2022-2023

ORANGE COUNTY

Mental Health Services Act

FY 2022-2023 Annual Plan Update

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

COUNTY OF ORANGE · CALIFORNIA

OC health CARE AGENCY

A Message from the Chief of Mental Health and Recovery Services

Thank you for your interest in the Orange County, Mental Health and Recovery Services (MHRS) Mental Health Services Act (MHSA) Annual Update Plan Fiscal Year 2022/23. I would like to take this opportunity to introduce myself to you as the new Chief of Mental Health and Recovery Services in Orange County. In January 2022, I returned to Orange County Health Care Agency after serving as the Director of San Bernardino County for over 10 years. I look forward to working in collaboration with you as we continue to embrace community input, and utilize MHSA funding, to transform our system of care.

This is the third and final year of the current (MHSA) Three-Year Program and Expenditure Plan for FY's 2020/21 – 2022/23. This plan is consistent and committed to advancing the three strategic priorities of the current MHSA Three-Year Plan: 1) extend the scope and reach of mental health awareness campaigns, community training and education; 2) strengthen the County of Orange's (County) suicide prevention efforts by expanding the programs making up our crisis services continuum; and 3) improve access to needed behavioral health services. These priorities remain relevant as we move forward in our planning process.

This is an unprecedented time for the residents of Orange County, particularly the most vulnerable populations, who are challenged to navigate the new realities of a post-demic community. Through a vision of quality health for all, and implementing the values of the MHSA Act, MHSA programs and services will continue to contribute to this effort by promoting recovery, wellness, and seek to fortify the personal resilience of individuals, family members and the community.
While it remains a top priority to ensure that we provide our consumers, family members and participants with exemplary services, we are also called to pay attention to our own cultural awareness and sensitivity. As we do our work, it is incumbent that we do so from a health equity perspective – addressing longstanding inequalities in service delivery and outcomes based on race, ethnicity and culture. An important step in this transformation is a continued commitment to engage meaningfully with the people, families and communities we have the privilege of working with every day, and whose voices have helped shape this MHSA Annual Plan Update.

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

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

Sincerely,

Dr. Veronica Kelley, LCSW
Chief of Mental Health and Recovery Services

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Executive Summary

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

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

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

MHSA Three-Year Plan Progress Update

STRATEGIC PRIORITIES FOR THE THREE-YEAR PLAN

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

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

In preparation for the community planning process for the FY 2022-23 Annual Plan Update, the HCA reviewed the current status of each of OC's MHSA priorities (see below) and how each was addressed during the past year.

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

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

Priority Populations	Strategies	Progress Update
■ LGBTIQ individuals ■ Boys ages 4-11 ■ Transitional Age Youth (TAY) ages 18-25 ■ Adults ages 25-34 and 45-54 ■ Unemployed adults ■ Homeless individuals ■ Individuals living with co-occurring mental health and substance use conditions ■ Older Adults ages 60+	■ Engage through Social Media, Internet, Events/Fairs, TV, radio, newspapers, senior centers for older adults ■ Focus on positive messages, simple language, good visuals & color, slogans & phrases, not jargon ■ Cultural representation (authentically) ■ Use trusted sources, celebrities, influencers ■ Increase inter-agency collaboration and group activities	Continue outreach and awareness initiatives targeting TAY populations ■ In 2021 HCA hosted a Virtual Veteran's Conference which was attend by 114 people. ■ The StigmaFreeOC Website continues to outreach to the community, with 398 Organizations taking the pledge to be Stigma Free. ■ The HCA website (www.ochealthinfo.com) was updated through work with a web designer to improve the organization and navigation for public usage. ■ OC Directing Change videos were shown prior to Angels Baseball games on Ballys Sports West as well as shared during Mental Health Awareness Month. ■ Due to the COVID-19 pandemic, an in-person Directing Change Award Ceremony has been postponed.

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations	Strategies	Progress Update
■ Youth ■ Families with children living with a mental health condition ■ Asian/Pacific Islander ■ Latino/Hispanic ■ Black/African American	■ Train staff on mobile technology, telehealth, other remote service options ■ Avoid merely providing devices (ex. Headsets and phones) due to issues with privacy and Wi-fi access ■ Avoid using a one-size fits all approach with both the language of content and the content itself, all material should be population specific ■ Use culturally appropriate and representative images, materials in preferred language(s) ■ Collaborative, group, community activities ■ Identify clinic lobby and common areas in MHRS outpatient clinics eligible and in need of upgrades. Conduct needs assessment. Encumber funds: up to $80k/clinic (Max/NTE $400k) to improve clinic lobby and common areas ■ Focus on the positive, use encouraging phrases ■ Avoid depicting sadness, despair or vulnerability through colors, imagery, stigmatizing and/or illness-focused language	■ Developed digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices. ■ 55% of respondents from the community survey in FY 2021-22 reported they have adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan. ■ Partnered with First 5 OC and Be Well OC in creating additional promotional and educational materials for families with young children. ■ The MHSA office has developed a workgroup and identified 7 potential lobby and common areas in MHRS outpatient clinics in need of upgrades. The workgroup meets regularly and is working with a vendor to develop designs. ■ Conducted focus groups to gather needs assessment (including focus on the positive, encouraging phrases, and vibrant colors) and direct input from consumers. ■ Continue to coordinate through peer project manager (e.g., PEACe, the MHRS peer workgroup and Workplace Wellness Advocates) on clinic improvements. ■ Developed an art strategy to enhance the art programs through the use of an art committee with consumers to create artwork that will be used in clinics. ■ Transportation contract expanded to support more priority populations.

STRATEGIC PRIORITY: Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations	Strategies	Progress Update
■ People from all MHSA age groups ■ Homeless individuals ■ Individuals living with co-occurring mental health and substance use conditions ■ LGBTIQ individuals ■ Veterans	■ On October 6, 2020, the Board of Supervisors directed the County to establish the Office of Suicide Prevention (OSP) to reach out to high-risk populations to find and engage those in need, maintain contact with those in need and support continuity of care, improve the lives of those in need through comprehensive services and supports, and build community awareness, reduce stigma and promote help-seeking ■ Create a systems approach to suicide prevention ■ Build hope, purpose, and connection for individuals in need. ■ Promising pilot programs ■ Integrate new and existing services and support throughout suicide prevention	■ OSP Office and OSP Division Manager was announced on 8/2/2021. The Office of Suicide Prevention will coordinate suicide prevention efforts at the Agency level and interface with local and statewide initiatives to identify and facilitate the implementation of evidence based and promising suicide prevention activities in Orange County. ■ Continue expanded reach of activities/campaigns (also leverage Cal MHSA's Know the Signs information: ● Suicide Prevention campaign for Adult/Older Adult Men ● Adult "Help is Here" website ● Youth "Be a Friend for Life" website ■ The OSP has established a Community Suicide Prevention Initiative (CSPI) Coalition for implementation of a variety of suicide prevention initiatives through public and private partnerships. ■ All prevention services and activities are designed to promote wellness and improve connectedness and build resiliency and protective factors and reduce risk factors. ■ A countywide Connect OC Coalition for TAY populations was launched to provide a platform for youth from colleges, universities, and the community at large to connect with each other, promote mental wellness activities, educate the community on a wide array of mental wellness, stigma reduction and suicide prevention topics and increase help-seeking behavior in the community. ■ Outreach and awareness targeting TAY was conducted through innovative approaches such as theater and plays, forums such as Honest Hour, podcasts and Instagram and Facebook live events focusing on mental health themes followed by discussions with the audience.

MHSA Components Proposed Recommendations

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

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 Funds. It supports comprehensive mental health treatment for people of all ages who are living with a serious mental health condition that is significantly impacting their daily activities and functioning. CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration.

Several changes to the CSS component are proposed for Orange County's FY 2022-23 MHSA Plan Update. These include shifts in program budgets, discontinuation of programs and implementation of new projects. Due to the anticipated increase in MHSA revenue, in this year's MHSA Plan Update is significantly higher that what was originally proposed in the MHSA 3-Year Plan for FY 2022-23.

- Expansion of the Adult Full Service Partnership Programs to increase access and services to underserved target populations including Older Adults, monolingual Spanish and Vietnamese individuals, as well as Veterans
- Expansion of Housing development in Orange County consistent with the Orange County Strategic Plan to end Homelessness and increase inventory of housing units
- Expansion of the Warmline to continue to address access and linkages to services

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

FISCAL YEAR	CSS
FY 2020-21 *(from 3YP)*	$155,088,175
FY 2021-22 *(from APU)*	$158,785,110
FY 2022-23 *(from 3YP)*	$165,320,336
FY 2022-23 (proposed)	**$225,440,320**

CSS HOUSING

Under direction from the Board of Supervisors, in two separate directives, a total of $95,500,000 of CSS funds was allocated during FY 2018-19 to the development of permanent supportive housing via the Special Needs Housing Program (SNHP). SNHP has provided funding for 17 project (6 built and 11 in process). Effective January 3, 2020, the California Finance Agency discontinued SNHP. The remaining SNHP funds were approved by the Board to be transferred back to the County ($15.5 million) to the 2020 Supportive Housing NOFA (2020 NOFA) and $20.5 million to the Orange County Housing Finance Trust (OCHFT) as approved by the Board in May 2020. Currently, the MHSA pipeline reflects 16 completed projects, which includes 312 MHSA units. In addition, there are 23 projects in progress which will result in 379 additional MHSA units.

PREVENTION AND EARLY INTERVENTION COMPONENT

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

- Expansion of services under the new Office of Suicide Prevention.
- Add Pre K – 12 School based services to address high needs in youth and families.
- OC Links 24/7 and monolingual expansion to increase access and linkage to services.
- Integration of Justice Involved Services to streamline efforts consistent with OC CARES initiative.

Several changes to the PEI component are proposed for Orange County's FY 2022-23 MHSA Plan Update. These include shifts in program budgets, discontinuation of a program and implementation of new projects, which are summarized in a series of tables below. Several changes to the PEI component are proposed for Orange County's FY 2022-23 MHSA Plan Update. These include shifts in program budgets, discontinuation of a program and implementation of new projects, which are summarized in a series of tables on below.

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

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

FISCAL YEAR	PEI
FY 2020-21 *(from 3YP)*	$47,061,483
FY 2021-22 *(from APU)*	$56,144,101
FY 2022-23 *(from 3YP)*	$40,988,101
FY 2022-23 (proposed)	**$76,532,238**

INNOVATION COMPONENT

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

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

- allcove
- Clinical High Risk for Psychosis
- Community Program Planning
- Social Media & Approaches to Stigma Reduction
- Young Adult Court

FISCAL YEAR	INN
FY 2020-21 *(from 3YP)*	$18,346,360
FY 2021-22 *(from APU)*	$10,999,190
FY 2022-23 *(from 3YP)*	$10,999,190
FY 2022-23 (proposed)	**$11,701,218**

WORKFORCE EDUCATION AND TRAINING COMPONENT

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

The proposed FY 2022 – 23 budget is higher than what was approved in the MHSA Three-Year Plan. The Covid-19 pandemic significantly impacted the Behavioral Health workforce. The need for mental health and recovery services has become increasingly evident as individuals and families have experienced loss of loved ones, physical health, scarcity of food and other resources, isolation, and loss of employment. Many opportunities have become available to health care professionals in the private sector to address the growing need for services. During the community engagement process, stakeholders reported the impact of these changes on service delivery including increased wait times, less provider availability, turnover in staff, and new inexperienced staff. Expanding Workforce Education and Training programs will support hiring, training, and retaining high quality staff members. A full description of each WET program is provided in the Plan Update.

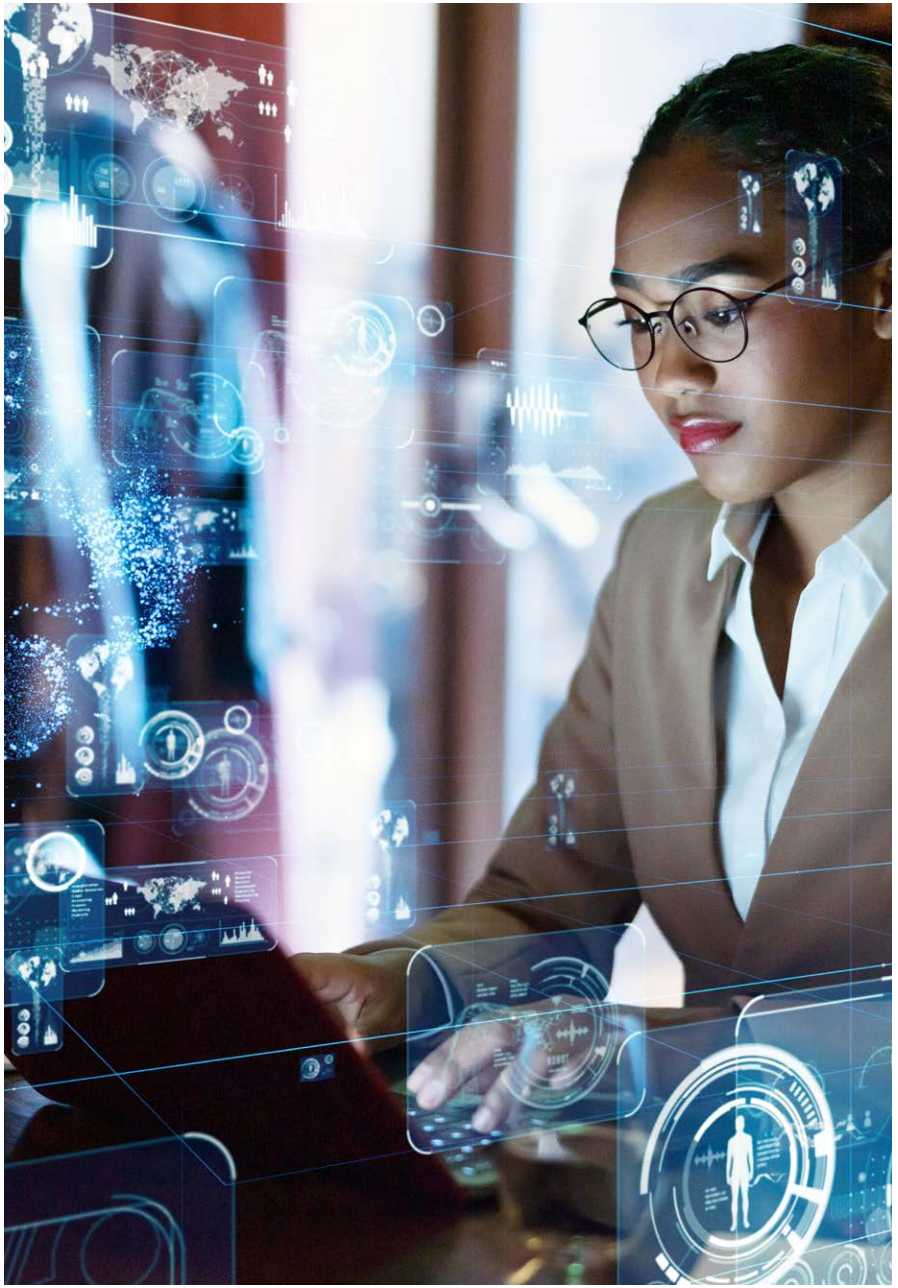
FISCAL YEAR	WET
FY 2020-21 *(from 3YP)*	$6,216,634
FY 2021-22 *(from APU)*	$5,219,984
FY 2022-23 *(from 3YP)*	$5,296,662
FY 2022-23 (proposed)	**$6,262,162**

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS COMPONENT

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

- Contribution of MHSA dollars to help fund a second Be Well campus to be located in South County
- Continued development and enhanced functionality of the HCA electronic health record (EHR), which will include the transfer of additional funds in FY 2022-23 to migrate the EHR into the cloud
- Development and ongoing support of a County Data Integration Project that will facilitate appropriate, allowable and timely data-sharing across County departments and with external stakeholders, to effectively deliver essential and critical services, including behavioral health care, to county residents

FISCAL YEAR	CFTN
FY 2020-21 (from 3YP)	$12,519,749
FY 2021-22 (from APU)	$16,301,384
FY 2022-23 (from 3YP)	$8,966,158
FY 2022-23 (proposed)	**$45,253,892**



STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services through workforce development initiatives and quality improvement issues

Priority Populations	Strategies	Proposed Activities:
■ Youth ■ Families with children living with a mental health condition ■ Asian/Pacific Islander ■ Latino/Hispanic ■ Black/African American	■ Hire knowledgeable and skilled staff members ■ Provide on-boarding training to new and existing staff ■ Address retention ■ Develop a pipeline of staff members for hard to fill positions (particularly bi-lingual/bi-cultural individuals) ■ Address staffing to meet the identified community needs ■ Implement Peer Certification ■ To re-build workforce infrastructure (post-pandemic) ■ Address quality improvement issuess through education and training ■ Outreach and engagement for vulnerable populations	■ Expand Workplace Wellness Advocates (WWA) roles and responsibilities (see appendice for WWA program) ■ Create collaboration opportunities for clinical staff and workplace wellness advocates ■ Expand training opportunities for staff for skill building and training in best practices such as rapid assessment skills and trauma informed assessment ■ Partner with local community providers and educators/universities to develop a pipeline of skilled staff ■ Develop and implement an on-boarding training to new and existing staff to improve continuity and access ■ Develop, expand, and implement various education incentive programs

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

Continue to develop the Office of Suicide Prevention through prevention efforts and campaigns

Priority Populations	Recommended/Preferred Strategies	Proposed Activities for FY 2021-22
■ All community members ■ LGBTIQ individuals ■ Boys ages 4-11 ■ Transitional Age Youth (TAY) ages 18-25 ■ Adults ages 25-34 and 45-54 ■ Unemployed adults ■ Homeless individuals ■ Individuals living with co-occurring mental health and substance use conditions ■ Older Adults ages 60+	■ Increase capacity of Warmline and suicide prevention and post-vention services ■ Continue partnering with OC Community Suicide Prevention Initiative ■ Implement strategies from the Mental Health Services Over-sight and Accountability Com-mission (MHSOAC) Striving for Zero report ■ Build community awareness ■ Implement upstream campaigns to raise awareness regarding stigma and mental health ■ Collaborate with community partners, including but not limit-ed to schools, HCA Correctional Health, first responders, veter-ans, and school-based programs to increase awareness and reduce stigma	■ Expand the Warmline to meet the high call demand and language capabilities. ■ Expand suicide prevention and postvention services. ■ Re-launch suicide prevention campaigns in various venues to reach a broader audience (post-pandemic). ■ Launch new suicide prevention campaigns. ■ Continue collaboration with local celebrities, familiar sports figures, and/or well-known community figures to target veterans, transitional age youth, their families, and other priority populations. ■ Increase participation in the OSP activities to focus on a population-based approach towards suicide prevention that is guided by an upstream ap-proach and in alignment with the MHSOAC's Striving for Zero Suicide Plan. ■ Increase outreach and awareness targeting TAY through innovative ap-proaches such as theater and plays, forums such as Honest Hour, podcasts and Instagram and Facebook live events. ■ Increase mental health promotion, outreach and engagement activities for all age groups and priority populations. Increase community collaboration to implement community stigma reduction and mental health education and promotion activities

