Veteran Courts and relationships with court personnel ensures a successful transition into family-specific services with SFSC.

Outcomes

SFSC served 49 families (n=323 individual family members) in FY 2017-18 and 40 families (n=288 individual family members) in FY 2016-17. The goals of the project were to improve family communication, functioning and overall well-being, which was assessed using the North Carolina Family Assessment Scale (NCFAS). The NCFAS assesses several domains of family functioning that are rated on a 6-point continuum, 0 (serious problem) to 6 (clear strength). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

Impact on Family Functioning by FY

Strong Family Strong Children



Impact on Family Functioning by FY

Strong Family Strong Children

Baseline and follow-up ratings on the NCFAS were provided for 40 families in FY 2017-18 and 49 families in FY 2016-17. Project services were associated with medium-to-large improvements in environment (e.g., housing stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health) in both fiscal years. Project services were associated with small-to-medium improvements parental capabilities (e.g., supervision of children), family interactions (e.g., relationship between caregivers) in social/community life and child well-being, with somewhat greater effects observed in these domains in FY 2016-17 compared to FY 2017-18.1 Taken together, these findings suggest that project services help families maintain and/or strengthen different aspects of family functioning, which can serve as an important protective factor for military families.

Challenges, Barriers and Solutions in Progress

SFSC has encountered several challenges throughout implementation of services, including the complex referral system with the veteran courts, a fragmented system of care for veterans and difficulty managing multiple agency data systems. With regard to court referrals, SFSC peer navigators were initially unable to outreach and engage domestic violence petitioners consistently. In response, a protocol was established to ensure SFSC staff were notified of court hearings in advance so that they could offer outreach and engagement services at the hearing. In addition, in February 2018, OC Family Court, the HCA, and SFSC successfully approved new referral policies for the OC Family Court Veteran and Service Member Domestic Violence Program. Furthermore, SFSC partners have been working on new strategies to engage veteran and military families during the initial phone screening, as well as creating training for staff to better assess and link families into domestic violence services. Language used with families about domestic violence is also being revised to be military-competent to support access and linkage to intimate partner violence prevention and interventions. It is anticipated that these efforts and cross-training will improve assessment, linkage and referrals.

Project staff also experienced challenges identifying service partners for substance use referrals for non-veteran family members. To address this, the project began implementing Seeking Safety to better respond to family substance use issues and provide prevention and early intervention.

Finally, data sharing among the five (5) partner agencies while in compliance with HIPAA, attorney-client and mental health privacy laws, has been a challenge. To address data management issues, SFSC is currently working with their partners to master resources needed by military

families and develop reliable data systems that move information across agencies. The Electronic Health Record system was reworked to allow all partner agencies to input and share data in order to help add value, ensure accountability, improve the program and serve families more effectively while complying with privacy laws. SFSC continues to refine how it uses data collected from all of the partner agencies to enhance and improve service delivery.

Community Impact

SFSC and its collaborative partners devoted considerable time to outreach and engagement activities throughout the community, as well as within county and community behavioral health programs. As a result of these efforts, the project has provided services to more than 540 veterans and their family members since its inception in July 2015. SFSC has also strengthened its relationship with other veteran- serving agencies, including the Veterans Administration (VA), Long Beach and the Los Alamitos Joint Forces Training Base. The relationship with the VA is especially significant in improving collaborative efforts, linking military-connected families to services and bridging the gap between agencies.

SFSC has shared their implementation model and lessons learned through various local and nationwide presentations. In September 2017, SFSC staff presented on "Methods of Interagency Collaboration to Successfully Serve Military Families" at the Community Behavioral Health Summit. Based on SFSC's involvement in the OC courts, SFSC staff presented their model on court partnerships in serving veteran and military families at the National Association of Drug Court Professionals (NADCP) Conference in Houston, Texas in June 2018. SFSC partners also presented on "Community Approaches to Serving Veterans and their Families" at the Sacramento, California Department of Veterans Affairs (CAL Vet) Leadership Conference in May 2018.

Reference Notes

Environment:
FY 2017-18: Baseline M=2.9, SD=1.13; Follow up M=2.3, SD=.85; t(39)=4.21, p<.001; Cohen's d=0.69
FY 2016-17: Baseline M=2.9, SD=1.1; Follow up M=2.1, SD=.90; t(48)=5.16, p<.001; Cohen's d=0.74

Parental Capabilities:
FY 2017-18: Baseline M=2.7, SD=.73; Follow up M=2.4, SD=.84; t(39)=2.67, p=.01; Cohen's d=0.43
FY 2016-17: Baseline M=2.6, SD=.73; Follow up M=2.3, SD=.84; t(48)=3.25, p=.002; Cohen's d=0.48

Family Interactions:
FY 2017-18: Baseline M=3.3, SD=.87; Follow up M=3.1, SD=.95; t(39)=2.13, p=.04; Cohen's d=0.34
FY 2016-17: Baseline M=2.9, SD=.87; Follow up M=2.5, SD=.95; t(48)=3.0, p=.01; Cohen's d=0.44

Family Safety:
FY 2017-18: Baseline M=2.8, SD=.79; Follow up M=2.4, SD=.93; t(39)=4.01, p<.001; Cohen's d=0.64
FY 2016-17: Baseline M=2.6, SD=.79; Follow up M=2.2, SD=.93; t(48)=4.16, p<.001; Cohen's d=0.60

Child Well-Being
FY 2017-18: Baseline M=3.0, SD=.50; Follow up M=2.9, SD=.61; t(39)=1.98, p=.06; Cohen's d=0.32
FY 2016-17: Baseline M=2.6, SD=.50; Follow up M=2.3, SD=.61; t(48)=3.56, p=.001; Cohen's d=0.51

Social/Community Life:
FY 2017-18: Baseline M=2.9, SD=.56; Follow up M=2.7, SD=.69; t(39)=1.75, p=.09; Cohen's d=0.28
FY 2016-17: Baseline M=2.7, SD=.56; Follow up M=2.4, SD=.69; t(48)=3.08, p=.003; Cohen's d=0.44

Self-Sufficiency:
FY 2017-18: Baseline M=3.6, SD=1.0; Follow up M=3.1, SD=1.1; t(39)=4.02, p<.001; Cohen's d=0.64
FY 2016-17: Baseline M=3.3, SD=1.0; Follow up M=2.8, SD=1.1; t(48)=4.15, p<.001; Cohen's d=0.59

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

LGBTIQ Services

While many of Orange County's MHSA and BHS services can meet the needs of its LGBTIQ participants, Orange County also offers early intervention outpatient services designed for individuals who are addressing issues specifically related to sexual orientation and/or gender identity. This program is known as OC ACCEPT (Acceptance through Compassionate Care, Empowerment and Positive Transformation).

OC ACCEPT (PEI)

Program Serves	Symptom Severity		Location of Services			Typical Population Characteristics									
0+	Early Onset	Mild-Moderate	Home	Field	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English and Spanish.

Target Population and Program Characteristics

OC ACCEPT provides community-based behavioral health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and to the important people in their lives. OC ACCEPT specializes in addressing issues that are common in the LGBTIQ community, such as confusion, isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medication with drugs, high risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness and lack of familial support. Referrals to the program are completed via telephone or walk-in. Self-referrals are preferred but other providers or family members may refer as well.

Services

OC ACCEPT provides a wide range of services to the Orange County community. Highly trained, skilled clinicians provide program participants with individual and/or family counseling using evidence-based therapeutic interventions such as cognitive behavioral treatment, motivational interviewing and other techniques. Peer specialists facilitate discussion groups; promote health and wellness activities; provide social, educational and vocational support; and offer targeted case management to help individuals access needed resources or meet other goal-specific needs.

In addition, OC ACCEPT raises awareness and reduces stigma by providing education about the LGBTIQ population to other mental health providers and the general community.

Strategies to Promote Recovery/Resilience

OC ACCEPT works from a strengths-based approach that incorporates recovery principles by using motivational interviewing, working with participants to develop client-centered and individualized care plans and focusing on participants' strengths.

Strategies to Improve Timely Access to Services for Underserved Populations

Factors such as stigma or lack of family support may inhibit individuals, particularly youth, from seeking services on their own. Limited transportation can also serve as barrier. To help address these challenges, the clinic is centrally located in Orange County, near major freeways and streets with access to public transportation. To increase access to care for those who are isolated, services can also be provided in the community.

In addition, for participants with additional needs and/or who are exiting the program, staff works to link them to community support. OC ACCEPT provided 73 referrals that resulted in 29 linkages in FY 2017-18 and 96 referrals that resulted in 47 linkages in FY 2016-17. Linkages were largely made to health care services and resources for food and nutrition, housing and advocacy.

Strategies for Reducing Stigma and Discrimination

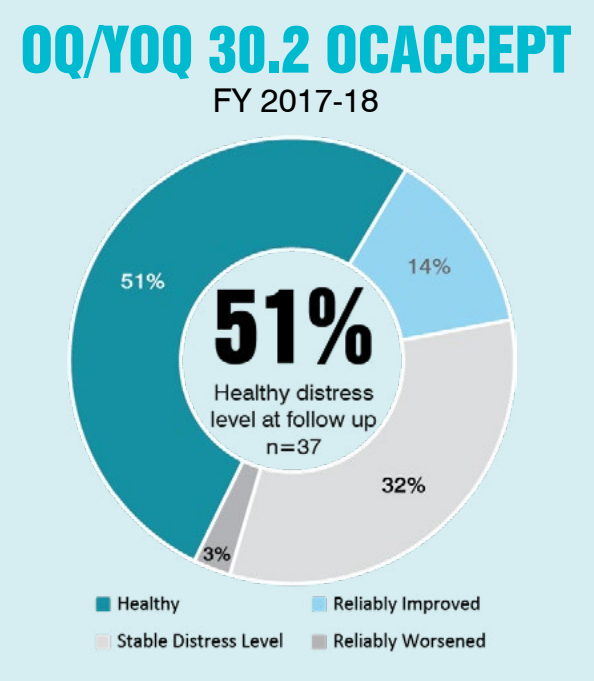
OC ACCEPT provides educational and program promotion presentations to the community, including other behavioral health providers, school staff/faculty, public health staff, social services staff and other community members. The focus of these presentations is to educate the community about the needs, challenges and issues faced by the LGBTIQ population, as well as to reduce stigma and discrimination through raising awareness of the various barriers and issues this population faces. In FY 2017-18, OC ACCEPT participated in 54 community events and/or promotions that reached 1,499 attendees and provided 15 community education presentations/trainings to 393 attendees. In FY 2016-17 the program provided education, support and technical assistance to more than 1,880 community members through its collaborations with Orange County agencies and community groups such as the Wellness Center, The Center OC, Public Health, and local high schools and colleges.

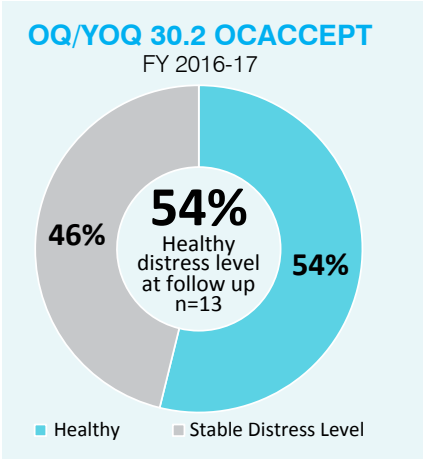
Outcomes

During FY 2017-18 and FY 2016-17, 121 participants were served by OC ACCEPT. The program aims to measure reductions in, or prevention of, prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth, OQ® 30.2 for adults). The goal was for participants to complete the form at intake, every three months of program participation and at program exit, and then to compare scores to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

In FY 2017-18, 37 of the 121 participants served completed both the baseline and follow-up measure. Of the 37 with paired assessments, about half reported feeling healthy or reliably improved distress levels at follow-up, and another third reported stable distress levels. Similar patterns were observed In FY 2016-17 (54% healthy and 46% stably distressed at follow-up), although the program experienced challenges with implementation that year, particularly at follow-up, and only 13 of the 121 participants served had completed more than one valid assessment.

In addition, the program had enrolled participants experiencing severe and persistent mental illness at the time these measures were collected, which may account for the larger proportion of participants reporting stable functioning (as opposed to healthy and/or reliably improved functioning) relative to other early intervention outpatient programs. As the intent of OC ACCEPT is to serve those who are experiencing mild to moderate mental health symptoms, the program has since implemented procedures to identify those with greater needs and refer them to the appropriate level of care. Thus, while OC ACCEPT has demonstrated some success at preventing symptoms of mental illness from becoming severe and disabling among the few who have completed measures, the conclusiveness of the program's effectiveness should be regarded as tentative until additional data are available for analysis.





Challenges, Barriers and Solutions in Progress

The program has been challenged with not having a full-time program supervisor located on site since the program transitioned to PEI from Innovations in March 2016. A full time program supervisor was hired in November 2018 and, since then, several program changes have taken place addressing issues with program operations, including staff training, outreach to new referral sources and clarification of eligibility criteria. In addition, the implementation of an intake counselor role is now ensuring timely access to care by providing immediate intake appointments. As a result, client enrollment has increased over the course of FY 2018-19 and outcomes data collection is anticipated to improve significantly.

Community Impact

OC ACCEPT has provided early intervention outpatient services to more than 481 LGBTIQ individuals since its inception in July 2011, first as an Innovation project and then as a PEI program. The program has also provided valuable education and resources to the Orange County community and continues to provide a safe, non-judgmental and therapeutic space for the LGBTIQ community and their loved ones, for which participants have expressed their gratitude.

Early Onset of Psychiatric Illness

As the name implies, early onset outpatient programs specialize in serving individuals who are experiencing the early onset of psychiatric illness with the goal of intervening early so that symptoms do not continue to go untreated and/or become untreated and become severe and disabling. Orange County currently offers two PEI programs that specialize in early onset diagnosis and treatment, one for youth and the other for older adults.

1st Onset of Psychiatric Illness (OC CREW; PEI)

Program Serves	Symptom Severity				Location of Services							Typical Population Characteristics							
12-25	At-Risk	Early Onset	Mild-Moderate	Severe	Home	Field	School	Workplace	Outpaitent Clinic	Hospitals	Residential	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Co-Occuring Medical	Students	Staff/ Providers/ Workforce

The program provides services in English, Spanish, Vietnamese and Korean.

Target Population and Program Characteristics

The 1st 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, as well as their families. 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 as well as referrals from County-operated and County-contracted specialty mental health plan clinics and community providers.

Services

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

To improve timely access to services, OC CREW staff provides outreach, presentations and trainings to staff and/or attendees at behavioral health clinics, schools, hospitals, community resource/ health fairs and community medical providers. During FY 2017-18, the program provided 27 outreach activities to 97 individuals and facilitated six continuing education trainings for 85 individuals that focused on understanding first episode psychosis and to increase timely referrals to the program. During FY 2016-17, the program provided 36 outreach activities to 167 individuals and facilitated seven continuing education trainings for 97 individuals.

Many referred participants and families who enroll in the program need extensive support and assistance to link with community resources that provide necessities such as food, shelter,

transportation and childcare. Without them, their ability to participate meaningfully in the program is compromised. The program provided 64 referrals that resulted in 22 linkages in FY 2017-18 and 104 referrals that resulted in 28 linkages in FY 2016-17 to supports such as behavioral health outpatient services; residential treatment; PEI programs; employment services and resources; information and referral resources; legal services and advocacy; employment services and resources; recreational activities; and special needs and disability services. The program also posts community resource information on bulletin boards in public areas for easy access by participants and their families.

With regard to addressing transportation and childcare-related issues specifically, the program provides field-based service as well as childcare and transportation assistance. In addition, bi-annually psychoeducation workshops are offered on Saturdays and Multi-Family Groups are offered in the evenings to improve access for working family members.

Finally, there have been an increasing number of referrals from non-English speaking families (Vietnamese, Korean). Bilingual/bicultural staff is employed to meet the program's needs for multi-lingual services and staff has access to a contracted language line for translation services in any needed language.

Strategies to Reduce Stigma and Discrimination

OC CREW strives to serve all eligible Orange County residents, and provides a warm and welcoming environment to all entering the clinic. The program seeks to reduce stigma and discrimination by educating families and participants in the course of services, as well as by providing education to the community.

Outcomes

A total of 91 and 82 youth received individual services in FY 2017-18 and FY 2016-17, respectively. The program's purpose is to reduce prolonged suffering from untreated mental illness as assessed through ratings on the Positive and Negative Syndrome Scale (PANSS), which is a culturally sensitive assessment that has been tested and validated with diverse ethnic/racial and cultural groups. Psychiatrists provided ratings at intake, every six months, and at program exit, and the difference between intake (baseline) and the most recent follow-up is used to determine whether there was a reduction of prolonged suffering. Results are reported according to the calculated effect size, which

Impact on Symptoms of Schizophrenia by FY

First Onset of Psychiatric Illness (OC CREW)

reflects, in part, the extent to which a change in scores over time is clinically meaningful for the youth served in the program.

In both FY 2017-18 and FY 2016-17, 51 youth had baseline and follow-up ratings on the PANSS. Medium to large improvements on symptoms were consistently observed, with slightly greater impact noted in FY 2016-17 than in FY 2017-18. Taken together, these findings suggest that OC CREW reduces prolonged suffering from untreated mental illness and helps prevent first episode psychosis from becoming severe, persistent and disabling.

Challenges, Barriers and Solutions in Progress

The primary barriers faced by the program participants are financial, which impacts their ability to access reliable transportation, childcare and many other daily basic needs that, in turn, impact their ability to access program services. OC CREW addresses this by providing transportation and childcare when needed but there has not been a dedicated position identified for this purpose. The feasibility of bringing on a dedicated staff member to provide these support services is being explored.

Community Impact

The program has provided services to more than 326 participants since its inception in Spring 2011. There has been a steady increase in family participation in multifamily groups (FY 2017-18 n=65; FY 2016-17 n=56), educational workshops (FY 2017-18 n=6 workshops for 85 individuals; FY 2016-17 n=7 workshops for 97 individuals), and screenings (FY 2017-18 n=118; FY 2016-17 n=98). By providing field-based services, the program is able to reach, serve and impact individuals who are reluctant to seek behavioral health treatment for fear of being stigmatized, have limited resources to access clinic-based care, or experience functional limitations due to their mental health symptoms.

Reference Notes

[1] ***Positive Symptoms:***
FY 2017-18: Baseline M=16.1, SD=7.0; Follow-up M=10.8, SD=7.9; t(50)=4.47, p<.001; Cohen's d=0.63
FY 2016-17: Baseline M=15.9, SD=7.0; Follow up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88

Negative Symptoms:
FY 2017-18: Baseline M=17.9, SD=7.1; Follow-up M=12.0, SD=7.4; t(48)=5.42, p<.001; Cohen's d=0.77
FY 2016-17: Baseline M=17.2, SD=8.3; Follow up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65

General Psychopathology:
FY 2017-18: Baseline M=33.5, SD=11.6; Follow-up M=24.7, SD=14.2; t(50)=3.95, p<.001; Cohen's d=0.56
FY 2016-17: Baseline M=32.2, SD=11.9; Follow up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72

Total Symptoms:
FY 2017-18: Baseline M=68.2, SD=24.0; Follow-up M=48.6, SD=29.6; t(50)=4.72, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=65.3, SD=25.0; Follow up M=42.7, SD=27.4; t(50)=5.74, p<.001; Cohen's d=0.81

Early Intervention Services for Older Adults (PEI)

Program Serves	Symptom Severity		Location of Services	
60+	Early Onset	Mild-Moderate	Home	Field

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Mandarin and Khmer.

Target Population and Program Characteristics

The Early Intervention Services for Older Adults (EISOA) program provides behavioral health early intervention services to older adults ages 60 years and older who are experiencing the early onset of mental illness and/or those who are at greatest risk of developing behavioral health conditions due to isolation. The program is designed to reduce risk factors that have been linked to mental illness among older adults. These risk factors include substance use disorders, physical health decline, cognitive decline, elder abuse or neglect, loss of independence, premature institutionalization and suicide attempts. Participants are referred to program from senior centers, FRC's, the Outreach and Engagement Collaborative, community centers and faith-based organizations.

Services

Program staff conducts a comprehensive in-home evaluation that includes psychosocial assessment, screening for depression, and measurement of social functioning, well-being and cognitive impairment. Using the results from the assessment and screening, the program then connects older adults to case managers who develop individualized care plans and facilitate participants' involvement in support groups, educational training, physical activities, workshops and other activities. A geropsychiatrist is also available to provide a psychiatric assessment of older adults who have undiagnosed mental health conditions. The program recently expanded psychiatry functions from one-time screenings and diagnosis to include follow-up visits and the prescribing of medication as needed. The change was adopted to fill a gap experienced by some older adults who were uninsured or did not have a psychiatrist at the time of screening.

The program utilizes the evidence-based practice Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) which employs a systematic, team-based approach to identifying and reducing the severity of depressive symptoms in older adults via case management, community linkages and behavioral activation services. To ensure fidelity, the program provides staff with comprehensive training on the Healthy IDEAS model, goals and deliverables of the program, 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-services. Program staff are also supervised and evaluated on an on-going basis.

Strategies to Promote Recovery/Resilience

Recovery and resilience are promoted by helping participants develop and/or expand their social networks and support systems, thus promoting greater well-being and participation in meaningful activities.

Strategies to Increase Timely Access to Services for Underserved Populations

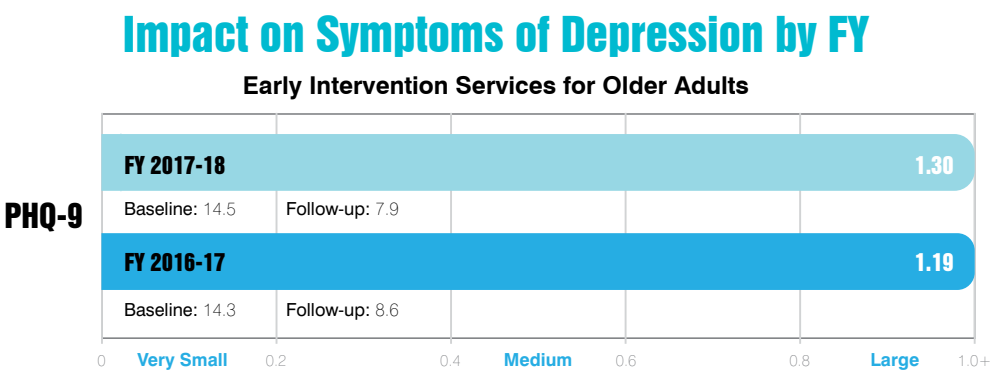
The program builds relationships with community agencies and other individuals who may come into contact with the target population. By doing so, the program is able to identify unmet needs and barriers specific to the underserved communities it aims to serve and to provide solutions for overcoming these barriers. To increase access for older adults who are homebound or may no longer drive, the program offers in-home services. Staff also works with participants to identify transportation solutions, which serves a dual goal of improving access to program services as well to the community-based healthcare, support services and social events to which the participants are referred. In FY 2017-18, EISOA provided 10,880 referrals and 6,191 linkages to these types of services and activities. In FY 2016-17, the program provided 9,028 referrals and 3,957 linkages to these types of services and activities. The program also added more psychiatrists with additional linguistic and cultural capabilities that include Korean, Vietnamese, Farsi and Spanish.

Strategies to Reduce Stigma and Discrimination

The program strives to make the services available to all Orange County residents, regardless of their background. The program utilizes culturally congruent, strength-based approaches when developing the participant's individual care plan and delivering individual, peer, family and group services. Examples of these approaches include recruiting staff who are bicultural and represent a number of different ethnicities and religions, may be more familiar with how to address the issue of mental health with the program participant, and can adjust their approach to serve diverse populations appropriately. Furthermore, the program employs strategies such as peer mentoring, participant and family education, public education and trainings, and community anti-stigma advocacy in order to decrease both public and self-stigma and discrimination.

Outcomes

EISOA served 601 older adults in FY 2017-18 and 536 older adults in FY 2016-17. Improvement in mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity. Among the 75 participants in FY 2017-18 and 116 participants in FY 2016-17 who scored in the clinical range at intake (i.e., score > 10), there was a substantial decrease in their depressive symptoms,[1] with average depression scores decreasing from the moderate range to the mild range between intake and most recent follow-up.[1]



Challenges, Barriers and Solutions in Progress

Transportation remains a barrier to traditional 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 provides bus vouchers and teaches participants to utilize the bus system. For older adults who are hesitant to take the bus, staff travel with them and teach them how to ride a bus, or seasoned bus riders are paired with new bus riders. Program staff also facilitates carpools between participants. To help alleviate transportation barriers, EISOA will expand transportation services for its participants with time-limited, PEI carryover funds.

To overcome the challenge of finding counseling services and other resources in the participants' preferred language, the program hires staff and volunteers who speak the same language as the participants to serve as interpreters/translators in circumstances where there are no available resources in the participants' preferred language.

Feedback from a recent PEI community planning process indicated that the eligible age for services should be lowered from the current age of 60 to include those who are 50 years or older as individuals from underserved communities within this broadened age range, especially those who are new immigrants and refugees, continue to feel isolated. These individuals not only face linguistic challenges, but are also unable to find employment successfully, which further adds to their isolation. To meet these identified needs, the time-limited carryover funds were also utilized to expand the program criteria to serve participants who are 50 years and older when assessed as needing these services.

In addition, the demographic data required by the PEI regulations, particularly regarding gender identity, presented an unanticipated challenge to staff. Many participants indicated that the word "queer" was stigmatizing and that they felt offended by the term. Additionally, due to stigma, many participants hesitated to disclose their sexual identity for fear of being "outed." To address this challenges, staff organized LGBTIQ sensitivity training for staff and participants.

Community Impact

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

Reference Notes

[1] *FY 2017-18: Baseline: M=14.5, SD=3.6; Follow-up M=7.9, SD=5.1; t(74)=10.96, p<.001; Cohen's d=1.30*
FY 2016-17: Baseline: M=14.3, SD=3.7; Follow-up M=8.6, SD=4.4; t(115)=12.68, p < .001; Cohen's d=1.19

Family Services

Early Intervention Outpatient services specifically designed to improve the overall quality of family life fall within the Family Services category. Orange County currently operates one such program funded through PEI, described below, although many BHS services – especially those that serve children and TAY – work with family members whenever possible.

OC Parent Wellness Program (PEI)

Target Population and Program Characteristics

Program Serves	Symptom Severity			Location of Services				Typical Population Characteristics							
															
16-40	At-Risk	Early Onset	Mild-Moderate	Home	Field/ Workforce	School	Outpaitent Clinic	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Co-Occuring Medical	Students	Staff/Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Farsi and Korean.

The Orange County Parent Wellness Program (OCPWP) serves youth and adults of all ages who are pregnant or who have had a child within the past 12 months. Youth, women and men who receive services from OCPWP are experiencing mild to moderate symptoms of anxiety and/or depression which are attributable to either the current pregnancy or recent birth of their child. Referrals come from a variety of sources including self-referrals, hospitals, schools and behavioral health outpatient facilities.

Services

OCPWP provides prevention and early intervention services that include eligibility and needs assessment, case management, individual therapy, family psychoeducation, psychoeducational support groups, wellness activities, psychiatric services, coordination and linkage to community resources, and community outreach and education.

OCPWP also utilizes the following evidenced-based curricula in its service delivery: Mothers and Babies Course: Relaxation Methods for Managing Stress; Mothers and Babies Course: A Reality Management Approach; and Triple P (Positive Parenting Program) tip sheets. Clinicians also utilize Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) when indicated.

Strategies to Promote Recovery/Resilience

Services provided are consumer-centered and strength- based with a focus on recovery, resilience and well-being. A critical component of this focus is the collaborative process between the participant and their therapist when developing treatment goals and a treatment plan.

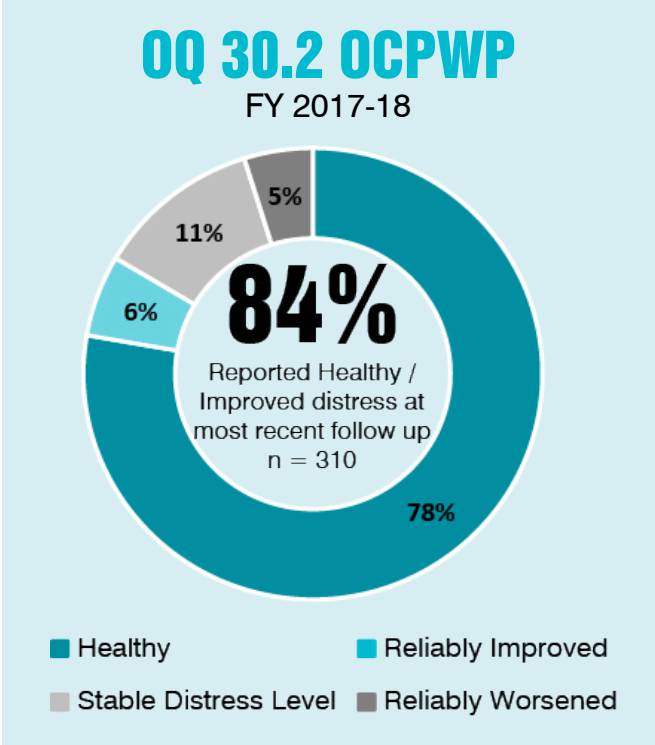
Strategies to Increase Timely Access to Services for Underserved Populations

Lack of transportation is a common barrier to accessing clin- ic-based services, including groups and psychiatric services. To address these obstacles, OCPWP provides services in the field, primarily at home or an agreed upon community location. The program also provides transportation assistance (i.e., bus passes, transportation, etc.) to assist participants in attending groups and wellness activities provided at the clinic.

Lack of childcare or in-home support can also be barriers for some families. For example, the parent of a toddler and an infant who has no in-home support may be unable to en- gage in home-based services due to the responsibilities of supervising and caring for young children. In these circumstances, OCPWP is able to provide supervision of minors during clinic-based services.

To raise awareness about the program and increase referrals for program services, clinicians conduct community outreach and offer psychoeducational presentations to other community providers. The program also provides outreach at continuation schools in order to increase the likelihood of pregnant youth receiving program services.

In addition to improving access to its program, OCPWP clinicians work to refer participants to community resources and supports as a way to assist them with their continued recovery after discharging from the program. To increase the likelihood that the participant will attend the first appointment, the clinician contacts providers with the participant present. The program provided 222 referrals and 40 linkages in FY 2017-18 and 447 referrals and 113 linkages in FY 2016-17 to family support services, PEI programs, legal services and advocacy, and basic needs (i.e., donated items, financial assistance and recreation). The unique needs of parent participants influence the number of referrals and linkages in any given fiscal year.

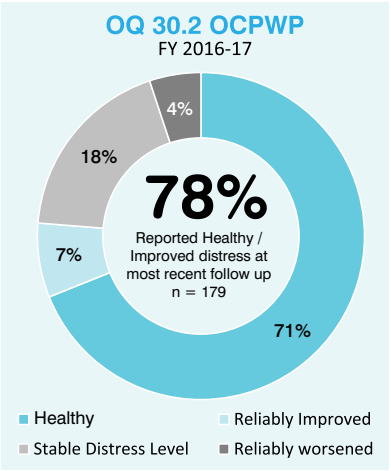


Strategies to Reduce Stigma and Discrimination

Many pregnant or new parents may feel isolated by their mood or anxiety symptoms because pregnancy and giving birth are commonly thought of as a happy time of life. The program helps to educate pregnant and new parents and normalize their feelings as a way to encourage help-seeking. Program staff also meets with the participant's significant other, if requested, to help educate them on mood and anxiety disorders.

Outcomes

During FY 2017-18, 506 participants were served by OCPWP (45 youth under age 18 and 461 adults 18 and older). In FY 2016-17, 617 participants were served by OCPWP (76 youth under age 18 and 541 adults 18 and older). The program aims to measure reductions in or prevention of pro- longed suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth and OQ® 30.2 for adults). Participants completed the measure at intake, every three months of program participation and program exit, and scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms. Of the 310 individuals in FY 2017-18 and 179 individuals in FY 2016-17 with paired assessments, 84% and 78%, respectively, reported a healthy or reliably improved level of distress at follow-up, thus demonstrating that OCPWP was associated with preventing symptoms of mental illness from becoming severe and disabling for the majority of individuals receiving program services. Due to the fact that roughly 5% during each fiscal year reported a significant worsening in their distress, program staff is working to streamline procedures to quickly identify these individuals earlier in the course of treatment and either modify the treatment plan accordingly or refer them to a higher level of care, as needed.



Challenges, Barriers and Solutions in Progress

The program is challenged to serve all of Orange County from a centralized location. Many of the services are provided in the field where clinicians do not have ready access to real-time resource information. To address this issue and provide a means for more efficient documentation for field-based clinicians, the program has been piloting the use of laptops over the past year. Although the program is now fully staffed, during FY 2017-18 OCPWP was challenged with hiring a new Service Chief and several direct service positions, which contributed to fewer participants being served. Despite these challenges, program staff were nevertheless able to more than double the number of paired outcome assessments completed by participants in FY 2017-18 compared to FY 2016-17.

Community Impact

The program has provided services to more than 2,529 individuals since its inception in December 2009. The program works closely with providers in the community who work with pregnant and postpartum women. Parents who are depressed or anxious face increased risk for experiencing difficulty bonding with their babies and/or caring for the day-to-day needs of their children effectively. The provision of services to this population may, thus, reduce the potential for child neglect or maltreatment and result in a healthier, happier home life for children in the family.

School-Based Outpatient Services

PEI currently funds two Early Intervention Outpatient programs that operate on school campuses. One program provides treatment for children who exhibit difficulties with attention, learning and/or behavior and the other for middle school students who are experiencing symptoms of anxiety and depression.

School-Based Behavioral Health Intervention and Supports – Early Intervention Services (PEI)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
					
	At-Risk	School	Families	Co-Occurring Medical	Students

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Mandarin and French.

Target Population and Program Characteristics

School-Based Behavioral Health Intervention and Supports – Early Intervention Services (SBBHIS-EI) serves families with children in grades 1-8 who are experiencing challenges in attention, behavior and learning, and/or Attention Deficit/Hyperactivity Disorder (ADHD) that impair their regular educational placement and social competencies. Children are referred to the program by local schools, physicians and other mental health professionals in Orange County. Children are screened by clinicians to identify any behavioral health issues that need to be addressed and determine program eligibility, which includes financial need.

Services

SBBHIS-EI funds 16 of the 90 students served in the program each fiscal year and provides them with a regular education school experience in a classroom that has been specifically modified to meet their psychosocial and academic needs. It uses the Community Parent Education Program (COPE) Parenting Curriculum to guide services, which include academic support, social skills development, parent training and academic transitional support. The duration of the program is 12 to 18 months, after which the child is transitioned to the next academic setting. This specially adapted school-based intervention program is based on cognitive-behavioral strategies and supported with applied behavior modification techniques such as self-regulation; management of anger, anxiety, frustration and compliance. In addition, the program utilizes the School-Based Social Skills intervention model which is specifically designed to meet the needs of children exhibiting behavioral challenges that are preventing them from accessing education and curriculum in a less restrictive setting. This training addresses social pragmatics, relational skills and social reciprocity.

Strategies to Promote Recovery/Resilience

The program is designed to be a whole-family intervention program that uses intense school-based cognitive-behavioral training provided in a regular education setting extensively modified to meet the needs of children with behavior challenges and their families. Parents are required to attend an 8-week parent training course prior to or concurrent with enrollment, and then attend weekly multiple-family group sessions where they learn how to use the same behavioral interventions at home that their children experience in the classroom. This approach supports the generalization of the child's gains from school to the home. Families also set specific goals that give each child a way to chart their individual progress and experience success.

Strategies to Increase Timely Access to Services for Underserved Populations

The program encourages timely access to its services by offering multi-family groups and classes at flexible times, multiple days of the week. In addition, the program offers one-on-one consultations to accommodate the family's needs.

Although classes are taught in English, to help mitigate delays in accessing services due to language barriers, the program is able to use the staff who are bilingual in Spanish, Mandarin, Vietnamese, Korean, Farsi and French. The program also has translation services for other languages.

Another challenge is access to basic needs such as food, clothing, shelter, transportation and healthcare among socioeconomically-disadvantaged families, which impacts the well-being of the student as well as the family unit. Staff addresses these needs by teaching parents self-advocacy techniques, how to ask for assistance and how to identify resources to obtain needed services.

Strategies to Reduce Stigma and Discrimination

SBBHIS-EI strives to provide services that are sensitive and responsive to participants' backgrounds. In addition, unlike traditional schools where students are pulled out of regular classroom instruction for their individual service plans, the program fully integrates behavioral interventions with academic instruction into the classroom. This results in reducing the risk for stigma while building self-esteem. Parents are also required to learn to use the same behavioral interventions at home. This helps create a supportive environment in which the students can learn academics as well as new, more adaptive behaviors. Finally, to address the stigma and uncertainty that parents and/or children feel about the future transition to a different academic setting, the program teaches parents self-advocacy techniques and works with each family on how to collaborate with their child's home school district effectively, how to select an appropriate school placement and how to work with program officials to ensure a smooth transition to the new academic environment.

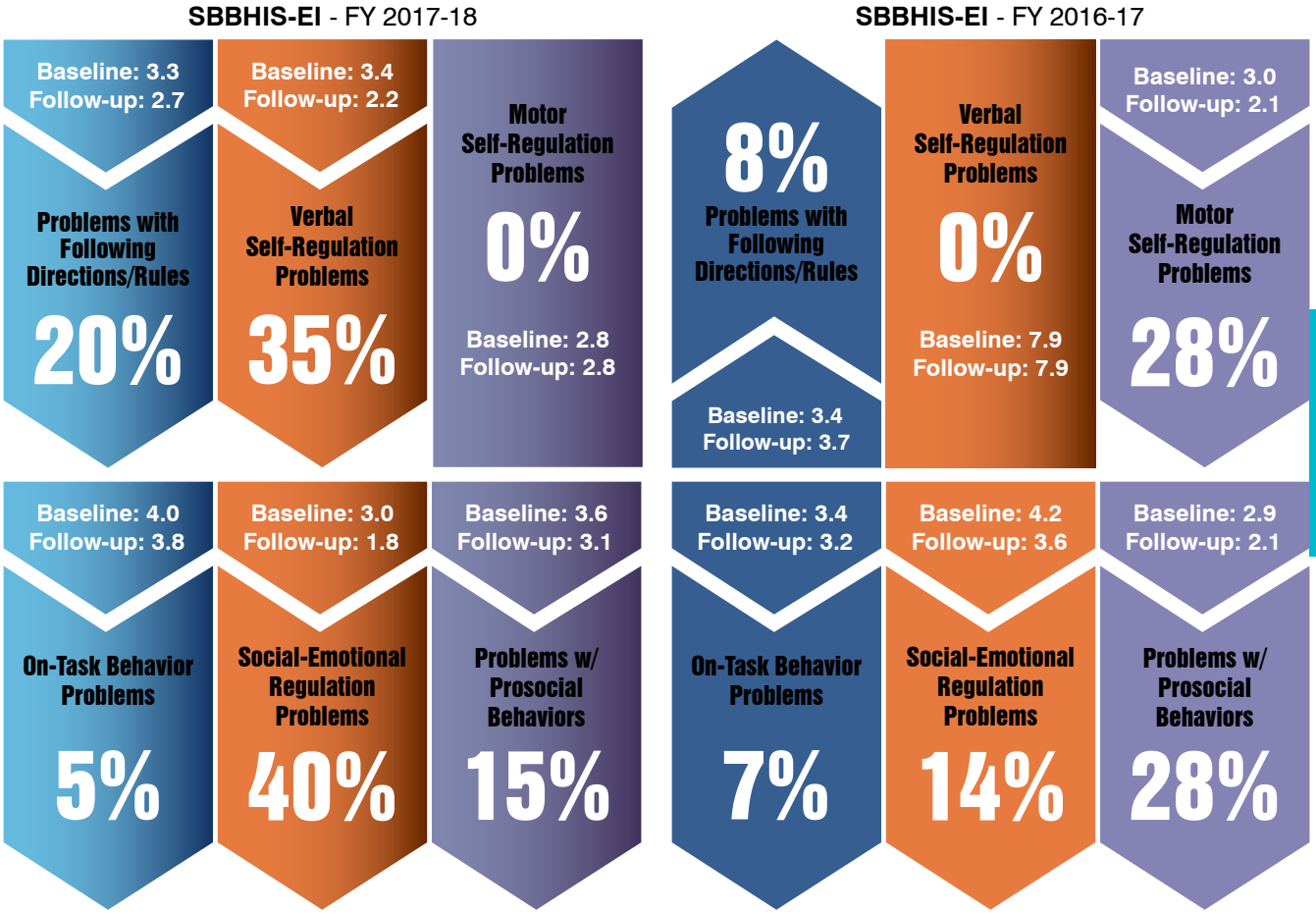
Outcomes

SBBHIS-EI served 33 students in FY 2017-18 and 24 students in FY 2016-17. Clinical staff worked with children to set goals aimed at correcting problematic behaviors. Target behaviors were monitored and assessed for severity on a daily basis to measure improvement over time. When participants achieved the goal for a specific target behavior, another goal was introduced, and participants worked on three to four goals at a time. Behaviors were categorized into the following areas: Following Directions/Rules, Verbal Self-Regulation, Motor Self-Regulation, On-Task, Social-Emotional Regulation and Prosocial Behaviors.

Severity of the target behavior problem was rated on a 7-point scale, with higher scores reflecting greater severity. Although consistent trends could not be identified across fiscal years and/or the target behavior areas, students were generally rated as showing decreases across the various problem behavior areas. In addition, all ratings fell within the low to moderate range, thus suggesting that the program was associated with preventing symptoms from becoming severe and disabling.

Due to the program design which limits the number of children served each year, the HCA is in the process of exploring alternate ways of evaluating and presenting outcomes data to assess the program's impact among those served.

Change in Problem Behaviors by FY



Challenges, Barriers and Solutions in Progress

The program has recently experienced challenges regarding the overall program funding beyond the MHSA contribution listed. Due to the intensive nature of these services, costs associated with providing the program have increased, which may impact future program operations. The provider is currently exploring options to address these challenges.

Community Impact

The program has provided services to more than 122 students and 175 parents/caregivers since its inception in March 2010. SBBHIS-EI also collaborates with community organizations, local school districts and providers like the Proposition 10-funded program "Help Me Grow," which is a consortium of community resources that connect families to services that enhance the development, behaviors and learning of children.

School-Based Mental Health Services – Early Intervention Track (PEI)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics	
	At-Risk	 Mild-Moderate	 School	 Parents	 Students

The program provides services in English, Spanish, and Korean.

Target Population and Program Characteristics

The School-Based Mental Health Services (SBMHS) - Early Intervention Track provides school-based, early intervention services targeting individual students in grades 6 through 8 who are experiencing mild to moderate depression, anxiety and/or substance use problems. Referrals to this program track are made by school staff and screened by program clinicians to determine early onset of mental illness.

Services

The early intervention track provides assessment, individual counseling, case management, referral and linkages to community resources utilizing evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat and Seeking Safety, as well as promising practices like Eye Movement Desensitization and Reprocessing (EMDR).

Strategies to Promote Recovery/Resilience

The target population often faces issues such as experiencing multiple traumas or community violence, or coming from first generation/monolingual communities. To promote recovery and resilience within the students' social network, the program creates buy-in from school partners and participant families by helping them understand that participation in the curricula creates resilience and protects against long-term challenges later in life.

Strategies to Increase Timely Access to Services for Underserved Populations

A number of strategies has been adopted to increase timely access to services. The program is implemented in the school setting, thereby providing access to students and families that might not seek help on their own. In addition, clinicians meet with participants weekly to address immediate needs and make regular attempts to check in with the participant's parent or guardian. The program also has the ability to focus on particular schools, districts and/or specific populations as needed.

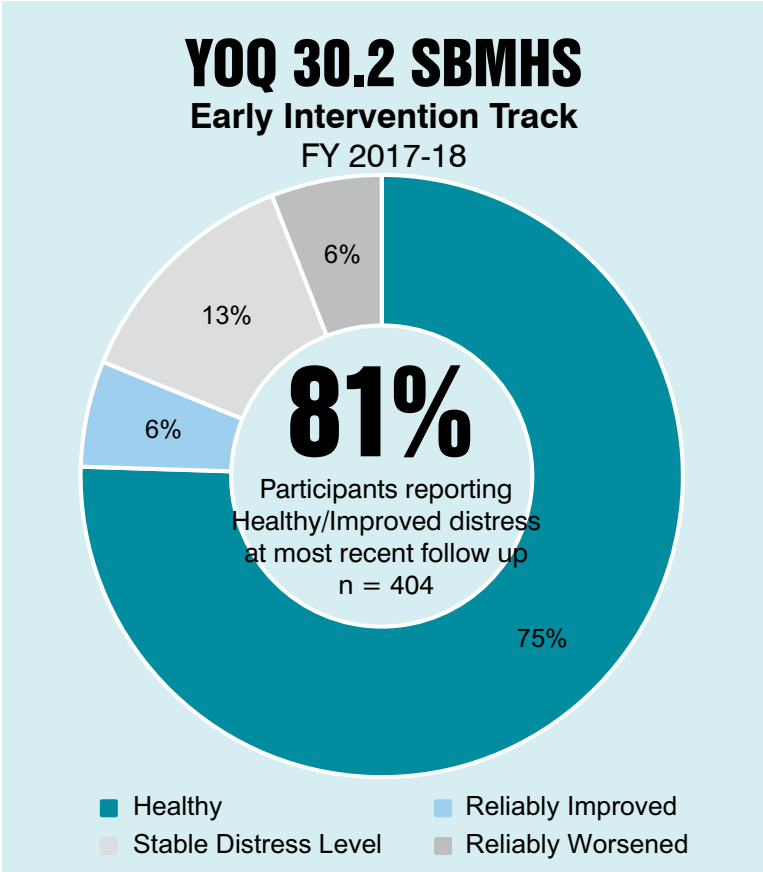
Because many participants have limited resources, referrals for supports may be provided to the participant or the participant's family as needs are identified. In addition, clinicians often provide instruction or guidance on how to contact other community providers so that families can be self-sufficient when they are no longer enrolled in services. The program provided 391 referrals and 44 linkages in FY 2017-18 and 397 referrals and 49 linkages in FY 2016-17 to providers who offer basic needs items; behavioral health outpatient services; PEI programs; crisis services; and health education, disease prevention, wellness and physical fitness services.

Strategies to Reduce Stigma and Discrimination

Participants often face parent or peer discouragement to engage in program services (stigma), lack of willingness or fear of participation. Program staff works closely with the school administrators and counselors through weekly meetings to assist in creating a school climate that promotes the benefits of seeking help and accessing counseling, providing psychoeducation to promote acceptance, and promoting school bonding to keep students from feeling marginalized. In addition, program staff receive regular in-service training to increase their understanding of the needs, values and challenges faced by the program population so that they are better able to serve them.

Outcomes

The early intervention track served 612 youth in FY 2017-18 and 623 youth in FY 2016-17. Program performance was evaluated through measures administered at intake, every three months of program participation and at discharge. The program assessed reductions in or prevention of prolonged suffering via the YOQ beginning in FY 2017-18, during which time 81% of the 404 youth who provided paired assessments reported a healthy or reliably improved level of distress at follow-up. Thus, the program was associated with preventing symptoms of mental illness from becoming severe and disabling for the majority of individuals receiving program services.



Challenges, Barriers and Solutions

In FY 2017-18, the program expanded services to two additional schools in a new district despite experiencing several staff vacancies. The staffing shortage was initially handled by cross-training staff from the SBMHS prevention track, and the program has since become fully staffed. In addition, implementing early intervention services in new schools was delayed as appropriate space needed to be identified and the referral processes worked out. Finally, students' access to services and the number of students seen in a day was limited as staff was asked not to schedule appointments during math and language arts classes whenever possible.

Community Impact

The combined Prevention/Early Intervention program has provided services to more than 14,750 participants since its inception in August 2011. The program collaborates with nine school districts and has helped to fill an important and growing need for mental health services in school.

CLINIC-BASED OUTPATIENT MENTAL HEALTH

Clinic-Based Outpatient Mental Health programs provide comprehensive outpatient services to individuals living with serious emotional disturbance or mental illness. Services are typically delivered in a clinic setting but can be provided in the field as needed. HCA offers the overwhelming majority of its clinic-based outpatient services through non-MHSA County-operated and County-contracted clinics located across Orange County. However, Orange County stakeholders identified a need to dedicate MHSA funding for a clinic-based outpatient program dedicated to serving older adults, which is described below.

Clinic-Based Outpatient Mental Health	Estimated Number to be Served in FY 2018-19	Annual Budgeted Funds in FY 2018-19	Estimated Annual Cost Per Person in FY 2018-19
Older Adult Services (CSS)	530	$1,668,135	$3,147

Older Adult Services (CSS)

Program Serves	Symptom Severity	Location of Services						Typical Population Characteristics			
60+	Severe	Home	Field	Outpatient Clinic	Courts	Hospitals	Residential	Homeless/ at-Risk	Co-Occurring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Amharic and Mandarin.

Target Population and Program Characteristics

Older Adult Services (OAS) serves individuals age 60 years and older who are living with serious and persistent mental illness (SPMI), have 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.

Services

OAS provides case management, referral and linkages to various community resources, vocational and educational support, substance use services, nursing services, crisis intervention, medication monitoring, therapy services (individual, group, and family), and psycho-education for participants, family members and caregivers. Evidence-based practices such as Cognitive Behavioral Therapy, Motivational Interviewing, EMDR, DBT, problem solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care.

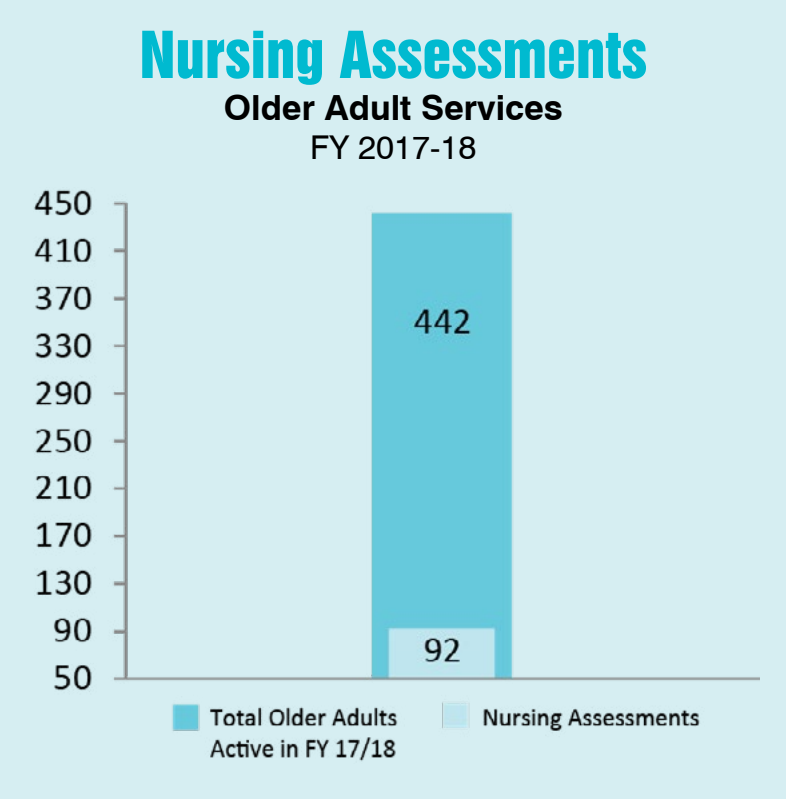
Strategies to Promote Recovery/Resilience

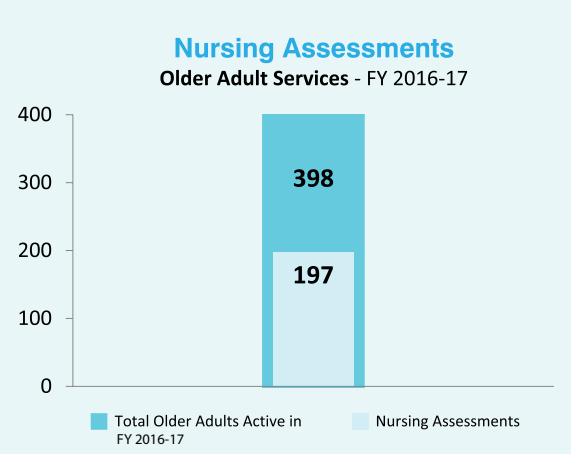
All services are highly individualized and provided with the aim of increasing access to community and medical services, maintaining independence and decreasing isolation. The goals are accomplished by providing services that focus on reducing symptoms and increasing skills to cope with life stressors.

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation is a huge barrier for the older adult population. Many lack the financial resources to own a private vehicle or use taxi services. Some rely on family and caregivers for transportation and are dependent on their availability. Others lack the physical and cognitive capacity to manage public transportation. By making all of its services available to participants out in the community, if needed, OAS recovery has greatly improved access to services for older adults living with SPMI in Orange County. In addition, program staff provides services in many languages (see grid) through staff who are bicultural/bilingual. Language line translation is also available to provide services in any language not spoken by program staff in order to reduce delays in accessing the program due to language barriers.

Staff also dedicates a considerable amount of time providing transportation to participants to assist them in accessing community-based providers for other needs not met directly by OAS (i.e., medical appointments, government offices, senior centers).





Strategies to Reduce Stigma and Discrimination

Older adults may hesitate to access OAS due to stigma related to being an older adult. For example, they may fear losing their independence or being removed from their homes, forced to take medications and/or forced to live in a nursing home due to their age. They may also feel shame due to their belief that, as adults, they should not need anyone's help to live their lives. OAS staff are trained and encouraged to take whatever time is needed to develop trust with participants in order to facilitate engagement into services. Older adults enjoy sharing their life stories and staff taking time to listen is an important engagement tool. OAS also collaborates with Social Services Senior Santa program to provide necessities to older adults such as household items, clothing and hygiene items, which can serve as a strong contributor to engagement. In addition, the OAS SHOPP program is dedicated to conducting outreach and engagement with individuals referred to OAS, where it can take several friendly home visits before an older adult engages in OAS services.

Outcomes

In FY 2017-18, the program served 443 older adults, 298 of whom were new admissions. In FY 2016-17, the program served 398 older adults, 263 of whom were new admissions. One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary

care, which is quantified as the number of nursing assessments completed. Of the total adults served during FY 2017-18, 21%, had a nursing assessment completed. In contrast, during FY 2016-17, approximately half (49%) had a completed nursing assessment. This reduction is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. Staff has not yet returned to their normal work location and employees are currently spread out over multiple offices until repairs can be completed, which has affected program operations and service delivery.

Challenges, Barriers and Solutions in Progress

OAS has encountered on-going issues collecting outcome measures that evaluate the program's performance (i.e., selection of an appropriate and feasible measure of symptom reduction, adequate completion rates of measures, etc.). Program staff has begun meeting to select metrics appropriate for the target population being served and future Plan updates will report on these outcomes once implemented.

The program moved to a new location in March 2019 that enables the program to offer EBP (Emergency Base Practice) groups and education for client and family members in a clubhouse atmosphere.

Community Impact

Older Adult Services collaborates with the Public Health Services Senior Health Outreach & Prevention Program (SHOPP), Council on Aging (Health Insurance Counseling and Advocacy Program, Friendly Visitor), Social Services Agency (Adult Protective Services), Community Senior Centers, Adult Day Health Care, Alzheimer's Association, Ageless Alliance, local police departments, Orange County Probation Department, hospitals and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face. In particular, program staff works collaboratively with Adult Protective Services to help older adults who are abused by caretakers, are neglecting themselves, isolating or living in poor conditions. They reach out to homebound seniors who are in need of mental health services and are able to provide all mental health services in participants' homes when necessary. Staff also collaborates with the SHOPP program to conduct joint home visits with the HCA Public Health nurses to ensure that participants' mental and physical health needs are addressed. Finally, the OAS pharmacist conducts many educational events both for participants and professionals on issues relevant to older adults such as medication management, health- and mental health-related matters and community services.

INTEGRATED OUTPATIENT CARE

Integrated Outpatient Care programs provide outpatient behavioral health services to individuals who are living with co-occurring chronic physical health conditions and serious emotional disturbance or mental illness. Multi-disciplinary teams of medical and mental health professionals coordinate the care for individuals receiving services at these specialized outpatient clinics as treatment can be complicated by the interplay of physical and mental health symptoms, medications and medical treatment side effects. Orange County currently funds two such programs through CSS, one program that targets youth who are being seen in specialty medical clinics and the other that targets adults with chronic primary care conditions.

Integrated Outpatient Care	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Children and Youth Behavioral Health Co-Occurring Medical and Mental Health Clinic (CSS)	325	$600,000	$1,846
Integrated Community Services (CSS)	200	$1,648,000	$8,240

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

Program Serves	Symptom Severity		Location of Services					Typical Population Characteristics					
0-20	At-Risk	Severe	School	Outpatient Clinic	Hospitals	Residential	Medical Specialty Clinics	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-risk	Medical

The program provides services in English, Spanish, Vietnamese, Korean, Japanese and other languages as needed through use of language line services.

Target Population and Program Characteristics

The target population for this program is youth through age 20 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Youth with severe eating disorders who are at-risk of life-threatening physical deterioration are also served in this program. Parents and siblings play an integral 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. Youth are referred to this program by physicians within the local childrens hospital. Many of these children and youth are MediCal beneficiaries and MHSA funds serve as a match to the drawdown of federal funds.

Services

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

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

Strategies to Promote Recovery/Resilience

Recovery and resilience are promoted by ensuring that a strong support network is in place to improve the lives of youth with medical and mental health conditions as well as their families. This is achieved by working closely with the child's family using a strengths-based approach to help develop skills that further improve their functioning outside the clinic setting, and by communicating and collaborating with the various providers within their system of care network (e.g. medical teams, school staff, wraparound team, Full Service Partnership, Therapeutic Behavioral Services, community resources, etc.). Because the program is located on the medical campus, program staff has the opportunity to work directly with, and educate the medical team about, the effects of the child's mental health condition and how they can best support the child and their family in their overall recovery rather than focusing exclusively on medical outcomes.

Strategies to Improve Timely Access to Services for Underserved Populations

Lack of transportation is a common issue that families face when seeking services. The clinic and hospital are located on bus lines, but it can be time consuming to use public transportation. The program continues to look for opportunities to provide services within the child's community, such as in schools, the mobile pediatric asthma clinic or the child's residential placement. The program also strives to remove barriers to accessing mental health services by communicating and collaborating with medical teams to ensure continuity of care. Clinicians are mobile and can also provide mental health services during medical appointments and/or hospitalizations to decrease the likelihood that the child and family will drop out of mental health treatment.

In addition to English, the program can provide therapy and psychiatry services in Spanish, Vietnamese, Korean and Japanese through staff who are bicultural/bilingual. All Co-Occurring Clinic clinicians have access to interpretive phone services to remove language barriers and facilitate communication and service delivery when a clinician who speaks the child's or family's language is not available.

Strategies to Reduce Stigma and Discrimination

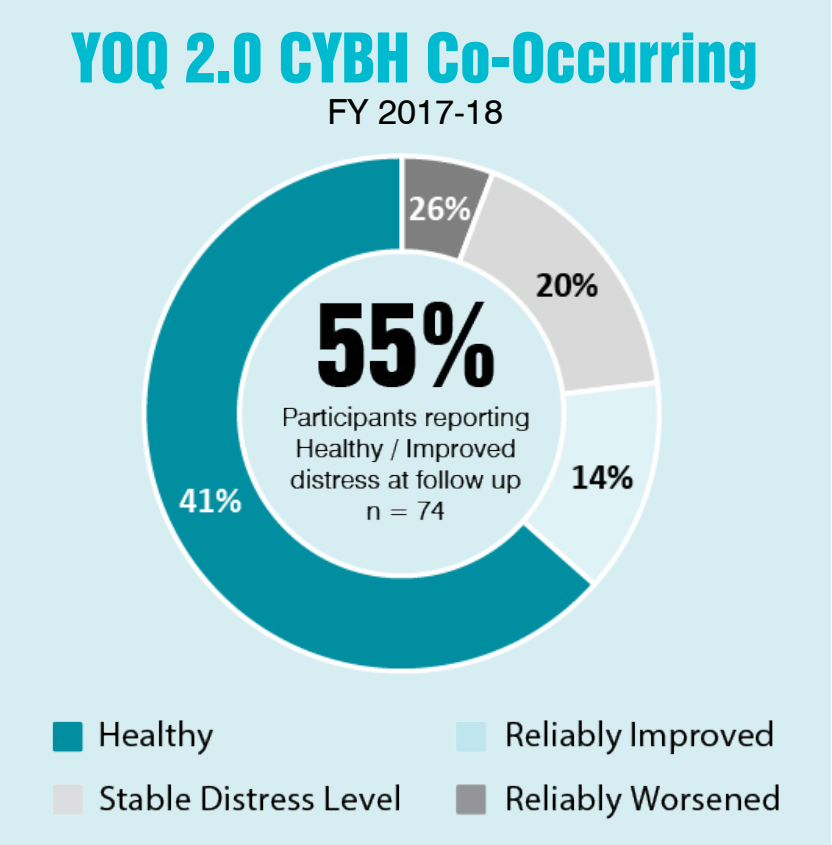
Spanish-speaking clinicians are encouraged to participate in a monthly Spanish-speaking clinicians' meeting aimed at discussing and training in topics and issues related to the provision of mental health services in Spanish and cultural and linguistic factors specific to the Hispanic population. Postdoctoral fellows regularly attend seminars that provide education and training on research and evidence-based practices that take into account cultural and diversity factors that impact mental health and psychosocial functioning. The program also regularly educates medical providers on issues related to mental health in an effort to increase understanding and reduce stigma.

Outcomes

The program served a total of 445 participants during FY 2017-18, which was an increase over the 348 served in FY 2016-17 and related to the expansion of the training program. During the program's first year of implementation in FY 2016-17, it was determined that the outcome measure initially selected (PROMIS Pediatric) was not adequately detecting mental health symptoms in this population. As a result, the measure was discontinued and replaced

with the YOQ 2.0. Individuals completed the measure at intake, every month of program participation and at discharge, and participants' scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

Of the 445 participants who were served in FY 2017-18, 74 had baseline and at least one follow-up measure. The majority (FY 2017-18: 55%), reported mental health distress levels that were either in the healthy or reliably improved category at the most recent follow-up. However it is important to note that the initial assessment does not actually reflect a true baseline for three-fourths of the participants since they had already been engaged in treatment for over a month at the time the OQ was implemented. Nevertheless, preliminary results indicate that the program's services are associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with a meaningful reduction in suffering among those who reported clinically elevated distress upon entering the program and/or shortly after beginning treatment.



Challenges, Barriers and Solutions in Progress

Since the program's inception two years ago, the CYBH Co-Occurring Clinic has had a fast and steady rise in the number of children it sees. As a result, the team of clinicians has grown exponentially to meet the demand for services. Also, the number of settings in which the clinicians provide mental health services has expanded significantly. At inception, the majority of mental health services were being provided in the outpatient Co-Occurring Clinic, with a small fraction of children being seen at one medical specialty clinic. Currently, program clinicians provide mental health services at several medical specialty clinics (i.e., eating disorder, transgendered, oncology, cystic fibrosis, diabetes), as well as inpatient medical units, schools and, on occasion, community settings such as a temporary shelter.

This fast growing client census and clinical team result- ed in the need for a uniform and standardized documentation manual to streamline the on-boarding of new clinicians, as well as part-time Quality Improvement staff to perform chart reviews and assure documentation compliance.

In addition, program staff had noted that there is a subset of youth served whose needs exceed the ability of the outpatient clinic to address. A new Full Service Partnership, Children's HEALTH (Harnessing Every Ability for Lifetime Total Health), was developed to meet this need and launched in September 2018 (see the Full Service Partnership section).

Community Impact

The program has already provided services to more than 613 youth and their families since its inception in July 2015, thus underscoring the need for these specialized services.

Integrated Community Services (CSS)

Program Serves	Symptom Severity				Location of Services						Typical Population Characteristics								
18+	At-Risk	Early Onset	Mild-Moderate	Severe	Home	Field	School	Outpatient Clinic	Hospitals	Residential	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occuring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese and Korean.

Target Population and Program Characteristics

Integrated Community Services (ICS) serves individuals ages 18 and older who have chronic primary care and mental health needs. The program, which was originally an Innovation project continued with CSS funding due to its demonstrated success, has two components: ICS County Home and ICS Community Home. On the ICS County Home side, primary care physicians (PCPs), registered nurses (RNs), and medical care coordinators are placed in behavioral health clinics. On the ICS Community Home side, County therapists and psychiatrists work with mental health caseworkers within contracted and subcontracted primary care sites. This collaboration with community medical clinics and County mental health programs is a healthcare model that bridges the gaps in service for the underserved low-income community. The program serves adults who are MediCal enrolled or eligible, or have third party coverage. Individuals are referred to this program by County behavioral health providers, community organizations and contracted community clinics.

Services

In addition to the medical care provided by the PCPs and RNs, ICS behavioral health staff conducts a number of psychoeducational support groups on topics such as nutrition, diet, chronic diseases, depression, anxiety, exercise and other physical and mental health care subjects. ICS clinicians also provide therapy, counseling, crisis assessment and intervention and utilize evidence-based and best practices such as Motivational Interviewing, Seeking Safety and Cognitive Behavioral Therapy.

Mental Health Workers also provide case management and help facilitate program participants' linkage to community organizations that provide a range of services (i.e., prescription eyeglasses, free clinic, Serve the People, housing assistance, 211 of Orange County, etc.). They help participants navigate the system of care and share their lived experience to help participants gain insight and make positive choices about their healthcare and behavioral health needs.

Strategies to Promote Recovery/Resilience

ICS' integrated, multi-disciplinary teams promote recovery and resilience by providing coordinated care and enabling adults to better navigate different systems of care within their communities. ICS support groups have also helped raise awareness and provide participants with information they need to make better decisions about their lifestyles that impact their overall health. These groups also serve as a safe place for participants to ask questions and get accurate information about physical and mental health care. By decreasing mental health symptoms and addressing and improving physical health problems, program participants are expected to increase their life expectancy and live a better quality of life. Peer support and role modeling also play a key role in promoting resilience in these participants.

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation poses an issue to program access as many participants do not have the means to get to the clinics. Although ICS staff have the ability to do community outreach, follow through from participants can pose a challenge. The program attempts to address these barriers by teaching participants how to use public transportation, providing bus passes and placing re- minder calls about the date and time of upcoming appointments. In addition, ICS staff are bicultural/bilingual in a number of languages (see grid) and have access to a lan- guage- line in order to reduce difficulties engaging in services due to language barriers.

Strategies to Reduce Stigma and Discrimination

ICS provides services to a large number of people in the Asian communities where stigma continues to be associated with mental illness and, as a result, many participants tend to keep issues within the family and not seek needed services. Staff work to reduce stigma by educating participants and their family members about mental illness as a brain disease and beginning engagement into services by focusing on somatic symptoms.

Outcomes

The program served a total of 500 adults in FY 2017-18, and 467 adults in the year prior (February 2016 - June 2017*). ICS monitored both mental health symptoms and physical health markers to assess program impact.

Across both fiscal years, adults with severe depression and/or anxiety at baseline, as measured by the PHQ-9 and GAD-7, experienced medium reductions in their symptoms.[1]

In addition, adults who met criteria for hypertension at baseline (i.e., ≥ 140/90) generally demonstrated moderate decreases both in their systolic and diastolic blood pressure, although the decrease in diastolic blood pressure was somewhat reduced in FY 2017-18.

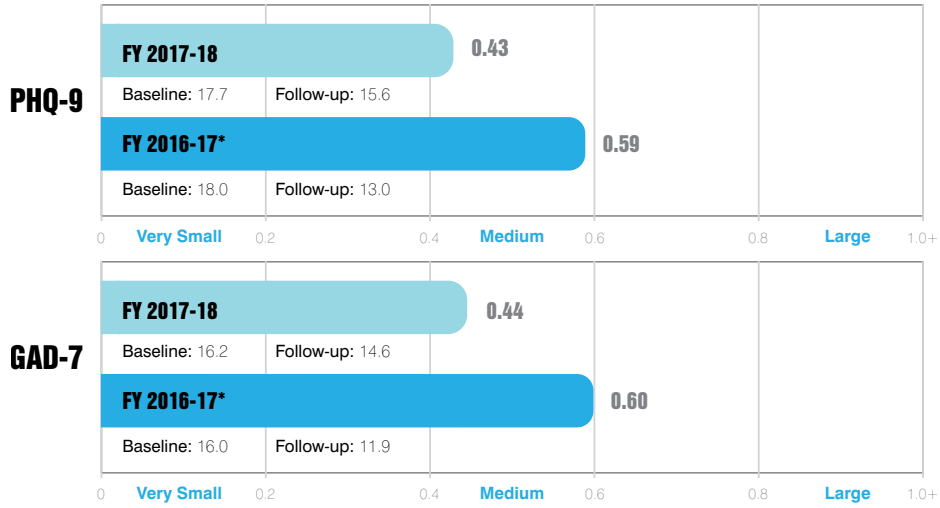
Changes/Challenges/Barriers

A continuing challenge for the program is not being able to provide psychiatric services to the ICS Community participants. The county Psychiatrist position remains vacant due to the hard-to-fill nature of psychiatrist positions within the County of Orange. Program staff continue to refer participants who would benefit from psychiatric services to community resources (e.g. county outpatient

** The time frame for FY 2016-17 analysis was extended to capture all participants served in ICS when the program transitioned to CSS, in February 2016.*

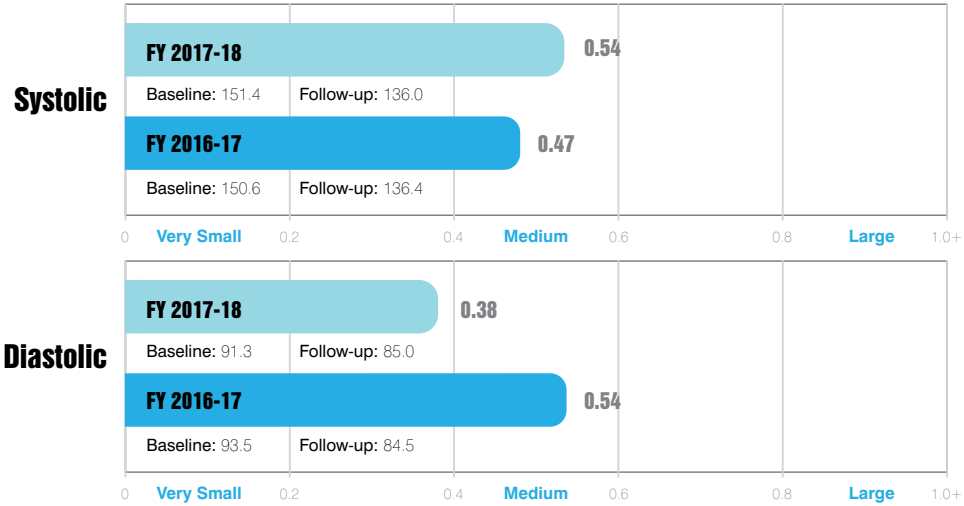
Impact on Severe Mood Symptoms by FY

Integrated Community Services



Impact on Blood Pressure for Participants Who Were Initially Hypertensive (BP≥140/90)

Integrated Community Services



clinics, CalOptima and private practice psychiatrists) when available. Additionally, staff retention continues to be a significant barrier to the program achieving a steady workflow. Staff turnover affects the transfer of knowledge, especially to the data analyst who is responsible for entering the ICS participant health data into the ICS Registry. Essentially, all disciplines within the program experienced staff turnover causing an overflow of work duties for the remaining staff and delays in workflow. These changes prompted the management team to analyze gaps in workflows and data gathering in order to improve the output of the program.

Historically the program has had low attendance rates for the Wellness Education series. In response, the program increased their outreach efforts during this period and purchased wellness-related incentives to increase attendance. The series includes topics such as physical education, social/interpersonal relationships, chronic health conditions, diabetes information and dietary counseling for high blood pressure. The number of attendees increased with one site having up to 8 participants in one group.

Community Impact

The program has provided services to more than 1,697 adults since its inception as an Innovation project in September 2011. ICS has helped improve participants' physical and mental well-being and fill an important gap in the BHS system of care. The program, through its partnership with a contracted provider that targets the Asian population, has also brought needed mental health services in a culturally accessible way to this underserved community.

Reference Notes

[1] ***PHQ-9:***
FY 2017-18: Prior M=17.7, SD=5.0; Since M=15.6, SD=6.1; t (135) = 4.97, p<.001, Cohen's d=.43
FY 2016-17: Prior M=18.0, SD=5.0; Since M=13.0, SD=6.9; t (104) = 7.23, p<.001, Cohen's d=.59

GAD-7:
FY 2017-18: Prior M=16.2, SD=3.6; Since M=14.6, SD=5.0; t (112) = 4.40, p<.001, Cohen's d=.44
FY 2016-17:Prior M=16.0, SD=3.5; Since M=11.9, SD=6.3; t (82) = 6.61, p<.001, Cohen's d=.60

[2] ***Systolic:***
FY 2017-18: Prior M=151.4, SD=15.7; Since M=136.0, SD=24.9; t (66) = 4.30, p<.001, Cohen's d=.54
FY 2016-17: Prior M=150.6, SD=18.4; Since M=136.4, SD=23.9; t (87) = 4.87, p<.001, Cohen's d=.47

Diastolic:
FY 2017-18: Prior M=91.3, SD=9.2; Since M=85.0, SD=15.6; t (66) = 3.00, p<.01, Cohen's d=.38
FY 2016-17: Prior M=93.5, SD=8.9; Since M=84.5, SD=14.5; t (87) = 5.29, p<.001, Cohen's d=.54

INTENSIVE OUTPATIENT

IIntensive outpatient programs provide comprehensive, wraparound services for individuals of all ages who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in these programs have the highest level of need among those served in the outpatient programs based on their history of psychiatric hospitalization, incarceration, criminal justice or foster care involvement, homelessness and/or other risk factors. Orange County currently provides three types of CSS-funded programs that serve individuals of all ages in this service area:

- Full Service Partnerships (FSPs)
- Programs for Assertive Community Treatment (PACTs)
- Youth Core Services - Field-Based Track

Intensive Outpatient Programs	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Children's FSP (CSS)	496	$11,054,575	$22,287
TAY FSP (CSS)	745	$8,184,468	$10,986
Adults FSP (CSS)	1,290	$21,592,093	$16,738
Older Adults FSP (CSS)	194	$2,683,249	$13,831
CYBH PACT (CSS)	75	$1,100,000	$14,667
Adult/TAY PACT (CSS)	1,200	$9,028,018	$7,523
Older Adult PACT (CSS)	120	$671,632	$5,597
Youth Core Services (CSS)*	380	$5,370,000	$14,132

* *The budget for Youth Core Services is the total figure that includes Youth Core Services' Intensive Outpatient and Short-Term Residential Therapeutic Program track described in the Residential Treatment section.*

Full Service Partnerships (CSS)

The Full Service Partnership/Wraparound programs (FSPs) provide intensive, community-based services that promote wellbeing and resilience in those living with serious mental illness. FSPs 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. All FSPs are provided by community-based organizations contracted by HCA.

Target Population and Program Characteristics

The target population for the FSPs include individuals of all ages who are living with a SED or SMI, are unserved or underserved and may be homeless or at-risk of homelessness, involved in the criminal justice system and/or are frequent users of inpatient psychiatric treatment. There are currently 13 distinct FSPs operating in Orange County, Four primarily focus on serving individuals who are homeless or at-risk of homelessness and tailor their services based on age/developmental needs (i.e., General FSPs) and the remaining serve those with specialized needs (i.e., criminal justice involvement, frequent hospitalization, cultural or linguistic isolation, etc.). More information about each of these programs is provided below.

General FSPs: All General FSPs outreach and engage individuals who are living with a SED or SMI and are unserved, underserved or not successfully engaged in traditional mental health services. Those served in the General FSPs tend to be at particular risk of homelessness and may also experience frequent hospitalizations and/or be involved with the criminal justice system. However, these programs can be accessed by the general community in contrast to the specialized programs that may require a referral from a collaborating agency. Additional eligibility criteria/characteristics for each program are described below.

Project RENEW (Reaching Everyone Needing Effective Wrap)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
0-18	Severe	Anywhere	Field	Parents	Families	Homeless/ at-Risk	Co-Occurring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Russian and American Sign Language (ASL).

Project RENEW provides services to children from birth to age 18. In addition to the above criteria, Project RENEW works with those who are experiencing a first psychotic episode, have parents living with serious mental illness (SMI), and/or are under the supervision of social services. Although the majority of children served are between the ages of 12-15 years, Project RENEW also serves very young children between the ages 0-5 years or school age children who are having notable difficulty functioning due to emotional problems. In addition to the services provided to the children and youth, parents frequently receive job assistance, especially when the needs of their child or youth are so significant that it impacts their ability to maintain employment. 16 to 18 year olds who are referred for FSP services will generally be enrolled in RENEW, however, if family involvement is limited, STAY is usually a better match for this population.

TAO (Telecare and Orange)

Program Serves	Symptom Severity	Location of Services				
						
18-59	Severe	Anywhere	Field	Homeless/ at-risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Korean, Hindi, Hebrew, Italian and Urdu.

TAO serves adults ages 18 and older who are living with serious and persistent mental illness. TAO has three locations that provides services to adults living anywhere in the county. Referrals can come from different sources including the general community, jails, probation, etc.

STAY (Support Transitional Age Youth) Process

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics									
16-25	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish, Hmong, Vietnamese, Khmer and Guajarati.

STAY Process serves TAY ages 16-25 who are living with SED or SMI that is frequently complicated by substance use and/or a history of trauma. TAY are provided support and opportunities to increase skills and abilities that are essential to becoming self-sufficient adults. The majority of TAY referred have experienced two or more mental health hospitalizations in the past 12 months, are currently homeless or at-risk of homelessness, may be/have been involved with social services (former foster youth), and require a level of services not afforded in other outpatient settings.

OASIS (Older Adult Support and Intervention System)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
60 +	Severe	Anywhere	Field	Homeless/ at-Risk	Co-Occurring SUD	Medical	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Tagalog and Hindi.

OASIS provides services to adults ages 60 and older who, in addition to the FSP target population criteria, may be at-risk of loss of independence or institutionalization, frequent users of emergency rooms and/or experiencing a reduction in personal and/or community functioning. Older adults served by OASIS tend to experience a number of health and mobility issues in addition to serious and persistent mental illness. They may also have co-occurring substance use issues.

Specialized FSPs: The specialized FSPs in Orange County serve individuals who meet the FSP target population criteria and would also benefit from the unique focus of a specialized program and/or are only open to those who are referred from a collaborating agency such as social services, probation or the courts. Consistent with the MHSA, all FSPs – even those affiliated with the Courts and Probation – are voluntary.

Project FOCUS (For Our Children's Ultimate Success)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
											
	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Students	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Khmer, Tagalog, Mandarin, Korean, Cantonese, Taiwanese and American Sign Language (ASL).

Project FOCUS specializes in serving culturally- and/or linguistically-isolated Asian/Pacific Islander (API) children and youth ages 0-25 who are living with SED or Serious Mental Illness (SMI). A bicultural, bilingual team works with children, TAY and their families to provide culturally responsive services while simultaneously working to counter stigma and discrimination associated with mental illness in the API community. This FSP is open to Orange County children, TAY and their families. Beginning in FY 2017-18, Project FOCUS continued providing services to TAY who aged out of the program when they turned 26. Project FOCUS continues to support the need of these culturally sensitive TAY because at this time there is not a specialized FSP for adults.

Project HEALTH (Harnessing Every Ability for Lifelong Total Health)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/at-Risk	Medical

The program provides services in English, Spanish and Farsi.

Project HEALTH is designed to meet the needs of youth ages 0 to 25 years who are diagnosed with SED and a significant and/or chronic physical illness that exceeds the ability of the current integrated care clinic to address (see "OC Children with Co-Occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs or Eating Disorders" in the Clinic-Based Outpatient section). This is a small group of youth and families with needs that are so different from those enrolled in other FSPs that a specialized program best addresses their range of unique concerns. The program launched in September 2018 and accepts referrals from the MHSA outpatient clinic program, OC Children with Co-Occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs or Eating Disorders and any program that identifies a youth who fits the profile outlined above.

Collaborative Courts FSP (CCFSP)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
0 - 25	Severe	Anywhere	Field	Parents	Families	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish and Vietnamese.

CCFSP for Foster Youth is the second CCFSP contract and works specifically with the Juvenile Girls and Boys Courts and Grace Court to support youth with SED/SMI who are/were in the foster care system and have experienced multiple placement failures. Because these youth face a considerable number of stressors, challenges and trauma, the program serves youth through age 25 so that they may receive support during their transition into early adulthood.

Youthful Offender Wraparound (YOW)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics	
0 - 25	Severe	Anywhere	Field	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish and Vietnamese.

YOW serves children and youth through age 25 who are experiencing SED/SMI and are involved with the juvenile justice system. The program focuses on maintaining the gains youth make while receiving services in custody and on reintegrating youth into the community after release from Juvenile Hall. Learning how to obtain and maintain employment despite significant mental health issues and a criminal history is a particular focus of this FSP. Eligible youth are primarily referred to YOW by the Orange County Probation Department.

Collaborative Courts FSP (CCFSP) for Foster Youth

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
0 - 25	Severe	Anywhere	Field	Parents	Foster Youth	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English and Spanish.

CCFSP has two separate contracts, with this one dedicated to working with youth who are living with SED/SMI and referred from the Juvenile Recovery Court or Juvenile Court's Truancy Response Program. Because many of these youth face multiple problems, stressors, a history of trauma and substance use disorders, the program supports them in developing alternative coping skills and providing them with educational opportunities and job training. CCFSP serves youth through age 25 and their families whenever possible.

STEPS (Striving Towards Enhanced Partnerships)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
18-59	Severe	Anywhere	Field	Families	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese and Hebrew.

STEPS is a program that serves adults ages 18 through 59 who are either on Lanterman-Petris-Short (LPS) conservatorship and returning to the community from long-term care placements or who have misdemeanor or felony offenses and are referred by the Assisted Intervention Court, – one of the Mental Health Collaborative Courts.

Opportunity Knocks

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
						
	Severe	Anywhere	Field	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, and Vietnamese.

Opportunity Knocks serves adults ages 18 and older with severe and persistent mental illness (SPMI) who have recent involvement in the criminal justice system or who experience recidivism with the criminal justice system. Individuals are referred by different sources including general community, jails, probation, etc.

WIT (Whatever It Takes)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics		
						
	Severe	Anywhere	Field	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi and Korean.

WIT serves adults ages 18 and older who are liv- ing with SPMI and are referred through the Orange County Mental Health Collaborative Courts. The program works in collaboration with the Collaborative Court team which includes the Judge, Probation, district attorney, and the Public Defender's Office to provide treatment and services aimed at reintegrating members into the community.

AOT (Assisted Outpatient Treatment)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
							
	Severe	Anywhere	Field	Families	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English and Spanish.

AOT FSP serves adults 18 and older who have been Court-ordered to participate in the AOT FSP and those who have voluntarily agreed to participate in the AOT FSP. For a more detailed description of AOT eligibility criteria, please see the AOT Assessment and Linkage program description under the Navigation/Access and Linkage to Treatment section.

FSP Services

The FSPs follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally competent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can include Marriage and Family Therapists, Clinical Social Workers, Personal Services Coordinators, Peer Mentors, Youth Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Clinical Dietitians, Licensed Clinical Supervisors, Psychiatrists and/or Nurses who are committed to the recovery model and the success of their participants. Working together, the teams provide intensive services that include counseling, case management and peer support, which are described in more detail below.

With regard to clinical interventions, the FSPs provide individual, family and group counseling and therapy to help individuals reduce and manage their symptoms, improve functional impairments and assist with family dynamics. A wide array of evidence-based practices are available and, depending on the age and needs of the individual, can include Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy, Integrated Treatment for Co-Occur- ring Disorders, Parent Child Interaction Therapy (PCIT), Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy, Program to Encourage Active Rewarding Lives for Seniors (PEARLS), Parent-Child Interaction Therapy, behavioral modification and others. Individuals enrolled in an FSP also receive psychiatric care, medication management, psychoeducation, co-occurring substance use disorder services, mindfulness training, crisis intervention and/or 24/7 support as needed.

Due to the notable increase in criminal justice-involved adults presenting with co-occurring substance use disorders, the adult FSPs have three certified substance use counselors who provide individual coaching, substance use education and groups such as Relapse Prevention and Co-Occurring Education. The WIT program also developed "Co-Occurring Pro- gram Extension (COPE)" which provides intensive outpatient services and support to participants with co-occurring substance use disorders. Since its implementation, COPE has demonstrated success in helping participants manage their substance use and apply learned skills in a real-world environment.

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

Some FSPs also have employment and/or housing coordinators who assist and support their participants in these essential elements of recovery. Employment coordinators or – when dedicated coordinators are not available – PSCs and other staff lead numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. FSP housing coordinators (and/or PSCs) also assist individuals with finding and maintaining safe, suitable housing as ameliorating homelessness is one of the target outcomes for the FSPs.

Peer Recovery Specialists/Coaches and Parent Partners are key members of the FSP teams and play an integral role in promoting wellness and resilience. By sharing their lived experience and learned skills, peer staff support recovery, empowerment and community integration. In addition, Parent/Family Partners work closely with parents, legal guardians, caregivers, significant others and other family members to provide suggestions on how they can best support the participant. Parent Partners also assist with the psychoeducation 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's and TAY FSPs approach to service and care planning. Some of the Children's FSPs' most recent efforts include Project FOCUS' and Project RENEW's implementation or planned implementation of PCIT, an evidence-based intervention that focuses on strengthening the parent-child relationship. In addition, the Adult FSPs have been working on increasing family inclusion at all levels of treatment and at social events, and AOT, STEPS, and TAO South offer a monthly family support group to provide families with information, education, guidance and support for their own needs, as well as to enable them to assist their family member's recovery.

Strategies to Promote Recovery/Resilience

Most of the adult FSPs utilize tools from the Recovery Centered Clinical System which focuses on exploring identity, defining hopes and dreams, making choices, reducing harm and making

connections. Participants are encouraged to broaden their resources and support systems by increasing their social contacts, improving family relationships when appropriate, and having meaningful roles in the community. Recovery and resilience are also promoted through individualized, client- and family-centered treatment that is strengths-based, aligned with participants' wants and needs, and matched to their level of functioning. FSP staff work alongside participants to improve self-direction, and promote health, wellness and stability in all aspects of their lives. Integral to these efforts are Peer Specialists, Peer Coaches and Parent Partners who encourage empowerment, facilitate community integration, and build, enhance and maintain resilience.

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals and families referred to the FSPs often face issues that may keep them from seeking services. These can include language/cultural barriers, recent immigration to the United States, homelessness and/or high risk of homelessness, housing instability, lack of financial or other resources, lack of childcare, transportation issues, stigma, criminal justice involvement and mistrust of "the system."

To counter these barriers, the FSPs seek to facilitate access to their programs in a number of ways. They provide presentations to educate the community about their services and tailor their messages to reach those who are not traditionally referred for mental health treatment. Within Project FOCUS, for example, which serves the API community, staff promote their services through "safe topics" such as how educational or employment attainment can be improved by receiving services that improve mental well-being. Once a referral is received, all FSP staff quickly do outreach and engagement wherever the referred individual is at, including their home, shelters, public areas such as parks/libraries, a hospital, correctional facility or anywhere else the person is known to be. During these contacts, staff focus on building therapeutic relationships in order to facilitate trust and encourage linkage to ongoing services.

In addition, all FSPs strive to provide services in a linguistically and culturally competent manner to diverse, underserved populations in Orange County (see tables for specific bilingual capabilities within each FSP). When bilingual staff are not available, the FSPs have access to all languages through a contracted interpreter service provider that is available when needed. The programs also offer regular staff trainings to increase cultural sensitivity and understanding when providing services to participants and their families who come from cultural backgrounds that are different from their own.

When individuals and/or families seem hesitant to participate in services, staff explore the obstacles preventing them from accessing resources or progressing through their care plan. The individual, family and FSP team attempt to work through the challenges together by adapting strategies, comparing positives and negatives of behaviors and consequences, reframing negative situations to create new momentum, engaging the participant in problem solving, eliciting change statements, reinforcing responsibility, giving praise and encouragement and cultivating hope in one's ability to succeed. The FSPs also make an effort to educate par- ticipants about, and link them to, appropriate resources outside of their programs. This can include financial assistance and benefits, housing, the behavioral health continuum of care and other resources that promote self-sufficiency and encourage community.

Strategies to Reduce Stigma and Discrimination

The FSPs recognize that providing quality services begins with taking into consideration the culture, values, preferences and needs of the individuals and families they serve and, as such, strive to hire bilingual and bicultural staff. All staff participate in on-going trainings related to ethnicity, religious observations, gender identity and sexual orientation. These trainings enable staff to better connect with unserved, underserved and culturally and linguistically isolated individuals through conversations that fit with the individuals' and their familys' values and worldview. For example, some of the perspectives that Project FOCUS considers when providing services to API participants include the medical and spiritual aspects of mental health, somatic symptoms and the chance to improve education or employment outcomes through mental health services. Project FOCUS also hires staff who are sensitive to the fact that the children and youth they serve may have values and perspectives that are different from those of their parents/guardians and staff actively work to bridge any cultural divide.

Outcomes

During FY 2017-18, the number of individuals served in the FSPs were: 401 Children, 768 TAY, 1,224 Adults and 205 Older Adults. During FY 2016-17, the number of individuals served included: 339 Children, 759 TAY, 1,156 Adults and 223 Older Adults. The programs evaluated changes on outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance by comparing functioning in the 12 months prior to enrolling in the FSP to functioning during the fiscal year being evaluated. With the exception of school performance, all results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP.

Mental Health Recovery: Mental health recovery was evaluated through changes in two measures: (1) number of days the individual had been psychiatrically hospitalized, and (2) the number of times the individual experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room/CSU visit, crisis assessment/WIC 5585 evaluation or police response due to a mental health crisis).

Across both fiscal years, the FSPs generally made a small impact on the amount of time participants spent in a psychiatric hospital, with TAY, adult and older adult participants having spent, on average, about 4-5 weeks in the hospital during the year prior to enrolling in an FSP compared to about 1-2 weeks in the hospital after enrolling. Relative to the other FSP participants, children spent considerably less time in the hospital both prior to and after enrolling in an FSP (i.e., 1-1.5 weeks an average prior; 2-4 days an average after). Overall, this suggests that participants experienced somewhat less disruption in their daily lives by spending less time in the hospital while receiving FSP services. The HCA further plans to explore whether hospitalization usage is related to the length of time a participant has been enrolled in FSP services.

Impact on Psychiatric Hospitalization Days by FY

Impact on Mental Health Emergency Intervention by FY

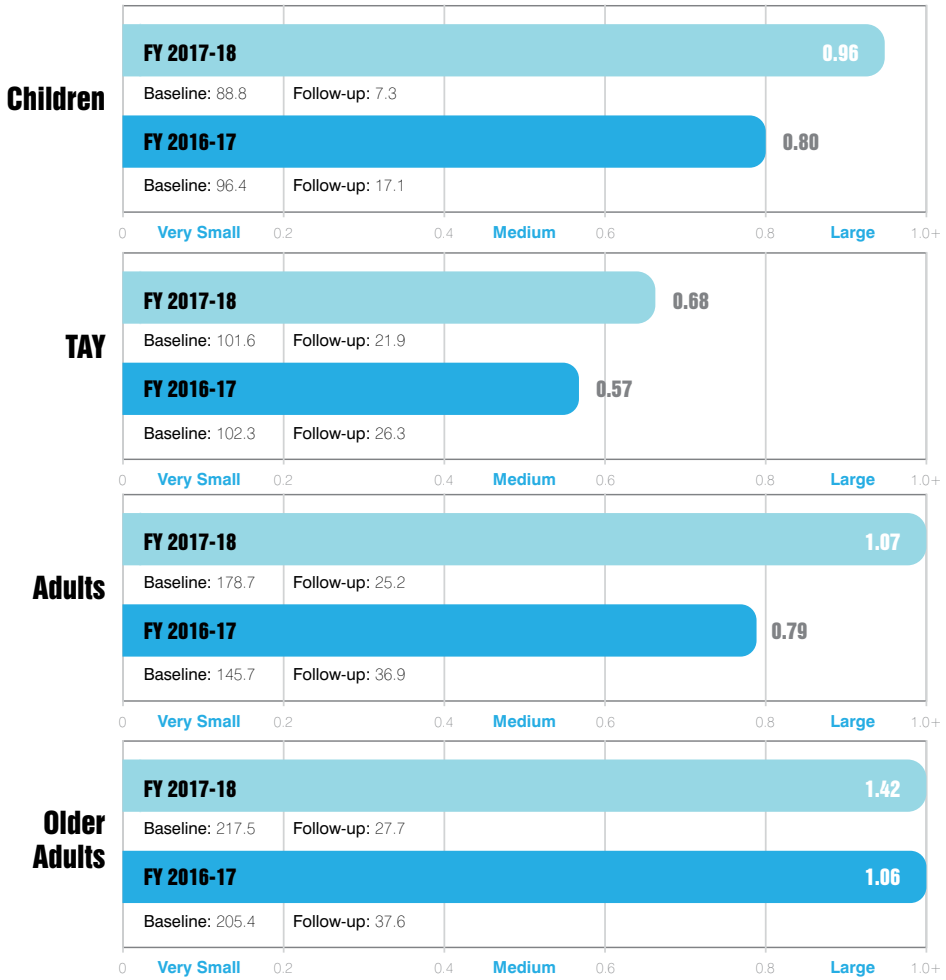
In addition, FSPs demonstrated medium to large decreases in the average number of mental health-related emergency interventions[2] that participants experienced during FY 2017-18 and FY 2016-17, further suggesting that they encountered less disruption from mental health-related symptoms and/or behavior while receiving FSP services. This effect was particularly pronounced for older adults, with the average number of events essentially dropping to zero.

Homelessness and Living Situation: Another goal of the FSPs is to prevent and reduce unsheltered homelessness, emergency shelter stays and, for children, out-of-home placements. For TAY, Adults and Older Adults, the FSPs also strive to increase the number of days they are able to live in the community independently (i.e., live safely in an unsupervised setting and perform their own activities of daily living).

The FSP programs continued to improve the housing circumstances of their participants as evidenced by the large reduction (moderate for TAY) in the average number of days spent

Impact on Unsheltered Homeless Days by FY

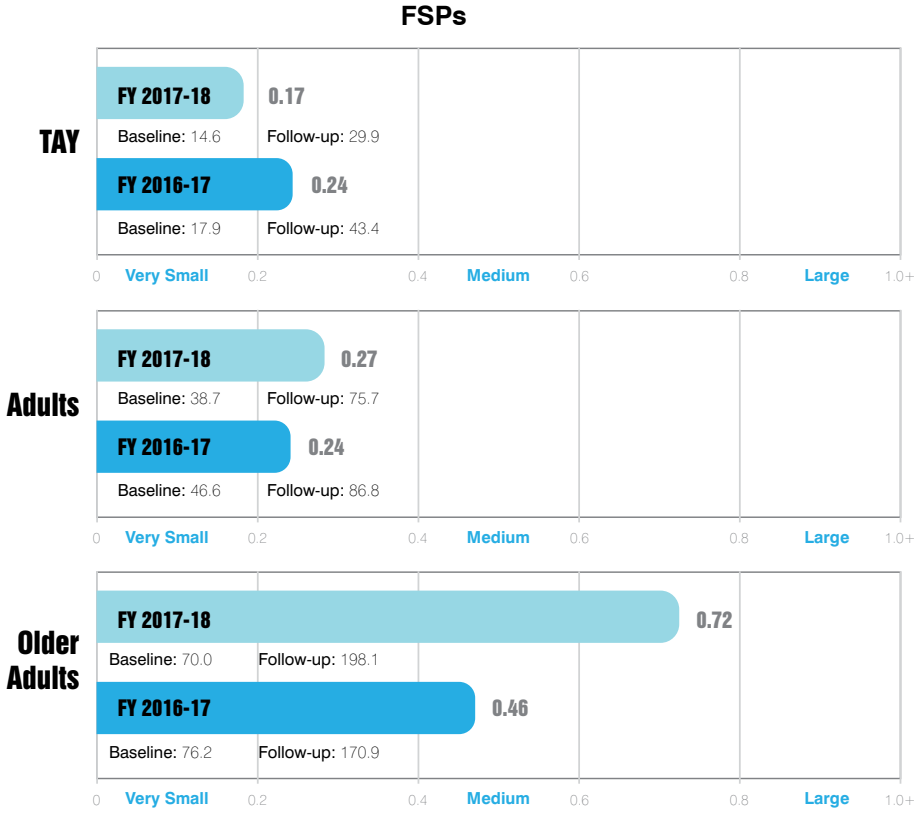
FSPs - FY 2017-18



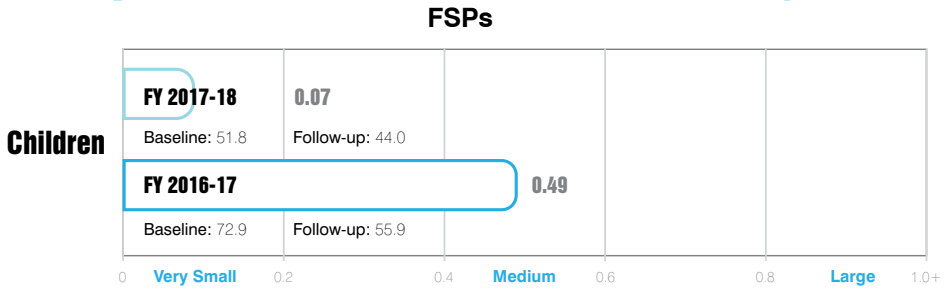
Impact on Emergency Shelter Days by FY

FSPs - FY 2017-18

Impact on Independent Living Days by FY



Impact on Out-of-Home Placements by FY



homeless during FY 2017-18 and FY 2016-17[3].Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc.

The impact of FSPs on reducing days spent in emergency shelter varied considerably across age group and/or fiscal year. Children, TAY and adults experienced small to moderate decreases, with stronger effects observed in FY 2016-17 than in 2017-18. In contrast, older adults experienced large reductions in days spent in emergency shelter across both fiscal years. Upon further exploration, some child and TAY providers indicated that they had used an overly broad definition for emergency shelter in FY 2017-18, which may have artificially reduced the impact on shelter use for that fiscal year; the HCA has since worked to clarify the definition with providers. Among the Adult FSPs, a single program (TAO Central) accounted for 44% of all emergency shelter days in FY 2017-18. During this same time, the county was working to relocate the large number of homeless adults living in the Flood Control Channel and Civic Center area. TAO Central worked to place these individuals in emergency shelter until they could transition to more appropriate, long-term housing, which may account for the reduced impact on emergency shelter days that fiscal year. In contrast, the Older Adult FSP demonstrated the opposite pattern (i.e., shifting from a moderate impact in FY 2016-17 to a large impact in FY 2017-18), which may have been attributable to a few participants who had very long emergency shelter motel stays while receiving services in FY 2016-17 and were eventually transitioned to permanent living placements during FY 2017-18. Thus, factors unique to FY 2017-18 (or FY 2016-17 for Older Adults) may account for the observed shifts in impact on emergency shelter use across the two fiscal years and may not necessarily reflect true changes in the FSPs' ability to improve this outcome.

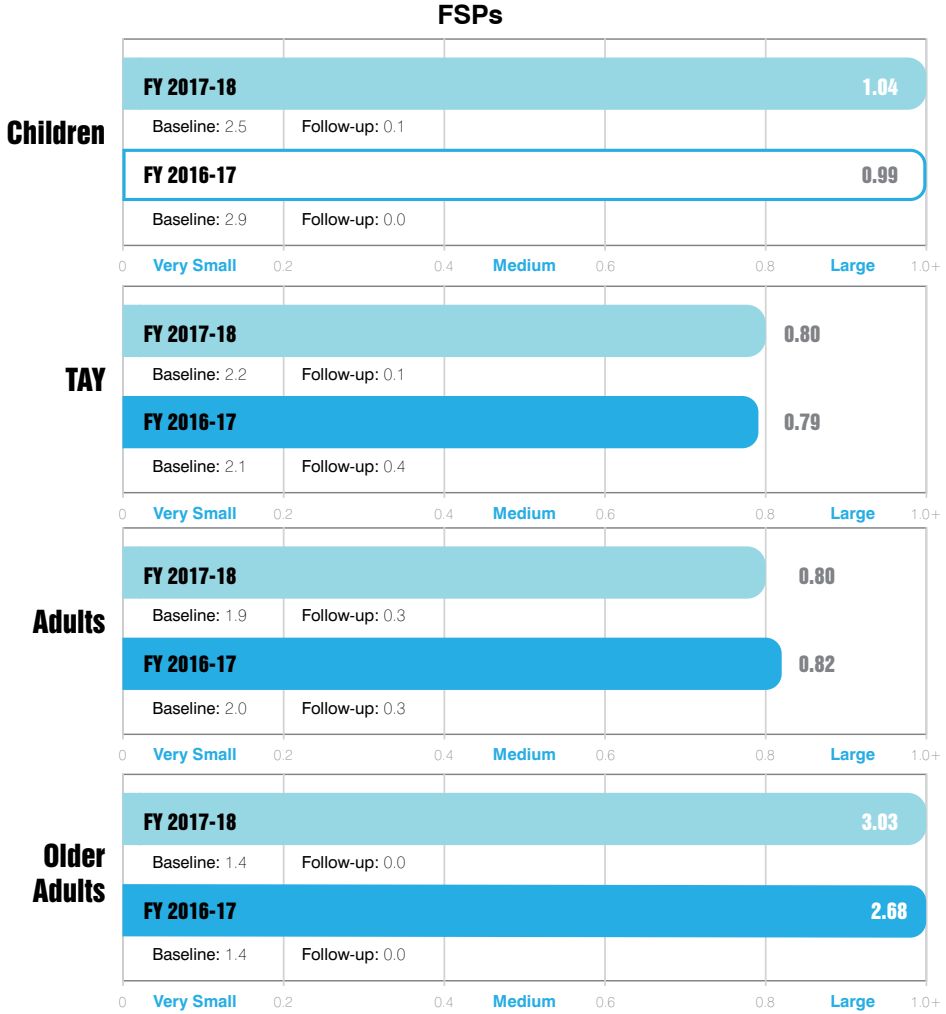
While the TAY and Adult FSPs had a small impact on increasing the average number of days participants spent living independently across both fiscal years, the Older Adult FSP demonstrated a moderate (FY 2016-17) to large (FY 2017-18) impact on this outcome. Thus the Older Adult FSP appears to be relatively effective at helping support independent living, and the HCA plans to further understand this trend. Independent living was defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement.