STRATEGIC PRIORITY: Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations	Recommended/Preferred Strategies	Proposed Activities for FY 2021-22
■ People from all MHSA age groups ■ Homeless individuals ■ Individuals living with co-occurring mental health and substance use conditions ■ LGBTIQ individuals ■ Veterans	■ Increase capacity of Warmline and Suicide Prevention Services ■ Continue partnering with OC Community Suicide Prevention Initiative ■ Implement strategies from Mental Health Services Oversight and Accountability Commission (MHSOAC) Striving for Zero report ■ Build community awareness ■ Implement upstream campaigns particularly with youth ■ Collaborate with schools and school-based programs to increase awareness and reduce stigma	■ Expand the WarmLine to meet the high call demand and language capabilities ■ Re-launch suicide prevention campaigns in various venues to reach a broader audience (post-pandemic) ■ Continue collaboration with local celebrities, familiar sports figures, and/or well-known community figures to target Transitional Age Youth and young adults, their families, and support networks and leverage its reach to target this demographic population ■ Increase participation in the OSP activities to focus on population-based approach towards suicide prevention that is guided by an upstream approach and in alignment with the MHSOAC's striving for Zero Suicide Plan ■ Increase outreach and awareness targeting TAY through innovative approaches such as theater and plays, forums such as Honest Hour, podcasts and Instagram and Facebook live events

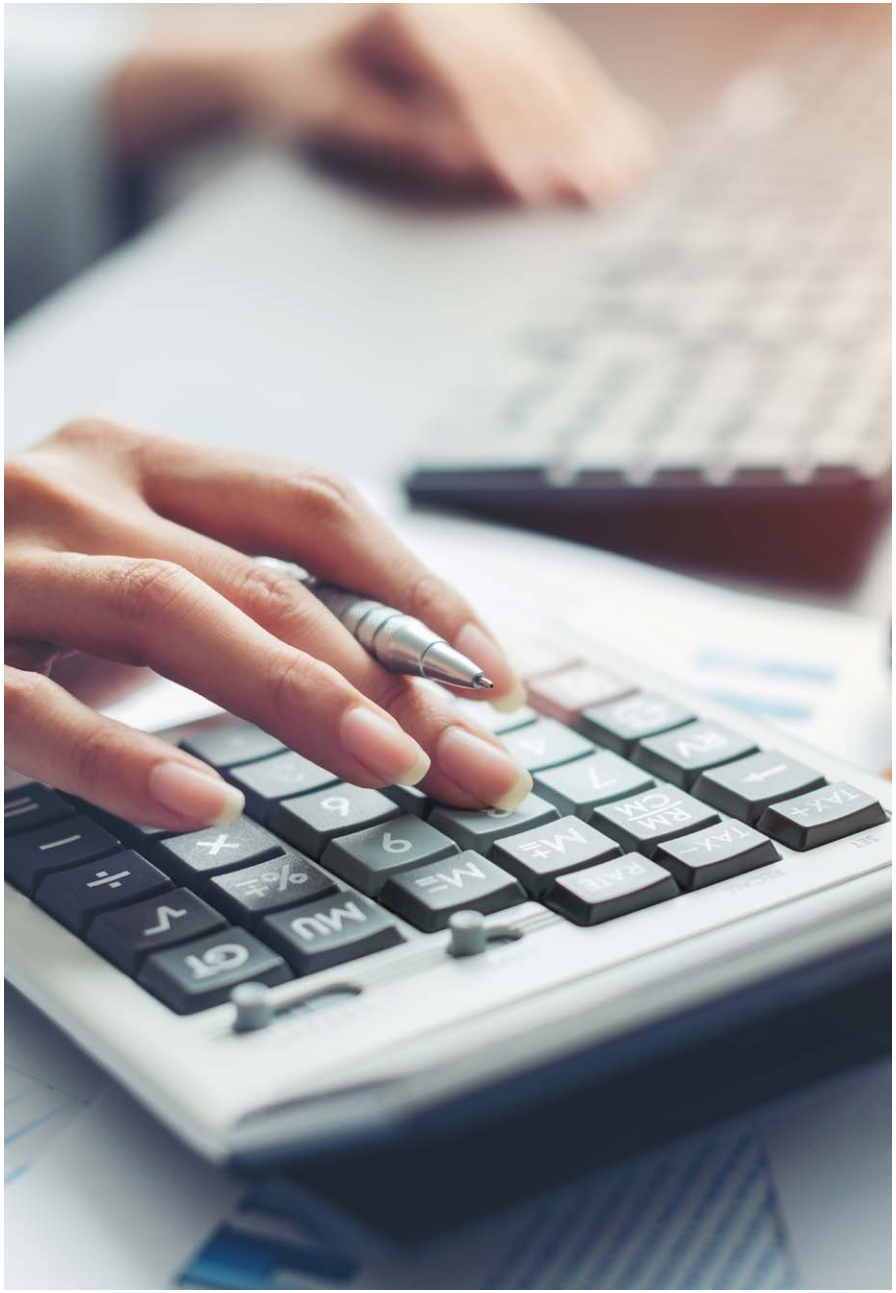
BUDGET DEVELOPMENT AND REVIEW

As part of the fiscal review done in preparation for the current MHSA Annual Plan Update, HCA staff engaged in a detailed process of aligning existing program budgets more closely with actual program expenditures from the most recent fiscal year (i.e., FY 2020-21). This budget "true up," which is done annually, allows managers to identify cost savings for programs that could be transferred to cover budget increases and/or implementation costs of other programs within the same MHSA component.

With an anticipated increase in available funding, after the final community engagment meeting (CEM) held on March 3, 2022, the MHSA Office rapidly analyzed stakeholder feedback, program and financial services managers re-evaluated program budgets and MHRS staff identified additional opportunities to update the MHSA Annual Plan based on consumer, family member, and provider feedback.

Orange County received close to $27 million additional MHSA dollars in actual revenue, than anticipated for FY 2020-21. Based on new revenue projections provided by the State consultant, as well as the updated Governor's budget, Orange County anticipates an additional $25 million for FY 2021-22 and an additional $85 million in FY 2022-23 (projections are volatile and subject to change).

The proposed changes to the FY 2022-23 Plan Update are reflective of ongoing community feedback, a process of right-sizing program needs and budgets, and leadership recommendations. In addition, there are proposals for new uses of CFTN, WET and PEI funding, described in more detail in this section. This flexibility was regarded as important given the marked volatility in MHSA projections and lingering uncertainties related to the post-pandemic landscape.



COMMUNITY SERVICES AND SUPPORTS PROPOSED EXPANSIONS

Service Area	Program Name	FY 2022-23 Budget as in the MHSA as approved 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments/Justification
Access to Services to Treatment (TX)	Multi-Service Center for Homeless/Adults with a Mental Illness	$900,000	$2,202,489	$3,102,489	■ Expand to add a second location to expand capacity and meet high demand. ■ Increase staff salaries to recruit and sustain. **Strategic Priority: Access to Services*
	Outpatient Recovery	$6,158,531	$2,003,642	$8,162,173	■ Adding positions including clinicians and a data analyst and billing specialist to improve quality and functioning of program. ■ Increase staff salaries to recruit and sustain. **Strategic Priority: Access to Services*
Crisis Prevention & Support	Warmline	$0	$12,000,000	$12,000,000	■ $1,116,667 funding from PEI budget moved to CSS for Warmline. ■ Expand to meet 24/7 program needs (based on staffing needs assessment). ■ Expand new Spanish and Vietnamese Warmlines. **Strategic Priority: Access to Services / Suicide Prevention Mental Health Awareness and Stigma Reduction*
	Mobile Crisis Assessment All age groups	**$9,135,858**	**$1,450,000**	**$10,585,858**	■ Expand for case management of individuals and their families following law enforcement response. ■ Proposed increase is proportionate to the volume of calls received for under 18 and over 18. **Strategic Priority: Access to Services / Suicide Prevention*
	Crisis Stabilization Unit	$10,000,000	$4,000,000	$14,000,000	■ Expand to add a County-operated CSU. **Strategic Priority: Suicide Prevention*
Supportive Services	Peer Mentor and Parent Partner Support	$4,249,888	$875,000	$5,124,888	■ Expand staffing to provide coverage for CSU at Be Well Campus and various hospitals. **Strategic Priority: Access to Services*
Supportive Housing & Homelessness	MHSA Housing	$311,564	$42,119,877	$42,431,440	■ Added $42 million for PSH through OCCR NOFA and OC Housing Trust. ■ Matched budget to current OCCR MOU budget and Community Supportive Housing (CSH) consulting contract. **Strategic Priority: Access to Services*

COMMUNITY SERVICES AND SUPPORTS PROPOSED EXPANSIONS... (CONTINUED)

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments/Justification
Outpatient Treatment: Full Service Partnership Programs	FSP	$42,362,509	$1,500,000	$43,862,509	■ Expand FSPs to include Vietnamese, Spanish monolingual, and a Veterans FSP. ■ Increase $400,000 to existing step-down program for a specialized Board and Care program. ■ Increase capacity, adding 60 slots to general population adult FSP's. ■ Right sized budget to increase staff salaries to recruit and retain staff – Level Services (Children's FSP). ■ Right sized budget due to actual expenditures (Adult FSP AOA/MHRS PSH). *Strategic Priority: Access to Services*
	Older Adult FSP	$3,219,899	$1,300,000	$4,519,899	■ Expand to meet growing older adult population needs. Increase capacity by adding staff positions, and 30 slots. *Strategic Priority: Access to Services*
CSS Admin		$20,053,336	(-$542,000)	$19,469,693	■ Budget underspent last year. ■ Total reflects right sizing and adding projects below.
	1. CSS Survey	1. $0	1. $2,100,000	1. $2,100,000	1. Investment in community needs assessments. *Strategic Priority: Mental Health Awareness.*
	2. BHAB Budget	2. $0	2. $40,000	2. $40,000	2. Add MHSA administrative funds to incorporate a separate budget for the Behavioral Health Advisory Board to assist with travel, training, and community engagement. *Strategic Priority: Mental Health Awareness*
	3. MHSA Website Enhancement	3. $0	3. $500,000	3. $500,000	3. Enhance the websites that host HCA information to make them more intuitive for the community. Improve access and provide timely information and increase transparency.
	4. MHSA Liaison	4. $0	4. $250,000	4. $250,000	4. Recommendation from CEO Budget for budget and audit staffing.

PREVENTION AND EARLY INTERVENTION PROPOSED EXPANSIONS

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments/Justification
Access to Services to Treatment (TX)	OC Links	$1,000,000	$4,380,000	$5,380,000	■ Expand to meet 24/7 coverage. (Based on staffing needs assessment) *Strategic Priority: Access to Services*
	BHS Outreach and Engagement	$2,232,523	$6,767,145	$8,999,668	■ Add five teams to increase case management for homeless and individuals with co-occurring conditions. ■ Add $2 million MHSA portion for O&E Street Medicine Program in collaboration with CalOptima. *Strategic Priority: Access to Services*
	Intergraded Justice Involved Services	-	-	$7,100,000	-
	1. Jail to Community Re-Entry Program	1. $2,800,000 (for JCRP only)	1. (-$600,000)	1. $2,200,000	1. Funding allocation moved from CSS to PEI to integrate justice-involved services. Reduction is due to right sizing actual expenditures due to staffing vacancies. *Strategic Priority: Access to Services*
	2. Assessment & Diversion from Jails	2. $0	2. $1,000,000	2. $1,000,000	2. Staffing to provide assessment and diversion from jails. Supports OC Cares Initiatives and new legislature regarding reentry.
	3. Family Support / Resource Centers	3. $0	3. $1,000,000	3. $1,000,000	3. Expand Services to Justice Involved individuals and their family members. *Strategic Priority: Access to Services/Mental Health Awareness*
	4. Re-Entry Success Centers	4. $0	4. $3,000,000	4. $3,000,000	4. Pilot project to expand linkage and supportive resources for individuals who are justice involved.
Crisis Prevention & Support	Suicide Prevention Services	$1,200,000	$2,000,000	$3,200,000	■ Expand the survivor support hotline for additional services including step down and follow-up care for all high-risk populations. *Strategic Priority: Suicide Prevention*
	Office of Suicide Prevention	$0	$1,500,000	$1,500,000	■ Expansion from the MHSA 3-Year Plan. *Strategic Priority: Suicide Prevention*
Outpatient Treatment – Early Intervention	Early Intervention Services for Older Adults	$1,469,500	$1,530,500	$3,000,000	■ Expand services with staff at Leisure World Seal Beach and Laguna Woods. ■ Expand capacity for assessment, linkage, coordination, brief intervention. *Strategic Priority: Access to Services/Suicide Prevention*
	OC4Vet	$2,400,000	$120,000	$2,520,000	■ Expand to meet high demand with current waitlist for adult veterans. *Strategic Priority: Access to Services / Mental Health Awareness & Stigma Reduction*

WORKFORCE, EDUCATION AND TRAINING PROPOSED EXPANSIONS

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments/Justification
Mental Health Career Pathways	Mental Health Career Pathways	$1,046,663	$20,000	$1,066,663	■ Dedicate staffing, supplies and resources to collaborate with University High School deaf and hard of hearing program. ■ Develop career path for deaf students and bilingual students for career in the mental health and recovery services field for due to severe shortage and need of ASL fluent workers. ■ Current Deaf and hard of hearing community workgroup to develop the strategy. **Strategic Priority: Access to Services*
Financial Incentive Programs	Financial Incentives for County and Contract Staff (FIP)	$526,968	$191,500	$718,468	■ Tuition program to assist current County and contract staff to pursue bachelor or master's degree in Human Services field toward a position in public mental health. ■ This is a retention strategy focused on hard to fill positions, including bi-lingual and bi-cultural staff. **Strategic Priority: Access to Services*
Training and TecŠical Assistance	CE/CME Program Workplace Wellness Advocates Supervisor Training Peer Personel Training	$1,241,794	$224,000	$1,465,794	■ Expand CME program by adding trainings for Nurses and Psychiatrists. ■ Workplace Wellness Advocate Program supplies and resources. ■ Expand training opportunities for Peer Certification. ■ Develop Supervisor training – onboarding for new employees and supervisors. ■ Retention strategy to improve morale through Trauma Informed Care Initiative. **Strategic Priority: Access to Services*
Residencies and Internships	Clinical Supervision and Intern Program	$170,000	$530,000	$700,000	■ Expand clinical supervision resources to support placement of interns and pre-licensed clinicians. Incentivize supervision. ■ Include students who are deaf and/or are ASL fluent as a target population. **Strategic Priority: Access to Services*

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS PROPOSED EXPANSION					
Service Area	**Program Name**	**FY 2022-23 Budget as requested in the MHSA 3-Year Plan**	**Proposed Change**	**Updated Proposed Budget for FY 2022-23**	**Comments/Justification**
TecŠological Needs	Electronic Health Record (E.H.R.)	$8,582,888	$16,446,004	$25,028,892	■ Add $6.3 million to contract for vendors for state compliance. ■ Add $7 million for Population Health. ■ Add $1.2 million for business intelligence. ■ Add $2 million for Cerner upgrade. **Strategic Priority: Access to Services*

MHSA PROPOSED NEW PROGRAMS FOR FY 2022-23

Please note that many new programs are reflected in expansion of existing budget categories

CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS PROPOSED NEW PROGRAM			
Service Area	**Program Name**	**Proposed Expansion**	**Comments/Justification**
Capital Facilities	Be Well South Campus	$20,000,000	■ Estimated construction cost for new South County Campus. **Strategic Priority: Access to Services / Mental Health Awareness and Stigma Reduction / Suicide Prevention*
Prevention and Early Intervention	Clinical High Risk for Psychosis	$3,000,000	■ PEI funding being leveraged to implement community outreach and education, clinical and consultation services for youth at clinical high risk for psychosis. This program evolved out of the proposed Innovation project "Improving the Early Identification of Youth at Clinical High Risk for Psychosis and Increasing Access to Care." PEI will fund the outreach and early intervention elements of the project, and HCA is seeing MH-SOAC approval for Innovation funding for the online screening and engagement element. **Strategic Priority: Access to Services*

COMMUNITY SERVICES AND SUPPORTS PROPOSED RIGHT SIZED BUDGETS

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments / Justification
Access and Linkage to Treatment (TX)	MHRS (BHS) Outreach and Engagement	$2,569,933	(-$2,569,933)	$0	■ Moved budget to PEI to consolidate and streamline.
	Open Access	$2,300,000	$700,000	$3,000,000	■ Right sized budget due to actual expenditures.
Crisis Prevention & Support	In-Home Crisis Stabilization (CYMHRS)	$2,935,480	$500,000	$3,435,480	■ Right sized budget to match staffing costs.
Outpatient Treatment: Clinic Expansion	Program for Assertive Community Treatment (PACT)	$10,599,659	$100,000	$10,699,659	■ Right sized budget for flexible funds and to meet the needs associated with 24/7 calls.
	Children & Youth Clinic Services	$3,000,000	(-$500,000)	$2,500,000	■ Right sized budget due to actual expenditures (previously planned to do LCAT program).
	OC Children with Co-Occurring Mental Health Disorders	$1,000,000	$500,000	$1,500,000	■ Right sized budget to maintain costs of doing business.
	Services for Short-Term Therapeutic Residential Program (STRTP)	$8,000,000	(-$1,000,000)	$7,000,000	■ Right sized budget due to actual expenditures.
	Telehealth/Virtual Behavioral Health Care	$3,000,000	(-$1,000,000)	$2,000,000	■ Right sized budget due to actual expenditures.
Supportive Services	Wellness Centers	$3,354,351	$570,000	$3,924,351	■ Right sized budget to match staffing needs and costs.
	Transportation	$1,300,000	(-$450,000)	$850,000	■ Right sized budget to match MHRS system of care needs. ■ $200k moved from CSS to PEI. ■ $250k moved from CSS to SUD programs.

PREVENTION AND EARLY INTERVENTION PROPOSED RIGHT SIZED BUDGETS

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments / Justification
Prevention	School Readiness	$1,600,000	(-$600,000)	$1,000,000	■ Right sized budget to align with current maximum obligation.
	Parent Education Services	$1,064,770	$429,533	$1,494,303	■ Right sized budget to maintain costs of doing business. ■ Level services.
	Children's Support & Parenting Program	$1,700,000	(-$1,700,000)	$0	■ Recommendation to sunset this program. ■ Staff reassigned during pandemic. ■ Other family strengthening services expanding in contracted providers. Continuing FY 22/23 to meet community need.
	School Based BH Intervention & Support	$1,808,589	$144,435	$1,953,024	■ Right sized budget due to increase for translation of "You And" app into additional languages.
	Gang Prevention Services	$253,100	$150,000	$403,100	■ Right sized budget to maintain costs of doing business. ■ Level services. ■ Program services that are tied to law enforcement activities will be discontinued to re-align with MHSA regulations.
Mental Health Awareness & Stigma Reduction Campaigns	Mental Health Community Education Events for Reducing Stigma and Discrimination	$214,333	$1,666,667	$1,881,000	■ Right sized budget to match community feedback needs.
	Outreach for Increasing Recognition of Early Signs of Mental Illness	**$6,433,245**	**$10,399,528**	**$16,832,773**	-
	1. Behavioral Health Training	1. $700,000	1. $1,500,000	1. $2,200,000	1. Increase to address health equity with special ethnic, gender, or age. Target population older adults.
	2. School-Based Stress Management	2. $155,000	2. ($-155,000)	2. $0	2. Sunset Program.
	3. Early Childhood Mental Health Providers Training	3. $0	3. $1,000,000	3. $1,000,000	3. Extended due to COVID-19.

PREVENTION AND EARLY INTERVENTION PROPOSED RIGHT SIZED BUDGETS... (CONTINUED)

Service Area	Program Name	FY 2022-23 Budget as requested in the MHSA 3-Year Plan	Proposed Change	Updated Proposed Budget for FY 2022-23	Comments / Justification
Mental Health Awareness & Stigma Reduction Campaigns *...(continued)*	4. Outreach and Engagement Collaborative/ Mental Health and Wellbeing for Diverse Communities	4. $2,719,044	4. $666,667	4. $3,385,711	4. Extended due to COVID-19.
	5. K-12 School-Based Mental Health Services Expansion	5. $0	5. $5,000,000	5. $6,277,923	5. Outreach and education to increase awareness on the early signs of mental health conditions among youth. Ensure outreach and engagement is equitable and designed to reach underrepresented students and their families. Programming should be designed to leverage state school allocated funds to increase services for children, families, caregiver's and teachers for onsite and offsite school locations
	6. Services for TAY and Young Adults	6. $0	6. $609,938	6. $609,938	6. Extended due to COVID-19.
	7. Statewide Projects	7. $2,859,201	7. $500,000	7. $3,359,201	7. Expanding stigma reduction campaign.
Outpatient Treatment – Early Intervention	1st Onset of Psychiatric Illness (OC CREW)	$1,500,000	(-$50,000)	$1,450,000	■ Right sized budget due to actual expenditures.

COMMUNITY PLANNING EXPENDITURES

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

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

ORANGE COUNTY MHSA THREE-YEAR PLAN BUDGETS BY FISCAL YEAR

Fiscal Year	CSS	PEI	INN	WET	CFTN	TOTAL
FY 2020-21	$155,088,175	$47,061,483	$18,346,360	$6,216,634	12,519,749	$239,232,401
FY 2021-22	$158,785,110	$56,144,101	$10,999,190	$5,219,984	$16,307,384	$247,455,769
FY 2022-23*	**$225,440,320**	**$76,432,238**	**$11,701,218**	**$6,262,162**	**$45,253,892**	**$365,089,830**

** Reflects proposed revised budgets for FY 2022-23 Annual Plan Update*

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

COMMUNITY PLANNING PROCESS

Orange County At-A-Glance

CA COUNTY RANKING

3rd Most Populous

2nd Most Densely Populated

OC RESIDENTS

About **3.2 million**

Veterans: **3.3%**

LGBTQ+: **7%**

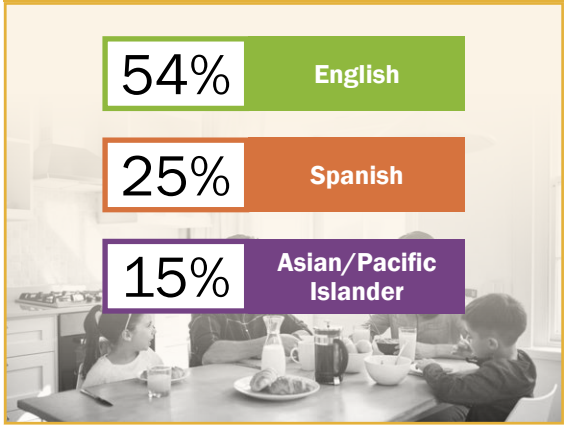
Adults w/HS Diploma: **86%**

OC AGE GROUPS

22% Under 18

15% 65 & Older

LANGUAGE SPOKEN AT HOME



54% English

25% Spanish

15% Asian/Pacific Islander

HIGHEST COST OF LIVING

Compared to neighboring counties, driven by high housing costs

Median Household Income
$94,441

Median Gross Rent
$1,928

Median House Price
$703,800

FINANCIAL INSECURITY

5.8% Residents Unemployed

9% Persons in Poverty

Census, v2021
CA Health Interview Survey, 2021

Individuals Served in CSS & PEI by Demographic Feature

OC CENSUS

ORANGE COUNTY RESIDENTS BY DEMOGRAPHIC CHARACTERISTIC

Age	2020 Census
0-14 yrs	18%
15-24 yrs	13%
26-59 yrs	48%
60+ yrs	21%

2021 Population: 3,170,345

Gender Identity	2020 Census
Female	51%
Male	48%
Transgender	1%
Genderqueer	<1%
Questioning/Unsure	<1%
Another	<1%

Race/EtŠicity	2020 Census
African American/Black	2%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	21%
Caucasian/White	39%
Latino/Hispanic	34%
Middle Eastern/North African	Not Collected
Another	4%

CSS/MHSA

INDIVIDUALS SERVED IN CSS CLINICAL SERVICES DEMOGRAPHIC CHARACTERISTIC

Age	Estimated	Actual
0-15 yrs	9%	13%
16-25 yrs	16%	26%
26-59 yrs	48%	47%
60+ yrs	12%	12%

Projected Duplicated: 62,389
Actual Unduplicated: 11,646

Gender Identity	Estimated	Actual
Female	42%	47%
Male	56%	52%
Transgender	2%	0.1%
Genderqueer	-	0.1%
Questioning/Unsure	-	0.1%
Another	-	0.1%

Race/EtŠicity	Estimated	Actual
African American/Black	7%	6%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	10%
Caucasian/White	42%	40%
Latino/Hispanic	34%	3%
Middle Eastern/North African	1%	1%
Another	5%	10%

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

PEI/MHSA

INDIVIDUALS SERVED IN CSS CLINICAL SERVICES DEMOGRAPHIC CHARACTERISTIC

Age	Estimated	Actual*
0-15 yrs	47%	23%
16-25 yrs	18%	8%
26-59 yrs	25%	46%
60+ yrs	10%	17%

Projected Duplicated: 216,898
Actual Unduplicated: 178,009

Gender Identity	Estimated	Actual
Female	54%	58%
Male	42%	39%
Transgender	1%	<1%
Genderqueer	-	<1%
Questioning/Unsure	-	<1%
Another	2%	<1%

Race/EtŠicity	Estimated	Actual
African American/Black	7%	9%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	16%
Caucasian/White	42%	37%
Latino/Hispanic	34%	35%
Middle Eastern/North African	1%	-
Another	5%	24%

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

MHSA & The Community Program Planning Process (CPPP)

STATE REQUIREMENTS FOR THE DEVELOPMENT OF THE THREE-YEAR PLAN

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

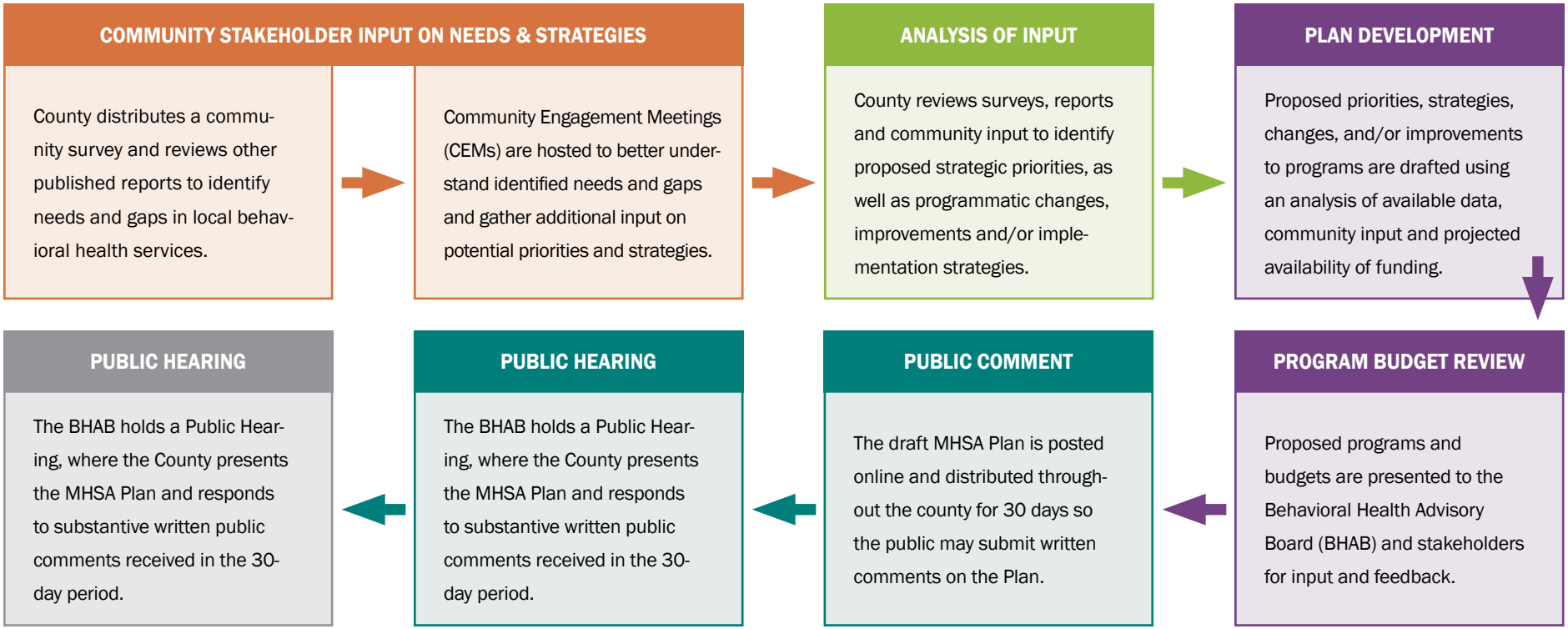
- **Assessment of the Mental Health Needs** of unserved, underserved, inappropriately and fully served county residents who qualify for MHSA services, including a) an analysis by age group, race/ethnicity and primary language, and b) assessment data that includes racial/ethnic, age and gender disparities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

OC COMMUNITY PROGRAM PLANNING PROCESS

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

As described in Orange County's MHSA Three-Year Plan (page 14) the HCA was and is committed to increasing meaningful engagement with clients, consumers and family members, particularly those who identify with one or more of the MHSA Priority Populations. However, due to the COVID-19 pandemic, the HCA continued to adapt its Community Program Planning Process (CPPP) activities in 2022 and shift away from in-person interactions and meetings. As such, the HCA recognizes that the feedback and input received to-date for the FY 2022-23 Annual Plan Update may more accurately reflect the perspectives and interests of those with the interest to participate virtually, financial means, access to technology and digital literacy to engage in a virtual and/or electronic format.

Orange County Community Planning Process



UPDATE TO LOCAL STAKEHOLDER COMMITTEE AND ADVISORY BOARD

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

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

In March 2021, the Orange County Board of Supervisors approved the merging of the Mental Health Board and Alcohol and Drug Advisory Board into a single Behavioral Health Advisory Board (BHAB). The first official consolidated BHAB meeting took place in April 2021. At the end of the Fiscal Year 2020-21 (June 30th), it was determined that the MHSA Steering Committee would be dissolved, and a new process would be developed in its place.

During this time of re-organization, the MHSA office continued to engage with the community through informational meetings, to maintain communication and sharing information while the new formalized structure is in development. The meetings focus on Mental Health and Recovery Services, community Behavioral Health issues and needs, and presentations by MHSA funded programs. Participants requested additional information, clarification, and presentations on MHSA Housing, OC Links 24/7, and the OC Digital Navigator. The HCA will continue to hold these meetings in the upcoming year. Additionally, the BHAB has discussed community planning issues during the System of Care Mental Health meetings held on the 2nd Tuesday of each month.

Currently, the HCA is working in collaboration with the Office of Strategic Planning and Office on Health Equity to develop a whole-person perspective to community planning which will encompass a wide range of partnerships surrounding community planning in Orange County. The premise is that by coordinating the various health planning efforts and sharing resources, it will reduce the duplication of meetings and use the community's time and input more efficiently. The HCA has established a workgroup and is developing the planning activity structure. The MHSA will play a key role in this collaborative effort, and it is anticipated that the new structure will expand our access to more underserved target populations in our planning process for the next Three-Year MHSA Plan (FY 2023-24).

As part of the planning process, Orange County CEO Finance presented budget updates to the public at the BHAB held on January 12, 2022, and again on February 23, 2022, following new information regarding MHSA projections from a State Consultant. The HCA presented the proposed budget for the MHSA Plan Update to the public at the BHAB on March 23, 2022. As a follow up, an MHSA community meeting was held on Wednesday, April 6, 2022, where over 70 community members and HCA leadership attended. After providing a brief status update regarding infrastructure changes and changes as the workforce returns to the workplace, the proposed plan changes document was presented (Please see Appendix II).

Community feedback was positive regarding having a community meeting and participants were clear that they wanted more opportunities to discuss programs and discuss outcome data. Additional feedback supported follow up meetings focusing on the transformation of the “system of care” that has been established.

COMMUNITY ENGAGEMENT

Orange County's community engagement strategies continue to evolve as the needs of the community, committees and advisory groups, and landscape have changed, but maintain a focus on engaging more meaningfully with clients, consumers, and family members. Other considerations in preparing this year's community engagement meetings included timing, as we are currently in the third year of a three-year plan, and there was extensive research and data from the initial three-year plan (FY 2019/20 – 2022/23) that identified the priority populations and strategic priorities. Additional research was done for the FY 2021– 22 MHSA plan update that continues to be relevant.

In review, during the FY 2021-22 planning process, the MHSA office partnered with special population providers to reach into the community and conduct community engagement meetings. Between November 23, 2020, and December 30, 2020, the HCA assessed the impact COVID-19 was having on the emotional well-being of Orange County residents through two electronic surveys: the Adult Stress Survey for adults 18+ years and a Parent Survey for parents of a child 4-17 years old. The surveys assessed individual's experiences with COVID-19, their emotional well-being, informal/peer/paraprofessional support, access and barriers to professional health care and demographic characteristics. The survey results are significant as they provided insights into the overall well-being and the impact of COVID-19 on the culturally diverse community in Orange County. The results indicated that these disparities were exacerbated during the COVID-19 pandemic. The survey results provided indicators of the varying mental health needs during the pandemic and established baseline data which can be used with future needs surveys as the community moves into the post pandemic and establishes a new three-year MHSA plan.

Specifically, the HCA identified that individuals from certain groups and communities in Orange County were disproportionately affected by mental health conditions or barriers to accessing needed mental health. The COVID-19 survey results indicated that adults in these priority populations have been disproportionately impacted by the COVID-19 pandemic.

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

Focusing on the needs of these underserved and unserved individuals continued to be a priority during the development of the FY 2022-23 annual plan update. The survey developed and used for the FY 2022-23 community engagement process, were developed with this data at the forefront.

The MHSA office conducted a survey that was open from December 30, 2021 and remained open until January 31, 2022. The survey was translated into threshold languages and distributed via email to more than 1,500 individuals. Individuals from each of the identified MHSA Stakeholder groups from the WIC were represented in the distribution and responses, and 222 completed survey responses were recorded.

Additional considerations included the target populations and strategic priorities established for the current three-year plan. The survey focused on three areas:

- MHSA Strategic Priorities from the Three-Year Plan
- Extensions to time-limited Prevention and Early Intervention Programs
- New Program Initiatives

Please see Appendix VI for a copy of the survey.

Feedback from these surveys (N=568 started, n = 222 completed) were analyzed using a mixed method approach, allowing for the combining of information from quantitative survey data and qualitative open-ended responses. The following section illustrates several item frequencies, brief data visualizations, and details of all CEM findings conducting from December 31, 2021 to January 31, 2022. Below is a synopsis of the strategies and approaches that consumers, family, and community members recommended for improving mental health-related messaging, and for making services feel more welcoming and engaging. These findings also include summary findings from the provider engagement meeting which included several community-based organizations.

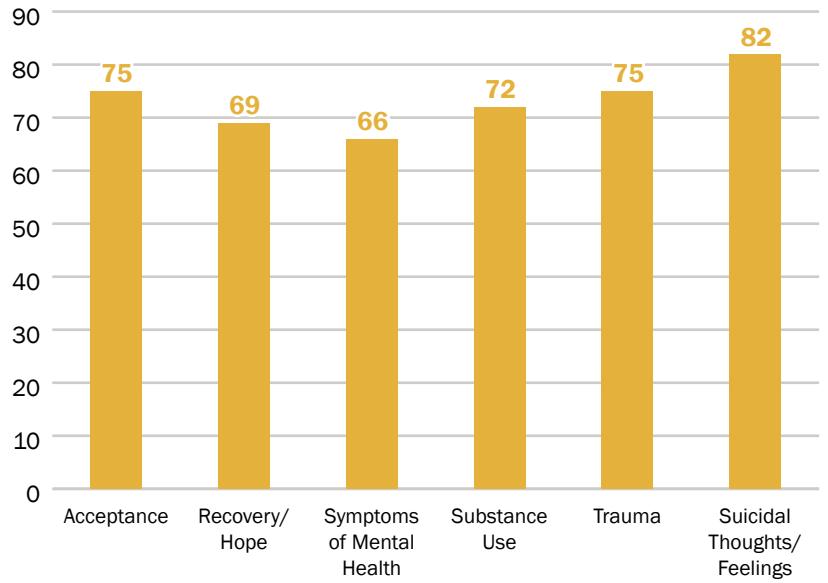
Of note, preferences for an overall approach (i.e., social media vs. social events) tended to **vary by a person's age** or were **universally shared** (i.e., focus on hope, positive messaging, reflect the culture of the person you are trying to reach). However, a combination of hybrid outreach and marketing was preferred (i.e., in person vs online mental health resources) underscoring the critical importance of the changing nature of service modality and preference.

QUESTION 1

A 2019 Rand Report on Social Marketing shows mental health campaigns have a positive effect on reducing stigma and on encouraging people to reach out for needed services (Click here to learn more about the report).

Although each area of focus listed below is of great importance, which would you prioritize in developing a campaign to raise mental health and recovery awareness? (Please rank at least your top 3 areas of focus):

Campaign Prioritization Categories



QUESTION 2

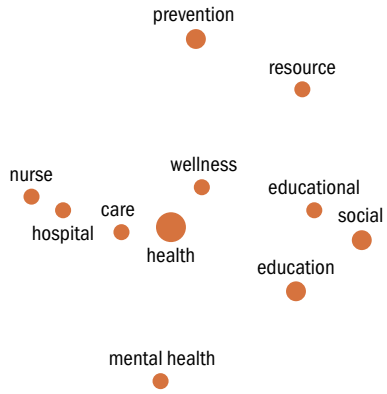
Language is important in developing campaigns. Of the three areas of focus you ranked above, can you please identify and list up to 3 non-stigmatizing words or phrases that would attract your attention if used in a campaign.