Finally, for children the goal of the FSPs is to reduce out-of-home placements, which are defined as placement in a group home or residential treatment facility. Across both years it should be noted that a very small number of children were affected by an out-of-home placement either prior to enrolling in the FSP or during the fiscal year being evaluated (i.e., n= 14 in FY 2017-18, n= 20 in FY 2016-17). Thus, it is difficult to draw firm conclusions on the overall efficacy of FSPs in reducing out-of-home placements for children, although the average number

of days children were placed out-of-the-home did decrease during both fiscal years when compared to the year prior to their enrollment in the FSP.

Legal Involvement: Outcomes related to decreasing individuals' involvement with the legal system were tracked using two measures: number of arrests and days incarcerated in jail or prison. The FSPs continued to have a large to very large impact on decreasing arrests during both fiscal years compared to the year prior to FSP enrollment.[7] Individuals ages 16 and older also reported large decreases in the number of days they had been incarcerated during both fiscal years compared to the year prior to FSP enrollment, with one exception in 2017-18 where older adults experienced moderate decreases. However older adults served in 2017-18, compared to those served in FY 2016-17, tended to have been incarcerated approximately 26 fewer days prior to enrolling in the FSP, thus reducing the relative impact observed in FY 2017-18. The impact of the FSPs on reducing the number of days that children spent incarcerated also

Impact on Arrests by FY

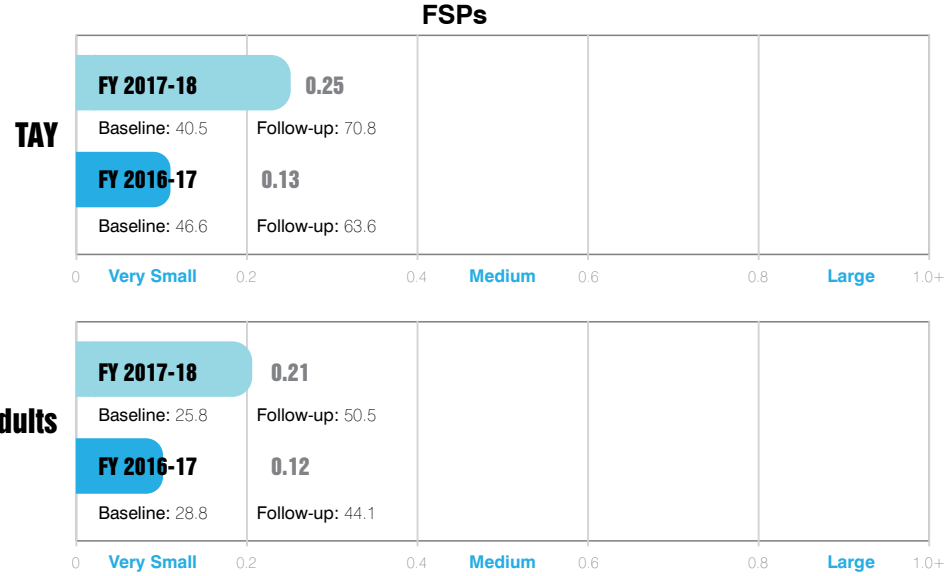


Impact on Incarceration Days by FY

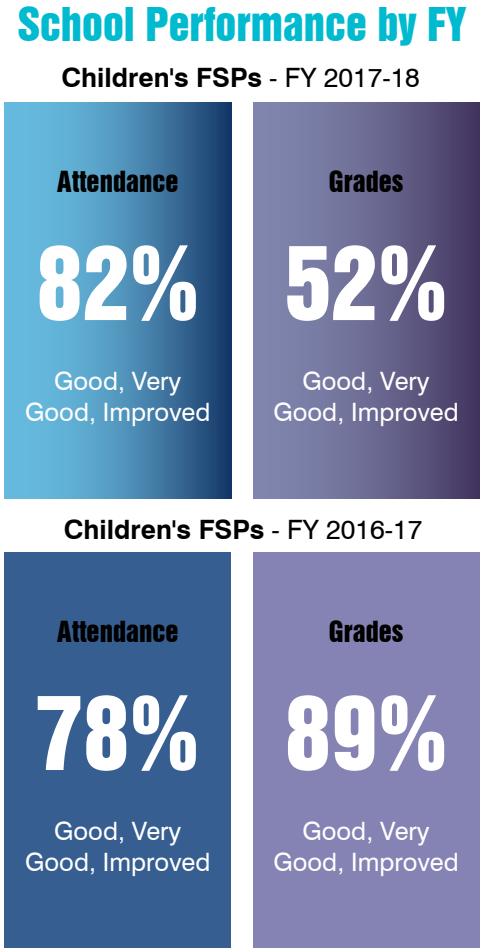
varied over the two fiscal years, with a moderate decrease seen in FY 2017-18 and negligible effects observed in FY 2016-17. Closer examination of the data suggests that this pattern may largely be due to one individual who was incarcerated for 141 days after enrolling in the FSP in FY 2016-17[8]. Of note, the overall number of children who had been incarcerated either prior to or while enrolled in an FSP increased in FY 2017-18, and HCA is currently exploring possible underlying reasons for this uptick.

Employment: The TAY and Adult FSPs also examined days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, substance use disorders, homelessness and/or a legal history. Per guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-house work, work experience, non-paid work experience and other gainful employment activity. Compared to the year prior to FSP enrollment, the FSPs had no impact in FY 2016-17 and a small impact in FY 2017-18 on employment for adults and TAY who were at least 16 years old at the start of the fiscal year (and therefore eligible to work the duration of the reporting period). Thus, increasing employment activity in a meaningful way continues to be a particularly challenging area for the FSPs.

Impact on Employment Days by FY



School Performance by FY



School Performance: The Children's FSPs examined the proportion of children who (1) maintained good/very good school attendance or grades and/or who (2) improved their attendance or grades while enrolled in the FSP. Although the majority of children reported good to improved attendance across both fiscal years, the proportion reporting good to improved grades fell from 89% in FY 2016-17 to 52% in FY 2017-18. Thus, while the findings generally suggest that the FSPs are successful in maintaining or improving school performance among the children served, HCA will continue monitor the FSPs' impact on grades to determine whether or not the FY 2017-18 results are an anomaly.

Challenges, Barriers and Solutions in Progress

Finding safe, affordable and permanent housing in the neighborhoods in which the individuals/families have support networks and/or the children are enrolled in school has continued to be challenging. To address immediate concerns with supply, FSP housing specialists work to build relationships in the community and develop housing resources for their participants. Once participants have been placed in housing, FSPs utilize a housing assistance strategy in which the individual/family becomes increasingly responsible with meeting costs so that, when clinical goals are met, the individual/family is able to maintain housing independently. This strategy creates stability so that clinical advances can be maintained upon discharge from the program. To address the shortage of permanent supportive housing, the HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, staff has been engaging in the community planning process for No Place Like Home.

Employment has also continued to be an on-going and significant challenge despite the recovering job market. The FSPs 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 an important aspect 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 FSPs are working to increase individuals' participation in meaningful, employment-re- lated 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. Nevertheless, more than any other target outcome, the FSPs continue to struggle with supporting individuals in sustaining employment in a consequential way.

In addition, the Older Adult FSP has noted that its participants don't always attend groups consistently. The FSP has made an increased effort to recruit potential participants by engaging them in conversation about the groups and benefits of attending, placing reminder calls, increasing socialization among group participants and assisting with and/or linking to transportation so that they may attend groups. Feedback from older adults served is also elicited regularly so that improvements to the groups' content and/or structure can be made on an on-going basis.

To address an increase of co-occurring substance use issues among TAY and adult participants, the FSPs are offering more co-occurring groups; working to partner with community substance use treatment programs to expand resources, including residential programs that specialize in co-occurring treatment; and creating their own co-occurring supports and interventions to fill identified service gaps. FSP staff also works collaboratively with Residential Care and Housing staff to address co-occurring issues to help individuals maintain their housing.

Finally, the AOT FSP actively continues to address misunderstanding within the community about what their program can and cannot do in relation to its implementation of Assisted Outpatient Treatment by virtue of being MHSA-funded and therefore required to be voluntary in nature.

Community Impact

Since program inception dates, the FSPs have served 1692 children (35%) and 3097 TAY (65%) were served since inception in the children's FSPs. The FSPs 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 FSPs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detoxification centers. In addition, the programs 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 FSPs also work closely with various County-Operated and County-contracted 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, sober living homes, Orange County Housing Authority, other housing providers, shelters, Family Resource Centers (FRCs), legal resources, food banks, vocational trade programs, LGBTQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policy makers, community based organizations and community clinics. By establishing such depth and breadth to their network of collaborators, the FSPs continue to be a leading force for mental health recovery in the community.

Reference Notes

[1] ***Psychiatric Hospitalization Days:***

Children:
FY 2017-18: Prior M= 7.7, SD= 6.7; Since M= 3.8, SD= 8.9; t(75)=2.67, p<.01, Cohen's d= 0.31
FY 2016-17: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t(70)=5.05, p<.001, Cohen's d=0.65

TAY:
FY 2017-18: Prior M=28.6, SD= 52.1; Since M=8.6, SD=26.8; t(274)=5.59, p<.001, Cohen's d= 0.35
FY 2016-17: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246) =-5.03, p<.001, Cohen's d=0.35

Adults:
FY 2017-18: Prior M=34.0, SD=59.7; Since M=14.4, SD=31.9; t(559)=6.92, p<.001, Cohen's d=0.31
FY 2016-17: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t (542)=6.78, p<0.001, Cohen's d=0.32

Older Adults:
FY 2017-18: Prior M=39.4, SD=76.1; Since M=5.0, SD=12.8; t (57)=3.41, p<.001, Cohen's d= 0.55
FY 2016-17: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t (58)=1.84, p=0.07, Cohen's d=0.28

[2] ***Mental Health Emergency Interventions:***

Children:
FY 2017-18: Prior M= 1.8, SD=1.9; Since M=0.5, SD=1.1; t(158)=7.61, p<.001, Cohen's d=0.62
FY 2016-17: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t (82)=4.57, p<.001, Cohen's d=0.55

TAY:
FY 2017-18: Prior M=2.7, SD=3.6; Since M=0.4, SD=3.6; t(365)=12.14, p<.001, Cohen's d=0.74
FY 2016-17: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t (295)=7.7, p<.001, Cohen's d=0.46

Adults:
FY 2017-18: Prior M=3.2, SD=3.7; Since M=1.0, SD=2.0; t(809)=14.88, p<.001, Cohen's d=0.54
FY 2016-17: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t(629)=13.10, p<.001, Cohen's d=0.59

Older Adults:
FY 2017-18: Prior M=3.2, SD=4.6; Since M=0.0, SD=0.0; t(121)=7.58, p<.001, Cohen's d=0.97
FY 2016-17: Prior M=1.7, SD=1.6; Since M=0.2, SD=0.5; t (79)=8.07, p<.001, Cohen's d=1.02

[3] ***Homeless Days:***

Children:
FY 2017-18: Prior M=88.8, SD=101.8; Since M=7.3, SD=19.7; t (23)=3.86, p<.01, Cohen's d=0.96
FY 2016-17: Prior M=96.4, SD=129.7; Since M=17.1, SD=51.7; t (19)=-3.0, p<.01, Cohen's d=0.80

TAY:
FY 2017-18: Prior M=101.6, SD=118.8; Since M=21.9, SD=46.1; t(168)=8.13, p<.001, Cohen's d=0.68
FY 2016-17: Prior M=102.3, SD=124.93; Since M=26.3, SD=55.79; t (154)=-6.69, p<.001, Cohen's d=0.57

Adults:
FY 2017-18: Prior M=178.7, SD=132.0; Since M=25.2, SD=60.7; t(666)=26.17, p<.001, Cohen's d=1.07
FY 2016-17: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t (611)=18.68, p<.001, Cohen's d=0.79

Older Adults:
FY 2017-18: Prior M=217.5, SD=136.2; Since M=27.7, SD=67.2; t(128)=14.99, p<.001, Cohen's d=1.42
FY 2016-17: Prior M=205.4, SD=138.5; Since M=37.6, SD=84.5; t (134)=12.14, p<.001, Cohen's d=1.06

[4] ***Emergency Shelter Days:***

Children:
FY 2017-18: Prior M=62.4, SD=100.4; Since M=27.5; SD=55.7; t(48)=1.99, p=.05, Cohen's d= 0.29
FY 2016-17: Prior M=72.9, SD=108.9; Since M=14.8; SD=35.4; t (31)=-2.97, p<.01, Cohen's d=0.61

TAY:
FY 2017-18: Prior M=69.3, SD=101.3; Since M=29.2, SD=54.5; t(155)=4.38, p<.001, Cohen's d=0.37
FY 2016-17: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t (162) =-5.90, p<.001, Cohen's d=0.50

Adults:
FY 2017-18: Prior M=68.4, SD=102.6; Since M=33.9, SD=53.6; t(430)=5.66, p<.001, Cohen's d=0.28
FY 2016-17: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t (341)=9.18, p<.001, Cohen's d=0.53

Older Adults:
FY 2017-18: Prior M=120.2, SD=136.9; Since M=12.8, SD=34.4;t(95)=7.27, p<.001, Cohen's d=0.84
FY 2016-17: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t (102)=3.96, p<.001, Cohen's d=0.43

[5] ***Independent Living Days:***

TAY:
FY 2017-18: Prior M=14.6, SD= 60.8; Since M=29.9, SD=81.2; t(743)=-4.57, p<.001, Cohen's d=-0.17
FY 2016-17: Prior M= 17.9, SD= 65.01;Since M=43.4, SD=96.66; t(747)=-6.46, p<.001, Cohen's d=-0.24

Adults:
FY 2017-18: Prior M=38.7, SD=95.8; Since M=75.7, SD=127.1; t(1144)=-9.01, p<.001, Cohen's d=-0.27
FY 2016-17: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t (1153)=-9.10, p<.001, Cohen's d=-0.24

Older Adults:
FY 2017-18: Prior M=70.0, SD=125.3; Since M=198.1, SD=152.3; t(190)=-9.82, p<.001, Cohen's d=-0.72
FY 2016-17: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t (219)=-7.41, p<.001, Cohen's d=-0.46

[6] ***Out of Home Placement Days:***

Children:
FY 2017-18: Prior M=51.8, SD=74.3; Since M=44.0, SD=66.2; t(13)=0.27, p=.79, Cohen's d=0.07
FY 2016-17: Prior M: 72.9, SD 102.2; Since M=55.9, SD=104.1; t(19)=.643m p=0.53, Cohen's d= 0.49

[7] ***Arrests:***

Children:
FY 2017-18: Prior M=2.5, SD=2.6; Since M=0.1, SD=0.4; t(24)=4.48, p<.001, Cohen's d=1.04
FY 2016-17: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6) =1.86, p=.11, Cohen's d=0.99

TAY:
FY 2017-18: Prior M=2.2, SD=3.1; Since M=0.1, SD=0.5; t(216)=9.81, p<.001, Cohen's d=0.80
FY 2016-17: Prior M=2.1, SD=3.0; Since M=0.4, SD=.83; t(270)=10.21, p<.001, Cohen's d= 0.79

Adults:
FY 2017-18: Prior M=1.9, SD=1.9; Since M=0.3, SD=0.8; t(586)=18.26, p<.001, Cohen's d=0.80
FY 2016-17: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t (598)=17.58, p<.001, Cohen's d=0.82

Older Adults:
FY 2017-18: Prior M=1.4, SD=0.7; Since M=0, SD=0.0; t(32)=12.34, p<.001, Cohen's d=3.03
FY 2016-17: Prior M=1.4, SD=0.8; Since M=0, SD=0.); t(31)=10.71, p<.001, Cohen's d=2.68

[8] ***Incarceration Days:***

Children:
FY 2017-18: Prior M=75.4, SD=97.4; Since M=29.8; SD=42.6; t(21)=2.07, p=.05, Cohen's d=0.48
FY 2016-17: Prior M=28.7, SD= 39.1; Since M=34.2; SD=67.9; t (9)=.194, p=.851, Cohen's d=-0.06

TAY:
FY 2017-18: Prior M=114.1, SD=107.4; Since M=22.5, SD=42.9, t(210)=12.19, p<.001, Cohen's d= 0.94
FY 2016-17: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1; t (217)=10.31, p<.001, Cohen's d=0.77

Adults:
FY 2017-18: Prior M=103.8, SD=97.6; Since M=17.3, SD=38.3; t(585)=20.38, p<.001, Cohen's d=0.93
FY 2016-17: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t (623)=19.24, p<.001, Cohen's d=0.79

Older Adults:
FY 2017-18: Prior M=46.6, SD=75.0; Since M=11.5, SD=39.5; t(29)=2.28, p<.05, Cohen's d=0.44
FY 2016-17: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t (29)=3.72, p<.01, Cohen's d=0.79

[9] ***Employment Days:***

TAY:
FY 2017-18: Prior M=40.5, SD=89.5; Since M=70.8, SD=115.3; t(764)=-6.88, p<.001, Cohen's d=-0.25
FY 2016-17: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624)=3.30, p<.001, Cohen's d=-0.13

Adults:
FY 2017-18: Prior M=25.8, SD=70.9; Since M=50.5, SD=108.2; t(1144)=-6.91, p<.001, Cohen's d=-0.21
FY 2016-17: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t (1150)=-4.58, p<.001, Cohen's d=-0.12

Programs of Assertive Community Treatment (CSS)

Programs of Assertive Community Treatment (PACT) offer an individualized treatment approach aimed at assisting individuals of all ages with their recovery from mental illness. Orange County PACTs are similar to the FSPs in that they utilize the evidence-based Assertive Community Treatment model to provide comprehensive, intensive outpatient services to persons with serious emotional disturbance or serious mental illness who may have a co-occurring substance use disorder and have experienced difficulty engaging with more traditional outpatient mental health services. The main differences are that the PACTs are County-Operated and do not have flexible funding, and their primary eligibility criteria target individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the last year. The PACTs' overarching goals include engaging individuals into voluntary treatment; helping them remain safely in the community and out of the hospital and criminal justice system; assisting them with reintegrating into the community through stable housing, education, and/or employment; and linking them to community-based support. Orange County currently offers four PACTs organized around the needs specific to different age groups.

Target Population and Program Characteristics

Children and Youth Behavioral Health (CYBH) PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics							
14-21	Severe	Anywhere	Field	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Medical	Criminal Justice

The program provides services in English and Spanish.

CYBH PACT works with youth ages 14-21 who are at a developmental stage crucial for attaining the independence and skills needed to be successful throughout their lives. The program is intended to serve those who are socially isolated and/or have minimal support systems. Caregivers may not understand their children's mental health issues and/or may feel disempowered by the hierarchy between traditional treatment teams of "experts" (e.g., psychiatrists, therapists) and the people receiving services. Youth and their families are referred to the program by CYBH County and County-Contracted programs.

Adult/TAY PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
18-59	Severe	Anywhere	Field	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean and Arabic.

This program serves TAY and adults ages 18-59 who, in addition to the primary PACT criteria, may be homeless or at-risk of homelessness or may have had an out-of-state placement. The program also works with culturally and/or linguistically isolated groups such as Latinos, Vietnamese, Korean, Iranian and the deaf and hard of hearing. Referrals are accepted from the community, psychiatric hospitals and jails. Participants are screened for appropriateness by the four regional Adult and Older Adult Behavioral Health (AOABH) outpatient clinics or the two Open Access sites and assigned to the PACT program that will best meet their needs.

Older Adult PACT

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics					
									
	Severe	Anywhere	Field	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic and American Sign Language.

The Older Adult PACT serves individuals who are ages 60 and older and who, in addition to the primary eligibility criteria described above, may have visited local emergency departments repeatedly or have had to call 911 frequently due to behavioral health issues. The program accepts referrals from the community, psychiatric hospitals and jails, and uses a screening process similar to that used for TAY and adults.

Services

The PACTs provide an individualized treatment approach that offers intensive services provided by multidisciplinary teams out in the community. These teams are staffed with Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Life Coaches, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance abuse services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused CBT. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family participants, which can include family therapy, is provided for youth and their families.

In addition, PACT provides intensive case management. Team members offer peer and/or care- giver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community resources such as NAMI, Family Resource Centers and the Wellness Centers to help facilitate their recovery and maintain their gains after being discharged from the program.

Strategies to Promote Recovery/Resilience

Central to all of Orange County's intensive outpatient treatment programs is the emphasis placed on helping individuals move forward in their recovery. The PACTs work with participants using a strengths-based model to customize their treatment plans. Team members strive to instill hope in the participants with whom they work, identify their and their families' strengths, maintain a non-judgmental stance, and have empathy for their and their families' struggles. Mental Health Specialists share their lived experience, serve as positive models, and provide valuable support and information both to the participants and the other team members. The ultimate goal of the PACTs is to help participants build positive relationships and social supports in the community so they can move forward in their recovery and manage their behavioral health care needs outside of the public mental health setting.

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals often have difficulty linking to services for a variety of reasons. Some examples include homelessness and/or difficulty finding permanent housing; lack of food, transportation, childcare and/or social support; anxiety about their legal status and the possibility of being deported; difficulty navigating the very large mental health system; lack of open program space; stigma related to having a mental illness; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals.

To overcome these wide-ranging challenges, PACT Teams operate under the "Whatever it Takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or wherever participants are comfortable meeting in order to overcome barriers to access or engagement. The teams also carry smaller caseloads so individuals and their families can be seen more frequently and have their needs met in a timely manner. Moreover, many PACT therapists are bilingual (see grids) and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

The TAY, Adult and Older Adult programs also offer a streamlined referral and linkage process to (1) allow direct referrals

into TAY PACT, and/or to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these changes, individuals are linked to services more quickly and feel supported through the process. In addition, some clinicians are specifically assigned to engaging individuals who are referred from hospitals, homeless shelters like The Courtyard and the MHSA housing projects.

CYBH PACT, the newest program implemented June 2017, has worked to increase timely access to its services by presenting to providers about PACT services and eligibility criteria. Once referred, CYBH PACT therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in greater detail and establish rapport with the youth and parent. Like the other PACTs, CYBH PACT staff also work with hospital staff, Probation Officers and others involved with the youth and family to engage them in their program services.

PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. Although this transition can be difficult and may take several visits, program staff appreciate the value of this process in allowing individuals to continue moving forward on their recovery journeys.

Strategies to Reduce Stigma and Discrimination

In addition to providing valuable direct services and supports to PACT participants, Mental Health Specialists also serve as inspirational role models, which can be powerful in reducing stigma among the people and families served. In addition, all clinicians and peer workers are trained yearly in cultural competency. The training provides an overview of how to incorporate culturally responsive approaches in their interactions with participants. The concepts of culture, race, ethnicity and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on judgment as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond mainstream American culture. In addition, many PACT staff are bilingual and bicultural. Thus, through training and/or experience, PACT staff understand the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities, and draw upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination.

Outcomes

A total of 45 children/youth 178 TAY, 887 adults and 89 older adults were served in the PACTs during FY 2017-18. One child/youth, 141 TAY, 928 adults and 103 older adults were served in the PACTs during FY 2016-17. Using the same method and approach as the FSPs, the PACTs evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP.

The outcomes presented below are for TAY, adults and older adults. CYBH PACT will present outcomes in future Plan updates when the data systems to report on these outcomes have been completed.

Psychiatric hospitalizations: Compared to the 12 months prior to enrolling in PACT, the TAY/Adult and Older Adult programs had a small to moderate impact on the average number of days spent psychiatrically hospitalized. The smallest effect observed was among older adults in FY 2016-17, which was likely attributable to the fact that several older adults remained hospitalized during that time, despite being ready for discharge to a lower level of care, because a placement option appropriate for their complex medical, physical or Activities of Daily Living needs was unable to be located.

Homelessness: PACT also had a moderate impact on decreasing homelessness for all three age groups in FY 2016-17 and for adults in FY 2017-18, as well as a large impact on homelessness for TAY and older adults in FY 2017-18.[2] It should be noted that the number of TAY and older adults affected by homelessness prior to or after enrolling in PACT was much smaller than the number of adults affected, thus the differences in impact observed in FY 2017-18 may reflect unique characteristics of the individuals served that year rather than a change in effectiveness of the TAY and Older Adult programs. HCA will continue to monitor outcomes over time.

Incarcerations: Compared to the year prior to enrollment, the PACTs had a moderate impact on incarceration across both fiscal years, with TAY PACT demonstrating a moderate-to-large impact during FY 2017-18.[3] Due to the small number of TAY served in FY 2017-18, however, it is unclear if this observed increase in impact reflects a shift in overall program effectiveness, the

unique characteristics of the TAY served in FY 2017-18, or some other factor. HCA will continue to monitor the trends in incarceration for PACT participants.

Employment: Across both fiscal years, TAY and Adult PACTs did not impact employment, with TAY and adults only increasing their average days employed by about one to one-and-a-half weeks.[4] As with the FSPs, PACTs continue to struggle with making inroads on this functional domain.

Challenges, Barriers and Solutions in Progress

TAY, Adult and Older Adult PACT have all been recently expanded due to increasing demand for this level of service. There are still 10 staff vacancies, and the programs hope to begin hiring for these positions in the coming fiscal year.

Like the FSPs, PACTs also struggle with supporting their participants in engaging in and/or sustaining employment. The programs and participants face many of the same challenges as the FSPs, such as difficulty identifying flexible employers and lack of participant work experience and/or confidence. Thus, staff are working to increase individuals' participation in volunteer work and/or educational/training courses as a way to enhance skills that will help them succeed and feel comfortable in the workforce.

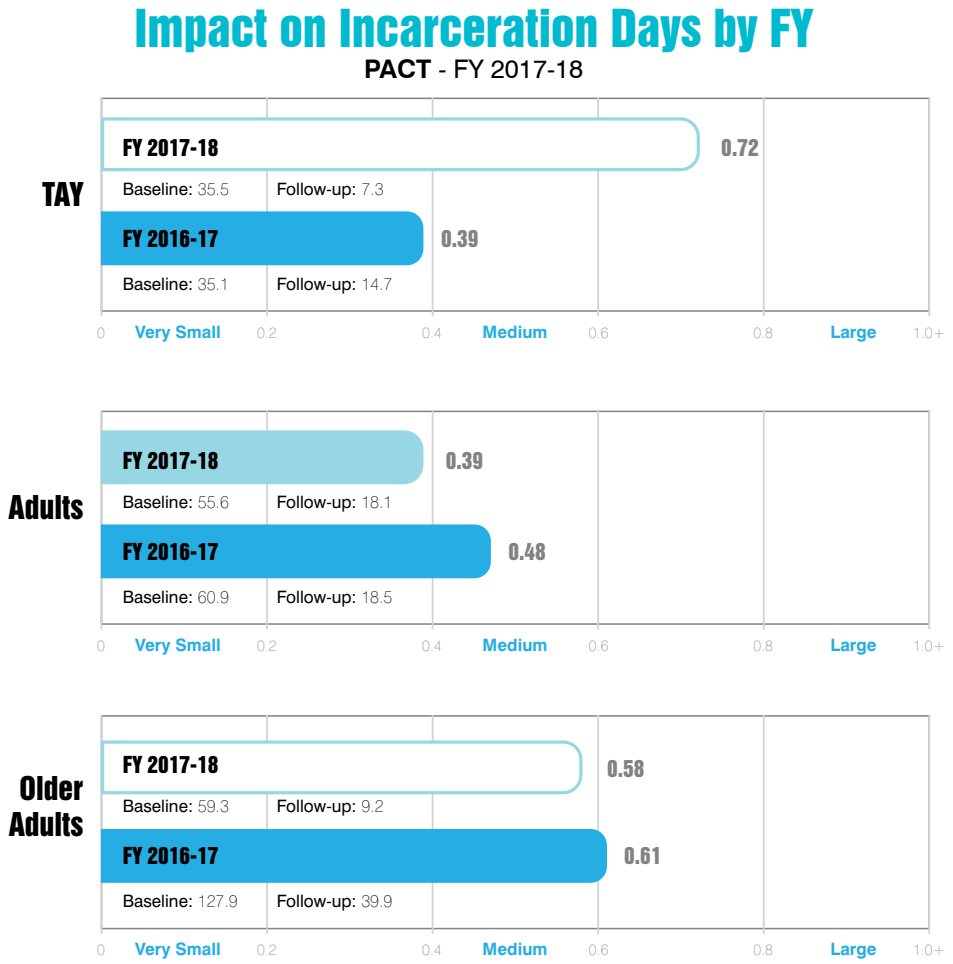
While finding safe and affordable housing is a challenge faced by all PACTs, the difficulty identifying housing options for older adults on Social Security and Supplemental Security Income who need assisted living and/or ADL-compliant housing is especially problematic. The Older Adult PACT continually works to expand its list of available resources, however limited options continue to make it very difficult to provide safe and timely placement of older adults.

The Older Adult PACT also encounters increasing challenges in serving those who are experiencing age-related cognitive decline. Such decline can have a negative impact on medication compliance, as well as follow-through with medical and other appointments. The program addresses this challenge by utilizing the Older Adult Life Coaches and the Peer Mentoring program to assist with appointments and by working closely with IHSS and SHOPP nurses and medical providers.

Community Impact

The Program of Assertive Community Treatment (PACT) teams in Orange County target high-risk underserved populations which include monolingual Asian/Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with mental illness. These programs have shown a modest reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

The Adult and Older Adult PACTs use a "whatever it takes" approach in assisting adults with serious and persistent mental illness maintain independence in the community and improve their quality of life, which, in part, is reflected in the program's impact on decreasing homelessness and the assistance they've provided to help individuals navigate their insurance benefits and successfully link to needed medical care.



Impact on Psychiatric Hospitalization Days by FY

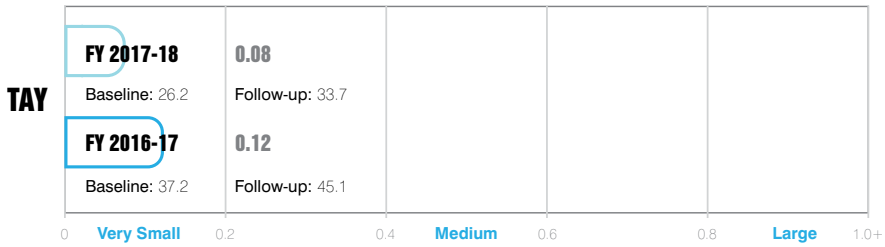
PACT

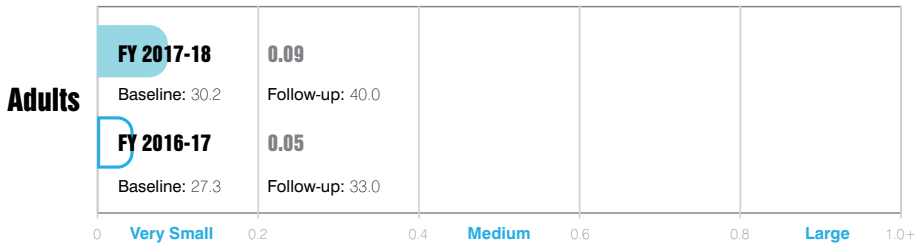
Impact on Unsheltered Homeless Days by FY

PACT

Impact on Employment Days by FY

PACT





Reference Notes

[1] ***Psychiatric Hospitalization Days:***

TAY:

FY 2017-18: Prior M=46.4, SD=62.8; Since M=16.8, SD=61.1; t(82)=2.97, p<.01, Cohen's d=0.33
FY 2016-17: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t(92)=4.12, p<0.001, Cohen's d=0.43

Adults:

FY 2017-18: Prior M=48.7, SD=77.8; Since M=10.0, SD=35.7; t(659)=11.86, p<.001, Cohen's d=0.50
FY 2016-17: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t(687)=12.59, p<0.001, Cohen's d=0.53

Older Adults:

FY 2017-18: Prior M=38.4, SD=74.8; Since M=4.3, SD=17.3; t(69)=3.73, p<.001, Cohen's d=0.53
FY 2016-17: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t(52)=1.64, p=0.11, Cohen's d=0.21

[2] ***Homeless Days:***

TAY:

FY 2017-18: Prior M=73.2, SD=59.2; Since M=19.9, SD=42.7; t(16)=3.36, p<.01, Cohen's d=0.83
FY 2016-17: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t(17)=3.37, p<0.01, Cohen's d=0.57

Adults:

FY 2017-18: Prior M=152.6, SD=136.1; Since M=65.8, SD=104.7; t(227)=7.62, p<.001, Cohen's d=0.51
FY 2016-17: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t(242)=7.97, p<0.001, Cohen's d=0.47

Older Adults:

FY 2017-18: Prior M=187.0, SD=141.5; Since M=49.6, SD=102.3; t(33)=4.96, p<.001, Cohen's d=0.86
FY 2016-17: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t(30)=2.81, p=<0.01, Cohen's d=0.54

[3] ***Incarceration Days:***

TAY:

FY 2017-18: Prior M=35.5, SD=36.0; Since M=7.3, SD=15.2; t(19)=3.02, p=.07, Cohen's d=0.72
FY 2016-17: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t(29)=2.48, p<0.05, Cohen's d=0.39

Adults:

FY 2017-18: Prior M=55.6, SD=83.9; Since M=18.1, SD=50.3; t(200)=5.38, p<.001, Cohen's d=0.39
FY 2016-17: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t(216)=6.38, p<0.001, Cohen's d=0.48

Older Adults:

FY 2017-18: Prior M=59.3, SD=85.1; Since M=9.2, SD=22.7; t(12)=1.93, p=.08, Cohen's d=0.58
FY 2016-17: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t(10)=3.24, p<0.01, Cohen's d=0.61

[4] ***Employment Days:***

TAY:

FY 2017-18: Prior M=26.2, SD=72.9; Since M=33.7, SD=82.7; t(90)=-0.73, p=.47, Cohen's d=-0.08
FY 2016-17: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t(92)=-0.68, p=0.50, Cohen's d=-0.12

Adults:

FY 2017-18: Prior M=30.2, SD=81.0; Since M=40.0, SD=93.6; t(718)=-2.41, p<.05, Cohen's d=-0.09
FY 2016-17: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t(753)=-1.55, p=0.12, Cohen's d=-0.05

Youth Core Services – Field-Based Track (CSS)

Program Serves	Symptom Severity	Location of Services				Typical Population Characteristics								
0-21	Severe	Home	Field	School	Outpatient Clinic	Foster Youth	Parents	Families	LGBTIQ	Homeless/ at-Risk	Co-Occurring SUD	Medical	Students	Criminal Justice

The program provides services in English, Spanish and Vietnamese.

Target Population and Program Characteristics

The Youth Core Services Field-Based Track serves youth under age 21 who meet medical necessity criteria for Specialty Mental Health Services and the Pathways to Well-Being sub-class (formerly known as "Katie A") which resulted from a settlement agreement that aimed to improve the delivery of MediCal covered mental health and supportive services for children and youth in – or at imminent risk of placement in – foster care in California. The program's field-based track accepts referrals from all sources. Youth Core Services also has a residential program track to serve foster youth placed under the Senate Bill 403 mandate, which is described in the Residential Treatment section of this Annual Plan update.

Funds for the Youth Core Services Field-Based Track will act as a match to allow for drawdown of Federal Financial Participation funds, which essentially doubles the number of children and youth served for the MHSA dollars spent.

Services

Per Pathways to Well-Being program requirements, participants must be provided an array of services largely provided out in the community, specifically Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) when medically necessary. Examples of activities provided through ICC and IHBS include assessment service planning and implementation, intensive case management, skill-building interventions and activities, psychoeducation and transition planning and services. These services are developed and implemented through the collaborative process of the Child and Family Team (described below).

Strategies to Promote Recovery/Resilience

The program is founded on the Core Practice Model, which states that mental health services and supports are coordinated through a child and family team and provide a forum for the child/youth and family to have a voice and choice in the services they receive throughout their involvement in the system. A service plan that is based on the child's and the family's strengths and needs is developed by the child and family in conjunction with other members of the child and family team. This plan is reviewed regularly to ensure changes are made and services added so that the child and family can achieve their goals for safety, well-being and placement permanency.

Strategies to Improve Timely Access to Services for Underserved Populations

Lack of transportation and stigma are some of the primary barriers to care for these participants, which are mitigated by bringing services directly to youth and their families anywhere in the community rather than relying on them to travel to a behavioral health clinic. In addition, in FY 2017-18 the funding for this track was centralized under one contract provider which facilitated coordination of care and allowed foster youth to receive the level of services required to address trauma and other mental health conditions in a more timely manner.

The program also provides services in multiple languages (see grid) through bicultural/bilingual staff, and can access a languageline translation service to assist those who speak other languages, thus reducing language barriers.

Strategies for Non-Stigmatization and Non-Discrimination

Services provided to participants in Youth Core Services are delivered based on the principles and values of the Core Practice Model (CPM). The CPM views the youth from a strengths-based view rather than a disease-based view. This shift in perspective helps reduce some of the stigma associated with mental illness. Services are also individualized, based on the unique assets and needs of the child/youth and family, and delivered in a manner that is respectful of the child's and family's culture and from a stance of humility that strives to understand the child's and family's world view.

The CPM also emphasizes the importance of providing services and supports in a manner that takes into account the child or youth's differences and unique life circumstances. The child's culture, ethnicity, gender, sexual orientation and socioeconomic status are accepted and addressed throughout the entire time the child or youth is involved with the different child service systems.

Outcomes

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

Challenges, Barriers and Solutions in Progress

Youth Core Services has experienced on-going-issues related to performance outcome measures (i.e., lack of guidance from the state on recommended tools at the time the program launched; implementation difficulties once a measure was selected; inability to extract and send data for analysis). Ongoing efforts are underway to improve the implementation of the selected measure, the Outcome Questionnaire, and future Plan updates will include more robust outcomes reporting.

Community Impact

The Youth Core Services Field-Based track has provided services to 136 clients in FY 2017-18 and cumulatively more than 516 youth since its inception in March 2016.

OUTPATIENT RECOVERY

Outpatient Recovery programs serve adults who are living with a serious mental illness and/or co-occurring substance use disorder and have made significant progress on their behavioral health recovery. While these individuals no longer require the same intensity of services provided in other outpatient programs, they could still benefit from ongoing support to build meaningful roles in the community, increase their ability to manage their own mental health care and link to lower levels of care.

Outpatient Recovery	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Recovery Centers/ Recovery Clinic Services/ Recovery Open Access (CSS) *	3,500	$8,458,531	$2,417

* *The Recovery Centers/Recovery Clinic Services/Recovery Open Access figures include numbers for all three programs. Recovery Open Access is described in the Navigation/Access and Linkage to Treatment/Services section.*

Outpatient Recovery: Recovery Clinics and Centers (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics				
18+	Severe	Field	Outpatient Clinic	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical

The program provides services in English, Spanish, Vietnamese, Farsi, Korean and Igbo.

Target Population and Program Characteristics

The Outpatient Recovery program is designed for adults ages 18 and older, offers services at multiple locations and is operated through County-contracted Recovery Centers and County-operated Recovery Clinics.

Services

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

Strategies to Promote Recovery/Resilience

The programs provide adults with self-directed services that focus on community reintegration and linkage to health care. An important feature is peer-run support through which adults are able to access groups and peer support activities. These services are delivered in an individualized, person-centered system of care that is tailored to each persons' unique stage of recovery and focused on increasing self-reliance and independence in the community.

Strategies to Increase Timely Access to Services

The Outpatient Recovery sites are either co-located or near the county-operated Adult Outpatient Clinics in order to ease the transfer to a lower level of care. This strategy proves to be essential in promoting a continuum of care model and providing an environment that addresses barriers to change. One of the sites also serves as an access point to services in which walk-ins are encouraged and subsequent referrals within the system are not necessary. All programs are highly encouraged to staff their sites with individuals who speak the county's threshold languages and this requirement is reviewed and discussed regularly when vacancies arise.

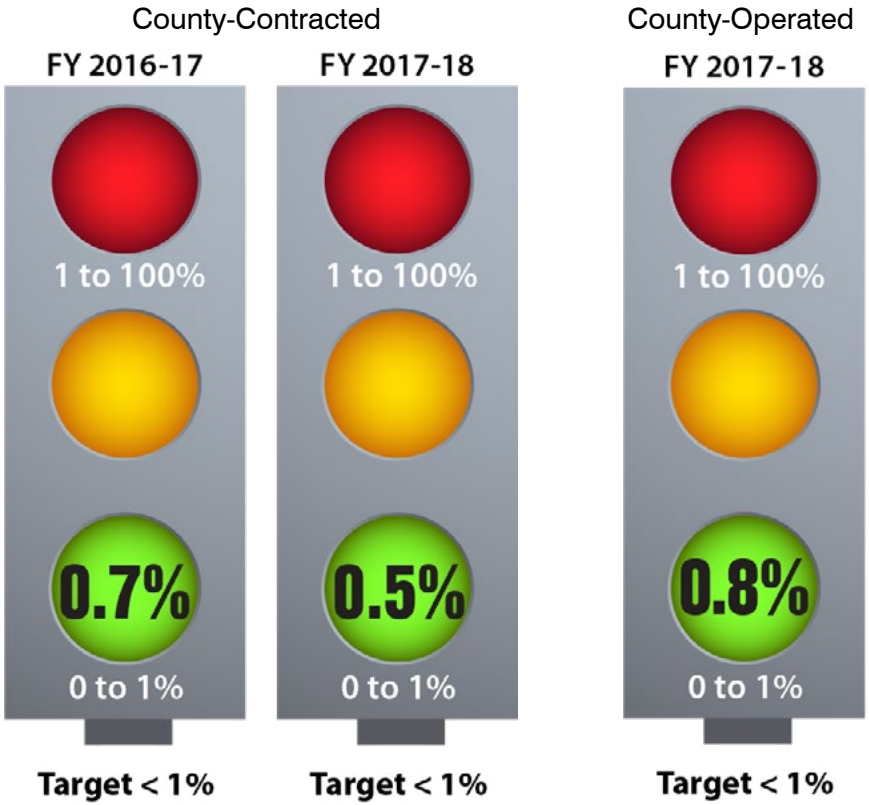
Strategies to Reduce Stigma and Discrimination

The program provides services to families and significant others based on the behavioral health needs of the individual. Such services include consultation and education to assist with increased utilization of services, improve understanding of mental illness, and encourage family involvement in treatment planning. Collateral services such as family counseling or therapy are provided when needed, and educational activities such as stigma elimination, education on common mental illnesses, recovery principles, and health and wellness classes are also offered on site and in the community. A primary focus around reintegration is linking the individual to community-based services that address employment, education, volunteering and other meaningful activities the individual has chosen as part of their recovery.

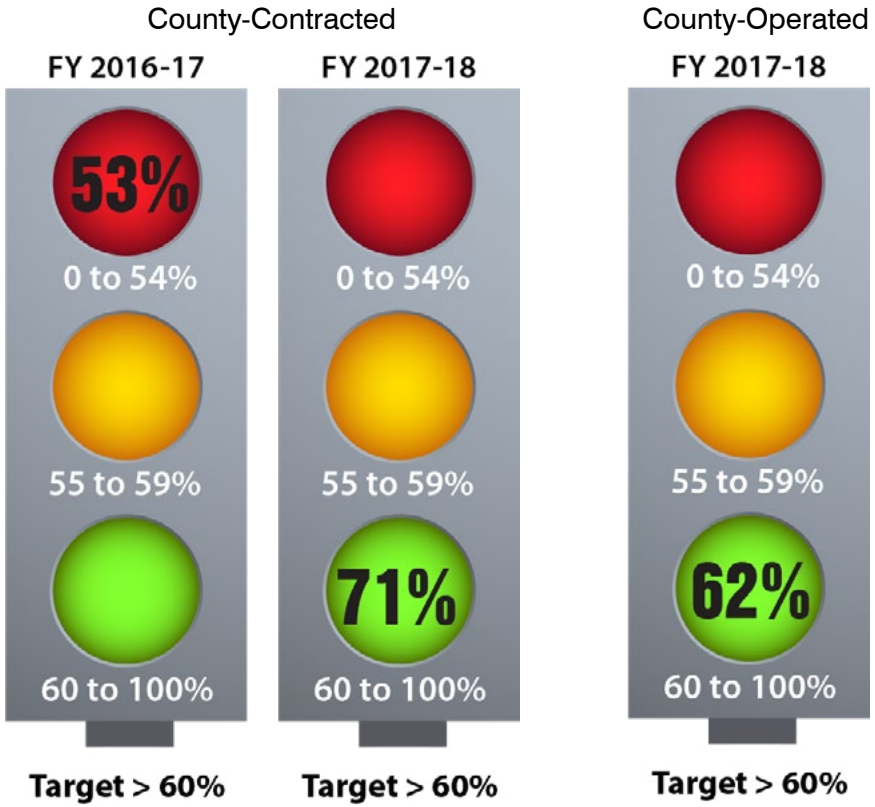
Outcomes

The contracted Outpatient Recovery sites served a total of 1,933 individuals in 2017-18 and 1,937 individuals in 2016-17, and the County-operated sites served 589 adults in FY 2017-18, its first full year of service, and 209 adults in FY 2016-17 during the partial year it was open. The program monitors whether it achieves its target of maintaining a psychiatric hospitalization rate of less than 1% while participants are enrolled in services. As can be seen in the graphic, the program achieved this goal in both fiscal years at its contracted and County-operated locations. In addition, the program strives to assist adults in achieving community reintegration and greater independence by setting a goal of discharging at least 60% of those served into a lower level of care. Of those with known discharge dispositions (i.e., not discharged as missing

Hospitalization Rates During Enrollment



Discharges to Lower Level of Care



in action, MIA), the program generally met its goal across the different sites and fiscal years with the exception of FY 2016-17.

Challenges, Barriers and Solutions in Progress

After exploring program data, this year 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. Often these participants are discharging with good progress on their treatment goals, however since these participants have left unexpectedly a level of care cannot be determined for these individuals. In order to monitor the status of those who are discharged in this way, HCA will begin to report the proportion who are making satisfactory progress towards treatment goals at the time they drop out of treatment for unknown reasons.

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.

Community Impact

The needs of the individuals accessing the Recovery Centers 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, are 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 from the program.

SPECIALIZED OUTPATIENT/INTERAGENCY COLLABORATIONS

As part of its continuum of outpatient services, HCA partners with other Orange County agencies to provide specialized outpatient services for individuals with mental health needs who are also involved in other systems. HCA currently partners with the Social Services Agency to provide support to caregivers referred by Child Protective Services. HCA discontinued its financial support of the Mental Health Collaborative Courts (MHCC) in FY 2018-19 after learning that MHSA funds could not support law enforcement activities, functions or positions. The services provided through the MHCC are nevertheless being continued through alternate sources of funding. Interagency collaborations involving the Full Service Partnerships are described in the Intensive Outpatient section.

Outpatient Specialized/ Interagency Collaborations	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Mental Health Court – Probation Services (CSS)	Discontinued	0	N/A
Stress Free Families (PEI)	160	$575,000	$3,594

Stress Free Families (PEI)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics			
							
	Mild-Moderate	Anywhere	Field	Parents	Families	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish, Vietnamese and Korean.

Target Population and Program Characteristics

The Stress Free Families program partners with the Orange County Social Services Agency (SSA) to serve families that have been reported to and/ or investigated by Child Protective Services (CPS) for allegations of child abuse and/or neglect. Target participants are the adult parents or care- givers who have come to the attention of the Social Services Agency. This PEI outpatient program is designed to reach and support families experiencing stressors that make family members more vulnerable to behavioral health conditions, including the child(ren) involved in the CPS report.

All referrals to the Stress Free Families program come from SSA, which refers families for whom the child abuse and/or neglect allegation(s) was/were found to be inconclusive, unfounded or unsubstantiated. There can also be no more than 10 investigations for the family. Stress Free Families accepts cases that are pending closure or are currently not open with SSA and that have no current safety threat.

Stress Free Families works with a variety of Orange County's underserved populations: homeless families, families with documented mental health and/or drug abuse issues, and/or history of family violence. The program serves families from a variety of underserved cultural backgrounds and ethnic and monolingual populations such as Spanish, Vietnamese and Korean.

Services

The program provides a range of services intended to reduce risk for behavioral health problems. Services include short-term interventions such as brief counseling, parent education and training, case management, and referral and linkage to community resources. The program uses elements of the Triple-P Positive Parenting Program (Triple P Tip Sheets) to educate parents on a range of topics such as trauma, child abuse, domestic violence, communication and positive parenting, and appropriate bonding techniques. Caregivers are also taught relaxation and anger management skills to help reduce the potential for additional trauma.

Strategies to Promote Recovery/Resilience

The Stress Free Families Program supports recovery by providing psycho-education on the wide range of topics described above to prevent additional trauma and, thus, encourage recovery and build resilience within the family. Participant service plans often include elements of self-care, steps to take toward development of appropriate bonding, and the development of effective, positive communication skills.

Strategies to Improve Timely Access to Services for Underserved Populations

Many participants have limited financial resources and must work during traditional business hours which can make keeping appointments more difficult. Families may also lack transportation or childcare to allow for in-office appointments. Families dealing with domestic violence may also discontinue services if one of the parents puts pressure on the other to drop out of the program.

To overcome transportation and childcare issues, clinicians can meet with participants in their homes or wherever else in the community that the parent agrees to meet, thereby improving access to services. Clinicians have met with participants in parks near their homes, at local Family Resource Centers, at restaurants, as well as the clinician's office, especially if there are any identified safety concerns in the home.