1. Hope
2. Recovery
3. Acceptance

QUESTION 3

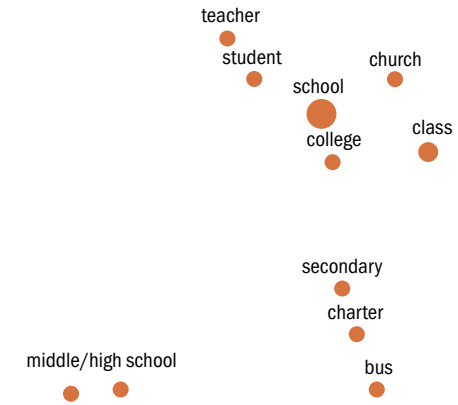
Orange County is making progress in establishing its local suicide prevention strategies using the MHSOAC's Striving for Zero Suicide Prevention Plan (Click HERE). One future area of focus will be how we can encourage and support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis. To help with planning, please share up to 3 recommendations:

Key words mentioned together in comments will appear closer together.



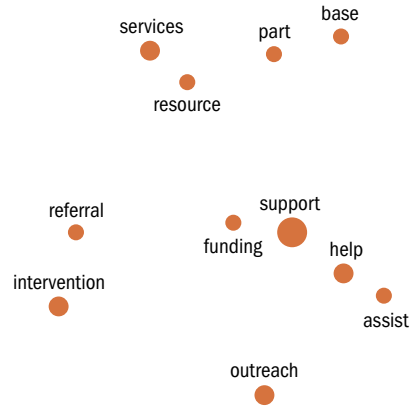
Recommendation 1: Health Education

Key words mentioned together in comments will appear closer together.



Recommendation 1b: School Based Health Education

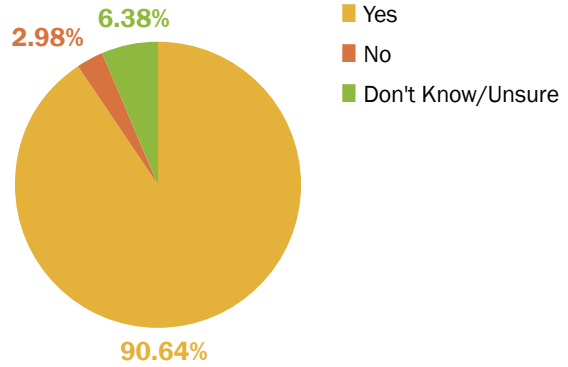
Key words mentioned together in comments will appear closer together.



Recommendation 2: Social Support

QUESTION 4

Recent review of call volume to the OC WarmLine has shown an increase in calls over the past several months. Many are missed because more staff can't be hired on the current budget. Would you support increasing the OC WarmLine budget to meet demand, including an emphasis on supporting Spanish- and Vietnamese-speaking callers?



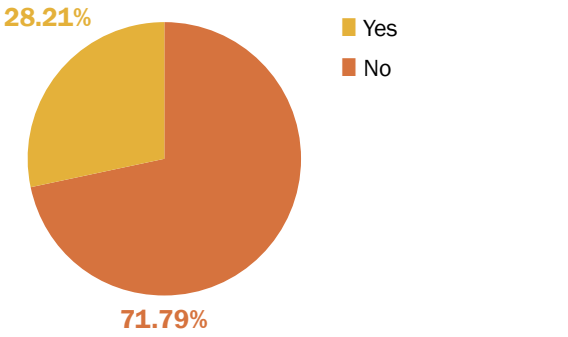
Survey Findings:

91%

of respondents Support increasing the OC WarmLine Budget to meet demand, including an emphasis on supporting Spanish- and Vietnamese- speaking callers.

QUESTION 5

During this current Three-Year Plan, the County initiated two Suicide Prevention Campaigns HelpIsHereOC.com and BeA-FriendForLife.com. Are you familiar with either of these two campaigns?



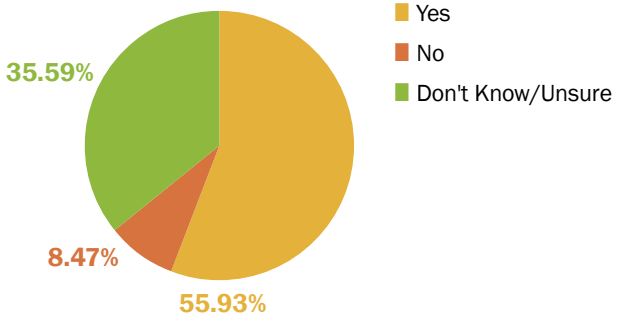
Survey Findings:

28%

of respondents were familiar with either of these two campaigns.

QUESTION 6

Do you feel these two suicide prevention campaigns increase connectedness between individuals, family members, and community?



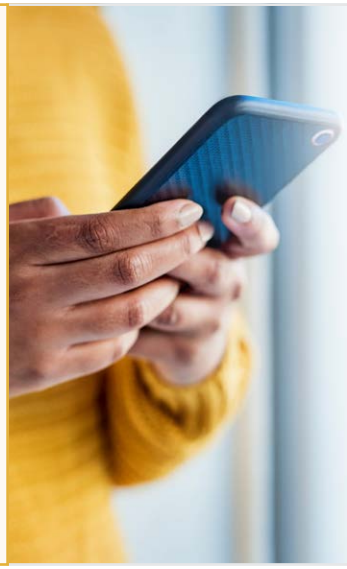
Survey Findings:

56%

of respondents feel these two suicide prevention campaigns increase connectedness between individuals, family members, and community.

QUESTION 7

What do you like about these campaigns? What do you dislike about these campaigns?



Liked

15 respondents

- Campaigns provided resources focused on prevention.
- Campaigns felt friendly and community-focused.
- Campaigns had quality messages and images.

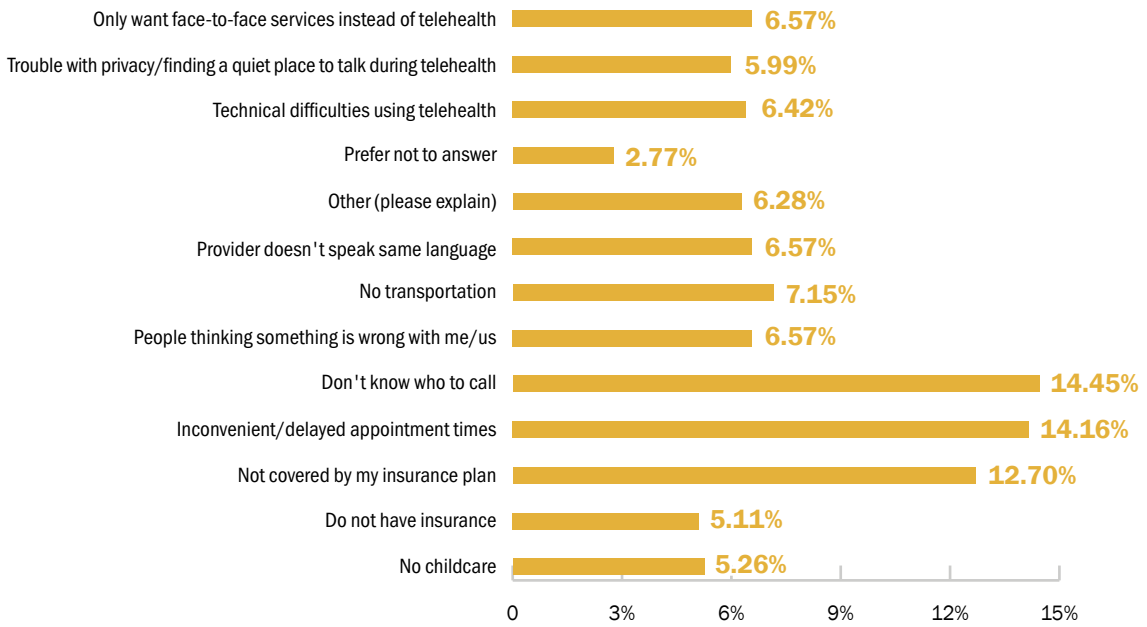
Disliked

4 respondents

- Campaigns remained disconnected, either in general or in regard to low income families.
- Campaigns do not go far enough. The resources are inadequate.

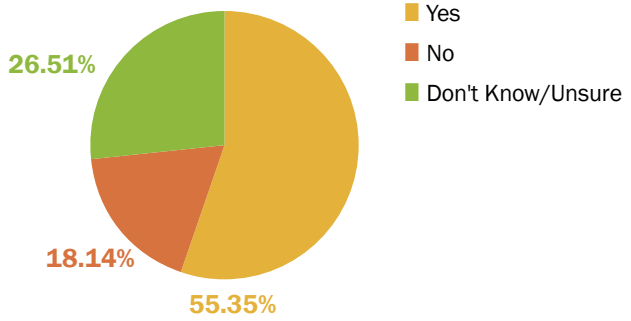
QUESTION 8

In your experience accessing mental health and recovery services, has any of the following kept you from getting help from a health care professional?



QUESTION 9

Would having adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan help you with using telehealth services?



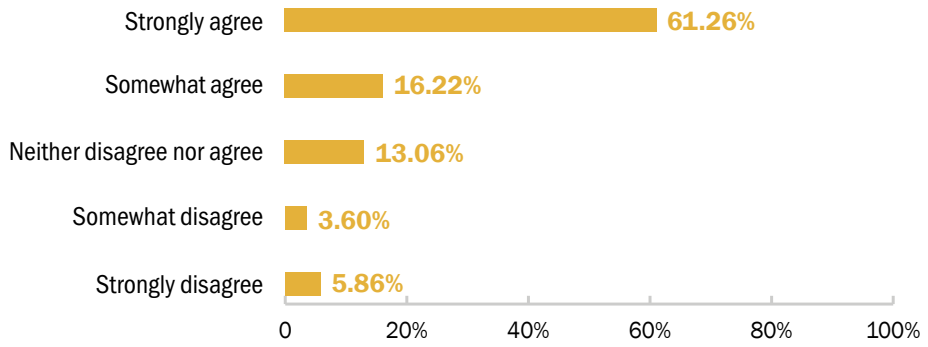
Survey Findings:

55%

of respondents have adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan.

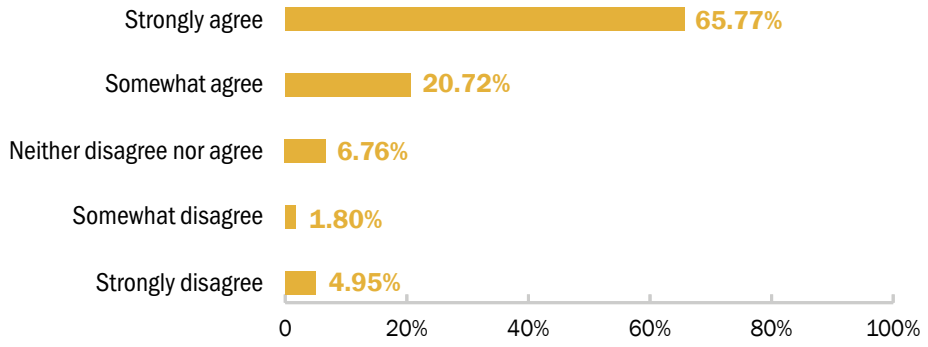
QUESTION 10

Parent Educational Services aims to prevent the occurrence or worsening of negative mental health outcomes in children by promoting protective factors in parents and caregivers.



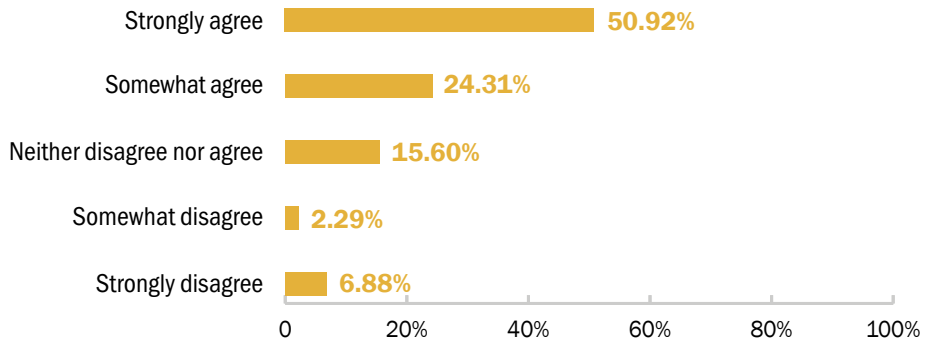
QUESTION 11

School-Based Behavioral Health Intervention Services provides three-tiers of services aimed at preventing and/or intervening early with students at risk of developing a mental health condition and their families.



QUESTION 12

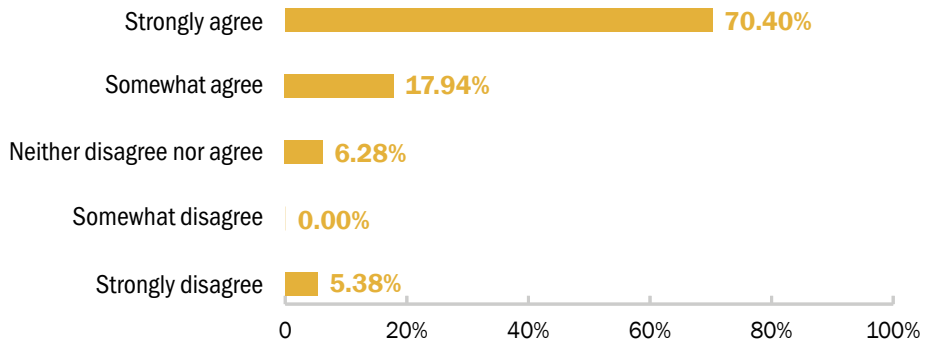
At participating schools, staff provide education to students, parents and teachers on gang prevention and offer workshops, structured group interventions, and weekly case management. Staff also work with students and their families to create an individualized action plan that addresses attendance, academic behavior, disciplinary improvement, parenting contracts and an anti-gang dress code plan.



QUESTION 13

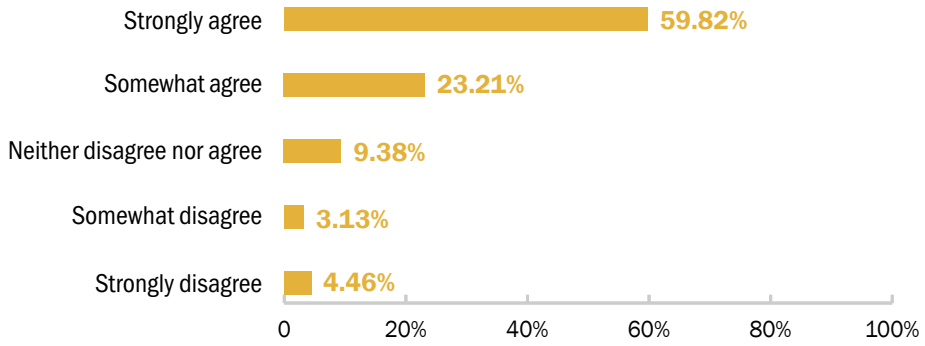
Outreach for Increasing Recognition of Early Signs of Mental Illness aims to prepare and inform a wide range of potential responders on how to:

- Identify behavioral health conditions as early as practicable in all age groups
- Assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively
- Increase knowledge regarding accessing behavioral health services
- Promote mental health and wellness throughout the community
- Provide free behavioral health trainings in schools and communities throughout the county



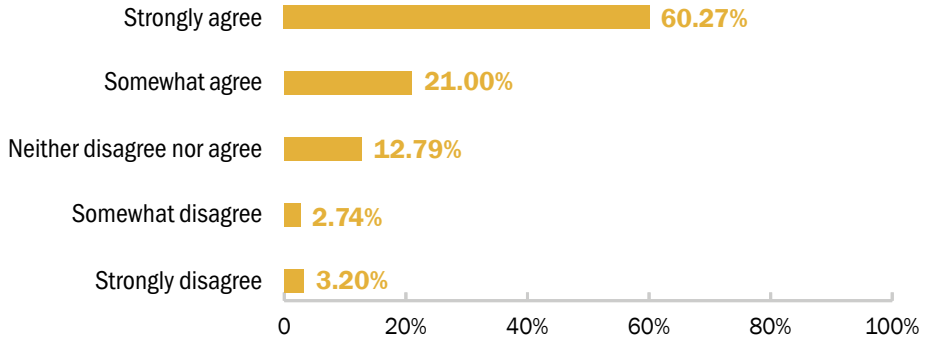
QUESTION 14

Early Intervention Services for Older Adults provides comprehensive in-home evaluations and services tailored to meet the needs of older adults. A new addition to this program would include an expansion of services into Leisure World in Laguna Woods and Seal Beach.



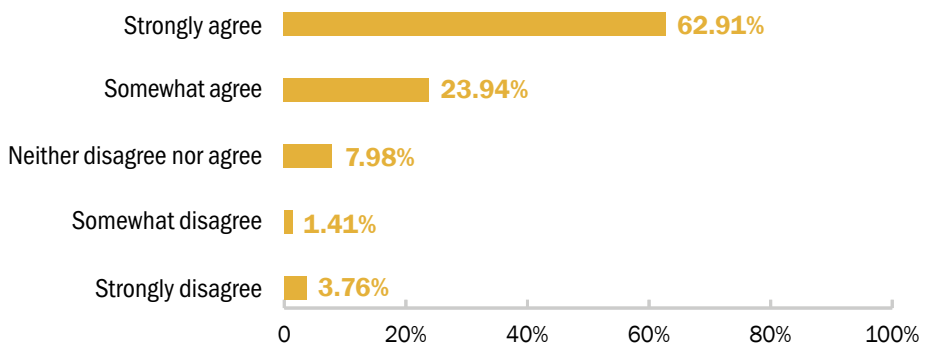
QUESTION 15

OC4Vets provides behavioral health screening and assessment, referrals to behavioral health treatment and other services as needed, brief individual counseling, case management, employment and housing support services, outreach and engagement, and community trainings. Services are provided to military-connected individuals and their families by trained clinicians and peer navigators with experience and knowledge of the military culture.



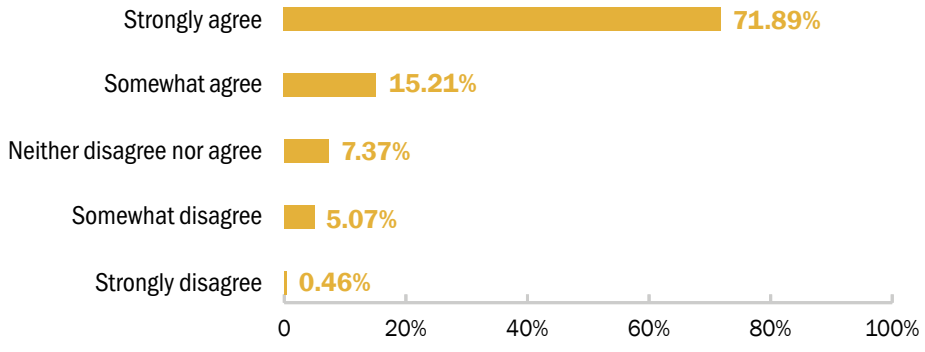
QUESTION 16

As part of the current MHSA Three-Year Plan, Orange County planned to launch school-based services leveraging different funding sources. Given the recent increase in funding available to schools for mental health support, to what extent do you agree supporting the expanded use of MHSA funding to include youth-focused mental health services that are provided outside of a school setting?



QUESTION 17

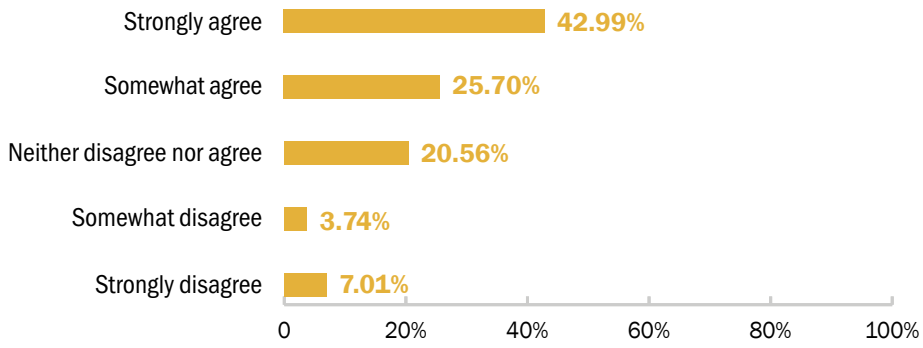
How supportive would you be of the County funding a Mental Health Rehabilitation Center/Therapeutic Residential Center (MHRC/TRC)? This 24/7 program would serve adults 18 years and older who are living with a mental health condition and would otherwise be placed in a state hospital or other mental health facility. The overarching goal of MHRC/TRC would be for adults to develop skills to become self-sufficient and capable of increasing levels of independence and functioning, with the goal of re-integrating into the community.



QUESTION 18

If the State/County were to experience a financial downturn and had to use the MHSA Prudent Reserve to sustain existing MHSA-funded programs, the law would prohibit the County from transferring funds to Workforce, Education and Training (WET) or Capital Facilities and Technological Needs (CFTN) in the same year. Would you support maintaining an on-going balance in WET and CFTN that would allow for one-year of continued funding to pay for the following items in the year the Prudent Reserve is accessed:

- WET and IT staff
- Provider trainings, prioritizing those that help clinicians maintain licensure
- Existing software licenses
- Replacement of outdated/broken technology hardware. Please note that these funds would not be used to expand training capacity or technology in years where Prudent Reserve funds are used.



COMMUNITY/PROVIDER ENGAGEMENT MEETINGS AND FOCUS GROUPS

To maintain continuity with the information collected in the surveys, the MHSA office hosted seven Community Engagement Meetings (CEMS), two Provider Engagement Meetings (PEMS), and four focus groups, between February 15, 2022, and March 3, 2022.

In addition to emailing over 1,500 individuals, staff members reached out to the Older Adults community committee, the Equity Steering Committee, and the PEACE group to encourage community participation in meetings. HCA staff explained the County's desire to increase representation from members of the MHSA Priority Populations and hear directly from unserved and underserved individuals as part of the Community Program Planning Process (CPPP) for the FY 2022-23 Annual Plan Update. Meetings ranged from open to the public, to targeting specialty groups, and separate provider groups to create a safe and culturally competent setting to reach all target populations and stakeholders.

Due to the COVID-19 pandemic, Community and Provider meetings were held virtually over Zoom with participants joining via computer, tablet and/or phone. Meetings were conducted in English, Spanish, and Vietnamese. A total of 244 people registered for a CEM and approximately 135 attended.

- Three virtual general population meetings were conducted from 6 p.m. – 8 p.m. on various weekdays
- One virtual general population meeting was held in Spanish from 6 p.m. – 8 p.m.
- One virtual general population meeting was held in Vietnamese from 6 p.m. – 8 p.m.
- One virtual meeting was held in conjunction with the Older Adult Planning Committee
- One virtual meeting was held in conjunction with the Peer Employee (PEACE) workforce group
- Two virtual meetings were dedicated to Community Service Providers, one during typical work hours and one from 6 p.m. – 8 p.m.

An agenda was developed with strategic questions to gain more clarity of the survey results, but also to create an open space for stakeholders to bring in additional information or share their personal experiences with the Orange County system of care. The same questions were asked in each meeting. Although the number of participants was lower than the previous year, participation was high as the groups were facilitated to be more interactive and process oriented.

Focus groups were hosted onsite at various adult programs to obtain feedback from individuals accessing services. The Focus Groups for clients/consumers of MHRS for Clinic Improvements Three in person meetings and one virtual meeting was held in various targeted existing programs to obtain specific feedback on creating more welcoming spaces in clinic common areas. The focus groups sought feedback on designing and development of a culturally inclusive, welcoming and "homey" outpatient clinic lobby and common area.

COMMUNITY ENGAGEMENT MEETING FORMAT

The Community Engagement and Provider Engagement Meetings followed the same structure, and included the following agenda items:

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

The meetings were facilitated by the MHSA Coordinator and the monolingual Spanish and Vietnamese were conducted by bi-lingual HCA clinical and supervisory staff members. In addition to the facilitator, each meeting had a minimum of two note takers.

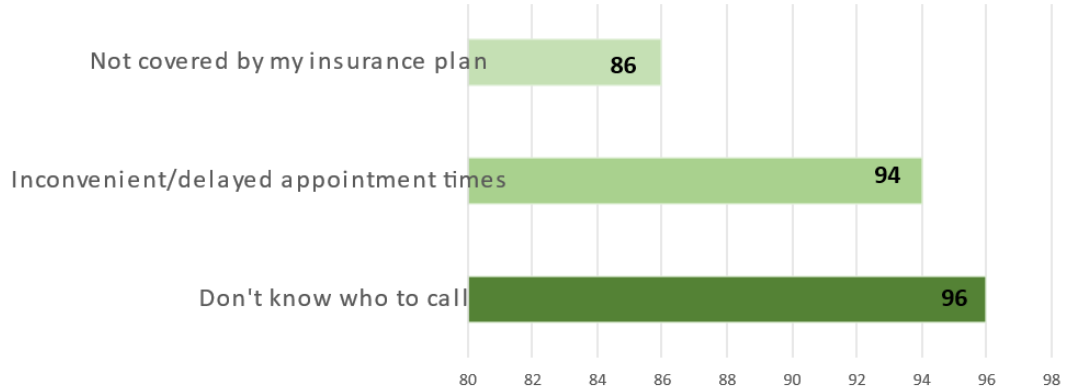
2022 CEM OUTREACH TO PRIORITY POPULATIONS								
Community Engagement Meeting	**Date**	**Time**	**# Registered**	**Children**	**TAY**	**Adults**	**Older Adults**	**Additional Population Characteristics**
Community Stakeholders	2/15/2022	6-8 PM	17			X	X	Older Adults
Clinic Improvements Focus Group - Wellness Center West	2/15/2022	11 AM-12 PM	18		X	X	X	LGBTIQ+ Community, Older Adults
Clinic Improvements Focus Group - Wellness Center Central	2/16/2022	11 AM-12 PM	28		X	X	X	LGBTIQ+ Community, Older Adults
Older Adults Behavioral Health Council	2/16/2022	2-4 PM	11			X	X	Older Adults
Community Stakeholders - Vietnamese	2/16/2022	6-8 PM	8			X	X	Asian/Pacific Islander
Clinic Improvements Focus Group- Wellness Center South	2/17/2022	11 AM-12 PM	10		X	X	X	LGBTIQ+ Community, Older Adults
Community Stakeholders	2/22/2022	6-8 PM	24		X			Asian/Pacific Islander, Veterans
Community Stakeholders - Spanish	2/23/2022	6-8 PM	2			X	X	
PEACe & OC Peer Workforce	2/24/2022	10 AM-12 PM	46			X	X	Older adults, individuals living with a co-occurring substance use and mental health condition,
Clinic Improvements Focus Group - Virtual	2/24/2022	2-3 PM	3		X			Asian/Pacific Islander
Community Stakeholders	3/1/2022	6-8 PM	23			X	X	Older Adults
Providers	3/2/2022	10 AM-12 PM	41		X	X	X	Veterans
Providers	3/2/2022	6-8 PM	13			X		Asian/Pacific Islander

Discussion Prompts/Questions for Improving Access

Results from the FY 2021-22 community survey identified that the three most common reasons that kept individuals from getting help from a health care professional included: 1) Don't know who to call 2) Inconvenient or delayed appointment times 3) Not covered by my insurance. Additional issues that rated high included transportation, provider not speaking the same language as the consumer, technical issues, and only wanting face-to-face services. The questions/prompts used during the community engagement meetings were specifically drawn from these survey results, to obtain more expansive information, clarification, and consensus or alternate points of view. Following a review of survey results, as seen in the slide below, the small groups were involved in a discussion around the questions highlighted below.

Accessing Mental Health and Recovery Services

In your experience accessing mental health and recovery services, has any of the following kept you from getting help from a healthcare professional?



No childcare**36**
Do not have insurance**35**
People thinking something is wrong with me/us **44**

No Transportation **47**
Provider doesn't speak same language **44**
Technical difficulties**44**

Trouble with Privacy/finding a quiet place to talk during telehealth**41**
Only want face-to-face services**43**
Prefer not to answer **17**
Other **38**

2021-22 Community Survey Results

Have you tried to access mental health and recovery services for yourself, a family member, or a friend within the past year?

Were you trying to access services to address a crisis, obtain information, schedule an appointment, or new request for services?

What age group were you trying to access information/services for? Older Adults, Transitional Age Youth (TAY), Children, Adult

In your experience, did you feel like you knew who to call based on the circumstances of the situation?

In your experience, was it a challenge to know who to call or where to call?

In your experience, did you feel any hesitancy calling for assistance?

Feedback on the survey indicated that appointments might be Inconvenient/delayed. What would help to make appointments more convenient?

19

Response Summary and Discussion

Participants shared personal experiences in trying to access services for themselves, a family member, or a client within the past year. Themes that emerged consistently throughout the meetings included more individuals reported trying to access crisis services or first-time services, more often for youth, veterans, and monolingual individuals. Additional themes that emerged included addressing the unique needs for the older adult population and trying to access services in the private sector. Many individuals reported experiencing long wait times for initial intakes due to more people reaching out for services and less providers, lack of resources for monolingual populations, individuals struggling to cover copays, and hesitating to reach out for services due to a concern it may not be covered under insurance, and significant turnover in staff within organizations which impacted continuity and ability to establish trust. Copays were a significant issue as individuals reported facing medical, medication, and mental health services copays which became too expensive. Although not knowing who to call was the highest identified barrier in the survey, individuals in the CEMS primarily reported knowing who to call, and identified using OC LINKS, the CAT team, and 211 for assistance and referrals in different circumstances. More individuals in the CEMS, shared that they didn't feel they received quality intervention when reaching out due to inexperienced staff, excessive clinical questions, and unclear "inaccurate" assessments. There was some expression of concern of being hospitalized or having the police come out to one's home when reaching out for help, but it was less common than anticipated based on the survey results.

CEMS discussion was focused on quality of the services received, with few recommendations for new programs. Quality improvement recommendations included:

- Improved training for navigation staff
- Improved crisis response time (CAT)
- Increase bi-lingual/bi-cultural staff
- Improved/Increased Outreach and Engagement (many recommended "going out into the community" to reach people in need)
- Information/Education in the community using various methods to reach various age groups and ethnic groups (include pamphlets, "SWAG", as well as social media)
- Increased Peer Employees "Every family should be linked to a peer advocate"
- Improved warm hand offs and follow up
- Increased efforts to educate the community on the services available in Orange County (suggestions included being more present at community events where mental health can be "normalized")
- Improve provision of resources to family members during a psychiatric emergency – particularly an involuntary hold
- Specific feedback from the meeting in Vietnamese indicated that the Older Adult Vietnamese community struggled with food scarcity and recommended reaching out to the older adult Vietnamese community through provision of direct services such as food and individuals seeking medical care
- Specific feedback from the meeting in Spanish recommended radio advertisements for older adult population as well as coordinating with religious organizations for outreach

Although inconvenient or delayed appointment times were identified as a barrier, community meetings focused more on delays due to workforce shortages, particularly with monolingual providers. Additional recommendations were provided to make appointments more convenient included:

- Extending to evening hours
- Extending some services 24/7
- Provide transportation
- Provide some virtual appointments

Common barriers to accessing services for yourself, family member or friend within the past year.

Difficulty finding the most appropriate resource

Copays and fees prevent some from accessing services

Parents having challenges accessing services for TAY

Common barriers when trying to access services to address a crisis, obtain information, schedule an appointment, or new request for services.

Increased or long waiting times

Providers lack resources

Trouble finding providers and services for children

Most common barriers when calling for services or resources.

Lack of experienced peers to navigate a complicated system

Unaware of some of the services

Did not know if a service or provider was covered by their insurance

Don’t know where to start

Reluctant to call due to stigma

First time caller hesitancy

Feedback on the survey indicated that appointments might be inconvenient and/or delayed. Respondents indicated that these suggestions would make appointments more convenient.

Having options for those who work Monday to Friday

Older adults may need help navigating online scheduling/service

More providers and staff

Respondents identified these as the top three themes that would support people, families and communities to reach out for help when experiencing a mental health or substance use disorder crisis.

Outreach and Awareness

Compassion

Prevention

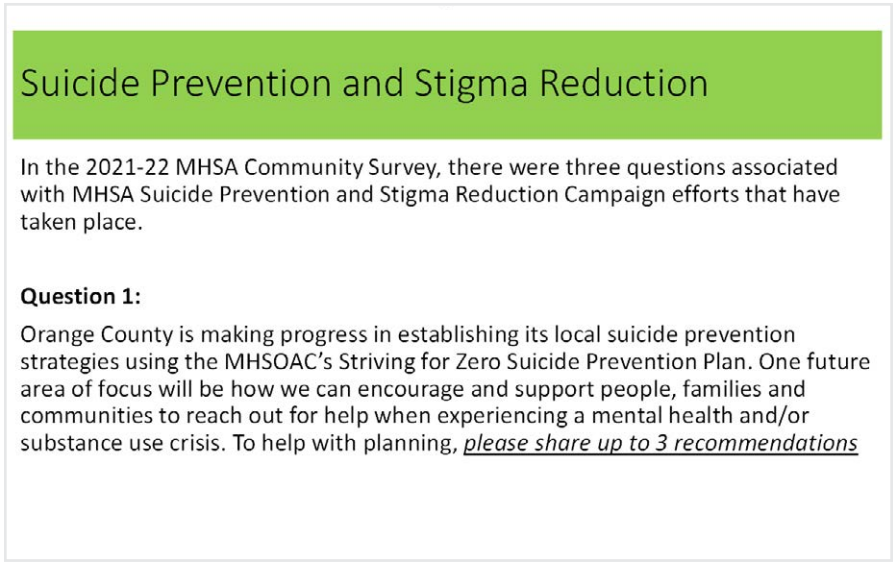
Discussion/Prompts for Suicide Prevention and Stigma Reduction

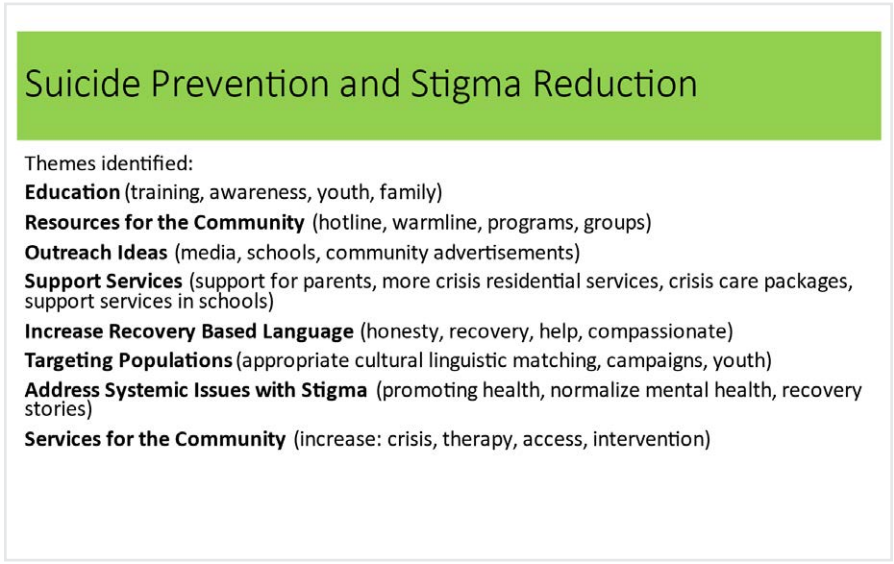
The second part of the CEMS and PEMS followed the same pattern of reporting results from the FY 2021-22 community survey that reflected the strategic priorities reducing stigma, and suicide prevention. The survey results presented were focused on three questions from the survey, including: 1) Orange County is making progress in establishing its local suicide prevention strategies using the MHSOAC's Striving for Zero Suicide Prevention Plan. One future area of focus will be how we can encourage and support people, families, and communities to reach out for help when experiencing a mental health and/or substance use crisis. To help with planning, please share up to three recommendations. 2) Are you familiar with the following suicide prevention campaigns; Be a Friend for Life and Help is Here O.C. 3) What do you like or dislike about the before mentioned suicide prevention campaigns? 4) If the campaigns were re-launched, what could be done to reach a broader audience? The slide below shows the results from these questions and was shared in the CEM's and PEM's meetings.

The follow up questions/prompts were: The themes that were identified in the survey as most liked, were also confirmed by the CEMS and PEMS. Through further discussion, priorities that were identified as missing included co-occurring services at every level of service, peer employees, and a more prevalent focus on veterans. The themes prompted more discussion than specific prioritization.

Specific feedback regarding launching campaigns to reach a broader audience included:

- Using multi-media platforms to reach various age groups, ethnic groups
- Go out into the community where people live or frequent to provide information
- Follow best practice models that work for Public Health
- Increased public/private partnership to have greater community impact
- Create/design campaigns with/for specific languages and ethnic groups instead of creating a campaign in English and translating
- Recommendations to reach a broader audience included use of TV, radio, bus stops, sporting events
- Use integrated marketing





Suicide Prevention and Stigma Reduction

Could we identify the top three themes that would support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis

2022 CEM Breakout Room 2: Suicide Prevention and Stigma Reduction

Could we identify the top three themes that would support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis?

How could we make these campaigns more noticeable/reach a larger audience?

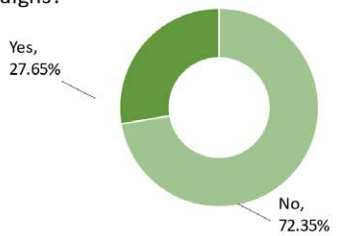
If we were to relaunch these campaigns, how and where would you recommend, they be distributed to reach a broader audience, including underserved populations?

Would you be interested in continuing conversations on any new campaign being developed by HCA as a part of a focus group?

Suicide Prevention and Stigma Reduction

Question 2:

During this current ThreeYear Plan, the County initiated two Suicide Prevention Campaigns: HelpIsHereOC.com and BeAFriendForLife.com. Are you familiar with either of these two campaigns?