When assessments and services are provided in the home setting, this presents a number of potential advantages. Program staff are able to observe and ascertain the needs of the families in their living environment so that they are better able to tailor their interventions to the family's dynamics. In addition, when parenting training is provided in the same environment in which the parents are expected to use the techniques learned, it increases the likelihood that they will use the new skills going forward.

In addition, parents enrolled in Stress Free Families need extensive support and assistance to link with resources that provide necessities such as food and clothing. Without these necessities, their ability to participate meaningfully in the program's higher-order treatment goals is compromised. To mitigate this challenge, clinicians serve as active case managers, providing referrals to families and diligently following up to ensure linkages to these necessary services are made. The program provided 229 referrals and 26 linkages in FY 2017-18 and 157 referrals and 32 linkages in FY 2016-17 to basic need items and services, behavioral health outpatient services, information and referral services, legal services and advocacy, PEI programs, financial assistance, health care services and family support services.

Strategies for Non-Stigmatization and Non-Discrimination

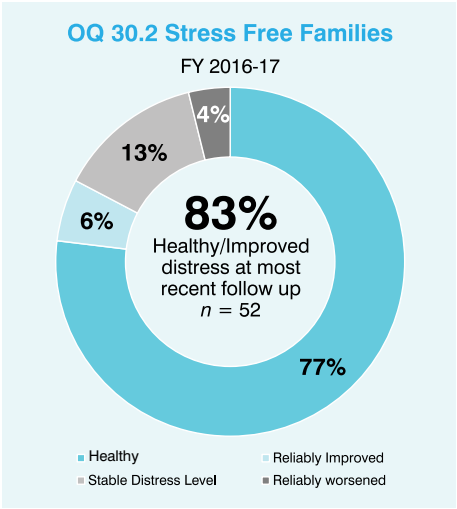
Stress Free Families strives to make services available to all Orange County residents, regardless of their background. The program provides services in English, Spanish, Vietnamese and Korean through staff who are bicultural and bilingual. Clinicians in the program work to meet parents

"where they are at" and educates them regarding mental health and substance abuse issues to reduce stigma and encourage engagement in any needed services.

Outcomes

During FY 2017-18, 148 parents/caregivers who had a total of 342 children living in the home were served by Stress Free Families. In FY 2016-17, 117 parents/caregivers who had a total of 147 children living in the home were served by Stress Free Families. The program measures reduction in prolonged suffering by examining clinically meaningful changes in psychological distress as measured by the OQ 30.2. Participants completed the OQ 30.2 at intake, every three months of program participation and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering experienced by the parents/caregivers served.

At the time of most recent follow-up, 90% of the 104 participants in 2017-18 and 83% of the 52 participants in 2016-17 who had completed more than one OQ reported healthy (84% and 77%) or reliably improved (6% for both years) levels of distress since starting services. Thus, the overwhelming majority of participants either avoided prolonged suffering or experienced clinically meaningful reductions in general psychopathology symptoms while enrolled in Stress Free Families. In addition, program staff is reviewing and implementing strategies to ensure that participants who require more intensive services and/or a higher level of care receive the appropriate supports and/or referrals in a timely manner.



Challenges, Barriers and Solutions in Progress

Referrals to this program are heavily dependent on a strong relationship with its partnering agency, SSA. During this reporting period, SSA moved their social workers out of the office that it shared with the program and into a field-based setting. This shift, combined with the high turnover rate in the CPS department introduced communication challenges between program staff and SSA social workers, which decreased referrals. This challenge was resolved by the service chief who prioritized meeting with SSA administration on an on-going basis to remind them of the services offered and potential benefits of making referrals. The service chief will continue to attend SSA meetings on a regular basis to keep a steady flow of referrals to the program and potentially even increase referrals. In addition, staff have been trained in providing a more intensive Triple P Parent education to further meet the needs of the families served.

Community Impact

The program has provided services to more than 527 individuals since its inception and has improved the functioning of the enrolled parents. The program also provides frequent consultation to the Orange County Social Services Agency which has improved SSA's ability to recognize mental health needs in those for whom an allegation of child abuse has been made. This recognition has helped to improve SSA's ability to provide families with timely and appropriate behavioral health resources to prevent further child abuse and/or neglect.

RECOVERY AND SUPPORTIVE SERVICES

Recovery and Supportive Services provides a broad array of supports generally designed to augment and expand an individual's gains made in treatment programs, particularly those within Outpatient Services, Crisis Services and Residential Treatment. These programs, which are funded by CSS, PEI and INN, serve individuals of all ages and are further subdivided into the following categories:

- Peer Support
- Veterans Support
- Family Support
- General Support

PEER SUPPORT

Peer Support programs are staffed with individuals who have lived experience with mental health and/or substance use recovery, and their family members. While Orange County includes peers as part of the service delivery teams in many of its behavioral health programs (i.e., FSPs, PACTs, Veteran's Outpatient, Survivor Support 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 are able to help support and encourage participants on their own recovery journey.

Recovery and Supportive Services: Peer Support	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
WarmLine (PEI)	36,000	$536,566	$15
Step Forward: On-Site Engagement in the Collaborative Courts (INN)	42	$93,340	$2,222
Peer Mentoring (CSS)*	875	$4,249,888	$4,857
Behavioral Health Services for Independent Living (INN)	100	$402,234	$4,022
Wellness Centers (CSS)	3,000	$3,254,351	$1,085

* *Peer Mentoring Budget includes Whole Person Care dollars.*

WarmLine (PEI)

Program Serves	Symptom Severity			Location of Services		Typical Population Characteristics
0+	At-Risk	Early Onset	Mild-Moderate	Telephone	Chat Based	Field

The program provides services in English, Spanish, Vietnamese, Farsi and Language line.

Target Population and Program Characteristics

The WarmLine serves unserved and underserved Orange County residents who are seeking peer support and experiencing mild to moderate symptoms of mental illness or are at-risk for mental illness, school failure and/or trauma exposure. This program also serves family members and operates Monday through Friday from 9 a.m. to 3 a.m., and Saturday and Sunday from 10 a.m. to 3 a.m.

Services

The WarmLine provides non-crisis support for callers over the phone or through live chat. Upon connecting with the WarmLine, individuals are screened for eligibility and assessed for needed mental health information, support and resources. Staff draw upon their lived experience to connect with callers and provide them with emotional support and referrals to ongoing services as needed. Callers who are experiencing a behavioral crisis are immediately referred to the Crisis Prevention Hotline (see *Crisis Services* section).

Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and building empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. In addition, the WarmLine uses Positive Psychology, a resilience-based model that focuses on positive emotions, individual 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.

Strategies to Promote Recovery/Resilience

WarmLine services promote recovery and resilience by providing mental health information, support and service referrals during extended weekday hours and over the weekend.

Strategies to Increase Timely Access to Services for Underserved Populations

A toll-free number is advertised to ensure access to all Orange County residents. Live chat, text and language-line capabilities are available to improve timely access and accommodate the increased need for services. In addition, WarmLine staff have participated in outreach events where they have connected with 6,246 residents, invited community members to staff meetings and advertised in different media sources serving Orange County's diverse communities. The program has increased bilingual staff capacity and services are currently available in English, Spanish, Vietnamese and Farsi.

In addition to providing direct support to callers, WarmLine staff refers individuals to on-going community resources as needed. The program made 2,139 referrals in FY 2017-18 and 2,189 referrals in FY 2016-17 to programs such as OC Links, mental health services, Family Support Service, Patients' Rights Advocacy and suicide prevention programs. At the present time, the WarmLine is not currently equipped to track linkages. In addition, calls were able to be conducted in most threshold languages and the Language line could be accessed to assist callers who spoke a different language.

Strategies to Reduce Stigma and Discrimination

The WarmLine provides services via phone, live chat and text so that callers who may otherwise not seek mental health services because of the associated stigma may feel comfortable doing so anonymously. The WarmLine staff, who are peers living with mental illness or family members of an individual living with mental illness, are provided comprehensive training in empathy, active listening and suicide assessment. They provide support and information about mental illness to reduce stigma, encourage participation in treatment and promote effective use of family support systems and community resources. Representatives from Orange County's diverse communities are invited to attend WarmLine staff meetings to promote understanding of program services and improve outreach in these communities. Call monitoring is used for training purposes to ensure non-stigmatizing and non-discriminatory services.

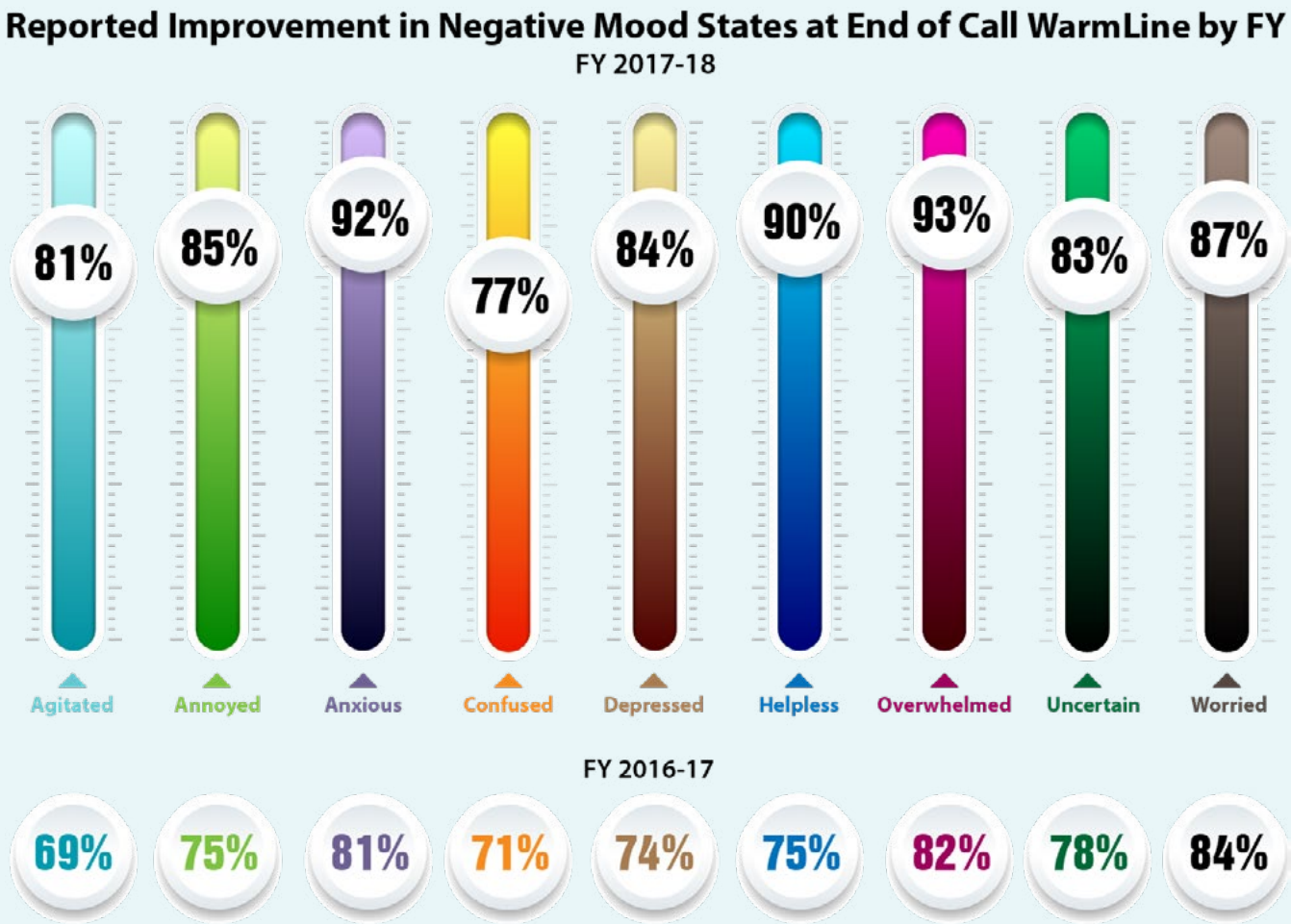
Outcomes

During FY 2017-18, the program received 47,973 calls from 22,678 unduplicated callers, as well as 603 live chats/texts and during FY 2016-17 the program received 48,317 calls from 18,381 unduplicated callers as well as 479 live chats/texts. The majority of calls were from individuals who had used the WarmLine before and calls typically lasted 20 minutes or less.

The WarmLine aims to reduce prolonged suffering from behavioral health problems, which was measured through changes in ratings on the Profile of Mood States (POMS). Callers were

asked at the beginning of the call whether they felt different emotions (i.e., worried, uncertain, etc.) and then asked at the end of the call whether they felt better, the same or worse. The evaluation reflects cultural competence in that it assessed for the presence of, and changes in, a range of negative mood states to ensure that different cultural expressions of distress were reflected.

Results across both fiscal years show that the majority of callers who reported feeling a specific mood reported feeling better at the end of the call, with the highest rates of improvement observed for callers who said they felt worried, overwhelmed or anxious. Thus, the program appears to be successful in reducing emotional distress through the support and services provided during the telephone contact.



Challenges, Barriers and Solutions in Progress

A challenge for the program is the significant increase in the overall number of calls. This increase has created longer wait times for callers as staff are not always available to answer incoming calls immediately. The program has adjusted staff shifts to accommodate when the call volume is highest and is always identifying and recruiting new volunteers in order to accommodate the increasing demand for services. In addition, the program received increased funding for FY 2018-19 and is currently exploring other strategies to best adapt to the increased volume, including methods to enhance their technology.

Community Impact

The WarmLine has provided services to more than 93,755 individuals since its inception August 2010. The provider also actively collaborates within the community as a whole in order to break down stigma, raise awareness and educate the community about available services.

Step Forward: On-Site Engagement in the Collaborative Courts (INN)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics		
						
	Severe	Mild-Moderate	Field	Families	Homeless/ at-Risk	Criminal Justice

The program provides services in English and Spanish.

Target Population and Program Characteristics

The Step Forward: On-Site Engagement in Collaborative Courts project serves adults ages 18 and older who are living with mild, moderate or severe and persistent mental illness and are participants of the Orange County Homeless Collaborative Courts. Services are also available to family members and support persons/loved ones. Participants must be involved in the Homeless Collaborative Court to be eligible for this project. Eligible participants may also be referred to project services by the judge, public defender and/or court coordinator. The homeless court provides a compassionate response to the fact that the homeless participants, many of whom suffer from chronic mental illness, may receive citations simply because they are homeless, with the result that such charges may hinder their efforts to obtain the government disability assistance that could aid in their rehabilitation. Through this voluntary court program, participants can address their citations and outstanding warrants by accessing, as appropriate, physical and mental health care and other needed services.

Services

The Step Forward: On-Site Engagement in Collaborative Courts project is staffed with peer specialists who have experience and knowledge of behavioral health to provide services on-site at the Homeless Collaborative Courts throughout Orange County. Peer staff attends the Homeless Collaborative Courts each week to outreach individuals who are on the court docket, as well as family members who are present to support their loved ones. Services include court outreach, participant and family engagement, supportive counseling, behavioral health education courses and referrals and linkages to County and community behavioral health services and support. Peer specialists facilitate one-on-one or group education modules to court participants and their family members/support persons. Court participants and their family members have the option to attend up to 10 education modules that cover a range of topics, including substance use, symptom management, medication management, relationship management, goal setting, mental health stigma, life skills, personal finance and community behavioral health resources.

This project was approved by the Mental Health Services Oversight and Accountability Commission on April 24, 2014. The primary purpose of this project is to increase the quality of mental health services, including measureable outcomes, with the 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. The Step Forward project began services December 1, 2015. Innovation funds for this project will end November 30, 2020.

Strategies to Promote Recovery/Resilience

The goal of this project is to empower participants to be engaged and proactive in the management of their recovery. Court participants are given the opportunity to apply project participation credit toward the completion of their court-required community service hours, enabling them to fulfill their obligation, while at the same time allowing them to focus on other aspects of their recovery. The behavioral health modules, created specifically for this project, educate participants about behavioral health and provide strategies to manage well-being, improve activities of daily living, strengthen relationships, as well as build support networks. Modules are offered one-on-one or in a group setting; however, group sessions are encouraged to foster social support and community among participants. Participant feedback is gathered after each module in order to improve content and tailor information to meet the needs of court participants and their family members/support persons. Along with the education modules, peer specialists collaborate with participants to identify goals and offer support to help them reach their stated goals. Family members and support persons are also engaged into services in order to support their loved one's recovery journey.

Strategies to Increase Timely Access to Services for Underserved Populations

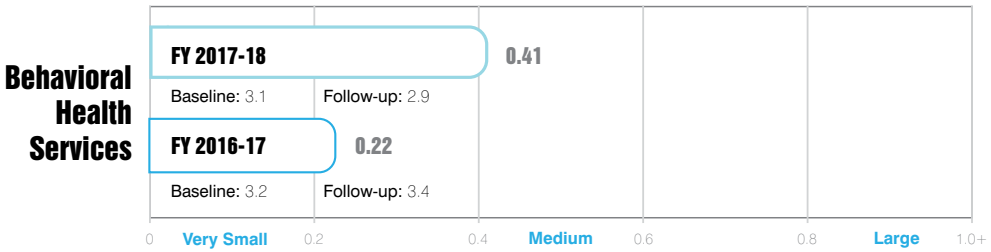
Timely access to services are built into the project structure. That is, services are offered to all individuals and their family members as they appear in court for their scheduled hearing. In addition, peer specialists collaborate with the court staff to encourage access to services and

the judge regularly promotes this project by encouraging court participants and their families to enroll in services.

In addition, peer specialists assist participants in navigating the complex health care system and actively link participants to needed community services and supports through intensive case management. This includes attending appointments with participants; completing applications for food stamps, disability and birth certificates as needed; and offering to watch over a homeless participant's belongings and/or pets so that they may attend appointments without the fear of having them lost or stolen while away. In FY 2017-18, the project provided 190 referrals and 142 linkages to services, such as affordable housing/housing advocacy/shelters; and mental health services. In FY 2016-17, 216 referrals and 102 linkages were made to these services. Thus this project has been particularly effective in linking participants to needed resources.

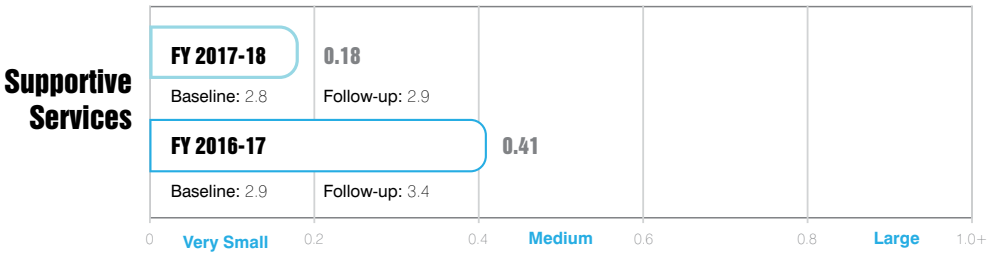
Impact on Knowledge of Behavioral Health Services by FY

Step Forward



Impact on Knowledge of Supportive Services by FY

Step Forward



Strategies to Reduce Stigma and Discrimination

This project utilizes behavioral health education to reduce stigma and discrimination. One of the 10 education modules is dedicated to educating participants about the impact of stigma. Within this module, Peer specialists identify common stereotypes associated with mental illness, address misconceptions, facilitate a discussion on self-stigma and discuss strategies to overcome stigma.

Outcomes

In FY 2017-18, the Step Forward project served 125 Court participants and family members with the goal of improving participants' understanding of how to navigate the County's behavioral health system and access needed services. This is comparable to FY 2016-17, in which 93 individuals were served. Based on responses to a survey administered at intake and follow-up in FY 2016-17 (n=20) and FY 2017-18(n=24), participants reported small gains in knowledge on how to access behavioral health (i.e., mental health, substance use) and supportive services, although it should be noted that the average scores were relatively high at intake, suggesting that participants may already be knowledgeable about behavioral health services prior to receiving enrollment in the program. Moreover, as described above, participants actually linked to services at a very high rate (i.e., 75% and 47% in FY 2017-18 and FY 2016-17, respectively).

Challenges, Barriers and Solutions in Progress

Participant engagement and enrollment in services continues to be a challenge due to various issues encountered by this target population. Factors include limited communication (e.g., lack of phone or stable residence) and loss of contact (e.g., moving; failing to appear in court). Individuals are not mandated to attend court, thus limiting the number of potential court participants that peer specialists can reach. To try and mitigate these barriers, peer specialists request multiple emergency contact numbers during enrollment to help locate missing participants and provide bus passes for future appointments, if needed.

Gathering survey data also continues to be a challenge due to the high rate of no shows, an inability to locate participants, and the appropriateness of the measure itself. In an effort to increase the number of follow-up measures collected, Peer Specialists began administering outcome measures every two months during project enrollment instead of only at intake and discharge.

Community Impact

The project has provided services to more than 155 participants since its inception in December 2015. To date, 65 participants completed their court required community service hours and were recognized by the judge with a certificate and an announcement of their achievement during court. Participants have also expressed positive feedback regarding the education modules. The most popular education course topics included goal setting, relationship management, personal finance, and substance use/co-occurring disorders.

Reference Notes

Knowledge of Behavioral Health Services:
FY 2017-18: Intake M=3.1, SD=.70; Follow-up M=2.9, SD=.23; t(24) = 1.45, p=.16, Cohen's d=0.41
FY 2016-17: Intake M=3.2, SD=0.9; Follow-up M=3.4, SD=0.7; t(19) = -1.45, p=.16, Cohen's d=0.22

Knowledge of Supportive Services:
FY 2017-18: Intake M=2.8, SD=.94; Follow-up M=2.9, SD=.28; t(23) = -.78, p=.45, Cohen's d=-0.18
FY 2016-17: Intake M=2.9, SD= 1.2; Follow-up M=3.4, SD=.60; t(19) = -1.70, p=.11, Cohen's d=0.41

Peer Mentoring (CSS)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics	
18 +	Severe	Field	Hospital	Outpatient Clinic	Homeless/ at-Risk	Co-Occurring SUD

The program provides services in Spanish, Vietnamese, Farsi and Korean.

Target Population and Program Characteristics

The Peer Mentoring program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring disorder, and would benefit from the supportive services from a peer. This CSS program consists of three unique tracks:

- Track 1 serves participants in County-operated and County-contracted outpatient programs (i.e., Clinics, FSPs) who are referred by their therapist or personal service coordinator for assistance with re-integration into their community following a recent psychiatric hospitalization or multiple Emergency Room visits and with short-term treatment goals such as daily living skills/life skills development, vocational and educational opportunities, social development and adaptation, improved family functioning, and identification of community resources.

  Peer mentoring services expanded in FY 2018-19 to children and adults who are receiving services in the County outpatient clinics as well as their families. Additional details will be provided in future Plans as the services are more fully developed.

- Track 2, which was originally funded through the Senate Bill 82 Triage Grant and will now be continued with MHSA CSS funds, serves participants being discharged from the County Crisis Stabilization Unit (CSU) or Royale Therapeutic Residential Center (RTRC) and require assistance linking to ongoing behavioral health or community services.

- Track 3, developed as part of the County's Whole Person Care plan, serves participants who are living with serious mental illness, are homeless or at-risk of homelessness and are MediCal beneficiaries. Participants are referred to this Peer Mentoring track by the BHS

Outreach and Engagement team and Housing Navigators from contracted providers after they have been placed in housing (see Whole Person Care in the Special Projects section).

Services

Services are customized depending on the individuals' needs and the track in which they are participating.

In **Track One**, peers, youth mentors and/or parent partners work with participants on achieving short-term treatment goals that are part of a larger, overall treatment plan established by their treatment providers. The goals generally take 60 days or less to achieve and may include, but are not limited to, learning to use and navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; increasing socialization activities such as attending groups or activities at the Wellness Centers; helping with the transition from inpatient care back into community living; assisting with stabilizing a person who has experienced multiple Emergency Department visits; coordinating crisis management; providing skills building workshops; facilitating referrals and linkages to needed resources; helping to identify the personal needs of participants; and/or facilitating or assisting with groups.

In **Track Two**, the peer navigator receive a warm hand-off from licensed Crisis Stabilization Unit staff or RTRC staff. After establishing a relationship with the participant, the peer navigator works to enroll the participant in the Peer Mentoring program and matches them with a peer mentor who will link them to necessary follow-up behavioral health or medical appointments. Peers also work with participants on accessing community-based services such as food pantries or emergency overnight shelters as needed. Peer mentors share their lived experience, which often provides the encouragement a participant needs to engage in ongoing services following a crisis. Peers work to link participants to services within 30 days of engagement. Longer time periods are often associated with the inability to make or maintain contact with the participant after the engagement period, as many are homeless, don't have telephones and/or may stay at different locations on a nightly basis.

In **Track Three**, peers help Whole Person Care participants sustain their housing placements for longer than six months. Peer Mentors will provide supportive and tenancy-sustaining services that 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.

Strategies to Promote Recovery/Resilience

The principles of the Recovery Model are embedded in the program and peers focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on their recovery journey. Across all tracks, the Peer Mentoring programs strive to improve participants' well-being and resourcefulness, thus allowing them to re-integrate successfully into their communities.

Strategies to Increase Timely Access to Services for Underserved Populations

The Peer Mentoring program has proactively built relationships with leadership at County Clinics and County-contracted outpatient clinics by conducting presentations to inform staff of the referral process, and services provided, and to share success stories. Sharing data on linkage rates and successful goal completion as a result of using Peer Mentoring services has had a large influence on increasing referrals to the program.

Some individuals receiving Peer Mentoring services have children and/or work. While they understand the benefits of working with a peer, finding the time to meet is perceived as adding another responsibility and, at times, can cause some reluctance to engage in services. peer mentors educate the individual's family members or significant support persons about the recovery model and the benefits of participating in follow-up services so that they may encourage their loved one to access those necessary services.

Homelessness is another factor that can affect program access as Peer Mentors can lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. During initial contact with the participant, peer staff makes significant effort to learn about where a participant may be staying and how to contact them in order to minimize losing contact with them once their initial meeting has ended.

Strategies to Reduce Stigma and Discrimination

The core values of the Peer Mentoring program draw upon cultural strengths and provide services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. Cultural competence is an essential part of the program development, recruitment and hiring of staff. In addition, Peer Mentors encourage participants and other staff working with the participants to use recovery language. They normalize seeking mental health treatment by sharing their own lived experiences and by discussing how any

other individual would seek treatment for a physical illness. Peers also demonstrate empathy, caring and concern to bolster participants' self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, a doctor, etc.

Outcomes

Of the 457 adults and older adults enrolled in Track 1 during FY 2017-18, 385 individuals (84%) successfully completed their goals with assistance from their peer mentor. Of the 352 adults and older adults served in Track 1 during FY 2016-17, 248 individuals (70%) successfully completed their goals with assistance from their Peer Mentor. For both FY 2017-18 and FY 2016-17, the most common types of goals for which individuals were referred included learning to navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; and increasing socialization activities.

Of the 339 adults and older adults enrolled in Track 2 during FY 2017-18, 203 individuals (60%) were successfully linked to their follow-up behavioral health and/or medical appointments. Of the 403 adults and older adults served in Track 2 during FY 2016-17, 216 individuals (54%) were successfully linked to their follow-up behavioral health and/or medical appointments.

Track 3 is the newest of the peer mentor tracks. Of the 33 adults and older adults enrolled in Track 3 during FY 2017-18, 22 individuals (67%) successfully completed their housing goals with assistance from their peer mentor.

Challenges, Barriers and Solutions in Progress

The utilization of peer mentors within clinical programs is a relatively new strategy in Orange County and, as with any new program concept, it can take time to promote its services. Educating the various referring 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 to how to reach them. Initial results from these front-end efforts have been promising.

Community Impact

Peer Mentoring has provided services to more than 2,242 adults and older adults served since its inception November 2015. The program recognizes that building County and community partnerships is a priority. Besides the strong ongoing partnerships with referrals sources such as the County and County-contracted clinics and the County CSU, the program also partners with the Wellness Centers, the Council of Aging, NAMI and housing agencies.

Behavioral Health Services for Independent Living (INN)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics		
18+	Severe	Field	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in Spanish.

Target Population and Program Characteristics

The Behavioral Health Services (BHS) for Independent Living project serves individuals 18 and older who are living with behavioral health conditions and have typically been dependent on others to manage their day-to-day needs or have not had the opportunity to live in a residence without supervision. This includes individuals who are homeless, at-risk of homelessness, and/or have had a history of homelessness or unstable housing situations. Eligible participants should also be receiving behavioral health treatment throughout the duration of services to participate in this project. The project accepts referrals from County and/or community behavioral health providers.

Services

This project utilizes Peer Specialists with experience and knowledge of behavioral health and/or co-occurring disorders to educate participants about the relationship between behavioral health management and independent living. Peer Specialists help participants develop independent living skills by facilitating modules based on five broad categories: health management, core/basic skills, daily living, social skills and vocational skills. Across the broad categories, participants may learn up to 16 independent living skill sets (i.e., symptom management, personal hygiene, transportation, etc.). The education modules for this project and include group activities to engage participants. During enrollment, Peer Specialists collaborate with each participant to identify modules and skills sets specific to the individual's goals. Additional services include outreach and engagement, assessment and screening, case management, peer support, and coordination with County and community behavioral health and supportive housing programs.

This project was approved by the Mental Health Services Oversight and Accountability Commission on April 24, 2014. The primary purpose of this project is to increase the quality of mental health services, including measureable outcomes, with the goal of applying to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings. The project was implemented July 1, 2017. Innovation funds for this project will end June 30, 2022.

Strategies to Promote Recovery/Resilience

This project empowers participants to be engaged and proactive in the management of their mental health. Peer specialists utilize the recovery model to collaborate with participants and identify their strengths; express their hopes and desires; and select the appropriate skills sets to fit their stated goals. The project also utilizes the Wellness Recovery Action Plan (WRAP), an evidence-based practice that is a self-management and recovery tool designed to empower participants, assist in managing behavioral health symptoms and improve quality of life.

Strategies to Increase Timely Access to Services for Underserved Populations

BHS for Independent Living enhances timely access to its services by providing skills training and interventions in the community where the participant is expected to demonstrate that skillset (i.e., in grocery stores, Wellness Centers, public transportation, etc.). It is also anticipated that teaching independent living skills with a focus on improving individuals' abilities to manage their behavioral health will increase participants' knowledge of and access to County and community behavioral health services. In FY 2017-18, project staff provided 19 referrals and 6 linkages to mental health care, transportation services and childcare.

Strategies to Reduce Stigma and Discrimination

Education modules are taught in one-on-one or group settings and facilitated in natural settings whenever possible to practice acquired skill sets. This interactive process, offered in a supportive group environment, establishes a safe, less stigmatizing approach to learning and mastering independent living skills alongside their peers and project staff.

Outcomes

This project began enrolling participants in January 2018 and enrolled a total of 14 participants in the second half of the fiscal year.

Outcomes will be reported in future Plan updates.

Challenges, Barriers and Solutions in Progress

During FY 2017-18, the project began start-up activities and curriculum development. Enrollments began in January 2018, and project staff initially encountered difficulties identifying and enrolling eligible participants. Project staff has been providing ongoing outreach activities to local agencies in order to increase awareness of services and encourage referrals to the project.

Community Impact

Of the initial participants served, a majority indicated health management and daily living as their primary areas of skill development. Specific skill sets within these categories include symptom management, behavioral health care management, shopping and transportation.

Wellness Centers (CSS)

Program Serves	Symptom Severity
18+	Severe

The program provides services in Spanish, Vietnamese, Farsi, Korean and Arabic.

Target Population and Program Characteristics

Orange County funds three Wellness Centers through CSS that serve adults 18 and older who are living with a serious and persistent 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.

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 activi-

ties 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.

Strategies to Promote Recovery/Resilience

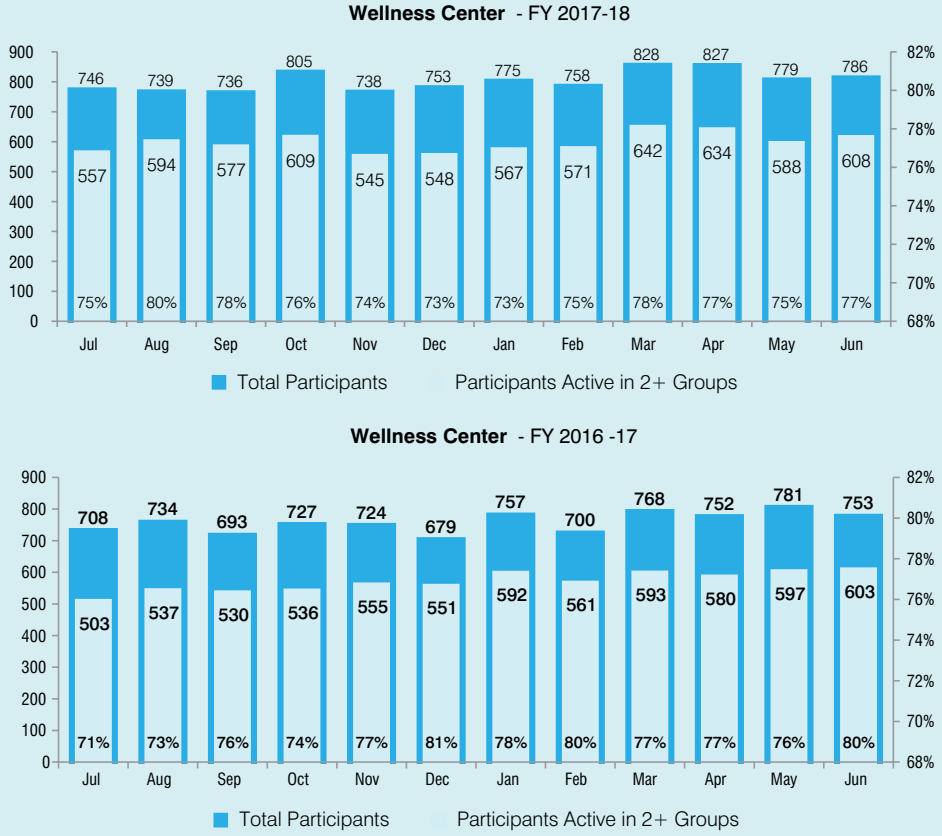
All three of the Wellness Centers provide a safe and nurturing environment for each individual to achieve their vision of recovery while providing acceptance, dignity and social inclusion. Programs are member-driven, utilize staff with a history of participating in mental health services, and are committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains.

Strategies to Increase Timely Access to Services for Underserved Populations

Many members have experienced isolation for years and have had limited exposure to the community in which they live. Housing, transportation and difficulties associated with homelessness and symptoms of mental illness also prevent members from joining in Wellness Center activities. To help address these barriers, staff at the Wellness Centers share their lived experience with members and connect with them on a more personal level. They serve as role models to members, provide encouragement and hope that recovery is possible, and share that participating in the groups, classes and/or activities could help them develop confidence and skills to assist them on their own recovery journey.

The Wellness Centers are supportive programs that complement clinical programs, and many members are referred by their treatment teams to assist with their recovery. To encourage on-going referrals, center flyers and monthly Wellness Center activity calendars are distributed to all County and County-contracted programs. In addition, the Wellness Centers frequently perform outreach activities by staffing booths at behavioral health and other community events, and by presenting to community partners that may work with individuals who could benefit from Wellness Center programming.

Monthly Consumer Participation in Groups by FY



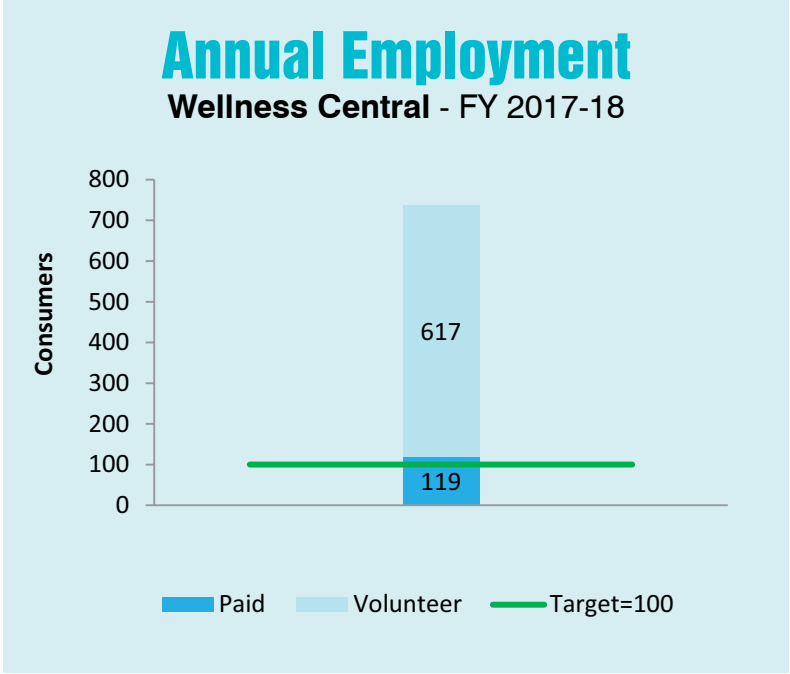
Strategies to Reduce Stigma and Discrimination

All three Wellness Centers provide a warm, welcoming and accepting environment, and serve all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members, and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. The Wellness Centers also offer a variety of groups such as

Diversity Plus and the LGBTIQ group that are specifically designed for the widely diverse membership.

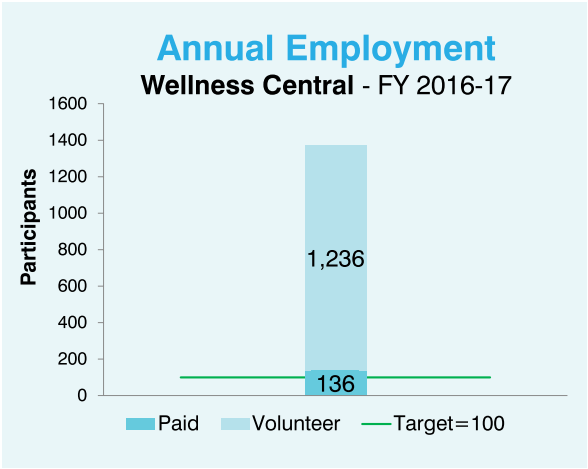
Utilizing peer staff with lived experience with behavioral health issues is key to operating programs of this nature as these staff can relate on a much deeper level with members because they have often walked in their shoes. Peer staff are from a variety of cultures, ethnicities and backgrounds, and have the ability to serve members from all threshold languages.

Employment preparation offered by the centers help members focus on their experience, skills and what they have to offer, rather than focusing on their illness. Socialization activities held in the community help to develop confidence in members that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear. Members often meet up on their own in the community after these socialization activities.



Outcomes

The Wellness Centers served a total of 2,412 adults in FY 2017-18 and 2,424 in FY 2016-17. The program assesses performance in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two inter-related ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, the Centers met this goal with 76% of members participating in two or more groups/activities each month during FY 2017-18. This is comparable to FY 2016-17 in which 77% of members participated in two or more groups/activities each month. Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. In FY 2017-18, 2,026 (84%) adults participated in community integration activities and in FY 2016-17, 2,038 (84%) adults participated.



The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 146 and 141 adults enrolled in education classes in FY 2017-18 and FY 2016-17, respectively. Thus, school enrollment remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes. In contrast, 736 adults in FY 2017-18 and 1,372 adults in FY 2016-17 were involved in employment, largely due to the large proportion in volunteer positions (see graphs). The programs will continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.

Challenges, Barriers and Solutions in Progress

A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to two hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel on public transportation. With the centers operating in the west, central and south regions of the county, access has improved.

Community Impact

Since their respective programs' inceptions, 7,681 adults have received services at Wellness Center Central, with an average daily attendance of 80 members, six days per week; more than 850 adults at Wellness Center South, with an average daily attendance of 20 members, six days per week; and 1,500 members at Wellness Center West, with an average daily attendance of 55 members per day, six days per week.

FAMILY SUPPORT

A subset of Recovery and Supportive Services focuses on providing support to parents, caregivers and family members as a way to enhance the resilience of children and youth who are at-risk of developing, or who are living with, serious emotional disturbance or mental illness. Orange County has four such programs, three of which are funded through PEI and the fourth through CSS.

Recovery and Supportive Services: Family Services	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Parent Education Services (PEI)	1,600	$1,064,770	$665
Family Support Services (PEI)	500	$282,000	$564
Children's Support and Parenting Program (PEI)	1,100	$1,700,000	$1,545
Mentoring for Children and Youth (CSS)	225	$500,000	$2,222

Parent Education Services (PEI)

Program Serves	Symptom Severity	Location of Services						Typical Population Characteristics					
													
Parents of Children 0-18	At-Risk	Home	Field	School	Workplace	Outpatient Clinic	Residential	Families	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Students	Criminal Justice

The program provides services in Spanish, Vietnamese and Farsi.

Target Population and Program Characteristics

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

Services

The program's purpose is to prevent the occurrence of, or reduce prolonged suffering due to, negative mental health outcomes in children by promoting protective factors in parents and caregivers. It accomplishes this through parenting education classes and individual interventions for parents needing additional support when their issue was not discussed in group or when they needed additional help understanding the parenting curriculum designed to help parents improve their childcare rearing skills, strengthen relationships with their children, increase cooperation and develop problem-solving skills.

The program guides its services through Active Parenting, an evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills. To ensure fidelity, all parent trainers are required to attend a comprehensive training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month.

In addition, PES facilitates case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, and advocating for needs).

Strategies to Promote Recovery/Resilience

The program promotes recovery/resilience by offering individual sessions to allow participants to further refine their parenting skills. Services are also provided in schools, hospitals and community centers to serve parents in need and promote the role of parenting in the community.

Strategies to Increase Timely Access to Services for Underserved Populations

PES has developed and implemented county-wide outreach plans that inform residents and agencies on how to identify and refer vulnerable families to the program. The community outreach strategies are conducted by collaborating with existing county and non-profit organizations that serve individuals with trauma, substance use, co-occurring disorders or domestic violence; churches; community and child- and family-serving centers; schools with low achievement rates; early child care centers including Head Start and Early Head Start programs; and mental health agencies. The staff also conduct outreach by hosting information tables at health fairs and community and cultural events. Brochures that describe program activities and eligibility are distributed in English, Spanish, Vietnamese and Farsi.

One of PES' challenges is the retention of parents as family and work-life often make it difficult for them to attend program activities consistently. To mitigate this challenge, the program works to reduce barriers such as lack of transportation and childcare by conducting the program in locations that are convenient for participants and by providing childcare.

In addition to ensuring timely access to its services, the program works to refer families to appropriate community resources.

Strategies to Reduce Stigma and Discrimination

The program determines curriculum for groups based on emerging needs within a community and through collaboration with various community partners. The program employs foreign language speaking professional staff and interpreter services as needed. PES maintains a nondiscrimination admission policy with services making them inclusive to any individual or family that will benefit. To reach the LGBTIQ population, PES staff collaborates with local groups for effective community outreach. Parent Education Services conducts outreach to reach deaf and hard-of-hearing populations via a collaboration developed with the Orange County Deaf Equal Access Foundation (OC DEAF). OC DEAF provides language interpreter services when requested to accommodate participants.

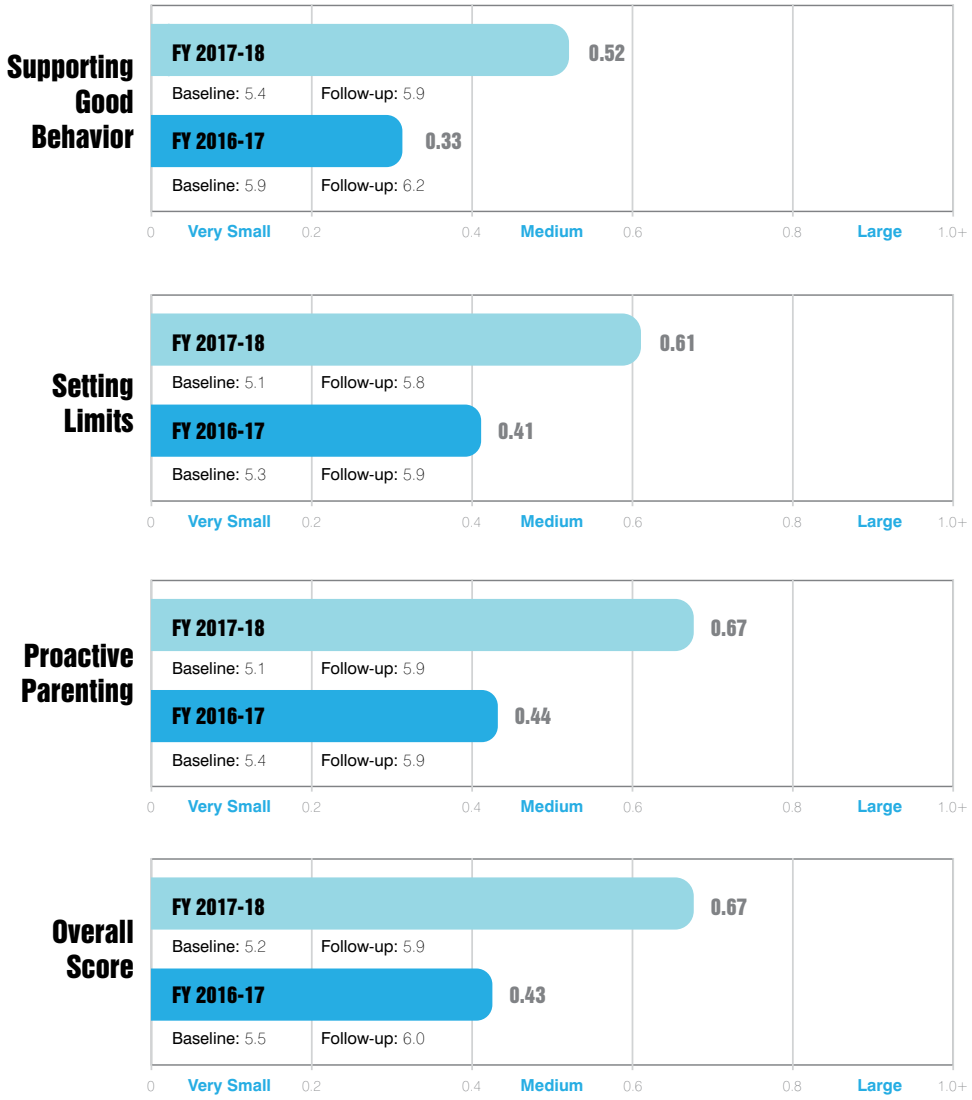
Outcomes

The program served 818 participants between October and June in FY 2017-18. Services were not offered in the first half of FY 2017-18 (July-October) due to the closure of one provider site a month prior to the start of the fiscal year. PEI staff worked to secure a new provider during the first quarter of the year, resulting in a delay in service delivery while the new provider was brought on board and began program start up. During FY 2016-17, when the program was fully operational, 2,317 participants were served. Program effectiveness was evaluated through an assessment of the protective factor, parenting self-efficacy. Different domains of parental self-efficacy were measured using the PARCA-SE, which reflects cultural competence as the survey is available in most threshold languages.

Results generally demonstrated that parents not only maintained high levels of parenting efficacy but also made additional small to medium gains while receiving services.[1] In addition, the program appeared to have greater impact across all domains in FY 2017-18 compared to FY 2016-17, which might be due to the fact that parents served in FY 2017-18, compared to those served in FY 2016-17, reported slightly lower levels of parenting selfefficacy when they first entered the program.

Impact on PARCA-SE by FY

Parent Education Services



Challenges, Barriers and Solutions in Progress

In FY 2017-18, PES streamlined operations by merging parent education services previously provided through two separate programs: Parent Education and Support Services, which served families with children ages 0-12, and Family Support Services, which served families with youth ages 13-18.

Community Impact

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

Reference Notes

[1] ***Supporting Good Behavior:***
2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.9, SD=0.9; t(631)=-12.92, p<.001, Cohen's d=0.52
2016-17: Baseline M=5.9, SD=1.1; Follow-up M=6.2, SD=0.9; t(780)=-9.21, p<.001, Cohen's d=0.33

Setting Limits:
2017-18: Baseline M=5.1, SD=1.2; Follow-up M=5.8, SD=1.0; t(629)=-15.07, p<.001, Cohen's d=0.61
2016-17: Baseline M=5.3, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-11.25, p<.001, Cohen's d=0.41

Proactive Parenting:
2017-18: Baseline M=5.1, SD=1.3; Follow-up M=5.9, SD=1.0; t(629)=-16.32, p<.001, Cohen's d=0.67
2016-17: Baseline M=5.4, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-12.09, p<.001, Cohen's d=0.44

Overall Score:
2017-18: Baseline M=5.2, SD=1.1; Follow-up M=5.9, SD=0.9; t(632)=-16.66, p<.001, Cohen's d=0.67
2016-17: Baseline M=5.5, SD=1.1; Follow-up M=6.0, SD=1.0; t(780)=-12.04, p<.001, Cohen's d=0.43

Family Support Services (PEI)

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics
0+	At-Risk	Early Onset	Field	Families

The program provides services in Spanish, Vietnamese, Farsi, Korean and Arabic.

Target Population and Program Characteristics

Family Support Services (FSS) serves individuals who are caregivers of persons struggling with behavioral health issues or other stressful conditions that place the caregiver, who is usually a family member, at-risk for developing behavioral health issues. The program can also serve other family members as needed. FSS collaborates with community and mental health service providers, especially those that serve ethnically diverse and monolingual communities, to help assess the needs of its community members. By working closely with individuals who know the community, the program is better able to identify those who could benefit from this prevention program.

Services

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

Strategies to Promote Recovery/Resilience

The model matches trained peer mentors (individuals with lived experience or their family members) who have successfully navigated systems of mental and behavioral health services to families who are currently navigating similar systems. Peer Mentors provide information and individualized instructional and emotional support for families from a first-hand perspective. Family engagement services focuses on creating helpful peer-to-peer relationships between participating families and a trained volunteer family mentor.

Strategies to Increase Timely Access to Services for Underserved Populations

In addition to English, services are available in Spanish, Vietnamese and Farsi, which increases access for monolingual, non-English speakers. The program schedules services at various times (morning, afternoons, and evenings) which allows families who work during the day to attend evening classes and families who work during swing or late shifts to attend morning sessions. FSS also conducts classes at locations that are accessible to participants, such as school sites, family resource centers, community centers, churches, county libraries, hospitals, shelters and county jails. Program makes referrals as needed.

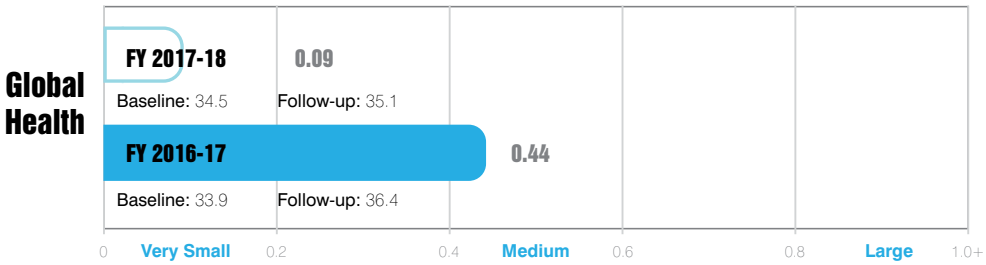
Strategies to Reduce Stigma and Discrimination

The program strives to make its services available to all Orange County residents and provides services that are sensitive and responsive to participants' backgrounds. Group support and family matching services are available in English, Vietnamese and Spanish. Peer mentoring and childcare services are available in English and Spanish.

Outcomes

Impact on Global Health by FY

Family Support Services



The program served 1,502 parents and caregivers between October and June of FY 2017-18, and 1,741 during FY 2016-17. The goal is to help prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of Global Health as measured by the PROMIS. The PROMIS was administered at intake (baseline) and program exit (follow-up), and the difference in scores was analyzed and reported according to calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served.

A total of 107 parents and caregivers served in FY 2017-18 and 557 served in FY 2016-17 provided both baseline and follow-up assessments of the PROMIS. Participants generally reported high levels of global health as they entered the program in both years and even made modest gains in FY 2016-17. Thus, FSS appeared to be effective in maintaining and/or enhancing the protective factor of global health among the participants it serves.

Challenges, Barriers and Solutions in Progress

The program's service is challenged with recruitment of participants in the summertime when school is typically out of session and families may be on vacation or busy with summer activities. To mitigate this challenge, the program partners with local community organizations, including Family Resource Centers, which may have direct contact with potential participants during the summer.

Community Impact

The program has serves 12,448 total caregivers since program inception October 2012. FSS collaborates with agencies and community groups to ensure that services are provided throughout Orange County. Services are often held at community locations such as libraries and schools.

Reference Notes

[1] ***PROMIS Global Health:***
FY 2017-18: Baseline M=34.5, SD=6.2; Follow-up M=35.1, SD=7.1; t(106)=-0.93, p=.35, Cohen's d=0.09
FY 2016-17: Baseline M=33.9, SD=6.7; Follow-up M=36.4, SD=5.6; t(556)=-10.31, p<.001, Cohen's d=0.44

Children's Support and Parenting Program (PEI)

Program Serves	Symptom Severity	Location of Services						Typical Population Characteristics									
6-68	At-Risk	Home	Field	School	Workplace	Outpatient Clinic	Residential	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Students	Criminal Justice

The program provides services in Spanish and Vietnamese.

Target Population and Program Characteristics

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

Services

The Children's Support and Parenting Program (CSPP) provides a range of services intended to reduce risk factors for children and youth and to increase protective factors through parent training and family-strengthening programs. Services include family assessment; group interventions for children, teens and parents; brief individual interventions to address specific family issues; referral/linkage to community resources; and workshops.

CSPP provides these services utilizing Evidence Based Practice (EBP) curricula, and the program offers two different tracks depending on participant need: Strengthening Families or The Parent Project®. The curricula are delivered in a classroom-type setting in many different types of organizations and agencies such as schools, Family Resource Centers (FRC), treatment facilities, juvenile probation offices and the CSPP program's suite of offices. All staff utilizing one of the EBPs have been trained and certified to deliver the curriculum and adhere to it when presenting the material to participants.

Strategies to Promote Recovery/Resilience

CSPP program curricula are designed to promote recovery from trauma-induced family dysfunction and to increase family resilience. This is done through teaching communication skills, strengthening family roles, defining family goals and rules, teaching families how to take advantage of their own resources and collateral resources, etc.

Strategies to Increase Timely Access to Services for Underserved Populations

Transportation and coordination of schedules can be barriers to services. To address these issues and encourage access to its program, CSPP services are offered in every part of Orange County and are scheduled in the evening to allow most working families to attend.

Meals are also served at most CSPP services as a way to encourage participation.

When families share that they have a need for a particular type of resource, clinicians in the program make referrals and follow-up with families to determine whether linkages were successful. The program provided 114 referrals resulting in 105 linkages in FY 2017-18 and 224 referrals resulting in 67 linkages in FY 2016-17 to services such as Behavioral Health Prevention, Intervention, and Outpatient programs; transportation services; basic needs (e.g., donate services); food and nutrition assistance; housing resources and advocacy; and legal services and advocacy. The decrease in referrals and improvement in linkages in 2017-18 as compared to 2016-17 is reflective of the program referral procedural change; that is, clinicians were only providing a single referral type as opposed to multiple referrals for the same type of service. This change was put in place in effort to improve referral-linkage, which is reflected in numbers for FY 2017-18.

Impact on PARCA-SE by FY

Children's Support and Parenting Program

Strategies to Reduce Stigma and Discrimination

Because the stigma of being a "family in need" can be a barrier to seeking services, CSPP is marketed in such a way as to reduce stigma. Most notably, services are offered in community locations where families may already be going for other reasons, such as schools or family resource centers.

Outcomes

The program served 897 participants in FY 2017-18 and 1,065 in FY 2016-17, with the goal of preventing the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills. CSPP measured parenting using the PARCA-SE, which assesses different domains of parenting self-efficacy. The PARCA-SE was administered at intake, every three months of program participation and at discharge, and the change in scores between intake and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is clinically meaningful for the individuals served.

Results from both FY 2017-18 and FY 2016-17 show that parents not only reported maintaining healthy levels of parenting efficacy but also made additional small to medium gains, particularly with regard to setting appropriate limits, while receiving services.[1]

Challenges, Barriers and Solutions in Progress

Maintenance of program staffing has been challenging in this program as many of the positions are "entry level" in nature and staff quickly promote to other positions. The classification specifications for these programs are being examined to make appropriate changes.

Community Impact

The program has provided services to more than 4,442 participants since its inception in July 2011. The program continues to provide educational series throughout the community at schools, Youth Reporting Centers, Family Resource Centers and other CBO's.

Reference Notes

[1] ***Supporting Good Behavior:***

FY 2017-18: Baseline M=5.7, SD=1.1; Follow-up M=6.0, SD=0.9; t(340)=-4.43, p<.001; Cohen's d=-0.24
FY 2016-17: Baseline M=5.6, SD=1.1; Follow-up M=5.9, SD=0.9; t(296)=-3.71, p<.001; Cohen's d=-0.21

Setting Limits:
FY 2017-18: Baseline M=5.2, SD=1.3; Follow-up M=5.8, SD=1.0; t(338)=-9.68, p<.001; Cohen's d=-0.54
FY 2016-17: Baseline M=5.2, SD=1.3; Follow-up M=5.7, SD=1.0; t(296)=-7.50, p<.001; Cohen's d=-0.44

Proactive Parenting:
FY 2017-18: Baseline M=5.2, SD=1.3; Follow-up M=5.7, SD=1.0; t(338)=-7.76, p<.001; Cohen's d=-0.43
FY 2016-17: Baseline M=5.2, SD=1.3; Follow-up M=5.6, SD=1.1; t(296)=-6.42, p<.001; Cohen's d=-0.38

Overall Score:
FY 2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.8, SD=0.9; t(340)=-8.39, p<.001; Cohen's d=-0.46
FY 2016-17: Baseline M=5.3, SD=1.2; Follow-up M=5.7, SD=0.9; t(296)=-6.59, p<.001; Cohen's d=-0.39

Mentoring for Children and Youth (CSS)

Program Serves	Symptom Severity	Location of Services					Typical Population Characteristics	
0 - 25	Severe	Home	Field	School	Workplace	Outpatient Clinic	Parents	Families

The program provides services in Spanish, Vietnamese and Farsi.

Target Population and Program Characteristics

Mentoring for Children and Youth serves youth ages 0-25 who are living with a serious emotional disturbance and are currently receiving behavioral health services at a County or County-contracted outpatient clinic. Youth are referred to the program by their therapist if the therapist has determined that the child could benefit from additional mentoring and socialization experiences out in the community. Parents of participating youth can also receive parent mentoring services.

Services

Mentoring for Children and Youth is a community-based, individual- and family-centered program that recruits, trains and supervises adults to serve as positive role models and mentors for youth. Youth are matched to a mentor who plans 1:1 no-cost or low-cost activities and outings at least three times a month. In addition, the program hosts a group event monthly and a staff/volunteer training quarterly. Working with mentors provides the child an opportunity to socialize, as well as practice skills learned in therapy in a structured and supportive environment.

Strategies to Promote Recovery/Resilience

Independent research has demonstrated that formal youth mentoring programs promote positive outcomes such as improved self-esteem, enhanced social skills and resilience when strong relationships are formed and good mentoring practices are implemented.

Strategies to Increase Timely Access to Services for Underserved Populations

Mentoring for Children and Youth encourages timely access to its services by having the mentors provide transportation to and from events, which are scheduled after school hours and on the weekends. In addition, whenever possible, the family is matched with a mentor who speaks the same language to reduce any language barriers to services.

Strategies to Reduce Stigma and Discrimination

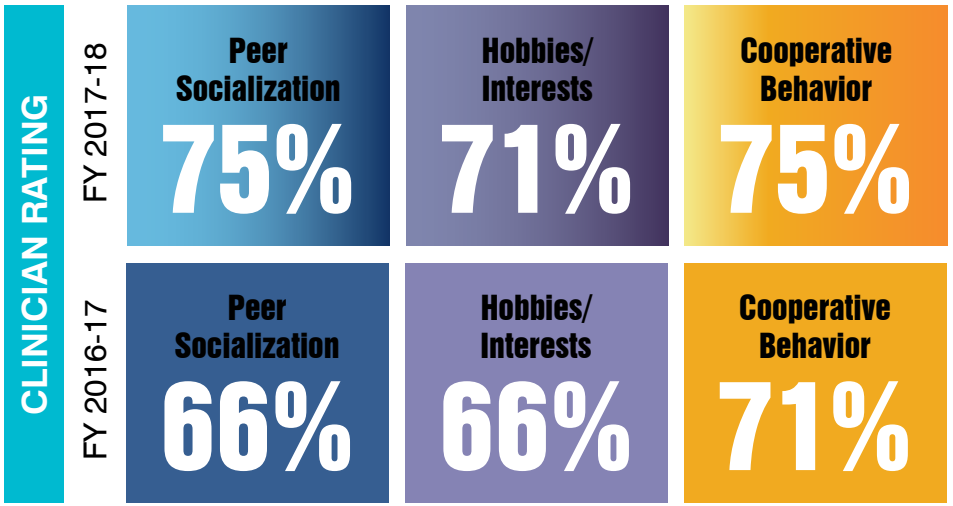
Many of the youth referred for these services are isolated, in part, due to experiencing self-stigma. The support of a mentor provides them with the opportunity to participate in important community recreational activities. Something as simple as riding the bus to the mall and having a snack builds confidence in the youth and hope for their families, thus building their resilience and wellness.

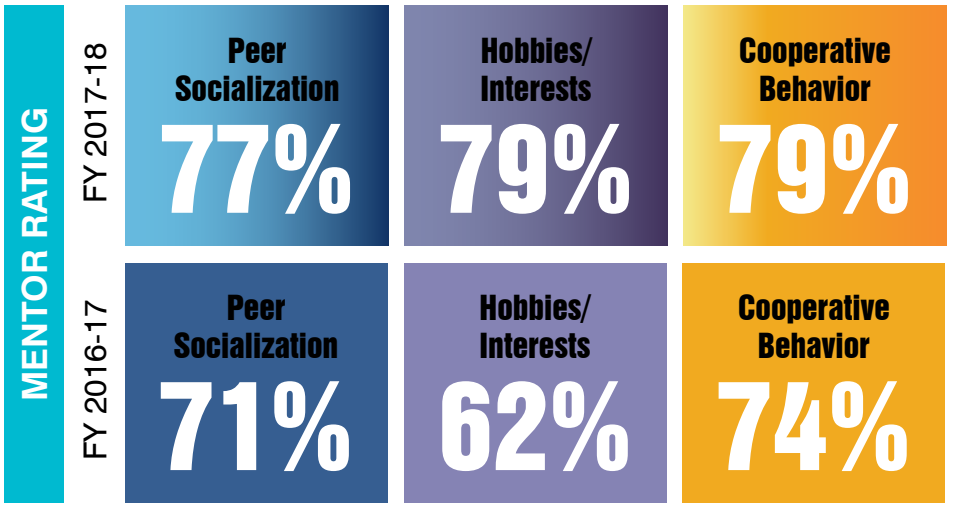
Outcomes

A total of 217 children and youth and 17 parents were served in the mentoring program during FY 2017-18, and 175 children and youth and 21 parents were served in FY 2016-17. At the start of services, clinicians and youth identified one or more behavioral goals that would be addressed through mentoring (i.e., increasing peer socialization, developing hobbies or interests, improving cooperative behavior). Clinicians and mentors then rated the extent to which participants had made progress on each of their goals at the time of discharge. Across both fiscal years, clinicians and mentors indicated that participants had made some progress or significant progress about two-thirds to three-quarters of the time, depending on the identified goal. These results help demonstrate the mentors' ability to support skill development among participating youth.

Youth Who Made Progress on Goals at Discharge by FY

CYBH Mentoring





Challenges, Barriers and Solutions in Progress

The program succeeds despite two complicated, but necessary processes. First, it is a challenge recruiting volunteer mentors, obtaining background checks and providing training and guidelines on "how to be a mentor." In addition, CYBH clinicians must identify children and youth who might benefit from the program and then the program must match the child or youth to an appropriate mentor according to characteristics such as gender, interests and/or language spoken. Because of the limited number of mentors available, on occasion it can take some time before a suitable mentor is available and/or identified.

Community Impact

The program has served more than 1,439 children and youth, and 167 parents since its inception in FY 2009-10. It provides children with the opportunity to practice skills learned in treatment in a safe and controlled environment. Children and youth are provided non-judgmental feedback in a supportive setting, especially when trying out new behaviors.

VETERANS SUPPORTIVE SERVICES

In addition to providing outpatient programs sensitive to the unique needs and culture of veterans, Orange County stakeholders identified a need to provide supportive services to veterans and their families. Services such as these promote the health and well-being not just of military-connected family members but of the veterans themselves by improving the overall resilience, coping strategies and support network of the family unit. HCA currently funds one Veterans Supportive Services project through INN.

Recovery and Supportive Services: Veterans	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Continuum of Care for Veteran & Military Children and Families (INN)	200	$962,445	$4,812

Continuum of Care for Veteran & Military Children and Families (INN)

The Continuum of Care for Veteran & Military Children and Families Innovation project provides behavioral health and peer support services to active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones. The project integrates military culture and services into Family Resource Centers (FRCs) located throughout Orange County to train non-veteran organizations on how to identify, screen and serve military connected families. It seeks to expand general service providers' knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population.

Program Serves	Symptom Severity		Location of Services	Typical Population Characteristics	
18+	At-Risk	Mild-Moderate	Family Resource Centers	Families	Veterans

Services

The project is staffed with peer navigators who are co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military cultural awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project is also staffed with clinicians who, with the on-going support of peer navigators, provide counseling and trauma-informed care utilizing evidence-based practices.

This project was approved by the Mental Health Services Oversight and Accountability Commission on March 23, 2017. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to application to a different population. The project began services July 1, 2018. Innovation funds for this project will end June 30, 2022.

Strategies to Promote Recovery/Resilience

This project is staffed with peer navigators who have experience and knowledge of military culture. peer navigators train FRC staff on military culture, thereby increasing military cultural awareness among non-veteran organizations. These efforts help promote recovery by building a stronger resource and support network to address the complex needs of veterans and their families.

Strategies to Increase Timely Access to Services for Underserved Populations

By providing services directly within the FRCs, project staff has the opportunity to connect with participants while they

are seeking other services and provide them with timely access to needed behavioral health support and treatment, either directly or by linking them to community programs. The project also trains FRC staff on how best to meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population. More importantly, FRCs also serve as a new point of entry into behavioral health services, including supportive and treatment services, for military families. The support offered by a military-connected peer is expected to increase family members' access to needed services, especially behavioral health care, which they may be reluctant to seek on their own due to the stigma associated with mental illness. The project began on July 1, 2018. Referrals and linkages to County and/or community behavioral health services will be reported in future Plan updates.

Strategies to Reduce Stigma and Discrimination

This project is embedded in at-risk communities and brings veteran-specific services and support into an easily accessible, inviting and nonclinical setting. Military-connected families seeking FRC resources have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer navigators also connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood.

Outcomes

The project began July 1, 2018. Outcomes will be reported in future Plan updates.

GENERAL SUPPORTIVE SERVICES

General Supportive Services provides a wide array of supplementary programs designed to improve recovery by helping participants develop skills and/or meet essential needs such as transportation assistance. At present, all programs in this service function are for adults 18 and older and are funded through CSS or PEI. The PEI Training in Physical Fitness and Nutrition program is being discontinued in FY 2019-20 following the closing of the gym facilities by the contracted provider.

Recovery and Supportive Services: General Support	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Supported Employment (CSS)	485	$1,371,262	$2,827
Training in Physical Fitness and Nutrition (PEI)	Discontinued	$0	N/A
Transportation (CSS)	1,200	$900,000	$750
Supportive Services for Residents in Permanent Supportive Housing (CSS)	200	$2,000,000	$10,000

Supported Employment (CSS)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics				
									
18+	Severe	Field	Workplace	Outpatient Clinic	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in Spanish, Vietnamese, Farsi and Korean.

Target Population and Program Characteristics

The Supported Employment (SE) program serves Orange County residents 18 and older who are living with severe and persistent mental illness, may have a co-occurring substance use disorder and require job assistance to obtain competitive or

volunteer employment. Participants are referred to the program from County and County-contracted Outpatient and Recovery programs, FSPs and select PEI and Innovation programs. Participants must be engaged in behavioral health services during their entire enrollment in the program and have an assigned plan coordinator or personal services coordinator who will collaborate with the SE team to assist with behavioral issues that may arise while participating in the program.

Services

The Supported Employment program Individual Employment Plans are developed by the employment team with the participant and use the evidence-based Individual Placement & Support employment model to provide services such as volunteer or competitive job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling and peer support services.

Employment Specialists (ES) and Peer Support Specialists (PSS) work together as an Employment Team. The ES assists participants with employment preparation including, but not limited to, locating job leads, assisting with application submissions and assessments, interviewing, image consultation and transportation issues. The ES also provides one-on-one job support, either by telephone or at the participant's workplace, to ensure successful job retention. The PSS are individuals with lived experience with behavioral health and substance use challenges, and who possess skills learned in formal training, and/or professional roles, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency. PSS work with participants in developing 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.

Strategies to Increase Recovery/Resilience

Securing meaningful employment represents a significant step toward recovery and re-integration into the community. Staff strives to build working relationships with prospective employers, educate employers to understand mental illness and combat stigma, and serves as the main liaison between the employers and program participants. The ES maintains ongoing, open communication with participant treatment teams to promote positive work outcomes. The PSS provide training and support to participants using the principles of hope, equality, respect, personal responsibility and self-determination. While it is sometimes a concern among the target population that they might lose their benefits such as SSI/SSDI if they become employed, they also recognize that this may be a final step to gaining full independence from the 'system.'

Strategies to Improve Timely Access to Services for Underserved Populations

The SE program engages in a number of activities to encourage timely access to its services. First, SE staff regularly present at County and County-contracted clinics to encourage referrals to the program. From the day the participant enrolls, the program strives to foster an environment of empathy and hope, which contributes to their ongoing program participation. ES and PSS staff provide person-centered supports in line with the evidence-based model of Individual Placement & Support so that they can support participants in finding and keeping a good job in a supportive work environment. The team is highly mobile and can meet individuals in their communities to provide supported services. The employment team also collaborates with the referring treatment provider to discuss the participant's progress, success stories and/or any significant behavior that prompts need for clinical interventions. In addition, services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

Strategies to Reduce Stigma and Discrimination

Helping participants find and maintain good jobs in the community is, in and of itself, an act of reducing stigma and discrimination. More and more program participants are requesting assistance in disclosing their barriers to employers. This opens up ample opportunity for staff to have a supportive on-site presence that fosters collaboration and education between the participants and their employers and co-workers. The program promotes participants' successes in maintaining employment and highlights welcoming employers who provide individuals with mental health challenges the opportunity to meaningfully integrate into the communities via competitive employment. This effort is carried out through media exposure via news publication, newsletters and presentations of success stories at community meetings.

Outcomes

The program served 474 participants in FY 2017-18, which included 334 new enrollments. In FY 2016-17, 405 participants were served, which included 290 new enrollments. Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. A total of 128 of the 263 (49%) job placements in FY 2017-18 and 118 of the 203 (58%) job placements

in FY 2016-17 resulted in a successful graduation from the program after achieving the employment milestone. This is most likely due to changes in staffing structure; only one program manager instead of two managing the two regions. There was also rapid staffing turnover at both north and south.

Challenges, Barriers and Solutions in Progress

During FY 2017-18, SE experienced changes in staffing only one program manager instead of two managing the two regions. There was also rapid staffing turnover at both North and South.

Community Impact

The Supported Employment program has provided services to more than 2,766 adults since its inception August 2006. The program has established in 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, local MHSA steering committee meetings and CAAC meetings.

Transportation (CSS)

Program Serves	Symptom Severity	Location of Services			Typical Population Characteristics					
										
	Severe	Field	Outpatient Clinics	Hospitals	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Co-Occurring Medical	Criminal Justice

The program provides services in TBD.

Target Population and Program Characteristics

The Transportation program serves adults ages 18 and older who need transportation assistance to and from necessary County behavioral health and/or primary care appointments, as well as behavioral health supportive services. Individuals are referred to the program by their BHS treatment provider, following an assessment of their transportation needs and their history of missing their scheduled appointments due to transportation issues.

Services

Individuals are provided curb-to-curb service or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance and the driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin. Individuals also have the ability to stop and get their prescriptions filled as necessary.

Strategies to Promote Recovery/Resilience

A survey on transportation needs conducted at the four large county adult outpatient clinics (Santa Ana, Anaheim, Westminster and Mission Viejo) indicated that over 40% of missed clinic appointments was a direct result of transportation issues. These issues included, but were not limited to, lack of a car or money for gas or a bus, inability to navigate the public transportation system, the time it takes to use public transportation system, anxiety surrounding using public transportation or riding with others and reliance on others to get rides to and from appointments. By providing reliable pick-up and drop-off at their requested destinations, it is anticipated that participants will be better able to engage in treatment consistently, thus allowing them to pursue their recovery.

Strategies to Improve Timely Access to Services for Underserved Populations

The program facilitates timely access to needed behavioral health and medical services for participants with significant transportation-related barriers to care by providing them with the means to attend these appointments.

Strategies to Reduce Stigma and Discrimination

By offering free transportation, the program makes behavioral health and medical treatment equally accessible to individuals in need of care regardless of their socioeconomic means.

Outcomes

The contract began 7/1/2018, with the first ride taking place on 7/12/2018. Outcomes will be reported in future Plans.

Supportive Services for Residents in Permanent Supportive Housing (CSS)

Target Population and Program Characteristics

This new program will serve adults ages 18 and older who are living with serious mental illness, residing in permanent supportive housing in Orange County but lacking supportive services, thus placing them at risk losing their housing. Eligible participants will be referred from County outpatient clinics and programs, as well as private providers. The program will also serve underserved individuals, including those who have not successfully engaged in behavioral health services.

Services

The primary goal of this program is to assist participants with maintaining their housing by providing integrated and multi -disciplinary intensive case management services to those who do not have access to on-site housing support. The program will assess individual needs, assist individuals with housing sustainability and, when needed, link individuals to appropriate community resources and supports. The program is currently a three-year pilot project and is new to the FY 2019-20 MHSA Plan. Program services will be developed and described in more detail in future Plans.

SUPPORTIVE HOUSING

With the continually increasing cost of housing and its subsequent impact on homelessness, addressing the housing needs of some of our most vulnerable residents, those living with mental illness, has become one of Orange County's most pressing concerns. In partnership with the Orange County Board of Supervisors, the MHSA Steering Committee and community stakeholders, HCA has worked diligently to develop a continuum of MHSA supportive housing programs that range from emergency shelter to permanent supportive housing in order to meet the needs of those living with serious mental illness. In addition to the programs contained in this Service Function, the Full Service Partnerships and BHS Outreach and Engagement provide housing assistance as needed.

Supportive Housing	Annual Budgeted Funds in FY 2019-20
Year-Round Emergency Shelter (CSS)	$1,367,180
Bridge Housing for the Homeless (CSS)	$2,000,000
MHSA Special Needs Housing Program (CSS)	$30,500,000

Year-Round Emergency Shelter (CSS)

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics				
							
18+	Severe	In Shelter	LBGTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Criminal Justice

The program provides services in English, Spanish and Vietnamese.

Target Population and Program Characteristics

The Year-Round Emergency Shelter program serves homeless adults with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. Individuals will be referred to the shelter by BHS Outreach and Engagement (O&E), Orange County Community Resources (OCCR), and a contracted provider that reports to OCCR. Adults will be allowed to bring their pets with them to the shelter.

Services

This program will dedicate beds within an existing 200-bed shelter. In addition to shelter, the program provides basic needs items (i.e., food, clothing, hygiene goods), as well as case management and linkage to services designed to assist individuals in their transition out of the shelter and into a more stable housing situation. The estimated length of stay for each episode of shelter housing is 120 days. Extensions will be considered on a case-by-case basis.

Strategies to Promote Recovery/Resilience

The program addresses the basic needs of homeless individuals, such as food, shelter and physical safety. Having these needs met is a foundational element of facilitating recovery and preparing individuals for a transition to permanent housing.

Strategies to Improve Timely Access to Services for Underserved Populations

Staff from OCCR's contracted provider and the BHS Outreach and Engagement team are onsite to conduct needs assessments and make direct linkages to needed services such as more permanent housing, transportation, behavioral health services and assistance with benefits acquisition. Bicultural/bilingual staff provides services in English, Spanish and Vietnamese.

Strategies to Reduce Stigma and Discrimination

Individuals who are homeless face a great deal of stigma. While in the shelter, staff works with residents to prepare them to accept permanent housing, so they do not need to live on the streets. Additionally, housing navigators help outreach to potential landlords, to help them see beyond the person's homeless status. This helps to reduce stigma and discrimination from potential landlords and helps facilitate acquisition of permanent housing.

Outcomes

This has not yet launched and will report outcomes in future Plans.

Bridge Housing for the Homeless (CSS)

Program Serves	Symptom Severity	Location of Services		Typical Population Characteristics						
										
18+	Severe	Field	Residential Setting	Families	LBGTIQ	Veterans	Homeless/ at-Risk	Co-Occuring SUD	Students	Criminal Justice

The program provides services in English and Spanish.

Target Population and Program Characteristics

Bridge Housing offers transitional housing for adults who have received a certificate from the Orange County Housing Authority for the Continuum of Care (CoC) Program but have been unsuccessful at finding a rental unit, as well as homeless adults who have not yet received a certificate but are beginning the process. Adults (including couples) are eligible if they are homeless and have a serious mental illness, and may have a co-occurring substance use disorder. Participants are referred to the program primarily through HCA Outreach and Engagement (O&E) staff, Orange County Housing Authority (OCHA), County and County-contracted clinics, and Full Service Partnerships (FSPs). This program launched in 2018.

Services

The program uses a "Housing First" model, which is an evidence-based approach to getting people off the streets and into housing as soon as possible, even if they are not yet engaged in treatment. Although most are engaged in services, it is not a requirement for being housed. Services include housing, meals and assistance in guiding individuals through the CoC process. Staff assists participants in locating housing units that will accept their CoC certificate, prepares them to be ready to live in permanent housing, and links them to outpatient treatment, if not already linked. Program staff collaborates with housing navigators and landlords to identify appropriate permanent housing options. Bridge Housing is available for up to one year for those with certificates and up to 18 months for those who do not yet have a certificate.

Strategies to Promote Recovery/Resilience

The program addresses individuals' basic needs, including providing shelter and food. This creates a safe environment in which participants can make progress toward their recovery while securing permanent housing. Staff uses Motivational Inter-

viewing to engage participants and help them identify their own needs and struggles. This evidence-based therapeutic approach facilitates independence through self-discovery, and helps individuals become more ready for independent or supportive housing.

Strategies to Improve Timely Access to Services for Underserved Populations

The Housing First model aims to reduce or eliminate barriers to housing. Staff works with Housing Navigators and landlords to identify permanent housing options and work with treatment providers to link individuals to services, if they are not already engaged in treatment. Bicultural/bilingual staff ensure availability of services in a variety of languages. They also collaborate with County and County-contracted clinics and FSPs to link individuals to treatment, as needed.

Strategies to Reduce Stigma and Discrimination

Program staff conducts community outreach to educate and engage prospective landlords with the goals of improving access to housing options, reducing misconceptions about people living with mental illness and reducing the possibility of discrimination from landlords.

Outcome

This program launched in 2018 and will report outcomes in future Plans.

MHSA Special Needs Housing Program (CSS)

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the MHSA Special Needs Housing Program is a funding mechanism to develop permanent supportive housing units for individuals living with serious mental illness. It is funded through CSS and governed by requirements that are summarized below.

Program Description and Target Population

Funding for the Local Government Special Needs Housing Program (SNHP), formerly known as MHSA Housing, is used to develop new housing for eligible tenants, with MHSA funding limited to 30% of total development costs for each unit. The California Housing Finance Agency (CalHFA) created the SNHP to replace the MHSA Housing program which concluded in May 2016.

Since the inception of MHSA, Orange County has used MHSA Housing dollars to fund the development of permanent supportive housing (PSH) for some of its most vulnerable residents. Funding allocations include a one-time State allocation of $8 million in FY 2006-07 to develop PSH for Full Service Partnership participants; a one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation; the transfer of $5 million in CSS funds in September 2016 following input received during the local community planning process; and transfers totaling $20 million in CSS funds during FY 2017-18 following a directive from the Orange County Board of Supervisors and the local community planning process; and the transfer of $25,000,000 in CSS funds during FY 2018-19. The HCA currently has a remaining balance of $30,500,000 available for Orange County to continue creating permanent housing options for those living with SMI.

SNHP funding and the MHSA Housing program before it, 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. To be eligible for MHSA-funded permanent supportive housing, a person must be diagnosed with severe and persistent mental illness and be homeless or at-risk of homelessness. Additional eligibility requirements can vary at each project due to requirements of other funding partners. Individuals, including couples and families, are referred to permanent supportive housing by County or County-contracted outpatient clinics or FSP providers.

Projects

MHSA Housing/SNHP funds a combination of development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. Operating subsidies primarily help cover the cost 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 either entitlement or employment income. Behavioral health and other supportive services are located on-site and off-site to each housing development, to ensure access to mental health, counseling, case

management and other supportive services that help residents adjust to and maintain their independent housing.

One-Time Projects:
In FY 2006-07 Orange County was allocated $8 million in one-time CSS funds to develop PSH for individuals with serious mental illness who were receiving services in the Full Service Partnerships. Funds were used to develop 34 housing units in two developments.

MHSA Housing Program:
In FY 2007-08 the state provided Orange County with a one-time allocation of $33 million carved out of the CSS allocation. These funds have been used in 10 housing developments to create an additional 194 new units of PSH in Orange County.

The following table provides details about these one-time and MHSA Housing projects which, together, will result in the development of 194 new permanent supportive housing MHSA units for eligible tenants and their families.

The following table provides additional details showing how the $33 million that was allocated to Orange County as part of the initial MHSA Housing program was spent across the 10 MHSA Housing developments. The numbers reflect interest earned, which remains assigned to CalHFA.

Project	Year	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total MHSA Units	Total Units Including MHSA	Total
Alegre Apartments	2015	11	0	1	11	104	$2,912,200
Avenida Villas	2014	24	4	1	28	29	$6,519,200
Capestone Apartments	2014	19	0	1	19	60	$4,445,468
Cotton's Point Seniors	2014	15	0	1	15	76	$2,022,400
Depot at Santiago	2018	10	0	1	10	70	$1,615,320
Diamond Apartments	2009	15	9	1	24	25	$1,583,222
Doria Apartments, Phase I	2011	10	0	1	10	60	$1,500,000
Doria Apartments, Phase II	2013	8	2	1	10	74	$2,019,850
Fullerton Heights	2018	18	6	1	24	36	$6,300,000
Henderson House	2016	14	0	0	14	14	$3,542,884
Oakcrest Heights	2018	7	7	1	14	54	$2,550,798
Rockwood Apartments	2016	14	1	1	15	70	$3,222,974
Total					**194**	**672**	**$37,895,786**

MHSA Special Needs Housing Program (SNHP): Local stakeholders have identified an on-going and persistent need for housing for individuals who are living with serious mental illness and are homeless or at-risk of homelessness. As such, $5 million in CSS funds was transferred to the SNHP in FY 2016-17 and, upon directive by the Orange County Board of Supervisors, a total of $20 million was approved and transferred in FY 2017-18, and a total of $70.5 million was approved in FY 2018-19, $25 million of which was transferred in FY 2018-19, leaving a balance of $30,500,000 available for future projects. Four projects are currently in various stages of development that will add 73 new SNHP units (see table below).

SNHP Projects in the "Pipeline"

Service Planning Area	Board District	Project Name (City)	MHSA Units	Total Units	Estimated Construction Start	Estimated Construction Completion	SNHP Capital Request	Total
Central	1st	Santa Ana Veterans Village (Santa Ana)	20	76	January 2019	March 2020	$2,912,000	$2,912,000
Central	1st	Aqua (Santa Ana)	28	57	March 2019	May 2020	$7,035,800	$7,035,800
Central	1st	Santa Ana Arts Collective (Santa Ana)	10	58	Under Construction	May 2019	$2,362,215	$2,362,215
Central	1st	Westminster Crossing (Westminster)	15	65	December 2019	March 2021	$2,912,000	$2,184,000

Strategies to Promote Recovery/Resilience

Residential Clinical Services Coordinators (RCSCs) visit the various housing developments each week in order to help residents adjust to and maintain permanent housing, including acting as a liaison between property managers and residents to resolve issues.

Strategies to Improve Timely Access to Services for Underserved Populations

Behavioral health programs provide their services on-site or off-site, promoting easy access to services. In addition, most housing sites are located near public transportation routes in order to enhance residents' access to transportation, as many residents do not own a car.

Strategies to Reduce Stigma and Discrimination

Staff educates property managers about mental illness. Property management staff is also provided training in Mental Health First Aid, Safe Talk and other relevant trainings to help property managers know how to better respond and communicate with residents who have mental illness.

Challenges, Barriers and Solutions in Progress

The HCA recognizes that the demand for safe housing for individuals living with mental illness and their families is far outpacing current availability. Thus, staff continually look to identify new opportunities for developing housing for this vulnerable population, which includes staying apprised of other funding opportunities and leveraging resources with other community and County partners.

Community Impact

Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals with serious mental illness by improving housing stability, employment and mental and physical well-being. In addition, these MHSA units are integrated in larger housing developments that provide an additional 496 non-MHSA units of critically needed affordable housing in Orange County.

Projects Actively Applying for NPLH Competitive NOFA or Approved by Board

Service Planning Area	Board District	Project Name (City)	MHSA Units	Total Units	Estimated Construction Start	Estimated Construction Completion	Total
North	3rd	Altrudy Senior Apartments (Yorba Linda)	10	48	December 2019	August 2021	$2,402,528
Central	1st	Francis Xavier (Santa Ana)	9	12	December 2019 or early 2020	Late 2020	$3,382,388
Central	1st	Legacy Square (Santa Ana)	16	93	December 2019	July 2021	$6,013,134

Authorized by Governor Brown in 2016 and approved by California voters in November 2018, No Place Like Home (NPLH) dedicates $2 billion in bond proceeds for the development of permanent supportive housing for individuals who are living with serious mental illness or serious emotional disturbance and who are experiencing homelessness, chronic homelessness, or risk of chronic homelessness. NPLH offers competitive and non-competitive funding streams for housing development, and Orange County has several applications currently under review.

Behavioral Health Services
System Support

Workforce Education and Training

Capital Facilities and Technological Needs

BHS System Support refers to the infra-structure that maintains the behavioral health system itself. Funds develop the behavioral health workforce, the facilities in which MHSA services are provided and/or administered, and the technology that supports service delivery.

WORKFORCE EDUCATION AND TRAINING

The mission of the MHSA Workforce Education and Training (WET) component is to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings to county staff and contracting community partners that promote well-being, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern California Regional Partnership (SCRP) of WET Coordinators. WET Coordinators from neighboring counties collaborate on and coordinate mutual projects such as trainings, core competencies and conferences to increase workforce diversity and opportunities in the public mental health system.

Following the passage of Proposition 63, the State provided each county with a one-time funding allocation to develop its WET infrastructure. Orange County's allocation of $8,948,100 was exhausted in FY 2013-14. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET. Counties are allowed to transfer CSS funds to WET, as well as Capital Facilities and Technological Needs (CFTN) and the Prudent Reserve, so long as the total amount of the transfers within a fiscal year do not exceed 20% of the County's most recent five-year average of its total MHSA allocation. Below are the FY 2019-20 funding allocations for Orange County's WET programs – described in greater detail below – designed to serve the Orange County behavioral health workforce, mental health consumers and their family members.

Collectively, WET programs continue to reach a large audience: 6,258 and 8,949 individuals attended WET trainings and activities in FY 2017-18 and 2016-17, respectively.

Workforce Education and Training Programs	FY 2019-20 Budgeted Funds
Workforce Staffing Support (CSS)	$1,140,000
Training and Technical Assistance (CSS)	$1,573,000
Mental Health Career Pathways (CSS)	$927,000
Residencies and Internships (CSS)	$238,381
Financial Incentives Programs TOTAL (CSS)	$654,225

Workforce Staffing Support (WET)

Program Serves	Typical Population Characteristics			
18+	Parents	Families	Staff/Providers/ Workforce	Regional Counties WET Coordinator, Teachers, Caregivers, Consumers, General Community Members

The program provides services in English, Spanish, Vietnamese, Farsi and Arabic.

Program Description / Impact

The Workforce Staffing Support (WSS) program performs four functions: (1) Workforce Education and Training Coordination, (2) Consumer Employment Specialist Trainings, (3) Consumer Employment Specialist One-on-One Consultations, and (4) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the Orange County behavioral health workforce, consumers, family members, and the wider Orange County community. In FY 2017-18, WSS programs provided trainings to a total of 3,108 individuals including County staff, County-contracted staff and general community members. In FY 2016-17, WSS programs provided trainings for 3,997 individuals.

Workforce Education and Training Coordination:

Orange County WET regards coordination of workforce education and training as a key strategy to promoting recovery, resilience, and culturally competent services. As part of WSS, multidisciplinary staff members design and monitor WET programs, research pertinent training topics and contents, and provide and coordinate trainings. In FY 2015-16, staff members sought to increase training access by launching an online training program that offered Continuing Education (CE) and Continuing Medical Education (CME) credits. This online service provided an alternative to County and County-contracted providers who otherwise would not be able to attend a live training. WET provided nine online trainings in FY 2016-17 and also in FY 2017-18.

In addition, WET provided a large number of in-person professional development trainings in FYs 2016-17 and 2017-18. Training topics included Law and Ethics, 5150/5585 Involuntary Hospitalization and Designation, Patients' Rights Respect and Dignity, Rights for Individuals in Inpatient and Outpatient Mental Health Facilities, Developing and Enhancing Competence in Clinical Supervision, Housing Placement, Raising Awareness About First Episode of Psychosis, Response to Active Shooters, Meeting of the Minds, Continuum of Care, and Understanding ASAM Criteria in the Context of the California Treatment System.

The Multicultural Development Program (MDP), which falls under WET, consists of staff with language proficiency and culturally-responsive skills who support the workforce by providing trainings on various multicultural issues and by providing translation/interpretation services. A total of 122 interpretations in FY 2017-18 and 104 interpretations in FY 2016-17 in Spanish, Vietnamese, Arabic, Farsi and ASL were conducted at MHSA Steering Committee and other community meetings. MDP staff also translated, reviewed and field-tested a total of 254 documents in FY 2017-18 and 419 documents in FY 2016-17 into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic. In addition, a Licensed Marriage Family Therapist (LMFT) serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American-Signed-Language (ASL) interpretation support is provided at trainings and MHSA Steering Committee and community meetings.

In FY 2017-18, the Ethnic Services Manager and staff continued organizing the Cultural Competence Committee meetings. The Committee consists of multi-ethnic partners and multi-cultural experts in Orange County. A total of 219 (duplicated) and 223 (duplicated) in FY 2017-18 and FY 2016-17, respectively, committee members attended and provided input on how to incorporate cultural sensitivity and awareness into the BHS system of care. The goal of these activities was to provide linguistically and culturally appropriate behavioral health information, resources and trainings to underserved consumers and family members.

Consumer Employment Specialist Trainings/Consumer Employment Specialist One-on-One Consultations:

As part of WSS, a Consumer Employment Support Specialist works with Behavioral Health Services, contract providers and community partners to educate consumers on disability benefits. The specialist provided trainings on topics such as Ticket-to-Work, Reporting Overpayment, Housing, 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.

Liaison to Regional Workforce Education and Training Partnership:

The Liaison represents Orange County in the following activities: coordinating regional educational programs; disseminating information and strategies regarding consumer and family member employment throughout the region; sharing strategies that increase diversity in the public mental health system workforce; disseminating Orange County program information to other counties in the region; and coordinating regional actions that can take place in Orange County.

Training and Technical Assistance (WET)

Program Serves	Typical Population Characteristics					
18+	Parents	Families	Students	Law Enforcement	Staff/Providers/ Workforce	Teachers, Caregivers, Consumers, General Community Members

The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, and ASL.

Program Description/Impact

The Training and Technical Assistance (TTA) program offers trainings on evidence-based practices, the consumer and family member perspective, and multicultural competency for mental health providers, and mental health training for law enforcement. In FY 2017-18, TTA provided a total of 88 trainings for 2,573 attendees, which are described in more detail below. In FY 2016-17, TTA provided 112 trainings for 3,465 attendees.

FY 2017-18: 49 Trainings, 1,380 Attendees

FY 2016-17: 57 Trainings, 1,318 Attendees

Evidence-Based Practices:

Trainings on Evidence-Based Practices were conducted to help behavioral health providers stay current on best practice standards in their field. County and contracted staff, community partners, consumers and their family members attended evidence-based training on topics such as Mental Health First Aid, Eye Movement Desensitization and Reprocessing (EMDR), Nonviolent Crisis Intervention Training, Motivational Interviewing, Trauma Focused Cognitive Behavioral Therapy, Treating Trauma and Substance Use, and Dialectical Behavioral Therapy.

Consumer and Family Member Perspective:

Consumers and their family members sat on a panel where they shared their lived experience with County and County-contracted behavioral health personnel. The panel members presented on their lived experiences to help reduce stigma and to raise awareness of behavioral health conditions.

FY 2017-18: 6 Trainings, 230 Attendees

FY 2016-17: 9 Trainings, 378 Attendees

Cultural Competence:

FY 2017-18: 7 Trainings, 563 Attendees

FY 2016-17: 30 Trainings, 1,324 Attendees

Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Caring for Gender Nonconforming and Transgender Youth, Clinical Considerations when Working with Patients and Families from the Sikh Faith, Mindful Listening, Role of Forgiveness in Psychotherapy, Spirituality and Therapy, and Bio-Spiritual Focusing. Beginning in FY 2017-18, WET consolidated several content-specific trainings into a single, comprehensive training, which accounts for the decreased numbers in FY 2017-18 since participants no longer had to attend multiple trainings throughout the year.

Crisis Intervention Training for Law Enforcement:

FY 2017-18: 26 Trainings, 400 Attendees

FY 2016-17: 15 Trainings, 372 Attendees

The best-practice Crisis Intervention Training (CIT) was provided to Orange County law enforcement officers to help raise their awareness about the mental health needs of the community. As first responders, law enforcement officers can help provide linkages to available mental health resources when responding to mental health crises. The 16-hour CIT I curriculum was conducted by a psychologist, subject matter experts, law enforcement, contracted providers, and individuals living with mental illness and their family members. In FY 2015-16, an eight-hour CIT II class was added to the Professional Officer Standards Training (POST) and Standards and Training for Corrections (STC) certified curriculum to include training on Dementia, Developmental Disorders-including Autism Spectrum Disorder, and how to work with Deaf-and-Hard of Hearing individuals. An Interactive Video Simulator with behavioral health scenarios provided hands-on training and prepared law enforcement officers and public safety personnel to identify the various needs of individuals grappling with mental health, substance use, dual diagnosis and homelessness. CIT III provides an overview of signs and symptoms of community services available and identifies mental illness procedures within the justice system.

Mental Health Career Pathways (WET)

Program Serves	Typical Population Characteristics									
18+	Foster Youth	Parents	Families	LGBTIQ	Veterans	Homeless/ at-Risk	Co-Occurring SUD	Students	Criminal Justice	Staff/Providers/ Workforce

The program provides services in English, Spanish, Vietnamese, Farsi, and ASL.

Program Description/Impact

Mental Health Career Pathways offers courses through the Recovery Education Institute (REI), which prepares individuals living with mental illness and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff has personal lived experience. In FY 2017-18, REI provided 156 total trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% identified as both. In FY 2016-17, REI provided 187 total trainings to 750 active students. In FY 2016-17, REI provided 187 total trainings to 750 active students. Of the 223 newly enrolled students, 54% identified themselves as living with a behavioral health condition, 30% identified themselves as family members of those living with a behavioral health condition and 16% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. REI enrolled 292 new students in FY 2017-18 and 223 in FY 2016-17. The number of one-on-one support sessions provided to students is reported to the right.

At REI, a wide variety of trainings are offered including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence. REI collaborates with adult education programs, links students to local community colleges for prerequisite classes, and provides accredited college classes and certificate courses on-site.

REI also offers a series of pre-vocational workshops to prepare students to be in the workforce. These pre-vocational workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers ESL and

Support Sessions

	Academic Advisement	Success Coach Contacts	Total	
FY 2017-18	2,252 Duplicated	1,999 Duplicated	4,524 Duplicated	1,625 Unduplicated
FY 2016-17	2,130 Duplicated	1,119 Duplicated	2,130 Duplicated	479 Unduplicated

	FY 2017-18	FY 2016-17
Workshops and Classes	76 offered, 96% completion rate	95 offered, 66% completion rate
Pre-Vocational Courses	51 offered, 92% completion rate	65 offered, 94% completion rate
Extended Education	12 offered, 71% completion rate	10 offered, 71% completion rate
College Credit Courses	17 offered, 70% completion rate	17 offered, 93% completion rate

GED classes for students to benefit employment opportunities. As can be seen on the previous page, a high percentage of students completed the REI workshops and classes that were offered in FY 2017-18. This jump in completion rate from FY 2016-17 is due to an administrative efficiency created when WET consolidated classes and workshops and staff were better able to track course completion rates.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental illness and evidence-based practices to name a few. To receive certification, students must complete nine three-unit courses and a two-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies.

Residency and Internship Programs (WET)

Program Serves	Typical Population Characteristics	
18+	Students	Staff/Providers/Workforce

The program provides services in English and has a TDD number for hearing impaired callers.

Program Description/Impact

The Residencies and Internships program trains and supports individuals who aspire to work in the public mental health system. In FY 2017-18, six pre-doctoral student interns participated in the California Psychology Internship Council (CAPIC) program and volunteered an estimated total of 12,000 clinical hours. In FY 2016-17, eight pre-doctoral students participated in the program and volunteered an estimated total of 15,000 clinical hours. All CAPIC students were placed in a behavioral health program during FY 2017-18, with four student interns placed at WET's Neurobehavioral Testing Unit (NBTU) and two placed at Children Youth Behavioral Health (CYBH) sites. All interns were supervised by a licensed psychologist.

In collaboration with the Psychiatry Department at the University of California Irvine (UCI) School of Medicine, WET funded five residencies and three fellowships in FY 2017-18 and six residencies and three fellowships in FY 2016-17. The psychiatry residents and fellows provided a total of 3,280 clinical hours in FY 2017-18 and 3,744 clinical hours in FY 2016-17. Supervised trainings provided in the program 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 used to address the shortage of child and community psychiatrists working in community mental health.

	Psychology Interns	Psychiatry Fellows	Psychiatry Residents
FY 2017-18	6	3	5
	12,000 Clinical Hours	1,200 Clinical Hours	2,080 Clinical Hours
FY 2016-17	8	3	6
	15,000 Clinical Hours	1,248 Clinical Hours	2,496 Clinical Hours

Financial Incentive Programs (WET)

Program Serves	Typical Population Characteristics
18+	Staff/Providers/Workforce

The program provides services in Spanish, Vietnamese, and Korean.

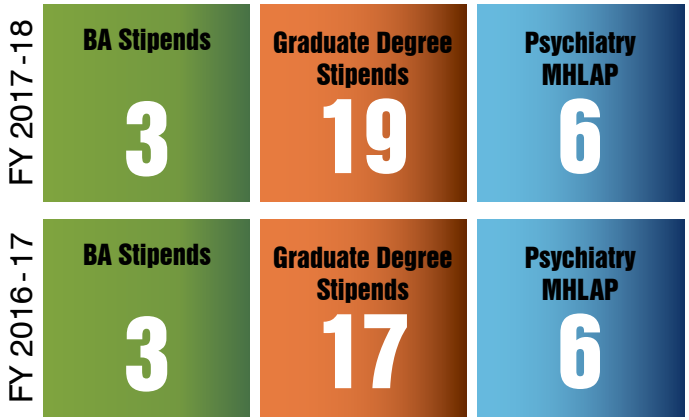
Program Description/Impact

As part of the current Three-Year Plan, the Financial Incentives Programs category now contains two tracks: the Financial Incentive Program for college students and the Psychiatrist Loan Repayment Program. The former program provides financial incentive stipends to BHS County employees at the Bachelor (BA/BS), and Masters (MA/MS) levels to expand a diverse bilingual and bicultural workforce. The Orange County WET Office collaborates with numerous colleges and universities to provide stipends to students who, in return, are encouraged to work for County or County-contracted agencies upon their graduation. In FY 2017-18, tuition incentives were provided to 22 staff, three of whom were undergraduates and 19 of whom were Masters' degree candidates. More than half of staff enrolled in FIP self-identified as Mexican or Hispanic (54.6%). The remaining staff were either from Asian (27.2%) or European (18.2%) decent. While over one-third of staff indicated their primary language as English (36.3%), a large proportion indicated they spoke more than one language (45.5%). In FY 2016-17, tuition incentives were provided to 20 staff, three of whom were undergraduates and 17 of whom were Master's degree candidates. Eleven identified as Mexican or other Latino, 10 of whom reported Spanish as their primary language, and six identified as Asian and Pacific Islander.