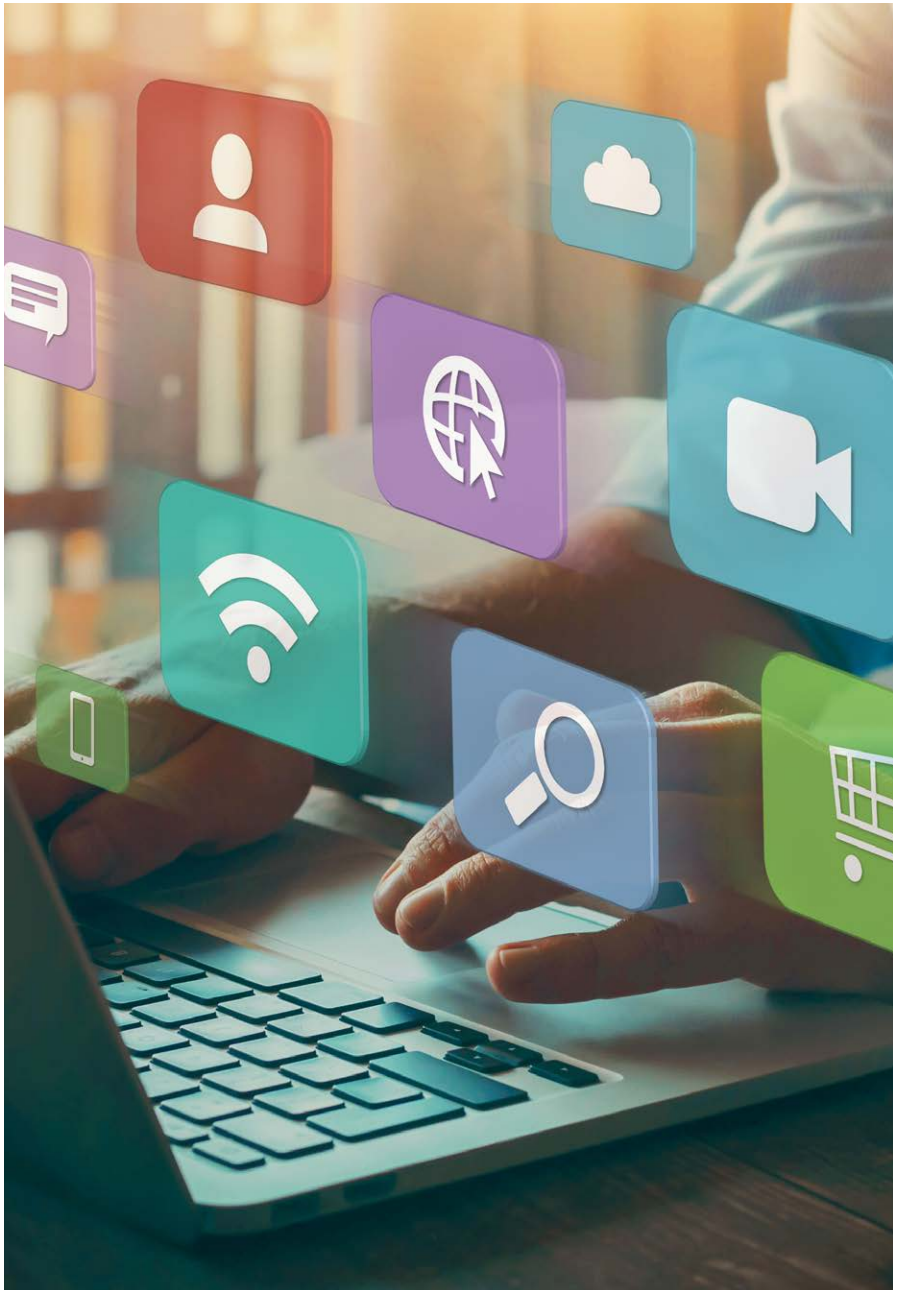
Response Summary and Discussion

The second part of the meeting followed the same pattern of reporting survey results that reflected the strategic priorities reducing stigma, and suicide prevention. The questions/prompts were:

Overall, the themes that were identified in the survey as most liked, were also confirmed by the groups. Priorities that were identified as missing included co-occurring services, and peer employees. The themes prompted more discussion than specific prioritization.

Specific feedback regarding launching campaigns included:

- Using multi-media platforms to reach various age groups, ethnic groups
- Follow best practices that work for Public Health
- Create/design campaigns with/for specific languages and ethnic groups instead of creating a campaign in English and translating
- Recommendations to reach a broader audience included use of TV, radio, bus stops, sporting events
- Use integrated marketing



Respondents indicated that these suggestions would make campaigns more noticeable and would help to reach a larger audience.

Advertise using several different forms of media

Utilize community centers and senior centers

Use thoughtful language

Respondents indicated that these recommendations would allow campaigns to reach a broader audience, including underserved populations.

Tailor campaigns to underserved populations

Use outreach methods besides online resources

Personalize language and messaging

FOCUS GROUPS FOR CLIENTS/CONSUMERS OF MHRS FOR CLINIC IMPROVEMENTS

The MHSA Coordination Office conducted (4) community Focus Groups. These focus groups were held at each of the three Wellness Centers- Central, West and South as well a virtual focus group on Zoom. The focus groups were attended by Wellness Center Participants and Wellness Center Peer Support Staff. These focus groups were seeking direct consumer participation and feedback on creating more culturally responsive, calming, inspirational, and a welcoming feel within the County outpatient clinic lobbies and clinic common areas.

The questions/prompts used during the community focus groups were specifically drawn from the previous year's CEM findings on clinic improvements, to obtain more expansive information, clarification, and consensus or alternate points of view. Following a review of previous CEM findings, these small groups were involved in a discussion around the questions highlighted below which are also linked to the strategic priority increasing access to services.

Each Focus Group was facilitated with the following four questions:

- **Question #1**: What does a Culturally-inclusive clinic lobby look like to you?
- **Question #2**: What kind of inspirational messaging and themes would you like to see in clinic lobbies?
- **Question #3**: How would you create a comfortable and welcoming lobby area?
- **Question #4**: How would you decorate clinic walls?

Clinic Improvement Questions	Themes	Themes	Themes
What does a Culturally-inclusive clinic lobby look like to you?	Art from different cultures and historic pictures of the city.	More bright, cheerful colors. "make the room feel alive."	Celebrate the culture of the local community.
What kind of inspirational messaging and themes would you like to see in clinic lobbies?	Positive affirmations.	Pleasant things to read.	Hope, empowerment, discovery.
How would you create a comfortable and welcoming lobby area?	Plants and trees are really nice to have.	Welcome greeters at the door that can help people.	Lighting is important- certain places I don't go because dark lighting.
	Chairs that don't hurt after long waits. Chairs with big arms create a natural boundary between people.	Electronic check in options or the window check in. both options.	Grounding activities in the lobby. crossword puzzles of the day, sudoku, coloring.
How would you decorate clinic walls?	"My anxiety goes up when I wait." It takes stress off when I look at something pretty. Nice pictures of ocean and nature. Love- the word. Each mind matters.	A communication board with a QR code that takes me to community resources- in all languages.	Professional paintings are nice.

Response Summary and Discussion of Focus Groups

Participants shared personal experiences in accessing mental health treatment at outpatient mental health service locations for themselves. This included assessing services at public County clinics as well as private insurance providers. Themes that emerged consistently throughout the meetings included the use of art from different cultures including the use of art from local cultures that most access the clinic, as well as historic pictures of the local city that reflect the community location. Furthermore, the use of professional art and client art-work in the lobbies and throughout the clinic are nice to look at and create cultural inclusiveness. Consumers expressed a desire for more color on the walls, in the lobbies and within the lobbies. Positive messages, positive affirmations, and the use of recovery orientated language throughout the clinic lobbies create a more hopeful, welcoming space. Comfortable furniture, plants and trees, and lighting that is warm create a welcoming space. Pictures of staff, wall murals, festive decorations and nice pictures can reduce the anxiety and create a space that is meaningful and welcoming as consumers wait in lobbies for mental health and recovery services. Overall, consumers shared a desire for County outpatient lobbies to connect with hope, empowerment, and discovery.

INTEGRATING COMMUNITY PLANNING PROCESS INPUT

Drawing upon findings from the established priority population and strategic priorities from the FY 2019/20 – 2022/23 Three-Year Plan, COVID-19 survey from FY 2020-21, community survey from FY 2021-22, CEMs, PEMs, and focus groups, several overarching themes continue to emerge that helped inform the recommended updates within this FY 2022-23 Plan Update:

- The COVID-19 survey revealed the overall well-being and coping of Orange County residents during the pandemic. The survey results were extensive and provided us with a snapshot of the impact at the height of the pandemic. Important points of interest include 59% of adult respondents reported high levels of stress, and 28% of adult respondents reported an elevated level of serious psychological distress. This was an increase from 14% reported by Orange County adults on the California Health Interview Survey in 2019. As we move into the post pandemic, it will be important to conduct a follow up survey and continue to assess the overall impact on Orange County residents and assess the implications and needs for mental health and recovery services.

- The COVID-19 baseline data indicated that Orange County parents noted that their children's well-being was affected during COVID-19, with approximately one-fifth of children exhibiting elevated levels of disruptive behavior and nearly one-half experiencing elevated sadness or worry. In addition, 87% of respondents in the community survey from FY 2021-22 "strongly agreed" or "somewhat agreed" with a plan to expand the use of MHSA funding to include youth-focused mental health services that are provided outside of a school setting. Continued and expanded collaboration with schools for both onsite and off-site programming is being proposed to meet the needs as children are returning to onsite school.

- An additional finding in the COVID-19 survey that is at the forefront of our planning process this year, was that particularly adult respondents in vulnerable populations were disproportionately impacted by the pandemic. The pandemic exacerbated the disparities already identified for the underserved and unserved groups in Orange County, indicating a need for improved strategies to reach vulnerable and priority populations.

- Suicide prevention efforts were a frequent theme throughout the CPPP with specific concerns over the veteran population, older adults, LGBTIQ+ community, ethnic communities, and youth. The office of Suicide Prevention consistently collaborates with the community and monitors current suicide death data to develop programs and campaigns. Please see www.ocheath-info.com/suicide for suicide death data.

- Increasing concern was also verbalized regarding accidental overdose deaths in Orange County due to Fentanyl. Fentanyl related death has increased 138% in 2021 from 2020 according to the Orange County Coroner's office.

- Additional recommendations regarding improving access to services included "normalizing" mental health and substance use disorder treatment by connecting with the community where people live, socialize, go for entertainment, or gather for events and provide information and education on availability and accessibility of services. These strategies are consistent with the upstream prevention strategies with youth in school settings, and priority populations, where interventions and campaigns are focused on building protective factors and resilience.

- Gaps in the system of care identified in the CPPP include co-occurring substance use disorder treatment, gaps in services to veterans, monolingual individuals, and crisis stabilization resources. An additional Crisis Stabilization Unit is included in the proposed changes to increase capacity and access. Development of the Irvine Be Well Campus proposes to expand crisis, outpatient, and substance use services. Full Service Partnerships (FSP) expansions are proposed to address veterans and monolingual populations.

- Orange County residents continue to report multiple barriers when trying to connect to mental health care with the most common reported challenges being uncertainty over who to call, inconvenient or delayed appointment times, and concern that services will not be covered under insurance. Upon further discussion, delayed appointment times seem to reflect workforce changes and shortages. This appeared to be a significant concern for individuals who are monolingual, and for individuals with limited ability to pay for services.

- Additional access issues identified and discussed throughout the CPPP reflect the quality of services. Specifically, the importance of having an experienced, well trained, knowledgeable, bi-lingual, and bi-cultural, trauma-informed workforce. These were consistently reported as key components necessary when community members call in for information, assessment, and referrals. Qualities such as compassionate, timely and accurate assessment, responsiveness, and follow up calls are valued based on CEM feedback.

- The post pandemic workforce is highly competitive. The HCA Mental Health and Recovery Services currently has an approximate 27% vacancy rate. Re-evaluation of the workforce needs, skills, and diversity is imperative to meet the community needs, gaps in services, as well as research/data and technological needs to succeed in the upcoming years.

- An additional component to address access includes efforts to re-design several programs to be more welcoming and inviting.

- Recent legislature related to Peer Certification has prompted discussion which supports a re-evaluation of peer employees including roles and responsibilities and earning a living wage.

- A review of data from the current WarmLine revealed that use of the WarmLine has steadily increased since FY 2018-19 through FY 2021-22, going from 53,890 calls in FY 2018-19 to 106,175 calls in FY 2020-21. An additional 45,696 calls from April 2021 – October 2021 were missed due to inadequate workforce and language capacity. Community survey results from FY 2021-22 survey reported that 91% of respondents support increasing the OC WarmLine Budget to meet the demand, including an emphasis on supporting Spanish and Vietnamese speaking callers.

- In a 2019 Rand Report on Social Marketing shows mental health campaigns have a positive effect on reducing stigma and on encouraging people to reach out for needed services. The top three priorities identified in the community survey, in developing campaigns to raise mental health and recovery awareness were suicidal thoughts/feeling, trauma, and acceptance. It was noted in the CEMS, “Language is powerful,” referencing the importance of recovery language throughout the system of care.

- Orange County has experienced significant changes in leadership and structure over this past year. Throughout the CPPP, recommendations and inquiries have been made on how to expand the community engagement process and create additional opportunities for community members to participate. The HCA has created an office of Health Population and Health Equity as well as an Office of Project Management and Quality Management to streamline, coordinate, and leverage various needs assessments throughout the county. It is anticipated that by leveraging these resources, the MHSA office will have multiple sources of data to contribute to the development of the next three-year plan.

- The HCA and MHSA Office will continue to utilize funds expeditiously to build and transform the Orange County Mental Health and Recovery Services system of care, based on needs assessments, data trends, input from Orange County residents, best practices, and legislative indicators. Moreover, we remain committed to partnering with consumers, family members, service providers and community organizations as, together, we strive to anticipate future needs, close existing gaps, address persisting disparities and support the health and well-being of Orange County’s residents.

PUBLIC HEARING AND APPROVAL BY THE BOARD OF SUPERVISORS

PUBLIC HEARING AND APPROVAL BY THE BOARD OF SUPERVISORS The MHSA Plan Update for FY 2022-23 was completed, reviewed and approved by the MHRS Director and posted to the Orange County MHSA website April 15, 2022 for a 30-day review by the public. At the close the of the public comment period the MHSA Office and MHRS Managers responded to all substantive public comments. The Plan, with the additional comments and responses, was submitted to the Behavioral Health Advisory Board (BHAB), and on May 25, 2022 the BHAB held a Public Hearing via Zoom Teleconference.

The Public Hearing was advertised through a posting with the Clerk of the Board and emails to members of the MHSA email distribution lists. In addition, the Public Hearing was advertised in local newspapers in different languages.

At the hearing, MHRS reviewed all 19 Public Comments received during the 30-Day Public Comment period and the HCA responses for each. Additionally, members of the public also shared their thoughts ideas for MHSA.

The BHAB affirmed that the county followed the standards of the CPP as outlined in the statute and are moving the plan to the BOS for approval. Additionally we recorded recommendations for MHSA program enhancements to be considered in future MHSA planning. (please see Appendix XIII)

PROGRAM DESCRIPTIONS & OUTCOMES

MENTAL HEALTH AWARENESS AND PREVENTION

Mental health awareness and prevention programs strive to prevent the development of serious emotional or behavioral disorders or mental health conditions in at-risk individuals. These programs achieve this through large-scale, population-based efforts designed to educate and inform the public about mental health and well-being, reduce risk factors or stressors, build protective factors and skills, and/or increase resilience. They aim to strengthen the resilience and well-being of a community as a whole by providing information, training and skill-building around mental health. The programs often use creative and culturally appropriate strategies for engaging different populations, especially unserved and underserved communities. Community planning identified that, should the demand or opportunities for awareness campaigns and educational/training efforts outpaces proposed budgets, impacted programs may have their funding augmented midyear, pending availability of funds.

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

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

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+ All Ages	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	40	Female	54	African American/Black	2
16-25	25	Male	45	American Indian/Alaskan Native	1
26-59	20	Transgender	-	Asian/Pacific Islander	9
60+	15	Genderqueer	-	Caucasian/White	17
		Questioning/Unsure	-	Latino/Hispanic	71
		Another	1	Middle Eastern/North African	-
				Another	-

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

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

**Proposed activities in FY 22-23 to Increase budget based on community feedback to decrease stigma and discrimination.*

SERVICES/EVENTS

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

During FY 2019-20, community-based organizations hosted a series of events. Due to the public health emergency beginning March 2020, all in-person events and activities were put on hold and allowed providers an additional six months to adapt their services to public health guidelines. In addition, the HCA funded four social marketing campaigns focused on mental health awareness, suicide prevention and stigma reduction to address the anticipated increase in need for mental health services and support due to the pandemic. All providers were contracted to host the event(s) under a provider-specific agreement titled "Mental Health Community Educational Event Services."

LATINO HEALTH ACCESS

LA VIDA A TODO COLOR DESCRIPTION:

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

CELEBRANDO NUESTRA CULTURA DESCRIPTION:

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

TARGET AUDIENCE:

Latino families, family friendly, open to the public

 # REACHED:

733

CASA DE LA FAMILIA

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

TARGET AUDIENCE:
Latino families w/limited English proficiency

 # REACHED:
3,951
in person

4,782
Facebook views

LGBTQ CENTER ORANGE COUNTY

DESCRIPTION:
Presentations, spoken narratives and educational workshops to create safe and supportive schools and community spaces for LGBTQ youth. (Three separate virtual workshops May 2020)

TARGET AUDIENCE:
LGBTQ youth & young adults

 # REACHED:
332
workshop attendees

ACCESS CALIFORNIA

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

TARGET AUDIENCE:
Middle Eastern, South Asian and Muslim American communities

 # REACHED:
410

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

TARGET AUDIENCE:
Middle Eastern, South Asian and Muslim American communities

 # REACHED:
248

MULTI-ETHNIC COLLABORATIVE OF COMMUNITY AGENCIES (MECCA)

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

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

TARGET AUDIENCE:
Community at large

 # REACHED:
355
workshop participants

970
online participants

WELLNESS PREVENTION CENTER (WPC)

BACK TOGETHER 4TEENS:

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

73
participants

MENTAL HEALTH AWARENESS WEEK EVENTS:

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

MENTAL HEALTH AWARENESS PUBLIC SERVICE CAMPAIGN:

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

YOUR TEEN TOOLBOX:

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

98
in person

91
virtually

TARGET AUDIENCE:

Youth 12+, parents, students, school staff, community

COUNCIL ON AGING SOUTHERN CALIFORNIA (COASC)

ART THERAPY FOR SENIORS:

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

3,957
art participants

TRUE COLORS MEDIA CAMPAIGN:

Campaign focused on reducing public and institutional stigma through participant art on public transit and bus shelters to counter negative stereotypes and beliefs. (First campaign: May- June 2020; second campaign: Dec. 2020)

7.7m
bus shelter impressions

10m
bus impressions

MENTAL HEALTH AND AGING EDUCATIONAL FORUM:

Forum focused on reducing stigma and promoting mental health awareness through lectures, community mental health resources, and keynote speakers. (Nov. 10, 2020)

206
forum attendees

140
YouTube views

TARGET AUDIENCE:

Older adults, mental health and aging providers, participating artists from the community

NATIONAL ALLIANCE ON MENTAL ILLNESS - OC (NAMI-OC)

LOUD AND PROUD MUSIC AND ART FESTIVAL:

A virtual Loud and Proud Music and Art series featured local LGBTQIA+ musicians and artists who performed and displayed art with the intention of opening up conversation about mental health for Pride celebrations during Pride month. (September 2020) Social/Digital Media: Channel Q made a targeted post containing a fun 22-second video including music by Loud and Proud performer, Chioke Dmachi.