Beginning in FY 2015-16, Financial Incentives Programs introduced the Orange County Mental Health Loan Assumption Program (OC-MHLAP) for psychiatrists. The program attempts to address the shortage of community psychiatrists working in the Orange County Public Mental Health System (PMHS) that is further impacted by strong recruiting competition from private sector organizations and other governmental agencies. To be eligible for the program, an award recipient must work in the County PMHS in exchange for the loan assumption. This additional OC-MHLAP program will help achieve staffing goals and enhance the quality of care to Orange County's population by improving the recruitment and retention of qualified psychiatrists. In FY 2017-18, a total of six psychiatrists participated in the Loan Repayment Program. In FY 2016-17, eight psychiatrists participated.

Program Outcomes

During FY 2017-18, BHTS conducted a survey with all staff who had participated in FIP since its inception. This survey was sent out to roughly 114 staff who previously participated in FIP, and a total of 27 staff responded (24% response rate). Of those who responded, the majority of participants self-identified as female (70%) and were between the ages of 26-59 (93%). A large proportion of participants indicated their racial or ethnic background as being either Mexican or other Latino (42%), Caucasian/White (15%), Vietnamese (12%), or Multi-Ethnic (12%). Participants were also asked about their employment and educational goals. After completing FIP, those surveyed reported that they were more likely to be promoted and/or earn advanced degrees (e.g., Bachelor's or Master's).



CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

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

1. Capital Facilities funding may be used to purchase, build or renovate land and/or facilities for the delivery of MHSA services for mental health clients and their families or used for MHSA administrative offices.

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

Counties were initiall given one-time allocation to cover both purposes, and had the discretion to divide the funding between Capital Facilities and Technological needs. Orange County received slightly more than $37 million for this component. Of that amount, 35% was allocated to Capital Facilities and 65% was allocated to Technology. This initial allocation has been spent and CFTN projects are now funded through transfers from CSS as allowed by the Act and accompanying regulations.

Capital Facilities

Requirements for CF Funds

A county may use MHSA Capital Facility funds for the following types of projects:

- Acquire and build upon land that will be county-owned
- Acquire buildings that will be county-owned
- Construct buildings that will be county-owned
- Renovate buildings that are county-owned
- Renovate buildings that are privately-owned and dedicated and used to provide MHSA services if certain provisions are met (i.e., renovations benefit MHSA clients or MHSA administration's ability to provide services/programs in the 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 Capital Facilities funds, and/or personnel cost directly associated with a CF project, i.e., a project manager, with the reserve controlled, managed and disbursed by the county.

In addition, the California Department of Mental Health outlined the following requirements for CF funds:

- Capital Facilities 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 Community Services and Supports and Prevention and Early Intervention 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 twenty 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 Capital Facilities funds is not feasible.

For purchase of land with no MHSA funds budgeted for construction of a building or purchase of a building (i.e. modular, etc.), the County must explain its choice and provide a timeline with expected sources of income for the planned construction or purchase of building upon this land and how this serves to increase the County's infrastructure.

Use of One-Time CF Allocation

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

Programs that occupy the Tustin Street Facility include the:

1. Wellness/Peer Support Center - Central, which facilitates over 85 groups weekly, including social outings, and has a growing number of members volunteering in the community as their way of giving back.
2. AOABH Crisis Residential Program, which serves as an alternative to hospitalization for individuals experiencing a behavioral health crisis who may be at-risk of psychiatric hospitalization.
3. Education and Training Center, which provides support to individuals living with mental illness and their families who want to enhance living skills or basic education, or aspire to a career in mental health.

CSS Transfers to CF

Youth Core Services Renovations: A one-time $200,000 transfer to CFTN from unspent FY 2017-18 Youth Core Services funds will be used to cover upgrade costs to a County-owned CYBH facility that houses MHSA staff and/or serves MHSA clients. Renovations will bring the facility up to code to meet safety and American's with Disabilities Act, etc. regulations. Renovations began in FY 2018-19 and are expected to be finished in FY 2019-20.

Crisis Stabilization Unit (CSU) Renovations: In FY 2018-19, the HCA was approved to transfer CSS funds to CFTN for capital expense renovations to space that will be used for one or MHSA-funded Crisis Stabilization Units. Due to contract negotiations, renovations will be carried over to FY 2019-20.

Behavioral Health Training Services Renovations: Beginning in FY 2018-19, the HCA will divert CSS funds from WET to CFTN for capital expense renovations to a long-term leased space used for the Behavioral Health Training Center. WET offers and facilitates hundreds of trainings to the Orange County behavioral health workforce each year, and has faced challenges in finding appropriate locations and workshops in which to provide them. This center will be able to accommodate up to 200 people with dedicated parking, and have the flexibility to provide multiple rooms for breakout sessions for smaller workshops as needed. This site will also be made available to the community for planning and meeting space. The total amount approved for the renovations will not exceed $650,000 and will be transferred incrementally over the course of the 10-year lease.

Anita Drive Wellness Campus: In the 2016 Strategic Financial Plan, a need for a wellness campus designed to provide urgent behavioral health care in Orange County was identified as a strategic priority. Since that time, the Health Care Agency (HCA) has worked collaboratively with the County's CEO Office/Real Estate to identify a building at 265 S. Anita Drive in the City of Orange. Following the community planning process in FY 2017-18 and subsequent Board of Supervisors approval, Orange County transferred $7.8 million in CSS funds to Capital Facilities for the purchase of the property.

The HCA program planning process for the Anita Wellness Campus has evolved in parallel with the co-creation of Be Well OC. Be Well OC is a coalition of Orange County behavioral health stakeholders, both in the private and public sectors, and includes HCA, CalOptima, hospital systems, nonprofit, academic and faith-based organizations. An opportunity emerged for a public-private partnership between HCA and Mind OC to design and construct a 60,000 square foot building for the purpose of providing co-located mental health and substance use disorder services for all resident of Orange County.

The Orange County MHSA Steering Committee was presented with initial Anita Wellness Campus construction estimates in December 2018 and then a projected $16.6 million contribution in MHSA/CFTN funds at the January 28, 2019 meeting. No objections to the funding estimates were made by committee members.

The Wellness Campus, once constructed, proposes to include mental health and substance use disorder services that include but are not limited to:

- Wellness and Social Services (community based organization resources for Anita residents)
- Crisis Stabilization Unit (CSU) for adults and adolescents ages 13 and older
- Crisis Residential
- Substance Use Disorder Intake & Referral
- Withdrawal Management
- Substance Use Disorder and Co-Occurring Residential Treatment

The Orange County Board of Supervisors unanimously approved the allocation of MHSA Capital Facilities and Technological Needs Funds to construct this Wellness Campus and the establishing of an agreement with Mind OC for construction and operation of the facility.

Technological Needs

Requirements for Use of Technology Funds

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

1. It must fit in with the State's long-term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.
2. It must be part of and support the County's overall plan to achieve an Integrated Information Systems infrastructure through the implementation of an Electronic Health Record (EHR).

Use of Technology Funds (One-Time and CSS Transfers)

Behavioral Health Services (BHS) is implementing a fully integrated EHR system that supports the goals of MHSA to promote well-being, recovery and resilience. It also aims to comply with the federal requirements for Meaningful Use which is a standard designed to benefit the individuals served. This is a large, on-going project that has been divided into three phases spanning several years, and includes acquisition and implementation of software, technology infrastructure upgrades and services to develop and implement the overall system.

The first phase of the project plan culminated in the completion of enhanced functionality to the BHS EHR (Integrated Records Information System or IRIS), and successful implementation at a pilot clinic. The enhancements included documentation software designed to help clinicians avoid common errors, as well as electronic prescription software to help psychiatrists manage clients' prescriptions. Additional technical improvements to the EHR include document imaging (which includes functionality such as electronic signature pads and the ability to scan documents), compliance monitoring, auditing and reporting for privacy and security, and enhanced disaster recovery. BHS also successfully implemented kiosks that provide individuals with mental illness and their family members with increased access to computers and the internet at several BHS County-operated outpatient clinics.

The second phase of the project is nearing completion. Technology infrastructure and software enhancements to support additional staff use of the EHR are ongoing. The client portal has been implemented and voice-activated documentation for staff with physical challenges

is being piloted at select location. Overall, implementation of the EHR at the County-operated outpatient Mental Health clinics has gone very well and user acceptance is extremely high.

The final phase will address the County's ability to interface securely with its contract providers and to participate in consent-based Health Information Exchanges outside County Behavioral Health Services, as appropriate, including continued compliance with the federal EHR Meaningful Use program. An additional $6,499,139 is being transferred from CSS to bring the FY 2019-20 TN budget to $11,142,797 including administrative fees. These funds will cover hardware and software server costs; comprehensive data analytics software; and other EHR and data warehouse upgrades.

Special Projects

Orange County Special Projects are projects that are unique in scale or scope and may cross over several Support Levels and/or Service Functions, often because they involve multiple services, systems and/or agencies.

Mental Health Technology Suite (INN)

Special Projects	Estimated Number to be Served FY 2019-20	Annual Budgeted Funds FY 2019-20	Estimated Annual Cost Per Person FY 2019-20
Mental Health Technology Solutions (INN)	TBD	$8,000,000	TBD

Target Population and Project Characteristics/Background

The Mental Health Technology Suite (i.e., Tech Suite) is a cross-county collaborative project that brings interactive technology-enhanced mental health solutions into the public mental health system through a highly innovative set or "suite" of internet-based and/or mobile applications (i.e., apps). The Tech Suite aims to provide diverse populations with free access to mobile apps designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral decline, connect individuals seeking help in real time, and/or increase user access to mental health services when needed.

Services

The project consists of the following components:

- Technology Apps (3):
  - 24/7 Peer Chat, which will offer around-the-clock, anonymous peer chat support to an individual
  - Therapy Avatar, which will offer scripted mindfulness exercises and Cognitive Behavioral Therapy interventions customized through AI and based on a person's responses, allowing for an interactive process between the person and the Avatar
  - Customized Wellness Coach, which will provide 24/7 telehealth services informed by digital biomarkers (i.e., motor movements on a phone touchscreen such as keystrokes, taps and swipes) that may allow for the earlier detection of emotional, behavioral or functional decline
- Marketing and Outreach
- Evaluation

This project was approved by the Mental Health Services Oversight and Accountability Commission on April 26, 2018. The primary purpose of this project is to increase access to mental health services to underserved groups, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

Strategies to Promote Recovery/Resilience

The technology apps each play a significant role in promoting resilience and recovery. The 24/7 Peer Chat component offers support to individuals with behavioral health concerns, helping individuals build resilience and/or supporting them through their recovery. The Therapy Avatar provides evidence-based interventions to aid in symptom management. Lastly, the Customized Wellness Coach allows an individual's existing Behavioral Health Services provider to offer telehealth support tailored to each individual's needs. Taken together, the suite of apps supports individuals at different stages of their mental health journey and are available when most traditional services are not available.

Strategies to Increase Timely Access to Services for Underserved Populations

Many individuals cannot access services in a timely manner due to challenges related to transportation, finances, employment and/or childcare. Some may also hold cultural beliefs that deter them from seeking help in traditional outpatient settings. Technology has the potential to address these barriers and increase timely access to services through its large-scale impact and around-the-clock access to services and support. The Peer Chat, Therapy Avatar and Customized Wellness Coach offer access to support at any time during the day or night via an internet-connected computer and/or smartphone, increasing the options available to individuals seeking help. Whenever possible, app services will also be available in County threshold languages to reduce barriers related to accessing services.

Strategies to Reduce Stigma and Discrimination

By allowing anonymity and/or privacy when engaging in services, mental health support services offered through technology can offer a sense of safety and security for individuals who experience stigma or shame associated with mental illness and are therefore reluctant to seek services in clinics or other public locations.

Outcomes

Orange County joined the Tech Suite in April 2018 and has been actively collaborating with CalMHSA, the other counties and identified vendors to build the project infrastructure and prepare the county system to implement technology-enhanced mental health services. Outcomes will be reported in future Plan updates.

Orange County's Additional Component to the Technology Suite Project (INN)

Special Projects	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Orange County Additional Component to Technology Suite*	TBD	TBD	TBD

* *Project features, elements and budget are subject to change based on on-going stakeholder input*

Proposed Target Population and Project Characteristics

With the approval of the Mental Health Technology Suite project, counties were also afforded an opportunity to propose additional components to the core suite of applications. Orange County plans to propose an additional component that will be available to all County residents and designed to increase access to behavioral health services and supports.

In conjunction with the planning process for the Mental Health Technology Suite project, Orange County facilitated ongoing, weekly meetings from December 2017 through January 2018, to develop the general concept for this additional component. Community planning meetings are expected to continue until the concept is more developed.

Services

The additional Orange County component will include several features to assist individuals in key areas related to mental health, including:

- Housing Assistance (i.e., matching individuals to real-time available housing and providing therapeutic support to promote housing stability)
- Transportation Assistance (e.g., step-by-step directions on how to travel to appointments)
- Coordinated Care (e.g., automated reminders/alerts, etc.)
- Education/Resources (customized to Orange County resources); and
- Crisis Management (pre-crisis/crisis/post-crisis management)
- Social media and mental health, including stigma reduction - Recently added as a result of community engagement meetings through the County in 2018

General features of this app will include:

- Synchronization with the Mental Health Technology Suite of apps
- Face-to-face peer support and case management for individuals currently receiving
- County behavioral health services to assist with system navigation and technical assistance with the app
- Information tailored to users, family members, healthcare providers, first responders

The primary purpose of this project will be to increase access to mental health services to underserved groups, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

This additional component is still in development. The app name, features, elements and budget may be modified based on stakeholder input during planning meetings, which are open to all Orange County stakeholders.

Whole Person Care

Special Projects	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Whole Person Care	Whole Person Care funds are included in the Peer Mentoring and BHS Outreach & Engagement program budgets		

Program Serves	Symptom Severity	Location of Services	Typical Population Characteristics
	 Severe	 Field	 Homeless/at-Risk

Target Population and Project Characteristics

Whole Person Care (WPC) is the coordination of physical, behavioral, health and social services in a person-centered approach with the goal of improving health and well-being through comprehensive, streamlined service delivery. WPC services are for MediCal beneficiaries living with serious and persistent mental illness (SPMI) and struggling with homelessness.

BHS is leveraging a total of $856,600 in MHSA funds per year for five years to draw down Whole Person Care Federal match dollars. Resulting in a total of $31 million over five years, these dollars fund an array of health services for adults participating in WPC.

- BHS Services:
  - The BHS Outreach and Engagement expansion team uses MHSA funds to identify individuals eligible for WPC and engage them into needed services ($475,927 in MHSA per year)
  - Housing Navigators address barriers that prevent BHS participants from making successful housing placements and work to increase the inventory of available units for homeless adults living with SPMI (funded by WPC)
  - Peer Mentoring expansion provides housing and tenancy-sustaining services to help WPC participants be successful in their housing placements ($380,673 in MHSA per year)
  - Recuperative/Respite Care provides recuperative care beds for homeless adults who are recovering from an acute illness or injury, are no longer in need of acute care but are unable to sustain recovery if living on the street or other unsuitable place (funded by WPC).

Statewide Early Psychosis Learning Health Care Collaborative Network (INN)

Special Projects	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Statewide Early Psychosis	50	$500,000	N/A system evaluation not service delivery

Proposed Target Population and Project Characteristics

The Statewide Early Psychosis Learning Health Care Collaborative Network will be an evaluation project led by the University of California, Davis. The goal of this project is to assess program and cost-effectiveness of early psychosis (EP) programs across the state. This Innovation project will be a collaboration with the OC CREW program. The target population or intended beneficiaries/users of this learning health care network are:

- Individuals at increased risk or in the early stages of a psychotic disorder (i.e., OC CREW participants)
- OC CREW participants' family members or other support persons
- OC CREW program staff
- State authorities and policy makers
- National networks (EPINET)

Orange County seeks to participate in this project in order to: collaborate with other counties to standardize the evaluation of early psychosis programs; establish shared learning; and apply identified strategies that will improve OC CREW participant outcomes, program impact and cost-effectiveness.

Proposed Services

The initial phase of this project will involve qualitative interviews with OC CREW program staff and the selection of core measures. The second phase will include staff trainings on selected measures, implementation and data collection. The image below illustrates the implementation and evaluation process.

This project was approved by the Mental Health Services Oversight and Accountability Commission on December 17, 2018. The primary purpose of this project is to increase the quality of mental health services, including measureable outcomes, with 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.

Proposed Outcomes

This project will bring consumer-level data to the clinician's fingertips, allow programs to learn from each other, and position the state to participate in the development of a national network to inform and improve care for individuals with early psychosis across the US. The evaluation would assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs. This will allow counties to adjust their programs based on lessons learned through multiple research approaches. This project will enable Orange County to:

Proposed Learning Healthcare Network for CA Mental Health programs

Consumer Level

Consumer and/or family enters data on relevant questionnaires or survey tools into app-bassed platform at baseline and then regular follow-up

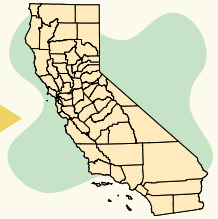
Provider Level

Clinician and/or MD can visualize responses on web-based portal for the individual over the course of treatment and share that data with the consumer during session.

Clinic Level

Program management can visualize summary of responses on portal for all consumers in clinic and iIn relation to CA average

State Level



Administrator level allows access to de-identified data across all clinics on the app for analysis

- Improve participant data collection and tracking methods
- Provide timely, effective and efficient service delivery
- Allow clinicians easy access to client-level data
- Offer participants the ability to view their data in real-time
- Engage participants in their treatment and recovery

The standardization of program outcomes proposed in the Collaborative Statewide Early Psychosis Learning Health Care Network Project parallels Orange County's current effort in standardizing metrics within its behavioral health programs. As the County works to standardize its programs at the local level, participating in this project will provide a unique opportunity to standardize and compare OC CREW outcomes to a statewide benchmark. In addition, this project will provide Orange County the opportunity to share and exchange knowledge with other counties about their early psychosis programs, adjusting the OC CREW program based on lessons learned. These lessons learned will not only contribute to improved participant outcomes, program efficiency and cost-effectiveness, but also help facilitate local planning efforts in identifying best practices for early psychosis programs.

Behavioral Health System Transformation (INN)

Special Projects	Estimated Number to be Served in FY 2019-20	Annual Budgeted Funds in FY 2019-20	Estimated Annual Cost Per Person in FY 2019-20
Behavioral Health System Transformation	N/A	$9,000,000	N/A system change project, not service delivery

Proposed Target Population and Project Characteristics

Local community planning efforts from 2016 to the present have identified a need to transform Orange County's behavioral health system to better meet the needs of the community. Right now, people too often don't get the right care at the right time and face obstacles such as figuring out how services will be paid for and where to turn for care in a very complex system. To address this problem, community stakeholders have identified the need for a partnership between the public and private health care systems that can work together to build a culturally responsive and inclusive system that allows everyone to get the behavioral health care they need, at the right time and the right place, no matter who is paying.

The first example of this public-private partnership for systems change in Orange County will be regional wellness campuses. The wellness campuses will include a variety of mental health and substance use disorder treatment programs that a client can access based on their health need and not their insurance status or type of insurance plan.

Developing the campuses and the bigger system changes requires sorting out three main issues: site selection, clinic operations, and the innovative systems changes. The primary focus of this innovation project is on the systems changes, planning the building blocks for a more responsive behavioral health system. Through this Innovation project, Orange County will develop the concepts needed to introduce a new approach to behavioral health services to improve the quality of services for everyone in the community.

Proposed Services

This Innovation project is a proof of concept on how best to create a system that will serve individuals in need of behavioral health services, regardless of payer source. The purpose of this project is to determine what ways Orange County can braid funding sources and work with regulations so that the person being served is the center of patient care and not the payment source. This proof of concept will involve the planning and early development of the following components:

- Performance- & Value-Based Contracting (PB/VBC)
- OC Community External Quality Review Organization (OC-EQRO)
- Cross-System Peer & Fiscal Navigation
- Digital Resource Directory
- Managed Behavioral Health Organization (MBHO)

The primary purpose of this project is to promote interagency and community collaboration related to mental health services or supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including but not limited to, prevention and early intervention.

Performance- & Value-Based Contracting (PB/VBC)

This component proposes to plan and develop provider contracts that pay for achieving meaningful client, clinical, and administrative goals and outcomes. This planning will focus on finding ways to pay for service quality and improved client outcomes rather than just how many services are provided. Early development activities for this component include, but are not limited to:

- Meetings with Department of Health Care Services (DHCS)
- Outlining methods for contract development
- Facilitating local planning meetings with community members and stakeolders to ensure engagement and for guidance and feedback
- updating the Mental Health Services Oversight and Accountability Commission (MHSOAC) on progress
- Providing Technical Assistance to providers
- Executing initial Request for Proposals (RFPs) and contracts
- Developing the Innovation implementation proposal

OC Community External Quality Review Organization (OC-EQRO)

This component proposes to plan the development of an organization that can conduct analysis and evaluation of information on how providers are doing with regard to quality, timeliness, and access to services to support quality improvement and monitor performance of programs. Early development activities for this component include, but are not limited to:

- Meetings with DHCS
- Outlining an ideal model
- Facilitating local planning meetings with community members and stakeholders to ensure engagement and for guidance and feedback
- Establishing provider standards and desired metrics
- updating the MHSOAC on progress
- Developing the Innovation implementation proposal

Cross-System Peer & Fiscal Navigation

This component proposes to plan how to offer 24/7 navigation assistance for clinical needs to clients and families by persons with lived experience, including parent partners, as well as how to offer financial/billing support for services received in this shared behavioral health care system. Early development activities for this component include, but are not limited to:

- Outlining proposed roles and duties of peer navigators
- Outlining proposed roles/duties of financial navigators
- Facilitating local planning meetings with community members and stakeholders to ensure engagement and for guidance and feedback
- updating the MHSOAC on progress
- Defining the scope (e.g., training, 24/7 staffing pattern, etc.)
- Developing the Innovation implementation proposal

Digital Resource Directory

This component proposes to plan how to create and maintain a dynamic online curated resource directory to assist navigation, allowing providers to keep their information updated and for client reviews of resources. This planning will be informed by a tool developed to assess community needs and strengths across social determinant and mental health domains. Early development activities for this component include, but are not limited to:

- Outlining the scope of the digital resource directory
- Identifying local stakeholders to include in planning groups
- Facilitating local planning meetings with community members and stakeholders to ensure engagement and for guidance and feedback
- updating the MHSOAC on progress
- Developing the social determinants survey
- Building the digital directory and survey
- Beta testing and ongoing revisions
- Developing the Innovation implementation proposal

Managed Behavioral Health Organization (MBHO)

This component proposes to plan how to create a network of providers who will serve clients regardless of payer source and can address cultural needs currently unmet by existing systems/services (e.g., Veterans, ethnic communities, deaf and hard of hearing, LGBTQ, etc.). This will also involve planning how to establish universal reimbursement rates in coordination with payer sources and establish processes for verifying providers' stated expertise/training and credentials. Early development activities for this component include, but are not limited to:

- Meetings with DHCS
- Outlining an ideal model
- Identifying potential vendor qualifications

- Contracting with a qualified vendor
- Facilitating local planning meetings with community members and stakeholders to ensure engagement and for guidance and feedback
- Developing the MBHO organizational structure, etc.
- Identifying all state and federal rules and regulations
- updating the MHSOAC on progress
- Developing the Innovation Implementation proposal

Additional activities are required to support the Infrastructure for this proof of concept proposal. These include Evaluation, Backbone and Legal Support, Joint Powers of Authority/Fiscal Intermediary, and Administrative Costs. A description of each activity and respective budget is provided below.

Evaluation

Activities include but are not limited to:

- Outlining the scope of the Proof of Concept evaluation
- Evaluating the Proof of Concept Project
- Writing the Proof of Concept final report
- Developing the Innovation implementation evaluation proposals

Backbone and Legal

Activities include but are not limited to:

- Managing, coordinating, and supporting the overall work of the planning project, including relationships with vendors and stakeholders

Administrative

Activities include but are not limited to:

- Managing, coordinating, and supporting the overall work of the planning project, including relationships with vendors and stakeholders

Joint Powers of Authority/Fiscal Intermediary

Activities include but are not limited to:

- Facilitating and coordinating all stakeholders to move forward with the overall system changes
- Providing the structure, finance administrative services, and expert counsel to ensure the project is successful and compliant with fiscal requirements
- Tax, audit, lobbying filings and other services to ensure project is in full compliance with local, state, and federal regulations

The primary purpose of this project is to promote interagency and community collaboration related to mental health services or supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including but not limited to, prevention and early intervention.

Exhibits and Appendices

EXHIBIT A: BUDGET EXHIBIT

FY 2019-20 Mental Health Services Act Annual update
Funding Summary

County: **Orange**

Date: **2/27/2019**

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
Estimated FY 2019-20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	37,705,128	38,866,848	31,273,494	0	5,200,000	
2. Estimated New FY 2019/20 Funding	124,032,000	31,008,000	8,160,000	0	0	
3. Transfer in FY 2019/20[a/]	(28,673,079)			5,085,282	23,587,797	0
4. Access Local Prudent Reserve in FY 2019/20	d1) 22,898,208 d2) 26,319,779	d1)3,421,571 d2) 0				0
5. Estimated Available Funding for FY2019/20[b/]	d1) 155,962,257 d2) 159,383,828	d1) 73,296,419 d2) 69,874,848	39,433,494	5,085,282	28,787,797	
Estimated FY2019/20 Expenditures	d1) 155,962,257 d2) 159,383,828	d1) 43,490,187 d2) 43,490,187	20,003,788	5,085,282	28,787,797	

Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2018	59,578,548
2. Contributions to the Local Prudent Reserve in FY 2018/19	0
3. Distributions from the Local Prudent Reserve in FY 2018/19	0
4. Estimated Local Prudent Reserve Balance on June 30, 2019	59,578,548
5. Contributions to the Local Prudent Reserve in FY 2019/20	0
6. Distributions from the Local Prudent Reserve in FY 2019/20	(26,319,779)
7. Estimated Local Prudent Reserve Balance on June 30, 2020	33,258,769

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

[b/] *Estimated expenditures for CSS for FY 19/20 are anticipated to be within fund limits available but are budgeted at full program costs. Historical trends show actual expenditures to be under the annual budget due to various factors, such as unanticipated revenue offsets or cost savings. The Financial Team monitors and projects the revenue and expenditures throughout the fiscal year to ensure funds are not overspent.*

[c/] *Maximum Prudent Reserve amount for FY 2019-20 is capped at the average of 33% of the previous 5 FY's CSS allocation. Orange County's Maximum Prudent Reserve amount for FY 2019-20 is $36,198,829. Minimum Prudent Reserve amount for FY 2019-20 is capped at the average of 23% of the previous 5 FY's CSS allocation. Orange Counties Minimum Prudent reserve amount for FY 2019-20 is $25,229,487. Orange County's current Prudent Reserve Balance is $59,578,548. Guidance to transfer excess Prudent Reserve balance has not been established at the time of this Plan update. Orange County will comply when guidance is provided by DHCS.*

[d/] *Pending the release of new State legislation from DHCS that will change previous guidence, Prudent Reserve(PR) funds over the 33% Cap of the average of the Previous 5 FY's CSS allocation will need to be transferred entirely to CSS or will be transferred to CSS and PEI porportionately to which components originally funded the PR. Both methods are displayed above and identified as "d1" or "d2". Orange County will follow DHCS's guidence on how to handle PR when DHCS confirms the proper method.*

[d1/] *Info Notice 19-017 directs counties to transfer Prudent Reserve funds over the 33% Cap to CSS and PEI proportionately to which components originally funded the PR. This transfer is required to be made for FY 19/20, prior to June 30, 2020.*

[d2/] *Proposed changes to Fiscal Regulations to DHCS 16-009 directs counties to transfer Prudent Reserve funds over the 33% Cap entirely to CSS. This transfer is required to be made for FY 19/20, prior to June 30, 2020.*

FY 2019-20 Mental Health Services Act Annual update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	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
Intensive Outpatient (FSP Programs)						
1. Children's Full Service Partnership/Wraparound	12,927,089	11,054,575	1,872,514	0	0	0
2. Children and Youth Behavioral Health Program of Assertive Community Treatment	1,400,000	1,100,000	300,000	0	0	0
3. Transitional Age Youth Full Service Partnership/ Wraparound	9,713,532	8,184,468	1,529,064	0	0	0
4. Adult Full Service Partnership	26,299,314	21,592,093	4,510,471	0	0	196,750
Adult Program of Assertive Community Treatment	0	0	0	0	0	0
5. Adult Transitional Age Youth Program of Assertive Community Treatment	10,874,382	9,028,018	1,758,158	0	0	88,206
6. Assisted Outpatient Treatment	5,367,205	5,015,841	344,200	0	0	7,164
Mental Health Court - Probation Services	0	0	0	0	0	0
7. Older Adult Full Service Partnership	2,891,800	2,683,249	201,965	0	0	6,586
8. Older Adult Program of Assertive Community Treatment	771,034	671,632	91,590	0	0	7,812
FSP Percent of Non Admin Programs Below	16,652,956	14,020,459	2,309,300	0	0	323,197

FY 2019-20 Mental Health Services Act Annual update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Non-FSP Programs Navigation/Access and Linkage to Treatment						
1. BHS Outreach and Engagement	1,027,973	1,027,973	0	0	0	0
2. Correctional Health Services: Jail to Community Re-Entry	2,600,000	2,600,000	0	0	0	0
3. The Courtyard (outreach)	855,000	855,000	0	0	0	0
Crisis						
4. Children's CAT	1,737,613	1,145,613	392,000	0	0	200,000
5. Adult and TAY CAT/PERT	4,789,441	4,419,151	340,216	0	0	30,074
6. Crisis Stabilization Units	3,527,500	3,527,500	0	0	0	0
7. Children's In-Home Crisis Stabilization	497,076	325,644	171,432	0	0	0
8. Adult/TAY In-Home Crisis Stabilization	1,487,500	1,275,000	212,500	0	0	0
9. Children's Crisis Residential	993,224	896,474	96,750	0	0	0
10. TAY Crisis Residential	85,318	74,568	10,750	0	0	0
11. Adult Crisis Residential	3,421,617	2,600,983	785,802	0	0	34,832

FY 2019-20 Mental Health Services Act Annual update
Community Services and Supports (CSS) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Outpatient Treatment						
12. Youth Core Services	7,170,000	5,370,000	1,800,000	0	0	0
13. OC Children with Co-Occurring Mental Health Disorder	750,000	300,000	450,000	0	0	0
14. Integrated Community Services	1,648,000	1,648,000	0	0	0	0
15. Recovery Center/Clinic Recovery (Open Access)	11,350,240	8,289,360	2,962,529	0	0	98,351
16. Older Adult Services	2,026,474	1,568,047	428,426	0	0	30,001
Supportive Housing						
17. Housing and Year Round Emergency Shelter	957,026	957,026	0	0	0	0
18. Bridge Housing for Homeless	1,000,000	1,000,000	0	0	0	0
19. OCCR Housing MOU	68,144	68,144	0	0	0	0
20. CSS Housing	30,500,000	30,500,000	0	0	0	0
Residential Treatment						
Adolescent Dual Diagnosis Residential Treatment	0	0	0	0	0	0
21. Adult Dual Diagnosis Residential Treatment	50,000	50,000	0	0	0	0

FY 2019-20 Mental Health Services Act Annual update
Community Services and Supports (CSS) Component Worksheet

County: **Orange**

Date: **2/27/2019**

	Fiscal Year 2019-20					
	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
Recovery and Supportive Services						
22. Mentoring for Children and Youth	500,000	500,000	0	0	0	0
23. Peer Mentoring	4,249,888	4,249,888	0	0	0	0
24. Wellness Centers	2,766,198	2,766,198	0	0	0	0
25. Supported Employment	1,097,010	1,097,010	0	0	0	0
26. Transportation Program	900,000	900,000	0	0	0	0
24. Supportive Services for Residents in Permanent Supportive Housing	5,000,000	5,000,000	0	0	0	0
CSS Administration	17,833,503	17,833,503	0	0	0	0
Total CSS Program Estimated Expenditures	**195,786,057**	**174,195,419**	**20,567,666**	**0**	**0**	**1,022,972**
FSP Programs as Percent of Total	51.0%					

FY 2019-20 Mental Health Services Act Annual update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	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						
School-Related Services						
1. Connect the Tots and School Readiness	2,800,000	2,800,000				
2. School Based Behavioral Health Intervention and Support	3,408,589	3,408,589				
3. School-Based Stress Management Services	155,000	155,000				
4. Violence Prevention Education	1,352,651	1,352,651				
5. Gang Prevention Services	403,100	403,100				
Community Events and Education						
6. Training, Assessment, and Coordination Services	700,000	700,000				
7. Mental Health Community Education Events	881,000	881,000				
8. Statewide Projects (CalMHSA)	900,000	900,000				
Navigation/Access and Linkage to Treatment						
9. OCLinks	1,000,000	1,000,000				
10. BHS Outreach and Engagement	2,232,523	2,232,523				
11. Outreach and Engagement Collaborative	3,385,711	3,385,711				

FY 2019-20 Mental Health Services Act Annual update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Crisis						
12. Crisis Prevention Hotline	392,533	392,533				
Outpatient Treatment (Early Intervention)						
13. OC Parent Wellness Program	1,713,072	1,713,072				
14. Stress Free Families	575,000	575,000				
15. 1st Onset of Psychiatric Illness, OC CREW	1,500,000	1,500,000				
16. Early Intervention Services for Older Adults	2,469,500	2,469,500				
17. School-Based Mental Health Services	2,315,236	2,315,236				
18. School-Based Behavioral Health Intervention & Support - Early Intervention Services	440,000	440,000				
19. Survivor Support Services	343,693	343,693				
20. Community Counseling and Supportive Services	1,986,136	1,986,136				
21. OC ACCEPT	550,000	550,000				
22. OC4VETS	1,295,957	1,295,957				
23. College Veterans	400,000	400,000				

FY 2019-20 Mental Health Services Act Annual update
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: **2/27/2019**

	Fiscal Year 2019-20					
	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
Recovery and Supportive Services						
24. Parent Education Services	1,064,770	1,064,770				
25. Family Support Services	282,000	282,000				
26. Children's Support and Parenting Program	1,700,000	1,700,000				
27. Warmline	536,566	536,566				
Training in Physical Fitness and Nutrition	0	0				
28. Strong Families Strong Children: Behavioral Health Services for Military Families	1,000,000	1,000,000				
29. Services for TAY & Young Adults at Community Colleges & Universities	500,000	500,000				
30. Expand K-12 School-Based Mental Health Services	925,000	925,000				
31. Early Childhood Mental Health Programs Targeting Early Childcare Providers Serving Families & Children	400,000	400,000				
PEI Administration	5,882,150	5,882,150				
Total PEI Program Budget	**43,490,187**	**43,490,187**	**0**	**0**	**0**	**0**

FY 2019-20 Mental Health Services Act Annual update
Innovations (INN) Component Worksheet

County: **Orange**

Date: **2/27/2019**

	Fiscal Year 2019-20					
	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
Prevention						
Community Events and Education						
Religious Leaders Behavioral Health Training Services	0	0				
Child Focused Mental Health Training for Religious Leaders	0	0				
Access and Linkage to Treatment						
1. Step Forward: On-Site Engagement in the Collaborative Courts	93,340	93,340				
Immigrant Screening and Referrals	0	0				
Outpatient Treatment (Early Intervention)						
Early Intervention						
Strong Families - Strong Children: Behavioral Health Services for Military Families	0	0				
Whole Person Healing Initiative	0	0				
Recovery and Supportive Services						
2. Behavioral Health Services for Independent Living	402,234	402,234				
3. Continuum of Care for Veterans and Military Families	962,445	962,445				

FY 2019-20 Mental Health Services Act Annual update
Innovations (INN) Component Worksheet

County: **Orange**

Date: **2/27/2019**

	Fiscal Year 2019-20					
	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
Special Projects						
4. Mental Health Technology Suite	8,000,000	8,000,000				
OC Additional Componenet to Technology Solutions	0	0				
5. Statewide Early Psychosis Learning Health Care Collaborative Network	500,000	500,000				
6. Behavioral Health System Transformation: Identifying the Building Blocks for a Culturally Responsive and Inclusive System No Matter Who is Paying	9,000,000	9,000,000				
INN Administration	1,045,769	1,045,769				
Total INN Program Budget	**20,003,788**	**20,003,788**	**0**	**0**	**0**	**0**

FY 2019-20 Mental Health Services Act Annual update
Workforce, Education and Training (WET) Component Worksheet

County: **Orange**

Date: **2/27/2019**

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Staffing Support	1,140,000	1,140,000				
2. Training and Technical Assistance	1,573,000	1,573,000				
3. Mental Health Career Pathways Programs	927,000	927,000				
4. Residencies and Internships	238,381	238,381				
5. Financial Incentives Programs	654,225	654,225				
WET Administration	552,676	552,676				
Total WET Program Budget	**5,085,282**	**5,085,282**	**0**	**0**	**0**	**0**

FY 2019-20 33% Maximum Prudent Reserve Calculations

Funding Year	Total MHSA Allocations July 1, 2013 - June 30, 2018
FY 13/14	$99,072,771.39
FY 14/15	$138,031,688.98
FY 15/16	$115,045,914.79
FY 16/17	$149,134,711.87
FY 17/18	$161,768,522.68
5-yr Total	663,053,609.71
CSS portion of total allocation (76%)	503,920,743.38
5-yr Avg of CSS funds	100,784,148.68
Prudent Reserve Limit for FY 18/19 (33%)	**33,258,769.06**

FY 2019-20 Mental Health Services Act Annual update
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange**

Date: **2/27/2019**

	Fiscal Year 2019-20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Projects - Capital Facilities Projects						
1. Wellness Campus (Formerly Co-Located Services Facility)	16,600,000	16,600,000				
2. Youth Core Services Building Upgrades	130,000	130,000				
3. Crisis Stabilization Unit Renovations	850,000	850,000				
4. Behavioral Health Training Facility	65,000	65,000				
CFTN Projects - Technological Needs Projects						
1. Electronic Health Record (E.H.R)	10,815,504	10,815,504				
CFTN Administration	327,293	327,293				
Total CFTN Program Estimated Expenditures	**28,787,797**	**28,787,797**	**0**	**0**	**0**	**0**

EXHIBIT B: COUNTY COMPLIANCE CERTIFICATION

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Orange

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Jeffrey Nagel, Ph.D.	Name: Eric Woolery
Telephone Number: 714-834-7024	Telephone Number: 714-834-2450
E-mail: jnagel@ochca.com	E-mail: eric.woolery@ac.ocgov.com
Local Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

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

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

Jeffrey A. Nagel — Local Mental Health Director (PRINT)
Signature — Date: 3/18/19

I hereby certify that for the fiscal year ended June 30, 2018, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated _____ for the fiscal year ended June 30,_____. I further certify that for the fiscal year ended June 30,_____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Cindy Wong for Eric Woolery — County Auditor Controller / City Financial Officer (PRINT)
Signature — Date: 3/19/19

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

EXHIBIT C: COUNTY FISCAL CERTIFICATION

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange ✓

Local Mental Health Director	Program Lead
Name: Jeffrey Nagel, Ph.D.	Name: Sharon Ishikawa Ph.D.
Telephone Number: 714-834-7024	Telephone Number: 714-834-6587
E-mail: jnagel@ochca.com	E-mail: SIshikawa@ochca.com
County Mental Health Mailing Address:	Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701

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

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

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

Jeffrey A. Nagel
Local Mental Health Director/Designee (PRINT)

Signature

3/18/19
Date

County: Orange

Date: _____

EXHIBIT D: COUNTY FISCAL CERTIFICATION

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: County of Orange
Fiscal Year: 2018/19

Local Mental Health Director

Name: Jeffrey A. Nagel
Telephone: 714-834-7024
Email: JNagel@OCHCA.com

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Jeffrey A. Nagel — Local Mental Health Director (PRINT NAME)
Signature
4/25/19 — Date

APPENDIX I: GLOSSARY OF OUTCOME MEASURES

Generalized Anxiety Disorder (GAD-7)

- Description: The GAD-7 is a widely used, 7-item measure of anxiety. It assesses the severity of symptoms related to social phobia, post-traumatic stress disorder and panic disorder. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, severe, etc.).
- Rater: Clinician, staff, self-report; for individuals ages 18 and older

Grief Experiences Questionnaire (GEQ)

- Description: The GEQ is a 55-item measure of grief that captures the unique experience associated with losing someone to suicide. It examines various components of grief, including somatic reactions; general grief reactions; search for explanation; loss of social support; stigmatization; self-destructive behavior or orientation; feelings of guilt, responsibility, shame or embarrassment, abandonment or rejection; and reactions specific to this unique form of death.
- Rater: Self-report

North Carolina Family Assessment Scale (NCFAS)

- Description: The NCFAS is an assessment tool designed to examine family functioning at the individual and aggregate level. Family functioning is measured on five domains: Environment, Parental Capabilities, Family Interactions, Family Safety and Child Well-Being. The NCFAS-General Services also includes the five domains of the NCFAS and three additional domains of Social/Community Life, Self-Sufficiency, and Family Health. Scores reflect the extent to which a family demonstrates strengths or problems in the respective domains.
- Rater: Clinician, Staff

Outcome Questionnaire (OQ) 30.2

- Description: The OQ measures the treatment progress for adults receiving any form of behavioral health treatment. This 30-item scale is sensitive to short-term change and assesses the frequency with which adults are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful rather than the result of random fluctuation.
- Rater: Self-report for adults ages 18 and older

PARCA-SE

- Description: The PARCA-SE is a 19-item survey with 3 subscales that measure parents' confidence (self-efficacy) regarding their ability to support good behaviors, set limits, and use proactive parenting strategies.
- Rater: Self-report

Patient Health Questionnaire (PHQ-9)

- Description: The PHQ-9 is a widely used, 9-item screening instrument for diagnosing, monitoring and measuring the severity of depression. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, moderately severe, severe).
- Rater: Clinician, staff, self-report; for individuals ages 18 and older

Profile of Mood States (POMS)

- Description: The POMS is a scale that assesses the extent to which an individual is experiencing affective mood states: calm, agitated, annoyed, anxious, confused, depressed, helpless, overwhelmed, uncertain and worried.
- Rater: Self-rated

PROMIS Global Health

- Description: The PROMIS Global Health is a 10-item self-assessment of a participant's perceived overall health and functioning. This measure is from the National Institutes

of Health (NIH) Patient Reported Outcome Measurement Information System (PROMIS) and includes subscales for Global Mental Health and Global Physical Health with a measure-defined cutoff score for each of the subscales.

- Rater: Self-report for adults ages 18 and older

PROMIS Pediatric Global Health

- Description: The PROMIS Pediatric and PROMIS Parent Proxy Global Health are 7-item measures that assess a child's overall evaluations of their physical, mental and social health. These scales are conceptually equivalent to its PROMIS adult counterpart, except these measures yield a single global health score that do not have a cutoff.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

PROMIS Pediatric Anxiety

- Description: The PROMIS Anxiety is an 8-item measure that assesses common experiences and sensations of fear, anxiety, hyperarousal and somatic symptoms in youth. The measure assesses anxiety over the past seven days and yields a clinical cutoff identifying scores that fall in the clinical range of severity.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

PROMIS Pediatric Depression

- Description: The PROMIS Pediatric Depression is a brief measure that assesses mood, cognitive, interpersonal and somatic symptoms experienced by youth over the past seven days. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity.
- Rater: Self-report for youth ages 8-17 and parent-proxy for children ages 5-17

Youth Outcome Questionnaire (YOQ) 30.2

- Description: The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful.
- Rater: Self-report for youth ages 12-18 and parent-report for youth ages 4-17

APPENDIX II: DEMOGRAPHIC DATA TABLES FOR PEI PROGRAMS

FY 2016-17

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME	Children's Support & Parenting Program - Track 1							
Prevention:	P	Early Intervention:		Access to Tx:		Timely Access to services for:		
Outreach:		Stigma/Discrimination:		Suicide:				

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	177
Age 16-25 (TAY)	35
Age 26-59 (Adult)	269
Age 60+ (Older Adult)	6
Decline/Unknown	2

PRIMARY LANGUAGE	
Arabic	1
English	291
Farsi	1
Korean	1
Spanish	189
Vietnamese	2
Decline/Unknown	1
Other	3

ETHNICITY	
Hispanic/Latino	401
Non-Hispanic/Non-Latino	
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	18
Black/African American	4
Native Hawaiian/PI	0
White	39
Multi-Race	1
Decline/Unknown	2
Other	21

SEXUAL ORIENTATION	
Gay or Lesbian	4
Heterosexual	424
Bisexual	6
Questionning	1
Queer	0
Decline/Unknown	53
Other	1

GENDER - Assigned sex at birth	
Male	181
Female	308
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	27
Disability "No"	462
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	26
Veteran "No"	351
Decline/Unknown	112

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 489

PROGRAM NAME	Children's Support & Parenting Program - Track 2 (Stop The Cycle)							
Prevention:	P	Early Intervention:		Access to Tx:		Timely Access to services for:		
Outreach:		Stigma/Discrimination:		Suicide:				

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	256
Age 16-25 (TAY)	38
Age 26-59 (Adult)	278
Age 60+ (Older Adult)	4
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	228
Farsi	0
Korean	0
Spanish	332
Vietnamese	2
Decline/Unknown	12
Other	2

ETHNICITY	
Hispanic/Latino	528
Non-Hispanic/Non-Latino	10
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	8
Black/African American	0
Native Hawaiian/PI	2
White	3
Multi-Race	0
Decline/Unknown	26
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	396
Bisexual	3
Questionning	1
Queer	0
Decline/Unknown	171
Other	4

GENDER - Assigned sex at birth	
Male	242
Female	332
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	11
Disability "No"	563
Decline/Unknown	2

VETERAN STATUS	
Veteran "Yes"	18
Veteran "No"	490
Decline/Unknown	68

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 576

PROGRAM NAME: Family Support Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	151
Age 16-25 (TAY)	187
Age 26-59 (Adult)	1,340
Age 60+ (Older Adult)	63
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	450
Farsi	61
Korean	2
Spanish	597
Vietnamese	123
Decline/Unknown	479
Other	27

ETHNICITY	
Hispanic/Latino	821
Non-Hispanic/Non-Latino	317
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	22
Asian	195
Black/African American	22
Native Hawaiian/PI	4
White	308
Multi-Race	0
Decline/Unknown	258
Other	117

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	381
Female	1,360
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	26
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	1
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,747

PROGRAM NAME: School-Based Stress Management Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1,108
Age 16-25 (TAY)	481
Age 26-59 (Adult)	59
Age 60+ (Older Adult)	4
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	646
Non-Hispanic/Non-Latino	243
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	24
Asian	52
Black/African American	50
Native Hawaiian/PI	3
White	464
Multi-Race	0
Decline/Unknown	0
Other	195

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	793
Female	844
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 3,097

PROGRAM NAME: Parent Education Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	8
Age 16-25 (TAY)	470
Age 26-59 (Adult)	1,727
Age 60+ (Older Adult)	35
Decline/Unknown	77

PRIMARY LANGUAGE	
Arabic	4
English	1,739
Farsi	7
Korean	2
Spanish	430
Vietnamese	1
Decline/Unknown	88
Other	46

ETHNICITY	
Hispanic/Latino	1,071
Non-Hispanic/Non-Latino	190
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	27
Asian	106
Black/African American	60
Native Hawaiian/PI	9
White	883
Multi-Race	0
Decline/Unknown	86
Other	74

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	21

GENDER - Assigned sex at birth	
Male	1,052
Female	1,246
Decline/Unknown	11
Other	8

DISABILITY	
Disability "Yes"	62
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	22
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 2,317

PROGRAM NAME: School-Based Mental Health Services - Prevention - Track 2 (Transition)

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1,646
Age 16-25 (TAY)	385
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	1,906
Farsi	11
Korean	5
Spanish	44
Vietnamese	1
Decline/Unknown	0
Other	68

ETHNICITY	
Hispanic/Latino	589
Non-Hispanic/Non-Latino	405
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	50
Asian	152
Black/African American	60
Native Hawaiian/PI	9
White	871
Multi-Race	0
Decline/Unknown	46
Other	347

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	1,195
Female	829
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	2,039

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 2,039

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Prevention

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	9,871
Age 16-25 (TAY)	365
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	26
English	8,920
Farsi	6
Korean	6
Spanish	903
Vietnamese	43
Decline/Unknown	0
Other	179

ETHNICITY	
Hispanic/Latino	4,084
Non-Hispanic/Non-Latino	1,537
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	182
Asian	619
Black/African American	76
Native Hawaiian/PI	45
White	1,499
Multi-Race	0
Decline/Unknown	0
Other	908

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	5,563
Female	5,237
Decline/Unknown	67
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 23,877

PROGRAM NAME: School Readiness - Track 1

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	546
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	3
English	261
Farsi	4
Korean	0
Spanish	271
Vietnamese	0
Decline/Unknown	3
Other	4

ETHNICITY	
Hispanic/Latino	346
Non-Hispanic/Non-Latino	78
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	56
Black/African American	1
Native Hawaiian/PI	0
White	92
Multi-Race	0
Decline/Unknown	27
Other	22

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	339
Female	206
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 546

PROGRAM NAME: School Readiness - Track 2 (Connect The Tots)

Prevention:		Early Intervention:	P	Access to Tx:		Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	315
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	139
Farsi	0
Korean	1
Spanish	148
Vietnamese	22
Decline/Unknown	1
Other	2

ETHNICITY	
Hispanic/Latino	237
Non-Hispanic/Non-Latino	44
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	35
Black/African American	8
Native Hawaiian/PI	2
White	19
Multi-Race	0
Decline/Unknown	2
Other	12

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	214
Female	101
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 315

PROGRAM NAME: Gang Prevention Services

Prevention:	P	Early Intervention:		Access to Tx:		Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	426
Age 16-25 (TAY)	4
Age 26-59 (Adult)	419
Age 60+ (Older Adult)	3
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	2
English	353
Farsi	0
Korean	2
Spanish	493
Vietnamese	2
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	802
Non-Hispanic/Non-Latino	12
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	4
Black/African American	6
Native Hawaiian/PI	6
White	26
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	852
Other	0

GENDER - Assigned sex at birth	
Male	334
Female	518
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	
Decline/Unknown	852

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	852
Decline/Unknown	

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 852

PROGRAM NAME: Violence Prevention Education

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	10,926
Age 16-25 (TAY)	950
Age 26-59 (Adult)	1,406
Age 60+ (Older Adult)	50
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	49
English	7,431
Farsi	32
Korean	178
Spanish	3,690
Vietnamese	308
Decline/Unknown	0
Other	518

ETHNICITY	
Hispanic/Latino	6,220
Non-Hispanic/Non-Latino	3,623
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	250
Asian	1,446
Black/African American	249
Native Hawaiian/PI	73
White	2,180
Multi-Race	0
Decline/Unknown	0
Other	2,235

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	5,764
Female	6,995
Decline/Unknown	0
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 48,805