TARGET AUDIENCE:

LGBTQIA+/Hearing Loss

EVENT:

176
virtual event attendees

110
YouTube livstream views

INSTAGRAM:

37 posts
12,877 reaches
1,049 likes
147 comments
147 shares

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

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

OUTCOMES

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

In FY 2019-2020 and 2020-21, one provider (MECCA) asked virtual event participants to complete a survey on their beliefs and attitudes about mental health:

- **Drawing Out Stigma - Youth Participants:** % "agreed" or "completely agreed" with the following statements (n=141)
  - **73%** "learned something new about mental health"
  - **85%** "learned how to respect people living with a mental health condition"
  - **75%** "learned how to help a friend find an adult if they wanted to talk about mental health"
  - **86%** "believe people with mental health conditions can get better with help"
  - **86%** "believe anyone can experience a mental health condition"
  - **84%** "believe that talking to someone about mental health is important"
- **Drawing Out Stigma - Adult Participants**: % "agreed" or "completely agreed" with the following statements (n=132)
  - **80%** are willing to talk about mental health with people they will meet
  - **83%** "learned how to treat people living with mental illness"
  - **73%** "learned how to find help for people living with mental illness"
  - **83%** "believe people living with mental illness have similar problems that they do"
  - **92%** "believe that anyone can experience a mental illness at some point in their lives"
  - **87%** stated that they "are willing to talk to someone about their mental health

The results suggest that the events were particularly effective in promoting positive messages about mental health and people living with mental health conditions among youth and adult participants.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

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

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+ All Ages	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	40	Female	54	African American/Black	2
16-25	25	Male	45	American Indian/Alaskan Native	1
26-59	20	Transgender	-	Asian/Pacific Islander	9
60+	15	Genderqueer	-	Caucasian/White	17
		Questioning/Unsure	-	Latino/Hispanic	71
		Another	1	Middle Eastern/North African	-
				Another	-

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$9,336,945	38,483
FY 2021-22	$13,118,412	39,081
FY 2022-23*	$16,832,773	TBD

**Proposed activities to FY 22-23 to maintain current level of contract funding. To address health equity with service needs for specific etŠic, gender, or age groups. Targeting the elderly population.*

SERVICES

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

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

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

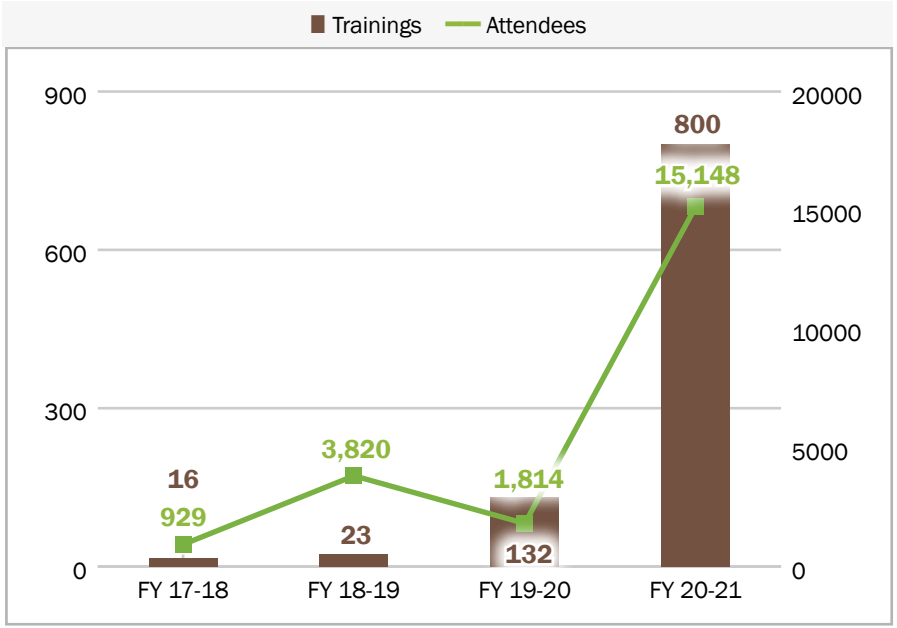
CIT FOR LAW ENFORCEMENT

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

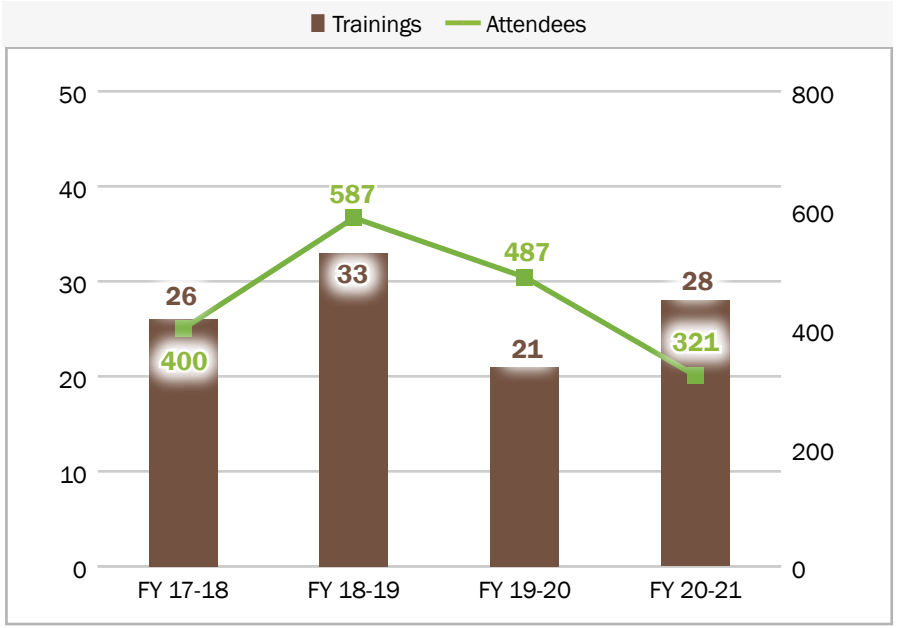
STRATEGY 1: TRAINING, TECHNICAL ASSISTANCE AND CONSULTATIONS

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

Trainings, TA & Consultations



CIT for Law Enforcement



TIER 1: TRAININGS FOR COMMUNITY MEMBERS*

EARLY SIGNS OF MENTAL ILLNESS:

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

TRAUMA-INFORMED CARE:

- Adverse Childhood Experiences

SUICIDE PREVENTION:

- Means Restrictions
- CalMHSA Know the Signs

RESILIENCE & WELL-BEING:

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

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

TIER 2: TRAININGS FOR NON-BEHAVIORAL HEALTH PROFESSIONALS*

EARLY SIGNS OF MENTAL ILLNESS:

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

TRAUMA-INFORMED CARE:

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

SUICIDE PREVENTION:

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

RESILIENCE & WELL-BEING:

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

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

For a list of all trainings offered in FY 2019-20, go to: https://www.eventbrite.com/o/behavioral-health-training-collaborative-27819159453
Online resources are available for select trainings so that students and families can access information after a training has been completed: ocstudentmentalhealth.org

STRATEGY 2: EDUCATIONAL/INFORMATIONAL MATERIALS

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

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

Each Mind Matters Ribbons & Wristbands

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

STRATEGY 3: COMMUNITY EVENTS, NETWORKING AND ACTIVATION EFFORTS

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

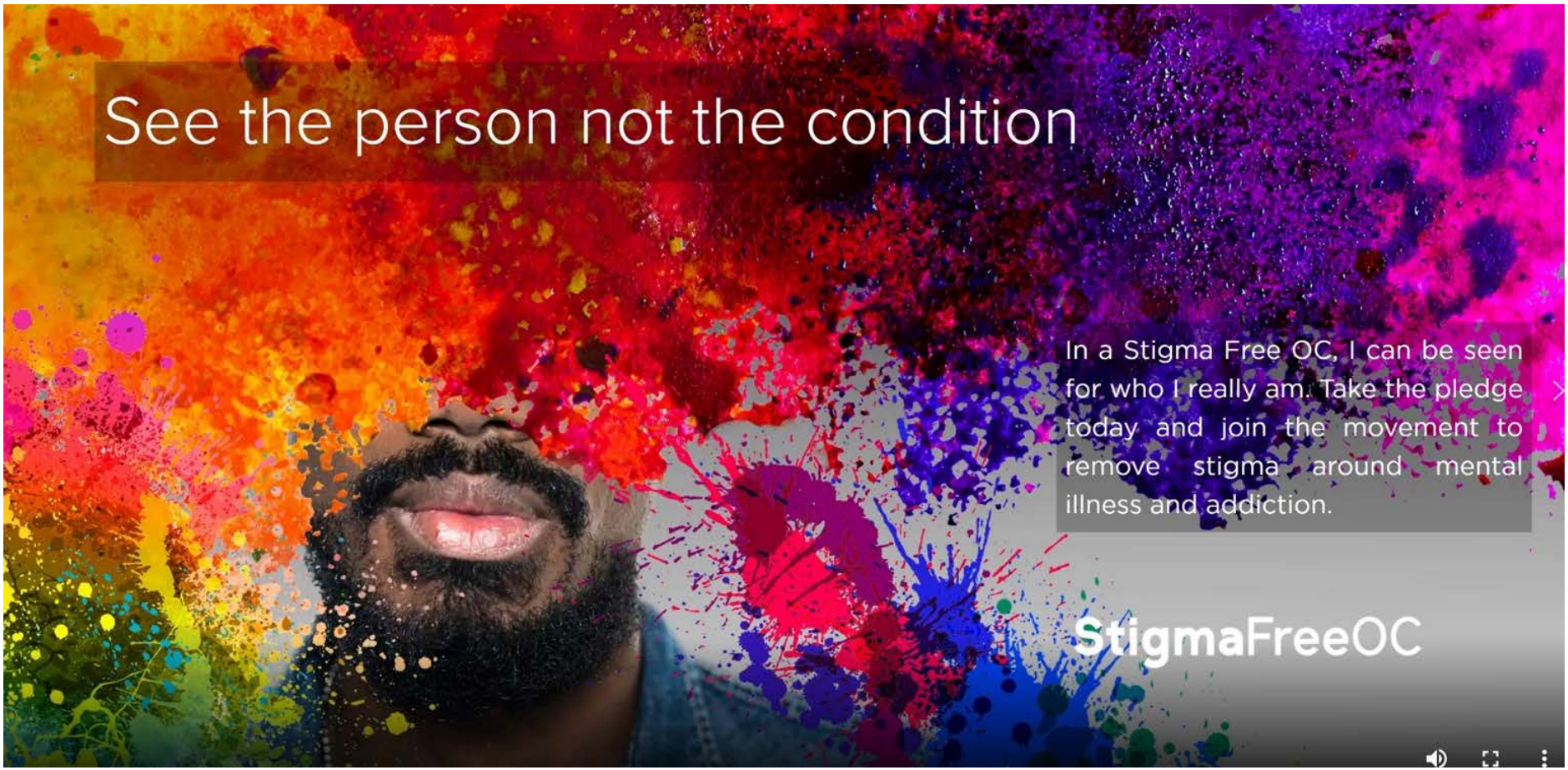
- **Events**: Tier 1
  - In-person and virtual art exhibits showcasing artwork created by program participants that promote mental health awareness, suicide prevention, stigma reduction, etc.; examples: Send the Silence Packing suicide prevention exhibit, local arts and photographic displays, etc.
-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

FISCAL YEAR	# SUBMISSIONS STATEWIDE	# SUBMISSIONS FROM OC	COUNCIL ON AGING SOUTHERN CALIFORNIA (COASC) View winning films from Orange County: https://www.directingchangeca.org/films-by-county/#Orange
FY 19/20	1,080	78 237 OC youth	**REGIONAL COMPETITION WINNERS:** ■ 3 Orange County films in the *"Mental Health Matters"* category ■ 2 Orange County films in the *"Suicide Prevention"* category ■ 1 Orange County film in the *"Animated Shorts"* category **HONORABLE MENTIONS:** ■ 1 *"Through the Lens of Culture"* category ■ 7 *"Mental Health Matters"* category ■ 6 *"Suicide Prevention"* category ■ 2 *"Sana Mente"* category ■ 1 *"Animated Shorts"* category ■ 2 *"Walk in Our Shoes"* category
FY 18/19	1,063	84 210 OC youth	**REGIONAL COMPETITION WINNERS:** ■ 3 Orange County films in the *"Mental Health Matters"* category ■ 3 Orange County films in the *"Suicide Prevention"* category **HONORABLE MENTIONS:** ■ 3 Orange County films in the *"Through the Lens of Culture"* category ■ 10 *"Mental Health Matters"* category ■ 9 *"Suicide Prevention"* category ■ 1 *"Sana Mente"* category ■ 2 *"Animated Shorts"* category
FY 17/18	742	134 342 OC youth	**REGIONAL COMPETITION WINNERS:** ■ 3 Orange County films in the *"Mental Health Matters"* category ■ 3 Orange County films in the *"Suicide Prevention"* category ■ 1 Orange County films in the *"Through the Lens of Culture"* category

STRATEGY 4: MEDIA CAMPAIGNS

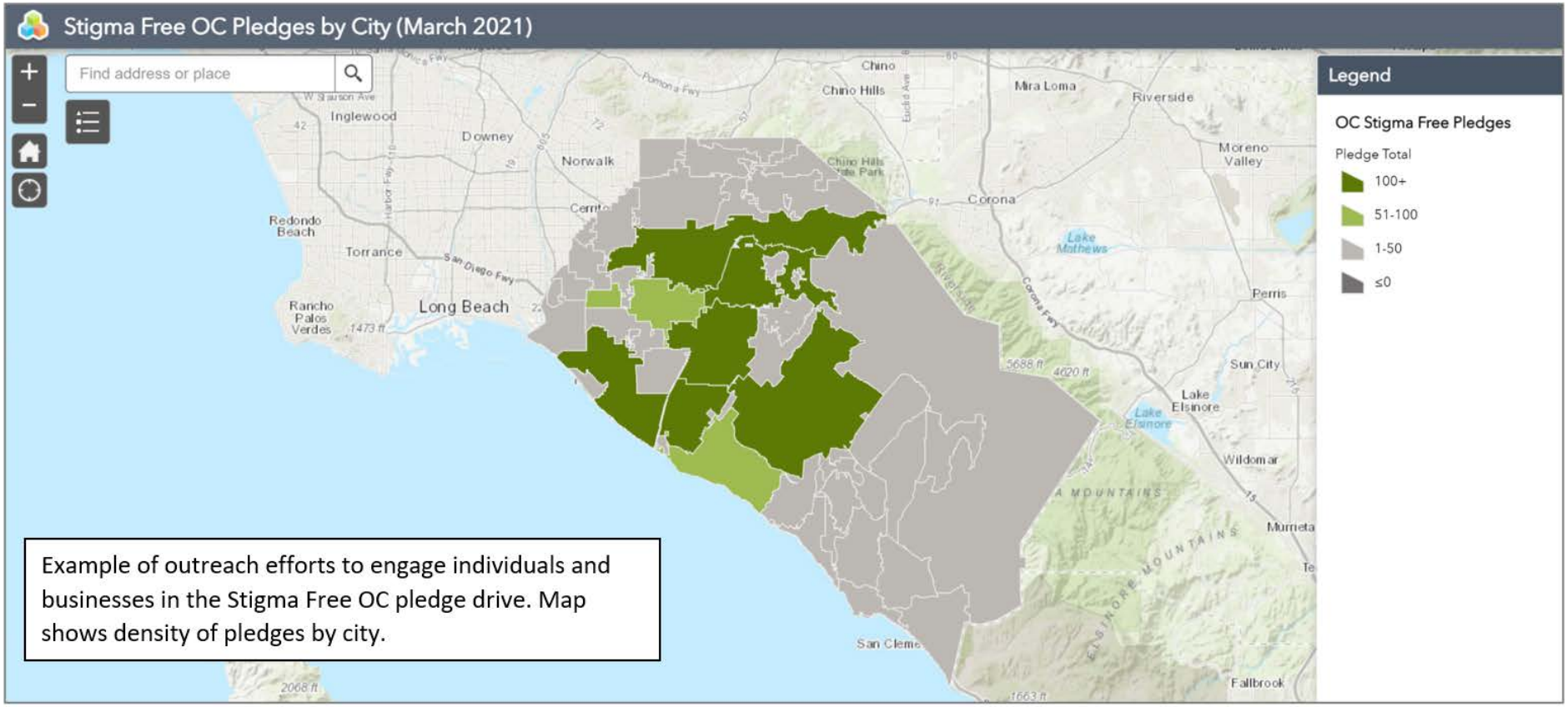
(i.e., culturally responsive/tailored print, radio, television, internet, social, etc.):

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



STRATEGY 5: DOOR-TO-DOOR/STREET/EVENT-BASED OUTREACH (TIERS 1, 2)

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



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

LOCATION OF OUTREACH TRAININGS, ACTIVITIES AND EVENTS (SEE TABLE BELOW FOR MORE DETAILS)

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

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

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

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

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

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

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

CHANGES, CHALLENGES AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

School Readiness (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0-8					
Ages 0-8	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

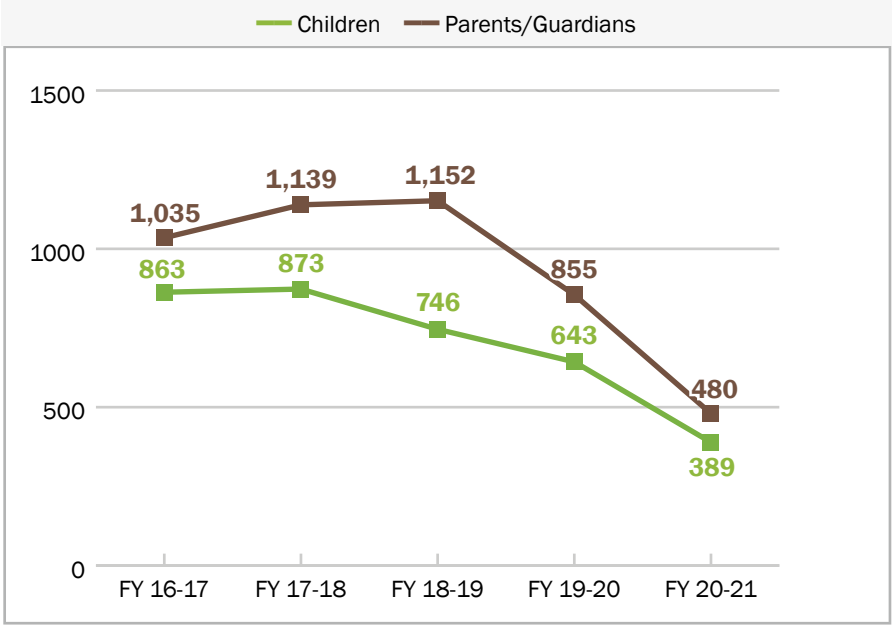
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,600,000	3,600
FY 2021-22	$1,000,000	1,705
FY 2022-23*	$1,000,000	TBD