PROGRAM NAME: Warmline

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	67
Age 16-25 (TAY)	1,891
Age 26-59 (Adult)	21,025
Age 60+ (Older Adult)	7,219
Decline/Unknown	5,879

PRIMARY LANGUAGE	
Arabic	20
English	35,389
Farsi	14
Korean	4
Spanish	153
Vietnamese	1
Decline/Unknown	0
Other	39

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	16,234
Female	19,056
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	401
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 48,576

PROGRAM NAME: Training in Physical Fitness & Nutrition

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	7
Age 26-59 (Adult)	48
Age 60+ (Older Adult)	13
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	56
Farsi	2
Korean	0
Spanish	8
Vietnamese	1
Decline/Unknown	0
Other	1

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	5
Black/African American	4
Native Hawaiian/PI	0
White	18
Multi-Race	0
Decline/Unknown	23
Other	18

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	41
Female	27
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 68

PROGRAM NAME: Outreach and Engagement Collaborative

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for: P

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	20,941
Age 16-25 (TAY)	17,405
Age 26-59 (Adult)	54,478
Age 60+ (Older Adult)	7,883
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	647
English	49,719
Farsi	191
Korean	276
Spanish	43,643
Vietnamese	2,285
Decline/Unknown	0
Other	2,276

ETHNICITY	
Hispanic/Latino	59,649
Non-Hispanic/Non-Latino	12,312
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	94
Asian	8,028
Black/African American	1,796
Native Hawaiian/PI	219
White	21,199
Multi-Race	0
Decline/Unknown	0
Other	5,490

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	30,144
Female	50,691
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	1,429
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	689
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 103,554

PROGRAM NAME: Community Counseling & Supportive Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	34
Age 16-25 (TAY)	73
Age 26-59 (Adult)	344
Age 60+ (Older Adult)	16
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	9
English	161
Farsi	0
Korean	3
Spanish	290
Vietnamese	3
Decline/Unknown	0
Other	1

ETHNICITY	
Hispanic/Latino	361
Non-Hispanic/Non-Latino	62
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	33
Black/African American	4
Native Hawaiian/PI	7
White	27
Multi-Race	0
Decline/Unknown	12
Other	22

SEXUAL ORIENTATION	
Gay or Lesbian	15
Heterosexual	271
Bisexual	9
Questionning	1
Queer	0
Decline/Unknown	94
Other	1

GENDER - Assigned sex at birth	
Male	140
Female	326
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	37
Veteran "No"	392
Decline/Unknown	38

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 467

PROGRAM NAME: OC ACCEPT

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	12
Age 16-25 (TAY)	42
Age 26-59 (Adult)	56
Age 60+ (Older Adult)	11
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	98
Farsi	2
Korean	0
Spanish	18
Vietnamese	3
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	47
Non-Hispanic/Non-Latino	15
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	9
Black/African American	5
Native Hawaiian/PI	0
White	37
Multi-Race	0
Decline/Unknown	16
Other	3

SEXUAL ORIENTATION	
Gay or Lesbian	39
Heterosexual	15
Bisexual	11
Questionning	3
Queer	0
Decline/Unknown	6
Other	5

GENDER - Assigned sex at birth	
Male	70
Female	46
Decline/Unknown	3
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	21
Veteran "No"	82
Decline/Unknown	18

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 121

PROGRAM NAME: 1st Onset of Psychiatric Illness - OCCREW

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	16
Age 16-25 (TAY)	66
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	67
Farsi	0
Korean	2
Spanish	12
Vietnamese	1
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	40
Non-Hispanic/Non-Latino	18
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	10
Black/African American	2
Native Hawaiian/PI	1
White	22
Multi-Race	0
Decline/Unknown	0
Other	7

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	52
Bisexual	4
Questionning	0
Queer	0
Decline/Unknown	21
Other	3

GENDER - Assigned sex at birth	
Male	59
Female	23
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 82

PROGRAM NAME: OC Maternal & Family Wellness - Track 1 (OCPPW)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	4
Age 16-25 (TAY)	150
Age 26-59 (Adult)	376
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	256
Farsi	4
Korean	0
Spanish	256
Vietnamese	6
Decline/Unknown	0
Other	4

ETHNICITY	
Hispanic/Latino	389
Non-Hispanic/Non-Latino	73
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	38
Black/African American	7
Native Hawaiian/PI	9
White	58
Multi-Race	0
Decline/Unknown	6
Other	21

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	406
Bisexual	5
Questionning	1
Queer	0
Decline/Unknown	1
Other	1

GENDER - Assigned sex at birth	
Male	1
Female	529
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	41
Veteran "No"	468
Decline/Unknown	21

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 530

PROGRAM NAME: OC Maternal & Family Wellness - Track 2 (Youth As Parent)

Prevention:		Early Intervention:	P	Access to Tx:		Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	11
Age 16-25 (TAY)	76
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	60
Farsi	0
Korean	0
Spanish	26
Vietnamese	0
Decline/Unknown	1
Other	0

ETHNICITY	
Hispanic/Latino	81
Non-Hispanic/Non-Latino	1
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	2
Native Hawaiian/PI	0
White	2
Multi-Race	0
Decline/Unknown	1
Other	1

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	64
Bisexual	1
Questionning	1
Queer	0
Decline/Unknown	18
Other	3

GENDER - Assigned sex at birth	
Male	9
Female	77
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	4
Veteran "No"	72
Decline/Unknown	11

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 87

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Early Intervention

Prevention:		Early Intervention:	P	Access to Tx:		Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	17
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	6

PRIMARY LANGUAGE	
Arabic	0
English	16
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	7
Other	0

ETHNICITY	
Hispanic/Latino	8
Non-Hispanic/Non-Latino	1
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	1
Black/African American	0
Native Hawaiian/PI	0
White	6
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	13
Female	3
Decline/Unknown	7
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 59

PROGRAM NAME: School-Based Mental Health Services - Early Intervention - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	623
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	388
Farsi	1
Korean	0
Spanish	234
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	594
Non-Hispanic/Non-Latino	12
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	6
Black/African American	3
Native Hawaiian/PI	0
White	4
Multi-Race	0
Decline/Unknown	9
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	492
Bisexual	8
Questionning	9
Queer	0
Decline/Unknown	28
Other	10

GENDER - Assigned sex at birth	
Male	282
Female	341
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 623

PROGRAM NAME: Stress Free Families

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	109
Age 60+ (Older Adult)	2
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	46
Farsi	0
Korean	0
Spanish	65
Vietnamese	4
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	89
Non-Hispanic/Non-Latino	9
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	28
Black/African American	1
Native Hawaiian/PI	1
White	12
Multi-Race	0
Decline/Unknown	4
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	76
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	40
Other	0

GENDER - Assigned sex at birth	
Male	14
Female	103
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	14
Veteran "No"	96
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 117

PROGRAM NAME: Survivor Support Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	12
Age 16-25 (TAY)	18
Age 26-59 (Adult)	85
Age 60+ (Older Adult)	17
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	5
English	99
Farsi	3
Korean	3
Spanish	19
Vietnamese	0
Decline/Unknown	2
Other	1

ETHNICITY	
Hispanic/Latino	45
Non-Hispanic/Non-Latino	38
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	13
Black/African American	0
Native Hawaiian/PI	2
White	48
Multi-Race	0
Decline/Unknown	8
Other	15

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	4

GENDER - Assigned sex at birth	
Male	38
Female	94
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	39
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 132

PROGRAM NAME: College Veterans Program

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	2
Age 26-59 (Adult)	23
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	25
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	9
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	0
Black/African American	4
Native Hawaiian/PI	0
White	9
Multi-Race	0
Decline/Unknown	2
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	23
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	1
Other	0

GENDER - Assigned sex at birth	
Male	19
Female	6
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	25

VETERAN STATUS	
Veteran "Yes"	24
Veteran "No"	1
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 25

PROGRAM NAME: OC4Vets - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	7
Age 26-59 (Adult)	93
Age 60+ (Older Adult)	39
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	133
Farsi	0
Korean	1
Spanish	3
Vietnamese	0
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	44
Non-Hispanic/Non-Latino	13
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	9
Black/African American	11
Native Hawaiian/PI	1
White	68
Multi-Race	0
Decline/Unknown	16
Other	4

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	114
Bisexual	2
Questionning	1
Queer	0
Decline/Unknown	7
Other	0

GENDER - Assigned sex at birth	
Male	106
Female	32
Decline/Unknown	1
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	139

VETERAN STATUS	
Veteran "Yes"	131
Veteran "No"	4
Decline/Unknown	4

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 139

PROGRAM NAME: OC4Vets - Track 2 (Veterans Court)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	4
Age 26-59 (Adult)	29
Age 60+ (Older Adult)	1
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	32
Farsi	0
Korean	0
Spanish	2
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	10
Non-Hispanic/Non-Latino	4
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2
Black/African American	2
Native Hawaiian/PI	0
White	13
Multi-Race	0
Decline/Unknown	5
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	30
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	4
Other	0

GENDER - Assigned sex at birth	
Male	33
Female	1
Decline/Unknown	0
Other	

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	28
Veteran "No"	4
Decline/Unknown	2

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 34

PROGRAM NAME: Early Intervention Services for Older Adults

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	2
Age 60+ (Older Adult)	523
Decline/Unknown	11

PRIMARY LANGUAGE	
Arabic	46
English	117
Farsi	27
Korean	38
Spanish	140
Vietnamese	95
Decline/Unknown	3
Other	70

ETHNICITY	
Hispanic/Latino	148
Non-Hispanic/Non-Latino	276
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	199
Black/African American	8
Native Hawaiian/PI	1
White	102
Multi-Race	0
Decline/Unknown	2
Other	75

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	1

GENDER - Assigned sex at birth	
Male	151
Female	383
Decline/Unknown	2
Other	0

DISABILITY	
Disability "Yes"	536
Disability "No"	177
Decline/Unknown	9

VETERAN STATUS	
Veteran "Yes"	31
Veteran "No"	257
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 536

PROGRAM NAME: Crisis Prevention Hotline

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide: P

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	414
Age 16-25 (TAY)	1,923
Age 26-59 (Adult)	1,872
Age 60+ (Older Adult)	219
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	8
Spanish	9
Vietnamese	4
Decline/Unknown	477
Other	0

ETHNICITY	
Hispanic/Latino	985
Non-Hispanic/Non-Latino	795
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	24
Asian	0
Black/African American	193
Native Hawaiian/PI	23
White	1,985
Multi-Race	0
Decline/Unknown	0
Other	795

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	2,487
Female	3,244
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	1,919
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	117
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 8,475

PROGRAM NAME: Training, Assessment and Coordination Services

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,354

PROGRAM NAME: Information and Referral / OC Links

Prevention: | Early Intervention: | Access to Tx: P | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	9
Age 16-25 (TAY)	1,538
Age 26-59 (Adult)	8,433
Age 60+ (Older Adult)	1,451
Decline/Unknown	2,674

PRIMARY LANGUAGE	
Arabic	8
English	12,725
Farsi	53
Korean	18
Spanish	1,097
Vietnamese	168
Decline/Unknown	3
Other	33

ETHNICITY	
Hispanic/Latino	4,224
Non-Hispanic/Non-Latino	853
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	57
Asian	226
Black/African American	381
Native Hawaiian/PI	36
White	5,625
Multi-Race	0
Decline/Unknown	2,703
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	30

GENDER - Assigned sex at birth	
Male	4,983
Female	9,097
Decline/Unknown	16
Other	9

DISABILITY	
Disability "Yes"	8
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	16
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 14,105

PROGRAM NAME	BHS Outreach & Engagement Services						
Prevention:		Early Intervention:		Access to Tx:	P	Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	669
Age 16-25 (TAY)	2,069
Age 26-59 (Adult)	26,068
Age 60+ (Older Adult)	6,750
Decline/Unknown	354

PRIMARY LANGUAGE	
Arabic	0
English	28,617
Farsi	69
Korean	12
Spanish	5,669
Vietnamese	1,430
Decline/Unknown	48
Other	65

ETHNICITY	
Hispanic/Latino	12,184
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2,385
Black/African American	5,156
Native Hawaiian/PI	0
White	15,553
Multi-Race	0
Decline/Unknown	0
Other	231

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	22,113
Female	13,697
Decline/Unknown	66
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	35,910

FY 2017-18

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME: Children's Support & Parenting Program - Track 1

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	133
Age 16-25 (TAY)	54
Age 26-59 (Adult)	265
Age 60+ (Older Adult)	4
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	3
English	288
Farsi	2
Korean	0
Spanish	136
Vietnamese	1
Decline/Unknown	8
Other	18

ETHNICITY	
Hispanic/Latino	324
Non-Hispanic/Non-Latino	51
More than one ethnicity	0
Decline/Unknown	6

RACE	
American Indian/Alaska Native	6
Asian	20
Black/African American	10
Native Hawaiian/PI	1
White	59
Multi-Race	0
Decline/Unknown	7
Other	29

SEXUAL ORIENTATION	
Gay or Lesbian	6
Heterosexual	376
Bisexual	5
Questionning	1
Queer	0
Decline/Unknown	58
Other	4

GENDER - Assigned sex at birth	
Male	159
Female	289
Decline/Unknown	6
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	40
Veteran "No"	345
Decline/Unknown	69

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 456

PROGRAM NAME: Children's Support & Parenting Program - Track 2 (Stop The Cycle)

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	167
Age 16-25 (TAY)	30
Age 26-59 (Adult)	241
Age 60+ (Older Adult)	3
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	146
Farsi	0
Korean	0
Spanish	188
Vietnamese	0
Decline/Unknown	36
Other	71

ETHNICITY	
Hispanic/Latino	328
Non-Hispanic/Non-Latino	12
More than one ethnicity	0
Decline/Unknown	32

RACE	
American Indian/Alaska Native	8
Asian	9
Black/African American	6
Native Hawaiian/PI	0
White	25
Multi-Race	0
Decline/Unknown	58
Other	7

SEXUAL ORIENTATION	
Gay or Lesbian	3
Heterosexual	302
Bisexual	10
Questionning	2
Queer	0
Decline/Unknown	98
Other	3

GENDER - Assigned sex at birth	
Male	139
Female	296
Decline/Unknown	6
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 441

PROGRAM NAME: Family Support Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	192
Age 16-25 (TAY)	191
Age 26-59 (Adult)	361
Age 60+ (Older Adult)	154
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	509
Farsi	3
Korean	3
Spanish	56
Vietnamese	4
Decline/Unknown	0
Other	20

ETHNICITY	
Hispanic/Latino	56
Non-Hispanic/Non-Latino	54
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	9
Asian	69
Black/African American	13
Native Hawaiian/PI	4
White	332
Multi-Race	0
Decline/Unknown	
Other	19

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	318
Female	569
Decline/Unknown	0
Other	4

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,502

PROGRAM NAME: School-Based Stress Management Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	171
Age 16-25 (TAY)	841
Age 26-59 (Adult)	69
Age 60+ (Older Adult)	7
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	31
English	1,745
Farsi	22
Korean	83
Spanish	355
Vietnamese	156
Decline/Unknown	0
Other	275

ETHNICITY	
Hispanic/Latino	609
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	14
Asian	953
Black/African American	66
Native Hawaiian/PI	30
White	543
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	1,224
Female	1,442
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 4,171

PROGRAM NAME: Parent Education Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1
Age 16-25 (TAY)	44
Age 26-59 (Adult)	733
Age 60+ (Older Adult)	16
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	15
English	229
Farsi	1
Korean	2
Spanish	459
Vietnamese	96
Decline/Unknown	0
Other	5

ETHNICITY	
Hispanic/Latino	558
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	9
Asian	118
Black/African American	11
Native Hawaiian/PI	4
White	100
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 818

PROGRAM NAME: School-Based Mental Health Services - Prevention - Track 2 (Transition)

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	968
Age 16-25 (TAY)	247
Age 26-59 (Adult)	144
Age 60+ (Older Adult)	3
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	3
English	1,120
Farsi	3
Korean	6
Spanish	151
Vietnamese	24
Decline/Unknown	0
Other	54

ETHNICITY	
Hispanic/Latino	737
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	27
Asian	123
Black/African American	13
Native Hawaiian/PI	8
White	279
Multi-Race	0
Decline/Unknown	0
Other	169

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 1,211

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Prevention

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	5,819
Age 16-25 (TAY)	206
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	14
English	5,341
Farsi	5
Korean	29
Spanish	492
Vietnamese	159
Decline/Unknown	0
Other	80

ETHNICITY	
Hispanic/Latino	2,492
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	90
Asian	409
Black/African American	9
Native Hawaiian/PI	14
White	792
Multi-Race	0
Decline/Unknown	569
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 26,374

PROGRAM NAME: School Readiness - Track 1

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	1
Age 16-25 (TAY)	44
Age 26-59 (Adult)	733
Age 60+ (Older Adult)	16
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	15
English	229
Farsi	1
Korean	2
Spanish	459
Vietnamese	96
Decline/Unknown	0
Other	5

ETHNICITY	
Hispanic/Latino	558
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	9
Asian	118
Black/African American	11
Native Hawaiian/PI	4
White	100
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 598

PROGRAM NAME: Gang Prevention Services

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	427
Age 16-25 (TAY)	18
Age 26-59 (Adult)	407
Age 60+ (Older Adult)	2
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	345
Farsi	0
Korean	0
Spanish	509
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	762
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	10
Black/African American	16
Native Hawaiian/PI	22
White	42
Multi-Race	0
Decline/Unknown	0
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	346
Female	508
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 854

PROGRAM NAME: Violence Prevention Education

Prevention: P | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	7,486
Age 16-25 (TAY)	1,579
Age 26-59 (Adult)	1,341
Age 60+ (Older Adult)	66
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	45
English	5,642
Farsi	41
Korean	180
Spanish	3,102
Vietnamese	159
Decline/Unknown	
Other	498

ETHNICITY	
Hispanic/Latino	5,281
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	180
Asian	1,143
Black/African American	173
Native Hawaiian/PI	51
White	1,656
Multi-Race	0
Decline/Unknown	0
Other	834

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	4,358
Female	5,525
Decline/Unknown	0
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 49,342

PROGRAM NAME	Warmline				
Prevention:	P	Early Intervention:		Access to Tx:	Timely Access to services for:
Outreach:		Stigma/Discrimination:		Suicide:	

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	44
Age 16-25 (TAY)	2,184
Age 26-59 (Adult)	22,360
Age 60+ (Older Adult)	8,908
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	6
English	37,028
Farsi	2
Korean	0
Spanish	137
Vietnamese	4
Decline/Unknown	0
Other	18

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	16,120
Female	20,751
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	50,392

PROGRAM NAME	Outreach and Engagement Collaborative				
Prevention:	P	Early Intervention:		Access to Tx:	Timely Access to services for: P
Outreach:		Stigma/Discrimination:		Suicide:	

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	28,492
Age 16-25 (TAY)	21,202
Age 26-59 (Adult)	65,491
Age 60+ (Older Adult)	14,188
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	72,359
Farsi	7,055
Korean	2,897
Spanish	39,362
Vietnamese	2,801
Decline/Unknown	0
Other	4,032

ETHNICITY	
Hispanic/Latino	
Non-Hispanic/Non-Latino	14,433
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	80
Asian	18,923
Black/African American	2,302
Native Hawaiian/PI	85
White	26,849
Multi-Race	0
Decline/Unknown	0
Other	8,832

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	49,473
Female	81,546
Decline/Unknown	0
Other	1,395

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	135,766

PROGRAM NAME: Community Counseling & Supportive Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	29
Age 16-25 (TAY)	87
Age 26-59 (Adult)	357
Age 60+ (Older Adult)	19
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	29
English	181
Farsi	2
Korean	0
Spanish	260
Vietnamese	7
Decline/Unknown	0
Other	13

ETHNICITY	
Hispanic/Latino	339
Non-Hispanic/Non-Latino	28
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	7
Asian	33
Black/African American	5
Native Hawaiian/PI	3
White	61
Multi-Race	0
Decline/Unknown	9
Other	35

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	25
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	9
Other	1

GENDER - Assigned sex at birth	
Male	149
Female	343
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	43
Veteran "No"	415
Decline/Unknown	2

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 492

PROGRAM NAME: School Readiness - Track 2 (Connect The Tots)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	275
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	6
English	134
Farsi	1
Korean	1
Spanish	116
Vietnamese	14
Decline/Unknown	0
Other	3

ETHNICITY	
Hispanic/Latino	194
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	27
Black/African American	9
Native Hawaiian/PI	1
White	28
Multi-Race	0
Decline/Unknown	0
Other	14

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	186
Female	89
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 275

PROGRAM NAME: OC ACCEPT

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	21
Age 16-25 (TAY)	49
Age 26-59 (Adult)	46
Age 60+ (Older Adult)	5
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	100
Farsi	1
Korean	1
Spanish	18
Vietnamese	0
Decline/Unknown	0
Other	1

ETHNICITY	
Hispanic/Latino	53
Non-Hispanic/Non-Latino	11
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	9
Black/African American	7
Native Hawaiian/PI	0
White	30
Multi-Race	0
Decline/Unknown	0
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	1
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	3

GENDER - Assigned sex at birth	
Male	56
Female	44
Decline/Unknown	3
Other	18

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	15
Veteran "No"	92
Decline/Unknown	

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 121

PROGRAM NAME: 1st Onset of Psychiatric Illness - OCCREW

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	32
Age 16-25 (TAY)	59
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	91

PRIMARY LANGUAGE	
Arabic	0
English	69
Farsi	0
Korean	3
Spanish	16
Vietnamese	1
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	44
Non-Hispanic/Non-Latino	26
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	14
Black/African American	2
Native Hawaiian/PI	1
White	21
Multi-Race	0
Decline/Unknown	91
Other	9

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	1
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	1
Other	0

GENDER - Assigned sex at birth	
Male	58
Female	33
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	2
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 91

PROGRAM NAME: OC Maternal & Family Wellness - YAP and PPW

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	9
Age 16-25 (TAY)	167
Age 26-59 (Adult)	330
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	4
English	271
Farsi	2
Korean	1
Spanish	216
Vietnamese	4
Decline/Unknown	0
Other	8

ETHNICITY	
Hispanic/Latino	394
Non-Hispanic/Non-Latino	20
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	20
Black/African American	8
Native Hawaiian/PI	10
White	69
Multi-Race	0
Decline/Unknown	2
Other	11

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	48
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	0
Other	1

GENDER - Assigned sex at birth	
Male	5
Female	500
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	41
Veteran "No"	449
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 506

PROGRAM NAME: School-Based Behavioral Health Intervention & Supports - Early Intervention

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	17
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	17
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	1
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	1
Black/African American	2
Native Hawaiian/PI	0
White	11
Multi-Race	0
Decline/Unknown	0
Other	1

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 62

PROGRAM NAME: School-Based Mental Health Services - Early Intervention - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	612
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	415
Farsi	0
Korean	0
Spanish	195
Vietnamese	0
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	561
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	2
Asian	6
Black/African American	3
Native Hawaiian/PI	0
White	12
Multi-Race	0
Decline/Unknown	0
Other	6

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	69
Bisexual	2
Questionning	1
Queer	0
Decline/Unknown	6
Other	2

GENDER - Assigned sex at birth	
Male	259
Female	352
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 612

PROGRAM NAME: Stress Free Families

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	12
Age 26-59 (Adult)	130
Age 60+ (Older Adult)	6
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	59
Farsi	0
Korean	0
Spanish	79
Vietnamese	8
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	109
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	16
Black/African American	0
Native Hawaiian/PI	1
White	15
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 148

PROGRAM NAME: Survivor Support Services

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	10
Age 16-25 (TAY)	16
Age 26-59 (Adult)	96
Age 60+ (Older Adult)	25
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	1
English	122
Farsi	2
Korean	4
Spanish	17
Vietnamese	0
Decline/Unknown	0
Other	2

ETHNICITY	
Hispanic/Latino	17
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	19
Black/African American	0
Native Hawaiian/PI	1
White	74
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 148

PROGRAM NAME: College Veterans Program

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	3
Age 26-59 (Adult)	11
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	14
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	4
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	2
Black/African American	1
Native Hawaiian/PI	0
White	5
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	9
Female	4
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	11
Veteran "No"	2
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 14

PROGRAM NAME: OC4Vets - Track 1

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	46
Age 60+ (Older Adult)	8
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	58
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	14
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	1
Asian	2
Black/African American	7
Native Hawaiian/PI	0
White	21
Multi-Race	0
Decline/Unknown	0
Other	1

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	6
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	54
Other	0

GENDER - Assigned sex at birth	
Male	47
Female	12
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	52
Veteran "No"	5
Decline/Unknown	3

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 60

PROGRAM NAME: OC4Vets - Track 2 (Veterans Court)

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	4
Age 26-59 (Adult)	38
Age 60+ (Older Adult)	2
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	42
Farsi	0
Korean	0
Spanish	1
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	
Non-Hispanic/Non-Latino	2
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	1
Black/African American	1
Native Hawaiian/PI	0
White	14
Multi-Race	
Decline/Unknown	
Other	1

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	1
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	42
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	38
Veteran "No"	3
Decline/Unknown	3

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 44

PROGRAM NAME: Early Intervention Services for Older Adults

Prevention: | Early Intervention: P | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	3
Age 60+ (Older Adult)	598
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	35
English	127
Farsi	52
Korean	31
Spanish	138
Vietnamese	119
Decline/Unknown	0
Other	99

ETHNICITY	
Hispanic/Latino	154
Non-Hispanic/Non-Latino	242
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	234
Black/African American	7
Native Hawaiian/PI	1
White	193
Multi-Race	0
Decline/Unknown	0
Other	8

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	172
Female	429
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 596

PROGRAM NAME: Training, Assessment and Coordination Services

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	0
Age 26-59 (Adult)	0
Age 60+ (Older Adult)	0
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	0
Farsi	0
Korean	0
Spanish	0
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	0
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Native Hawaiian/PI	0
White	0
Multi-Race	0
Decline/Unknown	0
Other	0

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 256

PROGRAM NAME: Crisis Prevention Hotline

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: P | Stigma/Discrimination: | Suicide: P

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	2,737
Age 26-59 (Adult)	2,415
Age 60+ (Older Adult)	298
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	10,970
Farsi	0
Korean	4
Spanish	630
Vietnamese	3
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	1,600
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	34
Asian	350
Black/African American	252
Native Hawaiian/PI	32
White	2,261
Multi-Race	0
Decline/Unknown	0
Other	323

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	4,606
Female	6,454
Decline/Unknown	0
Other	8

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 11,607

PROGRAM NAME: BHS Outreach & Engagement Services

Prevention: | Early Intervention: | Access to Tx: P | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	138
Age 16-25 (TAY)	1,628
Age 26-59 (Adult)	25,303
Age 60+ (Older Adult)	5,839
Decline/Unknown	3,936

PRIMARY LANGUAGE	
Arabic	8
English	30,027
Farsi	56
Korean	14
Spanish	3,624
Vietnamese	2,719
Decline/Unknown	327
Other	69

ETHNICITY	
Hispanic/Latino	10,176
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	3,615
Black/African American	3,460
Native Hawaiian/PI	0
White	15,001
Multi-Race	0
Decline/Unknown	4,394
Other	198

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	19,691
Female	13,846
Decline/Unknown	3,292
Other	2

DISABILITY	
Disability "Yes"	0
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 36,844

PROGRAM NAME	Information and Referral / OC Links				
Prevention:		Early Intervention:		Access to Tx:	P
Outreach:		Stigma/Discrimination:		Suicide:	

Timely Access to services for:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	66
Age 16-25 (TAY)	7,511
Age 26-59 (Adult)	42,781
Age 60+ (Older Adult)	6,976
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	62,878
Farsi	325
Korean	176
Spanish	5,297
Vietnamese	811
Decline/Unknown	0
Other	214

ETHNICITY	
Hispanic/Latino	20,615
Non-Hispanic/Non-Latino	0
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	311
Asian	4,220
Black/African American	2,108
Native Hawaiian/PI	0
White	28,369
Multi-Race	0
Decline/Unknown	0
Other	1,632

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	0
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	0
Other	0

GENDER - Assigned sex at birth	
Male	0
Female	0
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	33
Disability "No"	0
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	127
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 17,509

APPENDIX III: DEMOGRAPHIC DATA TABLES FOR INN PROGRAMS

FY 2016-17

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME: Religious Leaders Behavioral Health Training Services

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	1
Age 26-59 (Adult)	22
Age 60+ (Older Adult)	13
Decline/Unknown	1

PRIMARY LANGUAGE	
Arabic	0
English	15
Farsi	0
Korean	8
Spanish	5
Vietnamese	0
Decline/Unknown	0
Other	9

ETHNICITY	
Hispanic/Latino	12
Non-Hispanic/Non-Latino	22
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	13
Black/African American	1
Native Hawaiian/PI	0
White	13
Multi-Race	1
Decline/Unknown	1
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	17
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	19
Other	0

GENDER - Assigned sex at birth	
Male	16
Female	15
Decline/Unknown	6
Other	0

DISABILITY	
Disability "Yes"	1
Disability "No"	16
Decline/Unknown	20

VETERAN STATUS	
Veteran "Yes"	2
Veteran "No"	28
Decline/Unknown	7

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 37

PROGRAM NAME: Step Forward Program: Collaborative Courts On-site Engagement

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	76
Age 60+ (Older Adult)	11
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	86
Farsi	0
Korean	0
Spanish	7
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	34
Non-Hispanic/Non-Latino	43
More than one ethnicity	0
Decline/Unknown	0

RACE	
American Indian/Alaska Native	3
Asian	1
Black/African American	8
Native Hawaiian/PI	4
White	65
Multi-Race	1
Decline/Unknown	0
Other	9

SEXUAL ORIENTATION	
Gay or Lesbian	1
Heterosexual	86
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	5
Other	0

GENDER - Assigned sex at birth	
Male	46
Female	47
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	40
Disability "No"	47
Decline/Unknown	6

VETERAN STATUS	
Veteran "Yes"	2
Veteran "No"	80
Decline/Unknown	11

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 93

PROGRAM NAME	Strong Families-Strong Children: Behavioral Health Services for Military Families						
Prevention:		Early Intervention:		Access to Tx:		Timely Access to services for:	
Outreach:		Stigma/Discrimination:		Suicide:			

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	123
Age 16-25 (TAY)	23
Age 26-59 (Adult)	108
Age 60+ (Older Adult)	10
Decline/Unknown	13

PRIMARY LANGUAGE	
Arabic	0
English	267
Farsi	0
Korean	0
Spanish	4
Vietnamese	0
Decline/Unknown	3
Other	3

ETHNICITY	
Hispanic/Latino	276
Non-Hispanic/Non-Latino	58
More than one ethnicity	9
Decline/Unknown	211

RACE	
American Indian/Alaska Native	8
Asian	14
Black/African American	26
Native Hawaiian/PI	0
White	109
Multi-Race	37
Decline/Unknown	26
Other	57

SEXUAL ORIENTATION	
Gay or Lesbian	2
Heterosexual	245
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	30
Other	0

GENDER - Assigned sex at birth	
Male	128
Female	149
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	54
Disability "No"	136
Decline/Unknown	95

VETERAN STATUS	
Veteran "Yes"	61
Veteran "No"	214
Decline/Unknown	2

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program	277

FY 2017-18

There are known issues with the data extraction tool for these reports that may affect the accuracy of some numbers. HCA is currently working to address them.

PROGRAM NAME: Religious Leaders Behavioral Health Training Services

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	6
Age 26-59 (Adult)	37
Age 60+ (Older Adult)	7
Decline/Unknown	

PRIMARY LANGUAGE	
Arabic	4
English	23
Farsi	0
Korean	4
Spanish	15
Vietnamese	3
Decline/Unknown	2
Other	0

ETHNICITY	
Hispanic/Latino	22
Non-Hispanic/Non-Latino	28
More than one ethnicity	1
Decline/Unknown	0

RACE	
American Indian/Alaska Native	0
Asian	17
Black/African American	2
Native Hawaiian/PI	0
White	18
Multi-Race	0
Decline/Unknown	7
Other	7

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	29
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	22
Other	0

GENDER - Assigned sex at birth	
Male	11
Female	27
Decline/Unknown	13
Other	0

DISABILITY	
Disability "Yes"	0
Disability "No"	31
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	0
Veteran "No"	36
Decline/Unknown	

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 51

PROGRAM NAME: Step Forward Program: Collaborative Courts On-site Engagement

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	9
Age 26-59 (Adult)	95
Age 60+ (Older Adult)	19
Decline/Unknown	1

PRIMARY LANGUAGE	
Arabic	0
English	110
Farsi	0
Korean	0
Spanish	11
Vietnamese	0
Decline/Unknown	2
Other	1

ETHNICITY	
Hispanic/Latino	49
Non-Hispanic/Non-Latino	69
More than one ethnicity	3
Decline/Unknown	5

RACE	
American Indian/Alaska Native	2
Asian	1
Black/African American	10
Native Hawaiian/PI	3
White	88
Multi-Race	3
Decline/Unknown	4
Other	13

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	116
Bisexual	1
Questionning	0
Queer	0
Decline/Unknown	7
Other	0

GENDER - Assigned sex at birth	
Male	64
Female	59
Decline/Unknown	1
Other	0

DISABILITY	
Disability "Yes"	86
Disability "No"	62
Decline/Unknown	6

VETERAN STATUS	
Veteran "Yes"	3
Veteran "No"	107
Decline/Unknown	14

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 124

PROGRAM NAME: Strong Families-Strong Children: Behavioral Health Services for Military Families

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	154
Age 16-25 (TAY)	35
Age 26-59 (Adult)	119
Age 60+ (Older Adult)	11
Decline/Unknown	4

PRIMARY LANGUAGE	
Arabic	0
English	313
Farsi	0
Korean	0
Spanish	10
Vietnamese	0
Decline/Unknown	0
Other	0

ETHNICITY	
Hispanic/Latino	135
Non-Hispanic/Non-Latino	69
More than one ethnicity	25
Decline/Unknown	95

RACE	
American Indian/Alaska Native	6
Asian	8
Black/African American	30
Native Hawaiian/PI	0
White	141
Multi-Race	53
Decline/Unknown	8
Other	77

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	300
Bisexual	0
Questionning	1
Queer	0
Decline/Unknown	22
Other	0

GENDER - Assigned sex at birth	
Male	173
Female	150
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	76
Disability "No"	218
Decline/Unknown	31

VETERAN STATUS	
Veteran "Yes"	70
Veteran "No"	253
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 323

PROGRAM NAME: Behavioral Health Services for Independent Living

Prevention: | Early Intervention: | Access to Tx: | Timely Access to services for:

Outreach: | Stigma/Discrimination: | Suicide:

DEMOGRAPHIC

AGE	
Age 0-15 (Child)	0
Age 16-25 (TAY)	2
Age 26-59 (Adult)	9
Age 60+ (Older Adult)	3
Decline/Unknown	0

PRIMARY LANGUAGE	
Arabic	0
English	10
Farsi	1
Korean	0
Spanish	2
Vietnamese	0
Decline/Unknown	1
Other	0

ETHNICITY	
Hispanic/Latino	4
Non-Hispanic/Non-Latino	8
More than one ethnicity	0
Decline/Unknown	2

RACE	
American Indian/Alaska Native	1
Asian	1
Black/African American	0
Native Hawaiian/PI	3
White	5
Multi-Race	1
Decline/Unknown	1
Other	2

SEXUAL ORIENTATION	
Gay or Lesbian	0
Heterosexual	12
Bisexual	0
Questionning	0
Queer	0
Decline/Unknown	2
Other	0

GENDER - Assigned sex at birth	
Male	5
Female	9
Decline/Unknown	0
Other	0

DISABILITY	
Disability "Yes"	6
Disability "No"	10
Decline/Unknown	0

VETERAN STATUS	
Veteran "Yes"	1
Veteran "No"	0
Decline/Unknown	0

UNIT OF SERVICES

Unduplicated numbers of individuals served in the preceding fiscal year by program: 14

Summary of the MHSA Prevention & Early Intervention (PEI) Community Planning Orange County Health Care Agency Behavioral Health Services

Mark Lawrenz
Prevention & Intervention Division Manager

September 25, 2018

Overview of the Community Planning Process

- The first meeting on August 7th, provided an overview to create a common understanding and framework of the PEI Planning Process.
- Four targeted discussions on community needs identified, within specific populations:

August 14:	Focusing on family support programs, program serving families with children from birth to age 8
August 21:	Focusing on school-based programs, children/youth 9-16, and TAY
August 29:	Focusing on adult and older adult programs
September 11:	Revisited TAY

- A fifth meeting on September 25 will bring all the feedback together for a discussion on the over-arching themes and service needs identified

Identified Need #1:
Increased Awareness of/Improved Navigation of the Behavioral Health System

- Need for an comprehensive resources inventory to assess unmet need including geo-mapping of resources
  - A comprehensive resource inventory of school-based mental health resources, including all districts
  - Resource guide for older adults, their families and providers
- Care coordination to better link children with mental health challenges to appropriate specialty services.
- Use of technology, smart phones and apps, especially for the younger generations as it is being piloted in Innovations Technology Suite to link youth to services

Identified Need #2:
Systematic screenings for mental illness

- Expand screenings for older adults to determine if symptoms are caused by depression or dementia

Identified Need# 3:
Training for individuals, families and providers

- Expand workforce capacity/skills to work with young children to promote, educate, prevent, identify and link to services
- Increase training opportunities through BHS Training and PEI in higher education
- Training for parents whose children are on probation
- Prevention education to foster parents on LGBTIQ and TAY issues
- Trauma-focused trainings to providers serving all target populations & age groups

Identified Need #4:
Implementation and/or Expansion of Peer Support Models

- Peer support for families, such as parent partners, to build trust and assist in navigating the services, especially for underserved and homeless families
- Peer support in the schools to further address bullying, trauma and suicide prevention
- More peer support in colleges and universities, especially for the LGBTIQ community and Veterans
- Peer support for LGBTIQ, specifically in the foster care system
- Peer support for Veterans especially not in college system
- Peer navigators and support for seniors

Identified Need #5:
Time-Limited Expansion of Existing Direct Services

- System-wide expansion of resources to promote perinatal mental health services, including for fathers (more screenings, case management and early intervention)
- Expansion of County counseling program to support need for bilingual therapists
- Expansion of early intervention services for older adults, age 60 and older including more gero-psychiatric hours

Identified Need #6:
Time-Limited Funding of New Services

- Services for homeless youth and home schooled youth not accessing schools
- Services targeting TAY not attending Colleges or Universities
- Older adult services for adults, age 50 years and older, especially from the immigrant communities

Identified Need #8:
Additional Supports to Remove Barriers to Access/training

- Childcare

HCA Prevention and Intervention Planning Recommendations

October 15, 2018

A. Allocate funding for an early childhood mental health program targeting early childcare providers serving families and children

Recommendation includes components from identified need 1, 2, 3 and 6 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Allocate funding for an early childhood mental health program targeting early childcare providers serving young children exhibiting problematic behaviors, who are at risk of expulsion and mental illness. Services would include: • On-site Mental Health Consultation • Education and training of Early Childcare Providers • Screening/ Assessment • Parent Education • Navigation and Linkage to Services.	Per SB 1004, approved 9/27/18, "Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care.	• Children in preschool are expelled at 3 times the rate of children in K-12 • 1996 CSU Fullerton Survey, "Experiences Caring for Children with Behavioral Challenges or Possible Mental Health Conditions," demonstrated the need for these services • Early Developmental Index (EDI) measures the status of a child's early development. It provides information about kindergarteners in five developmental areas, including social-emotional that are known to affect well-being and school performance. This data demonstrates need for supports in specific areas of the County. • UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year.

B. Allocate funding to expand school-based services to better address the mental health needs, K-12

Recommendation includes components from identified need 1, 3, 4, 6 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand school-based services for addressing mental health issues in K-12 schools County-wide. Allocated PEI funding could be used for: • Educational and Networking Forums • Trauma-informed Teacher and Staff Trainings/ Parent Education • Pilot Evidenced- Based Peer-Support Models • School-based Suicide Prevention and Stigma Reduction Campaigns and Activities **Innovation is exploring an opportunity to help support this Recommendation through a potential expansion of the Tech Suite to address the mental health needs of children and adolescents ***Recommend schools to implement universal screening.	Per SB 1004, Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care. In addition, "Youth outreach and engagement strategies that target secondary schools". Services may include stigma reduction and suicide prevention education, training staff and parents on the early identification, intervention and referral of students with mental health needs and youth mental health programming.	• UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11 years, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year. In addition, UCSD identified that the mental health need for adolescents, ages 12-17 years, in OC was 4.2% with nearly two-thirds not receiving any treatment in the past year. Among adolescents, the mental health need was higher for younger adolescents, ages 12-14 years. • With 28 school districts with varying levels of need and resources, further assessment is needed to determine how to best impact system with available funding.

C. Allocate funding to expand existing Gang Prevention Services

Recommendation includes components from identified need 1, 3, and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand the existing MHSA/PEI Gang Prevention Services to increase services provided in the schools, targeting 5th to 8th graders at risk of gang involvement. Services would include: • Teacher, Parent and Student Education • Case Management • Navigation and Linkage to Services	Per SB 1004, Childhood trauma prevention and early intervention to deal with the early origins of mental health needs" is an identified priority. Included in these services is the implementation of appropriate trauma and developmental screenings and linkages to early intervention services/ primary care. In addition, "Youth outreach and engagement strategies that target secondary schools. Included are, "interventions for youth with signs of behavioral or emotional problems who are at risk of, or have had any, contact with the juvenile justice system."	• UCSD Needs & Gaps Analysis identified that the mental health need among children, ages 4-11 years, in OC was 5.9% and highest for Latino children (8.3%) with over half not receiving any treatment in the past year. In addition, UCSD identified that the mental health need for adolescents, ages 12-17 years, in OC was 4.2% with nearly two-thirds not receiving any treatment in the past year. Among adolescents, the mental health need was higher for younger adolescents, ages 12-14 years. • Current program demonstrates greater need than capacity through the growing number of schools in need of services. The program served 427 individuals in FY 17/18, and outcomes demonstrated improvements in protective factors and global health.

D. Allocate funding to implement services for TAY and young adults at community colleges and universities

Recommendation includes components from identified need 1, 3, 4, 6 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Implement new services specifically targeting partnerships with college mental health programs that educates and engages students and provide either on-campus support and/or linkage to off-campus mental health services. Services could be used for: • Educational and Networking Forums • Teacher and Staff Trainings • Pilot Evidenced- Based Peer-Support Models • Suicide Prevention and Stigma Reduction Campaigns and Activities • Prevention education to at-risk TAY (including LGBTIQ/Veterans) • Outreach to TAY (young men of color/LGBTIQ) ***The Innovation Tech Suite project could support this Recommendation through targeted outreach and marketing events on college campuses throughout the County to promote the use of the apps within the Suite, including the 24/7 peer chat support.	Per SB 1004, "Youth outreach and engagement strategies that target secondary schools and transitional age youth, with a priority partnership with college mental health programs". Furthermore, services may include stigma reduction and suicide prevention education, training staff and students on the early identification, intervention and referral of students with mental health needs and youth mental health programming. Serving underserved communities including LGBTIQ, victims of violence/abuse and veterans. Program would also be tasked with reducing racial disparities in access to mental health services.	• The only existing MHSA/PEI funded program formally partnering with Colleges is serving Veterans with a small amount of funding through CalMHSA to Active Minds • UCSD Needs and Gaps Analysis identified TAY as the age group with the highest unmet mental health need, especially for the LGBTIQ, Latinos and African Americans

E. Allocate funding to expand existing services for isolated older adults

Recommendation includes components from identified need 1, 2, 4, 5, 6 and 8 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand the only MHSA/PEI-funded program, specifically targeting older adults, age 60 and above: the Early Intervention Services for Older Adults Program. This would address the current wait list for services especially for the Cambodian community, services would include: • Geo-psychiatric services • Screening/Assessment • Case Management • Educational /Support groups • Navigation and Linkage to resources • Transportation Assistance (new component) • Peer Support In addition, the eligibility criteria would be expanded to include those adults age 50-59 who are isolated due social and/or economic circumstances	Per SB 1004, "Strategies targeting the mental health needs of older adults" is an identified priority for use of PEI funds.	• California Mental Health Older Adult System of Care Project by UCLA conducted key informant interviews and provided findings that identified a similar need • Current program demonstrates greater need than capacity. The program served approximately 600 individuals in FY 17/18, and outcomes demonstrated decreases in depression and increases in social functioning and global health. • Many seniors don't drive or have access to transportation. They need transportation to access basic needs, doctor's appointments, or EISOA classes at senior centers. There are not sufficient bus routes. Takes 2-3 hours to reach their destination. In addition, Senior Access program but has restricted access. Also, the cost is $7.20/ride. People on SSI cannot afford. • CalOptima Member Health Needs Assessment identified lack of transportation as a barrier to access and 29% surveyed indicated needing help getting transportation.

F. Allocate funding to provide a variety of behavioral health community trainings.

Recommendation includes components from identified need 1, 3 and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Provide a variety of behavioral health community trainings for individual, families and providers. Emphasis on trauma-informed, culturally and linguistically appropriate trainings, including suicide prevention and trainings for specific communities including TAY, Veterans, LGBTIQ, families with children on probation and parents of foster youth. Trainings would include: • Recognizing the early signs and symptoms of mental illness across life span • Education related to supporting and engaging someone who needs help • Increasing awareness of resources and how to access the behavioral health system of care • Training peer support navigators	PEI Regulations require a program and strategies for Outreach for increasing recognition of early signs of mental Illness, which is defined as the process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potential severe and disabling mental illness.	• CalOptima Member Health Needs Assessment identified Lack of Knowledge as a barrier to access with 40% of those surveyed didn't know who to call or ask for help • UCSD Needs and Gaps Analysis identified TAY as the age group with the highest unmet mental health need, especially for the LGBTIQ, Latinos and African Americans

G. Allocate funding to expand outreach to cultural and linguistic populations that continue to be underserved

Recommendation includes components from identified need 1, 2, 3 and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand Outreach & Engagement (O&E) for targeted populations who are underserved in the existing O&E programs. Services would include: • Outreach & Engagement • Screening/ Assessment • Case Management • Navigation and Linkage to Resources • Support Groups & Education ***The Innovation Tech Suite project could support this Recommendation by working with the Tech Suite Marketing vendor to identify and implement targeted outreach/marketing strategies that are designed to engage diverse communities.	Per SB1004, culturally competent and linguistically appropriate prevention and intervention services are an identified priority	• CalOptima Member Health Needs Assessment identified Lack of Knowledge as a barrier to access with 40% of those surveyed didn't know who to call or ask for help when seeking a mental health specialist

H. Allocate funding to existing Community Mental Health Educational Events to Reduce Stigma

Recommendation includes components from identified need 1, 3 and 7 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand funding for Community Mental Health Educational Events. Services would include: • Increasing awareness of behavioral health resources • Education regarding mental health and stigma associated with mental illness and seeking services, promoting positive messages of hope ***Innovation is exploring opportunities to help support this Recommendation through a technology-based project designed to identify specific regions with the greatest need for prevention and early intervention efforts and stigma reduction trainings.	PEI Regulations require a Stigma and Discrimination Reduction Program, which is defined as activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase acceptance, dignity and inclusion	• CalOptima Member Health Needs Assessment identified Stigma as a barrier to access with 26% of those surveyed being concerned about what happens if someone found out about their mental health needs

I. Allocate funding to expand services for Veterans

Recommendation includes components from identified need 1, 2, 3, 4, and 5 from the PEI Planning Meetings.

Need identified in the initial Public Forum, in the PEI Planning Meetings and in the BHS Community Engagement Meetings.

HCA Recommendation	What the MHSA/PEI Regulations Indicate	What we know about the need
Expand funding to support services for veterans and military connected families. Services would include: • Outreach & Engagement • Screening/ Assessment • Counseling • Case Management • Navigation and Linkage to Resources • Support Groups & Education ***Innovation is currently providing services to veterans and military connected families through the Behavioral Health Services for Military Families: Strong Families Strong Children project. The project is in its final year of services as an Innovation project. HCA recommends to continue funding this project through PEI funding beginning July 1, 2019 to maintain continuity of services. From project launch on July 1, 2015 through July 30, 2018, the project served 156 families and a total of 540 individual family members. Outcomes demonstrate improvement in family functioning and communication, particularly in areas of family safety, environment and social/community life.	PEI Regulations require a Prevention Program to reduce risk factors for mental illness that are associated with a greater than average risk of developing a potentially serious mental illness. Examples of risk factors include, but are not limited to, experience of severe trauma, ongoing stress, family conflict or domestic violence, traumatic loss, etc.	• Over 70% of military families live in civilian communities (National Military Family Association, 2011), but are often not known to be military-connected. • In a recent USC Veterans study and survey of over 1,200 Orange County veterans, over 70% of veterans reported their child's school was not aware that their child is military connected (Castro, Kintzle, & Hassan, 2015). • Military-connected families often go unnoticed due to the community's limited knowledge of military culture; limitations in assessment strategies; lack of coordinated community based services; and stigma associated with mental illness. • 44% of post 9/11 veterans reported not knowing where to go for help and about 24% of veterans believed they could handle the problem on their own (Castro, Kintzle, & Hassan, 2015).

Eight Needs Identified Across Planning Meeting:

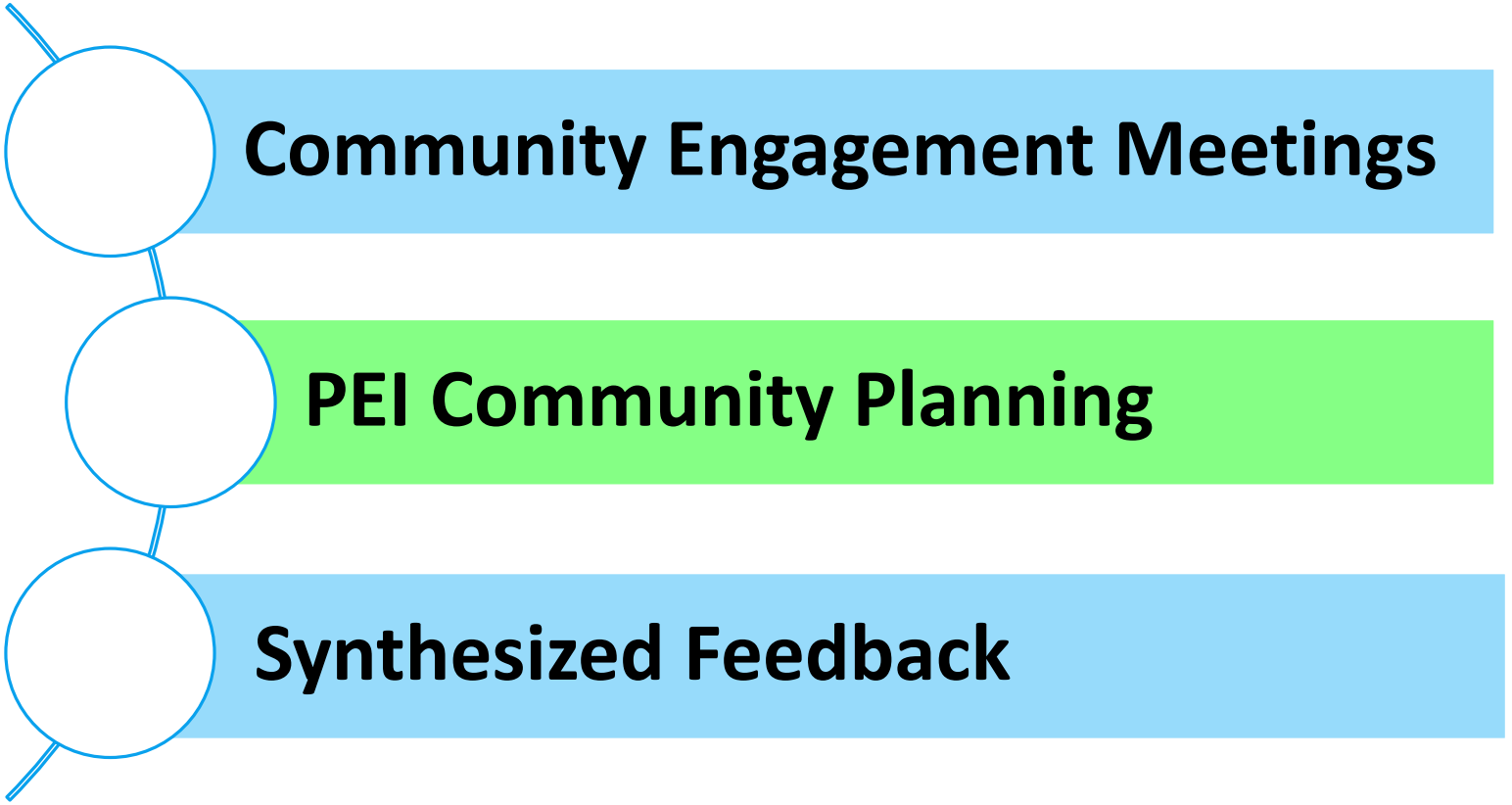
1. Increased Awareness of/Improved Navigation of the Behavioral Health System
2. Systematic screenings for mental illness
3. Training for individuals, families and providers
4. Implementation and/or Expansion of Peer Support Models
5. Time-Limited Expansion of Existing Direct Services
6. Time-Limited Funding of New Services
7. Targeted Stigma Reduction Programs
8. Additional Supports to Remove Barriers to Increase Access/Training

BHS Community Engagement / PEI Community Planning Meeting Summary

Sharon Ishikawa, MHSA Coordinator
Mark Lawrenz, PEI Division Manager
Anthony Le, HCA BHS Fiscal Manager

October 15, 2018

Overview


Community Engagement Meetings
PEI Community Planning
Synthesized Feedback

BHS Community Engagement Meetings

CEMs: When?

July 31: Central

- Delhi Community Center

August 8: North

- Fullerton Community Center

August 13: South

- Norman P. Murray Community & Sr Center

August 27: Central

- Community Action Advisory Committee

CEMs: What?

- Meetings in each of three county Service Planning Areas (SPA):
  - North, Central, South
- Two Workgroups per SPA (n = 131 total):
  - *Provider (n=93)*
  - *Community (n=38)*
- Focus on overall Behavioral Health system

CEMs: How?

- Participants randomly assigned to small workgroups (n=5)
- Each workgroup given a list of Service Areas
  - *all of BHS, not just MHSA*
- Each small workgroup identified the top 5 Service Areas
  - *not rank ordered*

Behavioral Health Service Areas

- Prevention
- Provider Training in BH Topics/ Issues
- Crisis Prevention
- Crisis Assessment
- Crisis Treatment
- Substance Use Education
- SUD Outpatient Clinic Services
- SUD Residential Treatment
- SUD Maint. Recovery Support
- Navigation/Access & Linkage
- BH Clinic Outpatient Services
- Mobile BH Outpatient Services
- School-Based Mental Health
- Parent/Family Education
- Transportation
- Services for those living in Supportive Housing
- Employment, Educational, Vocational Support
- LPS Conservatorship Support
- Peer/Family Support
- Other (specified)

CEMs: How? con't

For each meeting:

- Staff tallied the Top 5 areas across the tables
- Participants used Post-Its to provide feedback within each Service Area:
  - *types of services*
  - *target populations*
- MHSA Staff facilitated group discussion

CEMs: Results

	Provider			Community		
Service Priority Area	**N**	**C**	**S**	**N**	**C**	**S**
Prevention	●	●	●		●	●
School-Based Mental Health	●	●	●			●
Clinic-Based Outpatient	●		●	●	●	
Housing *		●	●	●		●
Crisis Assessment & Treatment *	●		●		●	●
SUD Services *	●		●	●		
Navigation / Access & Linkage		●				
Employ. / Educ. / Voc. Support		●				
Peer / Family Support		●			●	

** Only identified in CEMs (not PEI CPP meetings)*

Housing

Focal Target Populations:

- Older Adults
- TAY (Foster, LGBTIQ)
- Vulnerable populations

CEM Housing Themes

Increased Availability

- **Provider CEMs: Central, South**
- **Community CEMs: South**

Examples:

- **Permanent Supportive Housing**
- **Affordable housing**
- **In all regions of county**
- **SUD Housing for recovery / support**

CEM Housing Themes

Housing Assistance

- **Community CEMs: North, South**

Examples:

- **Rental Assistance/subsidized rent**
- **Eviction prevention and advocacy**
- **Better quality, basic standards**

CEM Housing Themes

Supportive Services

- **Provider CEMs: Central, South**

Examples:

- **Linkage to services**
  - **i.e., employment, therapy, support, case management**
- **Onsite services**
- **Skills building**
  - **i.e., financial, life skills, empowerment and knowledge, case management**

CEM Priority Service Area: Crisis Assessment/Treatment

Focal Target Populations:

- Children / Youth / Minors
- TAY

CEM Crisis Assessment/Tx Themes

Crisis Stabilization

- **Provider CEMs: North, South**
- **Community CEMs: Central**

Examples:

- **Site CSUs**
- **Expand In-Home Crisis Stabilization**
- **Implement 'buddy care' system to facilitate stabilization**

CEM Crisis Assessment/Tx Themes

Crisis Assessment

- **Provider CEMs: North**
- **Community CEMs: Central**

Examples:

- **Quicker response times for assessment, stabilization**
- **Culturally appropriate services 24/7**

CEM Crisis Assessment/Tx Themes

Crisis Aftercare/ Support

- **Provider CEMs: South**
- **Community CEMs: South**

Examples:

- **Link youth and minors to services**
- **Provide aftercare**
- **Coordinate care**
- **Enhance navigation assistance and resources for family members**

CEM Crisis Assessment/Tx Themes

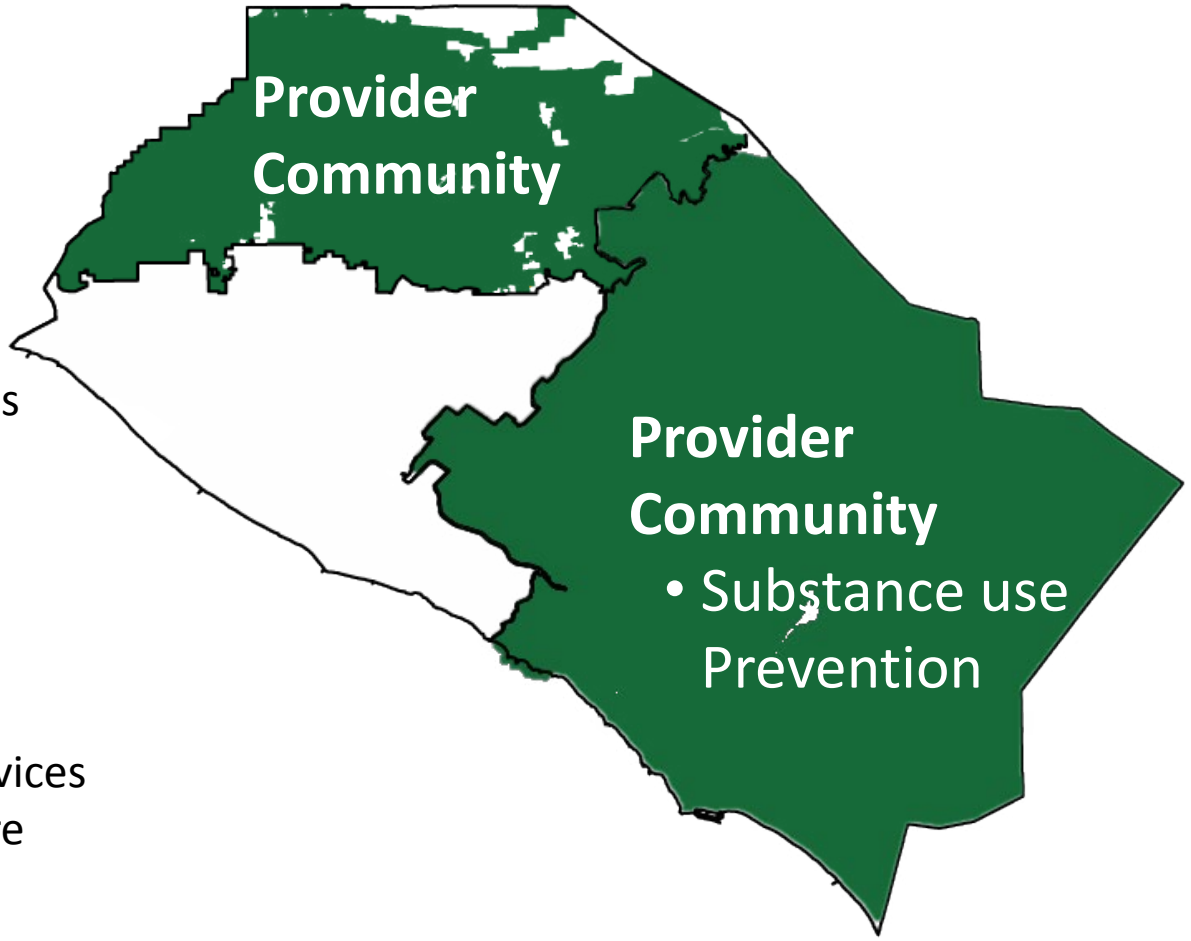
Additional

- ***Central Community:*** **Increase LPS trained nurse/staff**
- ***South Provider:*** **Provide family services**

Region-Specific CEM Priority: Substance Use Services

North Provider Themes

- Detox Centers
- Coordination of after care – lower levels of care
- TAY Services: detox, dual diagnosis treatment
- Expanded outpatient services



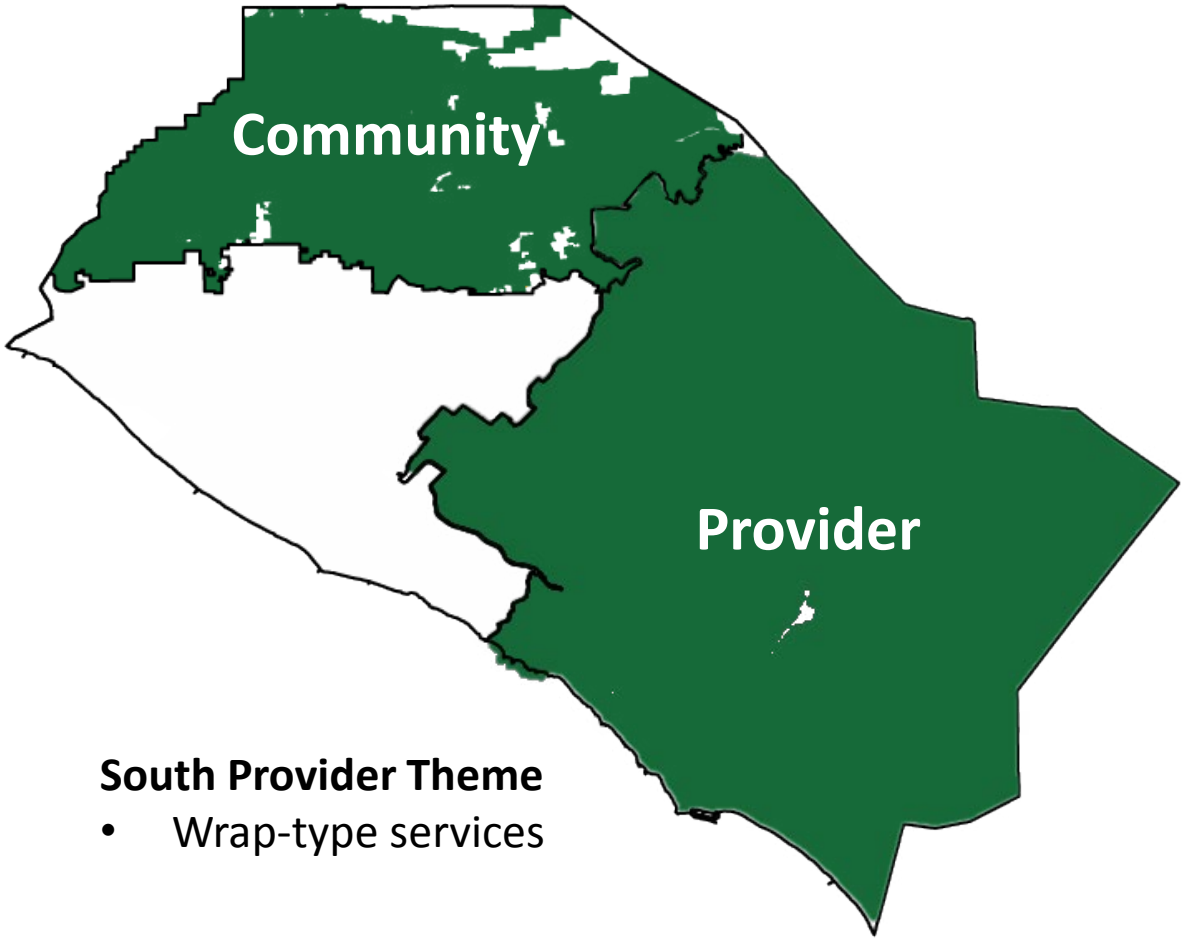
North Community Themes

- Wrap services
- Expanded medical detox services
- Housing options for after care
- SUD treatment for all ages

Region-Specific CEM Priority: Clinic-Based Outpatient

North Community Themes

- Wrap-type services for:
  - All ages
  - Culturally underserved
  - Individuals with co-occurring and substance use needs



South Provider Theme

- Wrap-type services

CEM Feedback Available at:

http://www.ochealthinfo.com/bhs/about/pi/mhsa

PEI Community Planning Meetings

PEI CPP: When?

August 7: Overview, MHSOAC PEI Regulations

August 14: Family support programs, programs serving families w/ children 0-8

August 21: School-based programs, children/youth 9-16, TAY

August 29: Adult and Older Adult programs

September 11: TAY revisited

September 25: Summary

PEI CPP: What?

- To provide the MHSA Steering Committee with a list of community service needs and target populations for prioritization in the use of available MHSA funds
- To take a deeper dive into the PEI needs of the community to better inform all MHSA/PEI programing

PEI CPP: How?

- Held a series of meetings, with each meeting focused on a specific target population
- Participants identified needs and priorities in small workgroups and reported out to group
- PEI Staff summarized feedback and themes from each meeting

PEI CPP: Results

PEI CPP Identified Needs	
1	Increased awareness / Improved navigation of the Behavioral Health System
2	Systematic screenings for mental illness
3	Training for individuals, families and providers
4	Implementation and/or expansion of peer support models
5	Time-limited expansion of existing direct services
6	Time-limited funding of new services
7	Targeted stigma reduction programs
8	Additional supports to remove barriers to access/training

PEI CPP-Specific Themes

Identified Need #2 - Systematic screenings for mental illness:

- Translate information and tools in a culturally aware manner
- Expand screenings for Older Adults to determine if symptoms are caused by depression or dementia

Identified Need #5: Time-Limited Expansion of Existing Direct Services:

- Expand screenings for Older Adults to determine if symptoms are caused by depression or dementia
- System-wide expansion to promote perinatal MH services, including for fathers (more screenings, case management, early intervention)
- Expansion of early intervention services for older adults, with a focus on immigrant communities; include increased geropsychiatry hours
- Services targeting TAY not attending Colleges or Universities

PEI CPP-Specific Themes con't

Identified Need #8 - Additional Supports to Remove Barriers to Increase Access / Training

- Provide childcare

Integrated CEM / PEI Results

Prevention

Focal Target Populations:

- Children
- 0-15 year olds
- TAY
- LGBTIQ
- College Students
- Older Adults
- Culturally / linguistically isolated and unserved

Prevention Themes

Stigma Reduction

- Provider CEMs: North, Central
- Community CEMs: Central
- PEI CPP

Examples:

- Awareness campaigns for:
  - first responders working w/ young children
  - older adults
  - Veterans, LGBTIQ community, immigrants
- Increased information and education in culturally sensitive and appropriate messaging with inclusive language

Prevention Themes

Improved Navigation / Access & Linkage

- **PEI CPP**
- **Also in Provider and Community CEMs**

Examples

- **Comprehensive resource inventory…:**
  - **to assess unmet need, including geomapped resources**
  - **of school-based mental health resources, including all districts**
  - **for older adults, their families and providers**
- **Care coordination to better link children to appropriate specialty/mental health services**
- **Use of technology, smart phones and apps as being piloted in INN Tech Suite, with emphasis on linking youth to services**

Prevention Themes

Suicide Prevention

- **Community CEMs: Central, South**
- **PEI CPP**

Examples:

- **Expansion of violence prevention and suicide prevention**
  - **focus on children, TAY, school-aged youth**

Prevention Themes

Parent/Family Support Peers

- **Provider CEMs: South**
- **PEI CPP**

Examples:

- **Peer support:**
  - **in schools to further address bullying, trauma and suicide prevention**
  - **in colleges and universities, especially for the LGBTIQ community and Veterans**
  - **for LGBTIQ, specifically in foster care**
  - **for Veterans not in the college system**
- **Peer navigators and support for seniors**
- **Parent partners who build trust and assist in navigating services, especially for underserved and homeless families**

Prevention Themes

Training

- Provider CEMs: North, Central, South
- Community CEMs: South
- PEI CPP

Examples:

- Expanded workforce capacity/skills to work with young children to promote, educate, prevent, identify, link to services
- Increased training opportunities through BHS Training and PEI in higher education
- Training for parents whose children are on probation
- Prevention educ. on LGBTIQ and TAY issues for foster parents
- Trauma-focused trainings to providers serving all populations
- Trainings for:
  - support service providers for isolated and older adults, e.g., Meals on Wheels volunteers
  - faith-based community
  - providers who serve TAY, LGBTIQ and Veterans

Prevention Themes

Integrated Care

- **Community CEMs: South**
- **PEI CPP**

Examples

- **Demonstration project of Behavioral Health integration in pediatric primary care**

School-Based Mental Health

Focal Target Populations:

- Students of all ages
- LGBTIQ students
- Parents
- School staff

School-Based MH Themes

Mental Health Services

- Provider CEMs: North, Central, South
- Community CEMs: Central
- PEI CPP

Examples:

- Increase school counselors, social workers, therapists to provide more early intervention
- Increase bilingual therapists
- Develop Wellness Centers in schools
- Provide specialized services for LGBTIQ students
- Provide mobile services

School-Based MH Themes

Parent Support

- **Provider CEMs: North, Central**
- **Community CEMs: South**
- **PEI CPP**

Examples:

- **Provide family strengthening programs**
- **Provide parent education and training**

School-Based MH Themes

Education/ Training

- Provider CEMs: North, Central
- Community CEMs: South
- PEI CPP

Examples:

- Training on mental health for:
  - school staff, counselors & administrators, including colleges and universities
- Compensation for substitutes so teachers can attend trainings

School-Based MH Themes

Screening

- Provider CEMs: North, South
- Community CEMs: South
- PEI CPP

Examples:

- Implement universal screening tools in pediatric primary care, early childcare and school settings
- Provide developmental screening for all ages
- Assess adverse childhood experiences (ACES)

Clinic-Based Outpatient

Focal Target Populations:

- Older Adults
- Children
- Vulnerable populations

Clinic-Based Outpatient Themes

Mobile Services/ Telehealth

- **Provider CEMs: North, South**
- **PEI CPP**

Examples:

- **Telehealth, especially for families with children from birth to age 8**
- **Transportation services**
  - **Including for seniors who are home-bound**

Clinic-Based Outpatient Themes

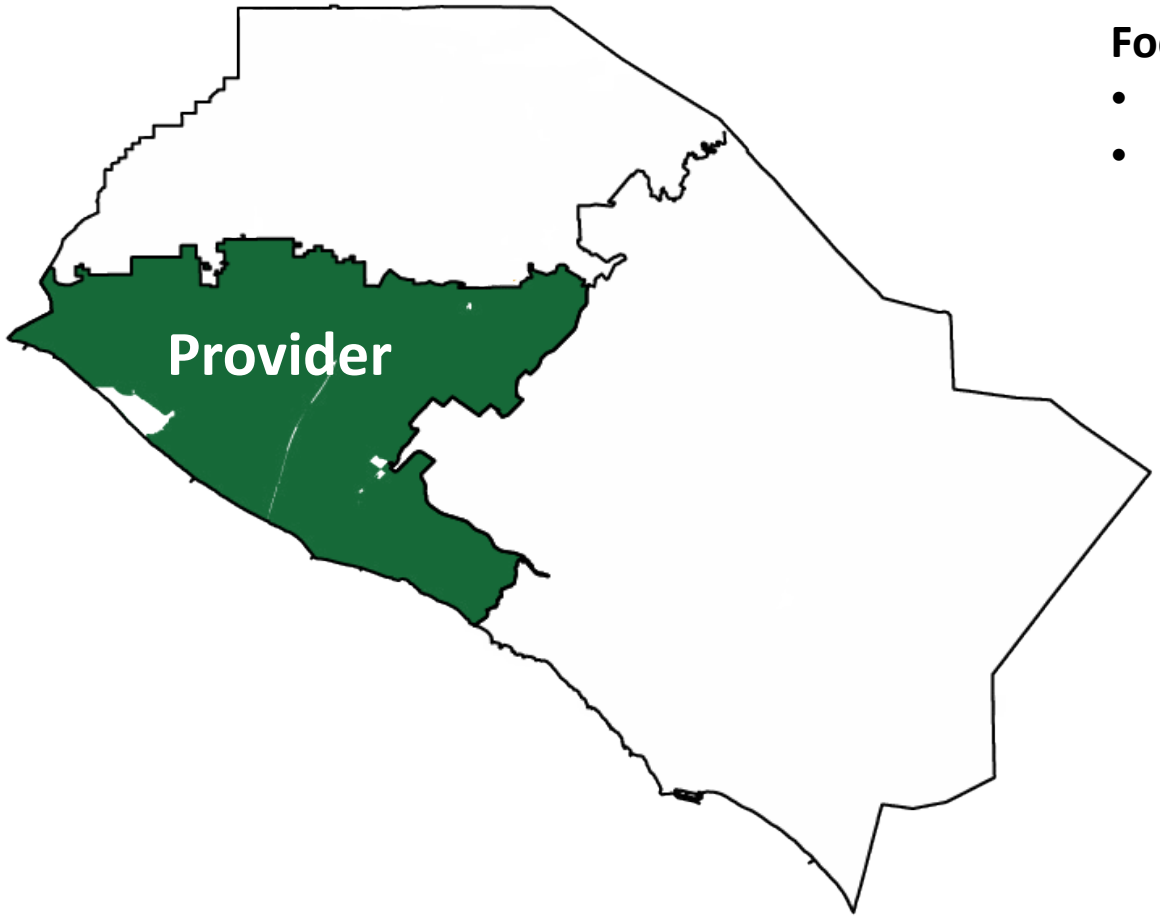
Expanded Services

- Provider CEMs: North, South
- Community CEMs: North, Central
- PEI CPP

Examples:

- **Expanded services:**
  - **Children's services**
  - **Co-occurring services, including for TAY**
  - **Bilingual CCSS therapists**
- **Daily groups on life skills, mindfulness, stress**
- **Stress reduction services**
- **Care Coordination**
- **Culturally/linguistically appropriate services addressing stigma, trauma, outreach, esp. for Cambodian community**

Navigation/Access to Treatment



Focal Target Populations:

- Older Adults
- Monolingual Communities

Navigation/ Tx Access Themes

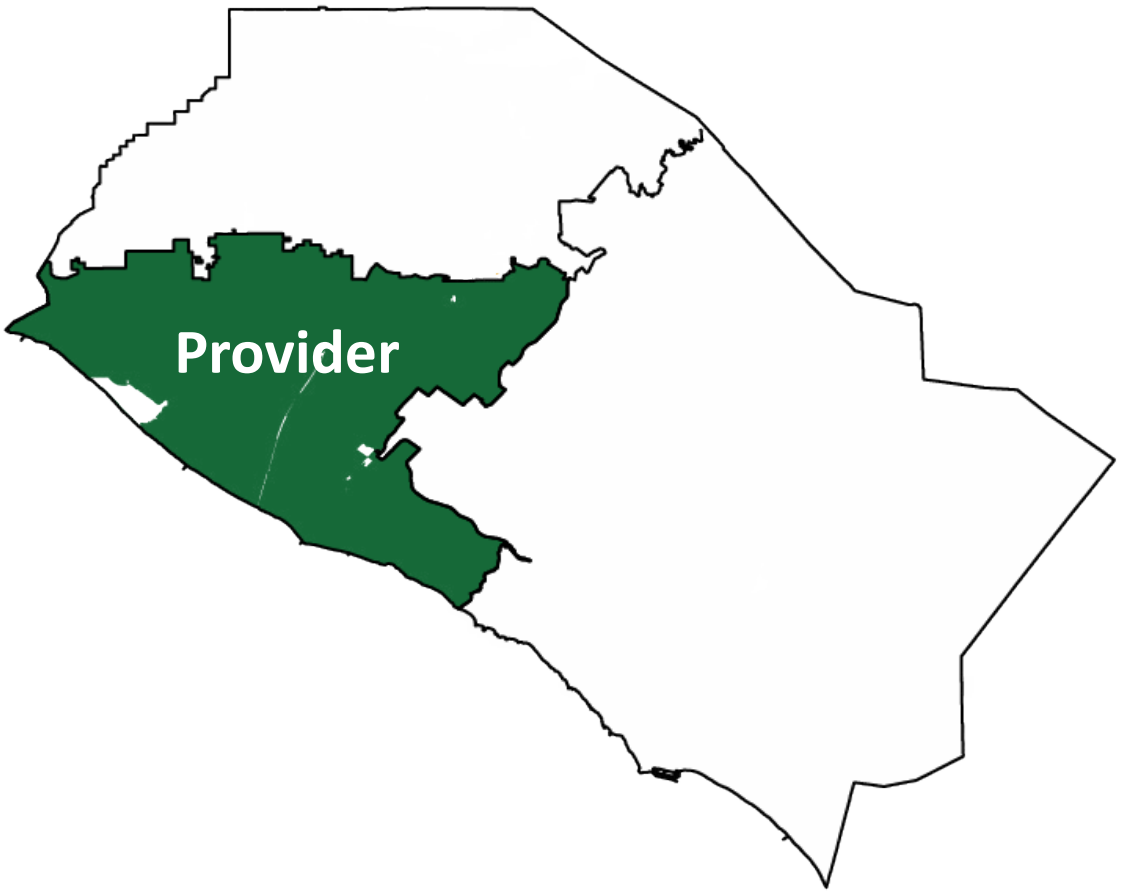
Navigation / Access

- Provider CEMs: Central
- PEI CPP

Examples:

- Expand Outreach and Engagement Services
- Target specific populations:
  - Older adults
- Cultural and linguistic services:
  - Bilingual staffing: Spanish, Vietnamese, Cambodian speaking
- Media Campaigns, linkage fairs, drop in centers

Employment / Education / Vocational Support



Focal Target Populations:

- TAY

Employ. / Educ. / Vocational Support Themes

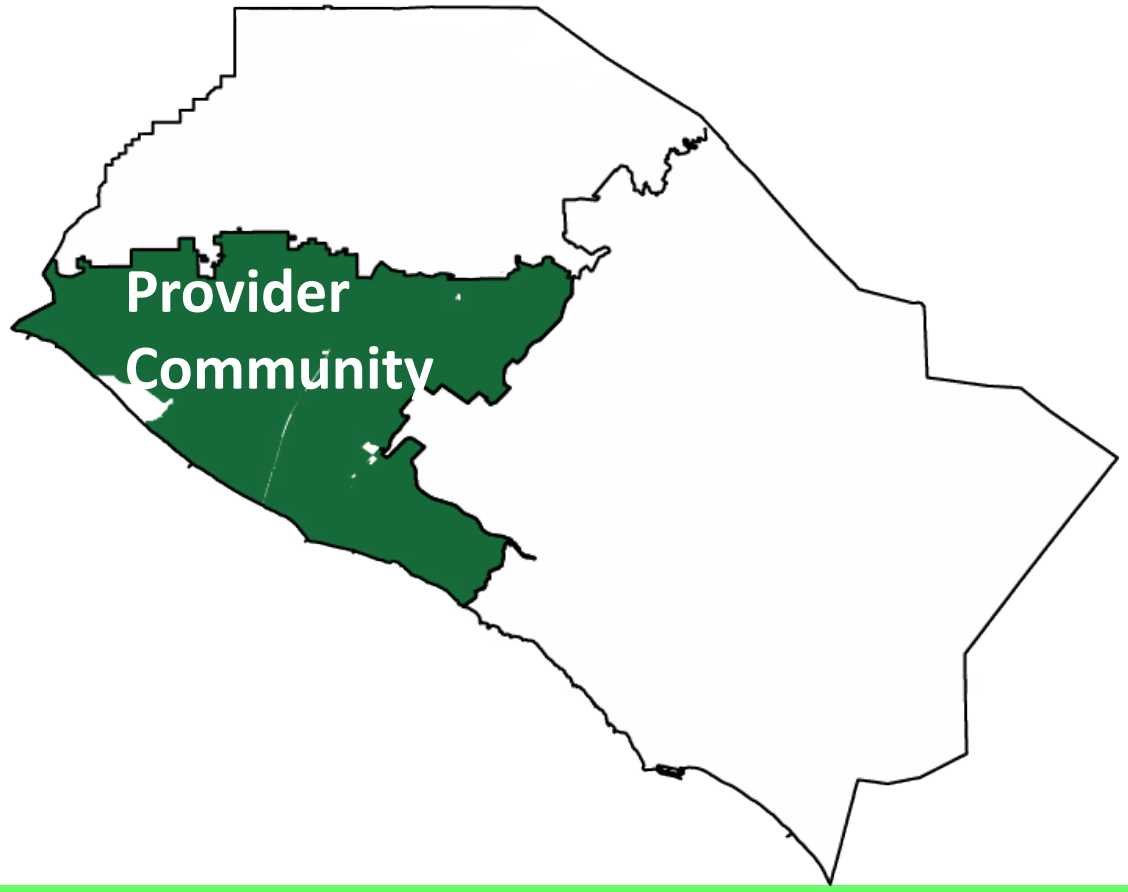
Employ. / Educ. Support

- Provider CEMs: Central
- PEI CPP

Examples:

- Expand employment services:
  - training, resources, job developers
- Employ paraprofessionals/staff with lived experiences
- Provide employment, training activities for individuals with mental illness to promote employment and meaningful activities

Peer / Family Support



Focal Target Populations:

- Older Adults
- LGBTIQ
- Veterans
- Foster Youth
- College Students
- Monolingual Communities

Peer / Family Support Themes

Peer / Family Support

- Provider CEMs: Central
- Community CEMs: Central
- PEI CPP

Examples:

- Expansion of peer services in all age groups:
  - Parent Partners/Peer support for families to assist in navigating services, especially for:
    - underserved and homeless families
    - culturally appropriate – Cambodian pop.
  - Peer support in the schools:
    - on bullying, trauma and suicide prevention
    - for LGBTIQ, Veteran communities
  - Board and care, designated facilities, private conservators
- Language access

PEI CPP System-wide Themes

Partnering, Integration and Collaboration

- Build relationships at the leadership levels between HCA, school superintendents, FRC's, colleges/universities to help eliminate systemic barriers such as time taken for MOU's, permission and access into schools
- Organized and systematic networking opportunities to share available resources, such as sharing success stories via a newsletter
- More partnering with community based organizations to provide behavioral health services at trusted community sites
- Private/Public partnerships/Integration

PEI CPP Summaries Available at:

http://www.ochealthinfo.com/bhs/about/pi/mhsa

Funds Available for PEI Planning

	Proj. FY 19/20 PEI Allocation (inc. int)	* PEI Carry Over Funds	Total
CEO Projected Available PEI Funds for FY 2019-20:	$30.6M	$34.1M	$64.7M
Current on-going PEI FY 19/20 budget:	($30.6M)	($4M)	($34.6M)
** Carry over funds for PEI programs in FY 18/19:		($0.2M)	($0.2M)
** Additional carry over funds for PEI programs in FY 19/20:		($2.9M)	($2.9M)
** Carry over funds for PEI programs in future years (FY's 20/21-22/23):		($4.5M)	($4.5M)
*** Projected funds available for PEI Programs:	$0	$22.5M	$22.5M

** Carry Over funds are finite. Once spent, these funds will not be replenished.*

*** PEI programs using Carry Over PEI funds:*

1. *OC4VETs–Carry over funding expires FY 19/20*
2. *OC Links–Carry over funding expires FY 22/23*
3. *School Based BH–Carry over funding expires FY 20/21*
4. *Violence Prevention–Carry over funding expires FY 22/23*
5. *School Readiness–Carry over funding expires FY 22/23*

**** As of 9/17/18. Amount available is subject to change pending further directed priorities.*

APPENDIX V: SUMMARY OF PUBLIC COMMENTS AND RESPONSES (March 22, 2019 - April 21, 2019)

RESIDENTIAL DRUG TREATMENT PROGRAM

Comment	Response
1. Co-occurring illnesses. Residential drug treatment programs needs continuing services for the addicted individual much like the SAMSHA EBP that would follow the individual back to the place of residency. Without the reinforcement of the original residential program, Anita House would be short on effectiveness. The only reference to an EBP in the 2019-20 Plan Update was targeted at children under 18 years of age. The MHSA Plan does not include any preventative measures against drug relapse following initial residential substance abuse programs.	**1.** Thank you for your comment. MHSA funds cannot be used to pay for SUD programs which is why programs solely focused on treating and/or preventing substance use disorders are not included in this Plan. Those services are provided in other parts of our County behavioral health system.
2. Adolescent Dual Diagnosis Residential Treatment – Discontinued through MHSA funding, instead funding through Drug Medi-Cal and Medi-Cal. Unclear if this is a full replacement of current program costs or if the program will have an opportunity for needed expansion once it is funded by Drug Medi-Cal and Medi-Cal. If this change does not allow for an expansion of services we should request that some MHSA funds still be provided to allow for this opportunity.	**2.** MHSA will pay for the mental health portion (Medi-Cal), and the residential portion of the program will be paid with Drug Medi-Cal, State General and Substance Abuse Block Grant (SABG) funding. MHSA funds are not needed because these other funding sources are sufficient to cover these program costs.

OLDER ADULT SERVICES

Comment

1. Disappointed in the funding inequity concerning older adults. Orange County remains woefully behind in recognizing the rising tide of older adults with mental health issues. The number or programs specifically designated for older adults is incredibly small which results in only a few of the thousands of un-served and underserved older adults with serious mental health issues being served. I encourage the MHSA Steering Committee to reevaluate the proposed plan and increase allocations of funds and programs to address Tsunami of aging adults in OC.

2. There is very little support/programs/services specific to older adults. The population 65 and older is the ONLY growing demographic in the County. They are at greater risk of homelessness, depression, and suicide. We encourage you to allocate a greater portion of the plan to Seniors.

3. **Two-part comment on older adults:**
    1. Increase cost-effective and timely housing options for older adults with serious mental health needs. This can be done by re-directing mental health funds to expand existing Assisted Living/Residential Care Facilities for the Elderly (RCFE's) community beds and increase mental health programming, wraparound supportive services and treatment funded at those locations. Payments to providers should be increased to reflect market level prices.
    2. Create a Silver TREEhouse. The county already has a TREEHouse program for adults (18-59) in psychiatric crisis. The TREEhouse is a crisis residential program that provides voluntary care to adults needing stabilization. A Silver TREEhouse would expand access for older adults (age 60 and over) and provide stabilization beds for those in crisis. In addition transition to long term care for post stabilizations and dual diagnosis support should be incorporated into the continuum of care pathways for seniors.

4. **Four-part comment on older adults:**
    1. Orange County is woefully behind in recognizing the rising tide of older adults with mental health issues who are cresting on the wave of the Silver Tsunami.
    2. The number of programs specifically designated for older adults is incredibly small (fewer than 10) and sever of these programs have not even begun to be implemented yet.
    3. The estimated number of older adults to be served in these programs is in the low to mid-hundreds (nowhere close to the thousands of older adults in the county with mental health concerns).
    4. The annual budgeted funds for these programs is likewise extremely low in proportion to the number of potential needy older adults with mental health issues. Please consider supplementing, enhancing, and expanding existing programs as well as increasing housing options for older adults with mental health needs at market level rates.

Response

Thank you to everyone who submitted comments related to services for older adults. HCA is continuing to work with the MHSA Steering Committee, and the Mental Health Board to address the issues raised around the need for services related to Older Adults.

While many older adults receive services in our adult MHSA programs and non-MHSA programs, efforts in the FY 2019-20 MHSA Plan Update to expand programs that specifically target Older Adults include $3 million of time-limited PEI funds over three years that were added to the Early Intervention Services for Older Adults Program. These additional dollars will expand existing services beginning July 1, pending Board approval.

HCA is also currently exploring the idea of implementing a Silver Treehouse Program, as noted in the Crisis Residential Program description in this Plan.

Finally, after the closing of a contracted RCFE a few years ago, HCA released an RFP and did not receive any bids. HCA will be working on a new procurement for an RCFE soon.

CHILDREN AND YOUTH SERVICES

Comment

1. How will very low school penetration levels by program be addressed?

2. Which school districts have MOU's to work directly with HCA?

Response

1. The School-Based Behavioral Health Intervention and Supports was expanded in Jan 2019, allocating four million of the PEI time-limited funds over three years. In addition, HCA recommended new school-based programing with another $5.5 million of PEI time-limited funds over three years. Beyond this expansion and addition, HCA has partnered with OCDE in conducting a mental health survey that went out to all school districts to better understand what non-MHSA services are currently available in the schools. The findings from this survey will provide better understanding of the current needs and gaps after taking into account services provided across systems and funding sources. By having a better understanding of behavioral health services that are provided within school districts, HCA will be able better prioritize MHSA-funded school-based programing. Continued collaborative partnerships with OCDE and school districts will be instrumental in this effort.

2. In regards to MHSA/PEI funded county-operated programs, HCA currently has MOU's with Santa Ana USD, Anaheim Union USD, and Newport Mesa USD and will have another with Tustin USD. MHSA/PEI funded county-contracted programs also have MOU's with several school districts. In addition, HCA CYBH county-operated programs are currently contracted with the following districts to provide services that schools are responsible to provide or make available per state legislation: Anaheim Union High School District, Centralia School District, Cypress School District, Garden Grove USD, Los Alamitos USD, Magnolia School District, Orange USD, Orange County Department of Education, Savanna School District, and Tustin Unified School District.

CHILDREN AND YOUTH SERVICES

Comment

3. Could PEI be expanded school system wide? Selected grade wide? General population county wide? (485K students, 30-40K per grade and 3.2 million residents, Medi-Cal 1/3)

4. Early Childhood Mental Health – inclusion of a new ECMH program. ECMH, School Readiness and Connect the Tots are included together still only represents a small percentage of the entire MHSA budget. Given the importance of identifying many mental health issues at the earliest ages possible (0-5), these portions of the plan are still out of balance with what the County needs to have a highly successful "Act early" approach. IT is recommended that additional PEI funds be used for projects that enhance the overall ECMH clinical services capacity (CPP, PCIT, etc) in the County to provide more options for School Readiness, Connect the Tots and the ECMH consultants to refer young children with the highest severity of need. Additionally, expanding the CSS Children's Outpatient Services to mainstream ECMH clinical services would help to sustain this expanded capacity.

Response

3. HCA is waiting for the School Mental Health Survey to better understand the need and what services are already in place.

4. $2 million of the time-limited PEI dollars was added for this target population to fund a new Early Childhood Mental Health Program focusing on services provided in early childcare settings. In addition, $2.7 million in time-limited funding over five years expanded the School Readiness Program, which also serves this target population. The program addition and expansion was strongly supported by the Early Development Index (EDI) data indicating the need across Orange County. Children's Outpatient services span both CSS-funded and non-CSS-funded programs and we are exploring workforce training on focused- ECMH assessment and interventions. Additionally, Children's Outpatient Services continues to work in conjunction with PEI services to create an increasingly seamless system of care for children and youth. The children's clinics currently use PCIT as a treatment approach and BHS will continue to explore the utilization of technology and other best practices in serving this population.

TRANSPORTATION

Comment

1. Transportation is mentioned throughout the plan. Has the transportation program been expanded to cover all aged people including caretakers using any of the MHSA programs?

Response

1. The Transportation program is for adults, 18 and over, including older adults over 60. This program does not serve TAY under 18 or children. The program has been rolled out to all AOABH MH and SUD programs, with the focus of getting adult clients to their treatment and medical appointments. This program is not open to caretakers.

   When transportation is mentioned in other programs contained within this Plan, that transportation assistance is provided by the respective program and is not referencing the Transportation program itself.

HOUSING

Comment

1. Is the $25 million at CalHFA completely assigned to specific projects? Any still available? Any reversion implications for CalHFA funs not spent within three years? Does the annual $30 million housing spending allocation match the county housing plan? If not, why? Can $30 million be realistically implemented in FY 19/20? What is the county projected housing flow to attach funds to projects?

2. What are the anticipated services for the supportive housing program? Are these 200 new people to county programs? What is the $10,000 per person based on?

Response

1. As Orange County Community Resources identifies projects in the pipeline, they are brought forward and assigned dollars. There are no reversion implications for dollars assigned to CalHFA.

2. The RFP for this program is still in development. The services to date include but are not limited to: Case management, peer support, linkage to behavioral health care with mental health or substance use disorders, benefits counseling and advocacy and housing retention skills. The program is not limited to clients new to County programs. The $10,000 estimate is based on input from the community, consultation and a review of FSP cost per client.

BUDGET

Comment

1. How much of the planned expenditures are at risk to become projected unspent carryover funds due to delayed implementation (RFP, internal delays like hiring)?

2. Why is the estimated Medi-Cal FFP low in relationship to toal dollars CSS $20.5 (10.7%) and PEI (0%)? Other southern California counties are CSS (28% to 40%) and PEI (8% to 25%).

3. Q4: Why are cost per person (so) so high? Lack of Broad-Based Programs? FSP vs. PACT? Navigation?

Response

1. In order to spend all of our funds, HCA has budgeted above available funds this year. HCA tries to spend down as much of the funds as possible and, based on previous expenditure rates, HCA estimates it will spend approximately 82% of the FY 2019-20 budget. HCA cannot spend more than the anticipated revenue. No CSS dollars are at risk of reversion.

2. Orange County has always been conservative in the Medi-Cal FFP estimates. HCA cannot comment on how other counties estimate their Medi-Cal FFP.

3. A4: Cost per person vary depending on the size and scope of work being provided. FSP programs have a higher cost per person compared to those in a PACT program due to the flex funds associated with an FSP that are not available with PACT program participants.

   The number of engaged participants does not accurately reflect the level of services that are being provided to O&E participants. Many outreach contacts choose to not “enroll” in services with O&E but are still receiving intensive case management by O&E staff to address their barriers to treatment and stabilize their living situation so that they are receptive to behavioral health services. Enrolled participant data also does not account for the multiple contacts made with individuals to build rapport and trust so that they are willing to share their needs and link to needed resources.

BUDGET

Comment

4. How can a more robust Community Planning Process (CPP) be incorporated in FY 19/20 as the county plans for the next three-year plan FY 20/20 to FY 22/23?

5. MHSA Budget – Progress has been made in the draft 2019-20 Plan with the inclusion of an expectation to spend more MHSA funds than previous years. (A) Develop a community funding mechanism to quickly capture and expend unspent funds for critical needs as an alternative to planning underspending. (B) A clearly articulated revenue downturn plan that maximizes multiple layers of one-time and easier to implement reductions in spending if needed. (C) Greater accountability for MHSA housing funds that were transferred to other accounts but were, for the most part, not actually spent.

6. Cause of Change Reporting Not Included in Draft Update – Each year, several programs that are planned are not fully implemented. It would be helpful to include in the Plan Updates a summary of which programs were delayed, the financial impact to the Plan, and the cause of why a change had to be made to what was originally planned. (i.e. if a program was delayed three months, list the name, the amount not spent and the reason for the delay).

Response

4. HCA continues to look to community stakeholders who can help identify important needs and gaps in the behavioral health system of care. The MHSA Office expanded community planning this past year with seven Community Engagement Meetings and five PEI Community Planning Workshops, and will look for additional strategies to increase community stakeholder involvement as we move into planning for our next Three-Year MHSA Plan.

5. CEO Budget, HCA and the MHSA Office are continuing to operationalize a plan to spend available funds as quickly and efficiently as possible. HCA will share updates on this plan with the MHB and MHSA Steering Committee as they became available.

6. The MHSA Plan Update does identify challenges and barriers to bringing a program up to full capacity, although it currently does not separate it out on a financial level.

APPENDIX VI: MINUTES FROM MENTAL HEALTH BOARD PUBLIC HEARING

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:
http://ochealthinfo.com/bhs/about/mhb

Tuesday, April 30, 2019
5:30 p.m. – 7:30 p.m.

Meeting Location
Brea Community Center
695 Madison Way, Brea, CA 92821

MINUTES
Page 1 of 2

Members Present: Clayton Chau, Christine Costa, Karyl Dupee, Matthew Holzmann, Kristen Pankratz, Michaell Rose

Members Absent: Supervisor Andrew Do, Sandra Finestone, Bethsabe Romero, Joy Torres

Call to Order at 5:41 p.m. by Michaell Rose

Welcome and Introductions
- Pledge of Allegiance.
- Each member of the Board introduced themselves and their respective affiliation.

Public Comment
- No Public Comments were made.

Open MHSA Public Hearing
- Opening Remarks: Sharon Ishikawa, MHSA Coordinator
  - Dr. Ishikawa thanked the guests in attendance and the members of the Mental Health Board. She explained the purpose of today's Public Hearing and made mention of the community planning process and timeline associated with the MHSA Annual Plan Update. Dr. Ishikawa provided a detailed presentation with an overview of MHSA's components, budgets and program updates. She provided information on the Prevention and Early Intervention (PEI) limited time funding programs (both expansions and new programs), a status update to the Innovation (INN) Behavioral Health System Transformation Project, and new allocations for a Community Services and Supports (CSS) Supportive Services for Residents in Permanent Housing program. The MHSA total budget for FY 2019/20 is $268,562,473, which is a total increase of $82,321,208 from the original MHSA 3-Year Program and Expenditure Plan. Furthermore, she provided a copy and overview of all public comments received during the 30-day public comment period for the plan. There were a total of 7 comment forms received by the MHSA Office, and responses were made based on the following categories: (Residential Drug Treatment Programs, Older Adult Services, Children and Youth Services, Transportation, Housing and Budget).

BOARD OF SUPERVISORS

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Michelle Steel, Vice Chair
Second District

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First District

Donald P. Wagner
Third District

Doug Chaffee
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Matthew Holzmann, Vice Chair

Supervisor Andrew Do,
First District

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Christine Costa, DNP, PMHNP-BC

Karyl Dupee, LMFT

Sandra Finestone, Psy.D.

Stephen McNally

Kristen Pankratz, MSW

Bethsabe Romero, PhD

Joy Torres

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Deputy Agency Director
Behavioral Health Services

Annette Mugrditchian, LCSW
Chief of Operations
Behavioral Health Services

Karla Perez
Staff Specialist
Behavioral Health Services

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:

Tuesday, April 30, 2019
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MINUTES
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- Public Comment:
  - A total of seven (7) individuals provided a public comment with regard to the MHSA Annual Plan Update for Fiscal Year 2019 – 20. These individuals represented consumer, family member, professional and public interest points of view. Out of the seven (7) public comments: three (3) individuals shared their gratitude for services received from an MHSA program or Wellness Center; one (1) individual expressed concern for the lack of inclusion of the California Health Policy Strategies MHSA Audit that was completed in the fall; one (1) individual shared their vision for a future collaboration on early childhood mental health; one (1) individual shared of her experience as a peer specialist and how empowering others in their goals has empowered her in her recovery; and one (1) individual spoke about his experience and expressed a need for culturally and linguistically competent services.

Close Public Hearing and MHB Vote: Action Item
- Michaell Rose called for a motion for their vote in support of approving the MHSA Annual Plan Update Fiscal Year 2019-20. The MHSA Plan Update was unanimously approved with a 5 yes/1 no vote.

Adjournment
- 7:40 pm

Officially submitted by: Karla Perez
Note: Copies of all writings pertaining to items in these MHB minutes are available for public review in the Behavioral Health Services Advisory Board Office, 405 W. 5th Street, Santa Ana, CA 92701, (714) 834-5481 or Email:* kperez@ochca.com *

APPENDIX VII: ORANGE COUNTY BOARD OF SUPERVISORS MINUTE ORDER

ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
May 21, 2019

Submitting Agency/Department: HEALTH CARE AGENCY

Approve annual updates to Three-Year Program and Expenditure Plan for Mental Health Services Act, Proposition 63 programs and services, 7/1/19 - 6/30/20; and authorize Director or designee to execute annual updates - All Districts

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

APPROVED AS AMENDED TO INCREASE THE AMOUNT FOR SUPPORTIVE SERVICES FOR RESIDENTS I PERMANENT SUPPORTIVE HOUSING PROGRAM TO $5 MILLION FOR 12 MONTHS

Unanimous ☒ (1) DO: **Y** (2) STEEL: **Y** (3) WAGNER: **Y** (4) CHAFFEE: **Y** (5) BARTLETT: **Y**
Vote Key: Y=Yes; N=No; A=Abstain; X=Excused; B.O.=Board Order

Documents accompanying this matter:

☐ Resolution(s)
☐ Ordinances(s)
☐ Contract(s)

Item No. 33

Special Notes:

Copies sent to:

HCA – Annette Mugrditchian

5/24/19

I certify that the foregoing is a true and correct copy of the Minute Order adop by the Board of Supervisors , Orange County, State of California.
Robin Stieler, Clerk of the Board

By: _____ Deputy

1

405 W. 5th Street
Santa Ana, CA 92701
ochealthinfo.com/mhsa
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