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

SERVICES

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

Persons Served by FY



OUTCOMES

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

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

Impact on Parent Self-Efficacy

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

REFERENCE NOTES

Supporting Good Behavior:

FY 2020-21: Baseline M=6.1, SD=0.78; Follow-up M=6.3, SD=0.61; t(89)=-3.86, p<.001; Cohen's d=0.42
FY 2019-20: Baseline M=6.1, SD=0.83; Follow-up M=6.4, SD=0.65; t(210)=-7.36, p<.001; Cohen's d=0.52
FY 2018-19: Baseline M=6.0, SD=0.90; Follow-up M=6.5, SD=0.63; t(234)=10.66, p<.001; Cohen's d=0.74
FY 2017-18: Baseline M=6.0, SD=0.95; Follow-up M=6.6, SD=0.53; t(298)=12.65, p<.001; Cohen's d=0.80
FY 2016-17: Baseline M=6.3, SD=0.68; Follow-up M=6.5, SD=0.56; t(118)=5.66, p<.001; Cohen's d=0.5

Setting Limits:

FY 2020-21: Baseline M=5.4, SD=1.14; Follow-up M=5.8, SD=0.86; t(89)=-4.24, p<.001; Cohen's d=0.46
FY 2019-20: Baseline M=5.3, SD=1.10; Follow-up M=6.0, SD=0.96; t(210)=-9.60, p<.001; Cohen's d=0.67
FY 2018-19: Baseline M=5.3, SD=1.15; Follow-up M=6.2, SD=0.81; t(234)=13.08, p<.001; Cohen's d=0.89
FY 2017-18: Baseline M=5.2, SD=1.30; Follow-up M=6.4, SD=0.74; t(298)=17.57, p<.001; Cohen's d=1.11
FY 2016-17: Baseline M=5.5, SD=1.13; Follow-up M=6.1, SD=0.86; t(118)=6.12, p<.001; Cohen's d=0.57

Proactive Parenting:

FY 2020-21: Baseline M=5.5, SD=1.03; Follow-up M=6.0, SD=0.83; t(89)=-5.85, p<.001; Cohen's d=0.63
FY 2019-20: Baseline M=5.6, SD=1.10; Follow-up M=6.2, SD=0.89; t(227)=-7.10, p<.001; Cohen's d=0.48
FY 2018-19: Baseline M=5.5, SD=1.21; Follow-up M=6.1, SD=1.04; t(288)=-9.62, p<.001; Cohen's d=0.57
FY 2017-18: Baseline M=5.3, SD=1.30; Follow-up M=6.5, SD=0.71; t(298)=17.65, p<.001; Cohen's d=1.13
FY 2016-17: Baseline M=5.6, SD=1.15; Follow-up M=6.3, SD=0.88; t(118)=17.65, p<.001; Cohen's d=0.6

Overall Score:

FY 2020-21: Baseline M=5.6, SD=0.84; Follow-up M=6.1, SD=0.65; t(89)=-5.79, p<.001; Cohen's d=0.63
FY 2019-20: Baseline M=5.7, SD=0.89; Follow-up M=6.2, SD=0.81; t(227)=-8.66, p<.001; Cohen's d=0.58
FY 2018-19: Baseline M=5.6, SD=0.94; Follow-up M=6.2, SD=0.76; t(288)=-13.06, p<.001; Cohen's d=0.78
FY 2017-18: Baseline M=5.5, SD=1.07; Follow-up M=6.5, SD=0.61; t(298)=18.49, p<.001; Cohen's d=1.18
FY 2016-17: Baseline M=5.8, SD=0.89; Follow-up M=6.3, SD=0.71; t(118)=7.34, p<.001; Cohen's d=0.6

Parent Education Services (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0-18					
Ages 0-18	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

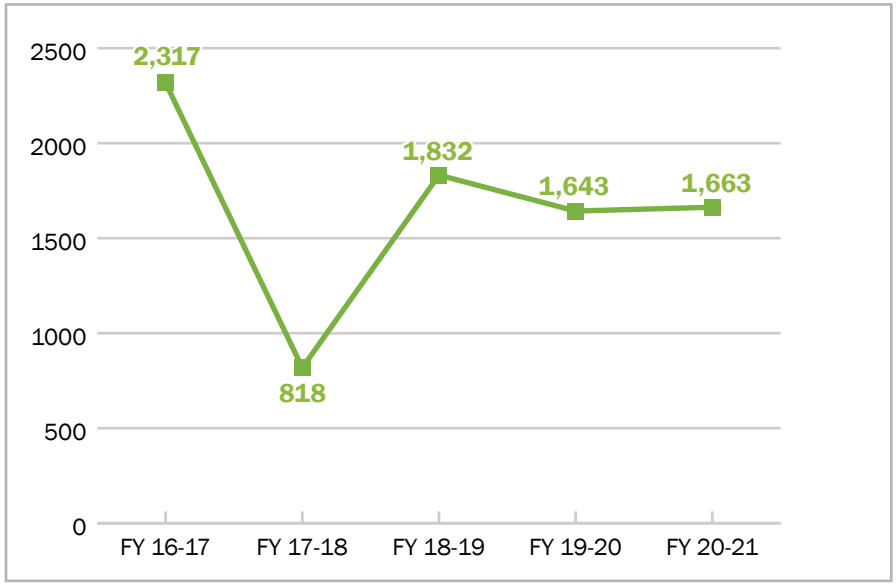
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,064,770	1,600
FY 2021-22	$1,450,000	2,000
FY 2022-23*	$1,494,303	2,000

**Increase Budget by $430K to maintain current level of services*

SERVICES

The program's purpose is to prevent the occurrence of, or reduce prolonged suffering due to, negative mental health outcomes in children by promoting protective factors in parents and caregivers. It accomplishes this by providing parenting education classes and individual interventions or additional support when parents need clarification about individual issues or help in understanding the parenting curriculum. The program guides its services through Active Parenting, an evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills such as assisting parents in strengthening relationships with their children, reducing problem behaviors exhibited by children and increasing success of children in schools, by increasing cooperation and developing problem-solving skills. To ensure fidelity, all parent trainers are required to attend a comprehensive training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month. In addition, PES provides case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, advocating for needs).

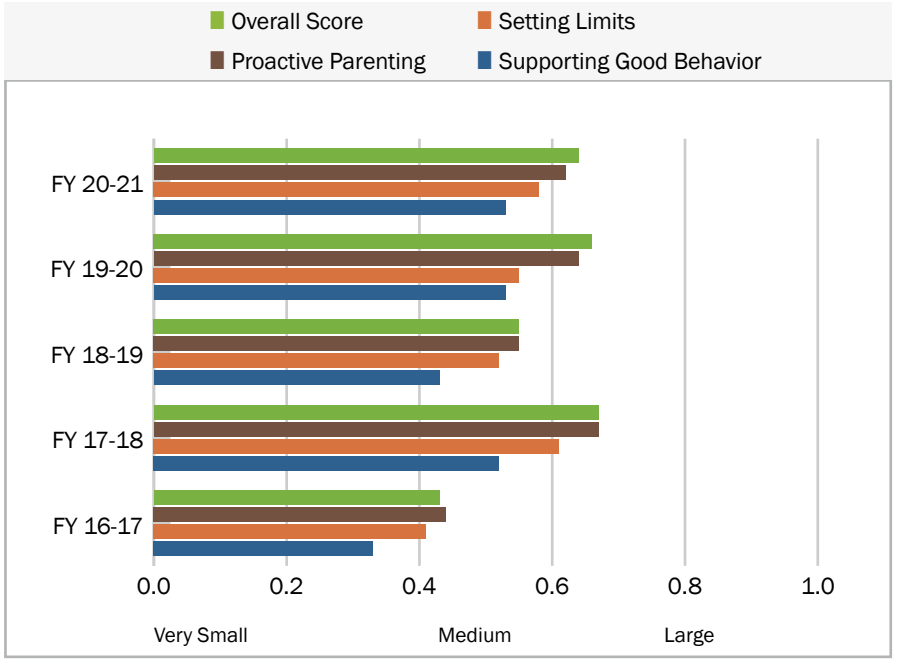
Persons Served by FY



OUTCOMES

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

Impact on Parent Self-Efficacy



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The program continues to expand its reach in the community to address the needs of the diverse population of the county. In FY 2021-22, additional funding was added to the program to increase program capacity to expand parenting courses that reach underserved areas of Orange County that include school districts, family resource centers, and underserved populations including shelters, and jails. These additional dollars will expand outreach, 1:1 intervention services, and parent education courses that specifically focuses on building strong relationships as well as increasing knowledge about discipline, and developing parenting skillsets for families with children from birth to age five, which is reflected in the expanded Units of Service (UOS) for FY 2021-22. Additional funding will also be utilized to translate educational materials into Arabic, Farsi and Vietnamese.

Parenting classes for all age groups are provided in multiple languages including Vietnamese, Korean, Farsi, Arabic, in addition to English and Spanish. In response to the pandemic, the program has successfully provided the Active Parenting training remotely to allow access to training during the pandemic shutdown.

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

Supporting Good Behavior:

FY 2020-21: Baseline M=5.5, SD=1.21; Follow-up M=6.1, SD=0.95; t(1281)=1854, p<.001; Cohen's d=0.53
FY 2019-20: Baseline M=5.3, SD=1.12; Follow-up M=5.9, SD=0.88; t(1386)=19.17, p<.001; Cohen's d=0.53
FY 2018-19: Baseline M=5.3, SD=1.22; Follow-up M=5.8, SD=1.02; t(1091)=14.04, p<.001; Cohen's d=0.43
FY 2017-18: Baseline M=5.4, SD=1.1; Follow-up M=5.9, SD=0.9; t(631)=-12.92, p<.001; Cohen's d=0.52
FY 2016-17: Baseline M=5.9, SD=1.1; Follow-up M=6.2, SD=0.9; t(780)=-9.21, p<.001; Cohen's d=0.33

Setting Limits:

FY 2020-21: Baseline M=5.3, SD=1.28; Follow-up M=6.0, SD=1.00; t(1279)=20.25, p<.001; Cohen's d=0.58
FY 2019-20: Baseline M=5.1, SD=1.26; Follow-up M=5.7, SD=0.97; t(155)=20.10, p<.001; Cohen's d=0.55
FY 2018-19: Baseline M=5.0, SD=1.22; Follow-up M=5.6, SD=1.02; t(1091)=16.93, p<.001; Cohen's d=0.52
FY 2017-18: Baseline M=5.1, SD=1.2; Follow-up M=5.8, SD=1.0; t(629)=-15.07, p<.001; Cohen's d=0.61
FY 2016-17: Baseline M=5.3, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-11.25, p<.001; Cohen's d=0.41

Proactive Parenting:

FY 2020-21: Baseline M=5.3, SD=1.21; Follow-up M=6.0, SD=0.94; t(1279)=21.56, p<.001; Cohen's d=0.62
FY 2019-20: Baseline M=5.1, SD=1.23; Follow-up M=5.8, SD=1.00; t(1381)=23.41, p<.001; Cohen's d=0.64
FY 2018-19: Baseline M=5.1, SD=1.32; Follow-up M=5.7, SD=1.06; t(1097)=17.88, p<.001; Cohen's d=0.55
FY 2017-18: Baseline M=5.1, SD=1.3; Follow-up M=5.9, SD=1.0; t(629)=-16.32, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=5.4, SD=1.3; Follow-up M=5.9, SD=1.1; t(780)=-12.09, p<.001; Cohen's d=0.44

Overall Score:

FY 2020-21: Baseline M=5.4,1 SD=1.2; Follow-up M=6.0, SD=0.94; t(1282)=22.23, p<.001; Cohen's d=0.64
FY 2019-20: Baseline M=5.2, SD=1.10; Follow-up M=5.8, SD=0.88; t(1386)=24.10, p<.001; Cohen's d=0.66
FY 2018-19: Baseline M=5.1, SD=1.18; Follow-up M=5.7, SD=0.97; t(1019)=18.06, p<.001; Cohen's d=0.55
FY 2017-18: Baseline M=5.2, SD=1.1; Follow-up M=5.9, SD=0.9; t(632)=-16.66, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=5.5, SD=1.1; Follow-up M=6.0, SD=1.0; t(780)=-12.04, p<.001; Cohen's d=0.4

Children's Support & Parenting Program (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
6-18					
Ages 6-18	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

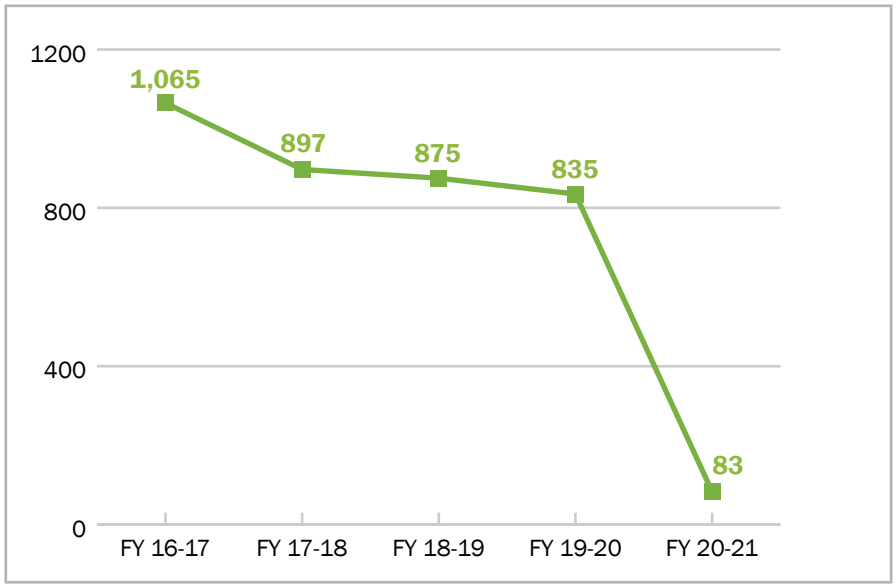
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,700,000	1,000
FY 2021-22*	$1,000,000	1,000
FY 2022-23	$0	0

Sunsetting Program.

SERVICES

The program is designed to provide parent training and family-strengthening programs to reduce risk factors and increase protective factors for children and youth. Services include family assessment; group interventions for children, teens and parents; brief individual interventions to address specific family issues; referral and linkage to community resources; and workshops. As these services are provided in person and in community group settings, the COVID-19 pandemic resulted in a complete shutdown of services due to the stay-at-home order. During this time, CSPP staff reviewed existing evidence-based curricula, Strengthening Families or The Parent Project® for virtual platforms. Both curricula are designed to be delivered in a classroom-type setting in many different types of organizations such as schools, Family Resource Centers (FRC), treatment facilities, juvenile probation offices and the CSPP offices. The pandemic created opportunities to identify virtual platforms and curricula that could be used to continue providing parenting and family-strengthening trainings to the community in a safe manner.

CSPP Persons Served by FY



OUTCOMES

CSPP strives to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills. CSPP measured parenting development using the PARCA-SE, which assesses different domains of parenting self-efficacy. Administered at intake, every three months of program participation and at discharge, the PARCA-SE was analyzed for change in scores between intake and the most recent follow-up and reported according to effect size. Results from FY 2016-17 through FY 2019-20 show that parents not only reported maintaining healthy levels of parenting efficacy but also made small additional gains while receiving services. In FY 2020-21, reported high levels of parenting efficacy and made larger gains while receiving services compared to previous years. During the last year CSPP transitioned to virtual services. The curriculum was modified to include only parents, and the groups sizes were significantly smaller, which meant that CSPP staff were able to provide more individualized support to parents. Teaching the curriculum on a small group basis produced better outcomes for parents.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to the nature of services provided on school campuses or community sites, the COVID-19 pandemic continued to impact CSPP services. As the schools and the community re-open, program conducted outreach to partners to begin scheduling new virtual parenting classes. Additionally, CARES Act funds purchased licenses for the Positive Parenting Program (Triple P) online for caregivers to have remote access to parent education and supports. CSPP staff were made available as parent liaisons for those desiring additional assistance with the curriculum.

REFERENCE NOTES

Supporting Good Behavior:

FY 2020-21: Baseline M=5.8, SD=1.02; Follow-up M=6.5, SD=0.51; t(41)=5.25, p<.001; Cohen's d=0.94
FY 2019-20: Baseline M=5.7, SD=1.04; Follow-up M=5.9, SD=0.91; t(215)=2.67, p=.008; Cohen's d=0.18
FY 2018-19: Baseline M=5.7, SD=1.05; Follow-up M=6.0, SD=0.92; t(340)=4.43, p<.001; Cohen's d=0.24
FY 2017-18: Baseline M=5.8, SD=1.19; Follow-up M=6.1, SD=0.92; t(141)=3.96, p<.001; Cohen's d=0.34
FY 2016-17: Baseline M=5.3, SD=1.25; Follow-up M=5.8, SD=1.04; t(310)=6.95, p<.001; Cohen's d=0.40

Setting Limits:

FY 2020-21: Baseline M=5.2, SD=1.39; Follow-up M=6.4, SD=0.77; t(41)=5.88, p<.001; Cohen's d=1.02
FY 2019-20: Baseline M=5.3, SD=1.21; Follow-up M=5.8, SD=1.00; t(215)=5.40, p<.001; Cohen's d=0.37
FY 2018-19: Baseline M=5.2, SD=1.29; Follow-up M=5.8, SD=1.00; t(338)=9.68, p<.001; Cohen's d=0.54
FY 2017-18: Baseline M=5.3, SD=1.28; Follow-up M=5.8, SD=1.09; t(141)=3.96, p<.001; Cohen's d=038
FY 2016-17: Baseline M=5.3, SD=1.31; Follow-up M=5.7, SD=1.09; t(310)=5.03, p<.001; Cohen's d=0.29

Proactive Parenting:

FY 2020-21: Baseline M=5.5, SD=1.24; Follow-up M=6.5, SD=0.70; t(41)=5.29, p<.001; Cohen's d=0.90
FY 2019-20: Baseline M=5.3, SD=1.27; Follow-up M=5.7, SD=1.00; t(215)=4.70, p<.001; Cohen's d=0.33
FY 2018-19: Baseline M=5.2, SD=1.31; Follow-up M=5.7, SD=1.02; t(338)=7.76, p<.001; Cohen's d=0.43
FY 2017-18: Baseline M=5.2, SD=1.39; Follow-up M=5.8, SD=1.04; t(141)=5.47, p<.001; Cohen's d=0.47
FY 2016-17: Baseline M=5.4, SD=1.13; Follow-up M=5.8, SD=1.00; t(310)=5.48, p<.001; Cohen's d=0.31

Overall Score:

FY 2020-21: Baseline M=5.5, SD=1.13; Follow-up M=6.5, SD=0.61; t(41)=6.22, p<.001; Cohen's d=1.10
FY 2019-20: Baseline M=5.5, SD=1.87; Follow-up M=5.8, SD=0.88; t(215)=4.96, p<.001; Cohen's d=0.34
FY 2018-19: Baseline M=5.4, SD=1.10; Follow-up M=5.8, SD=0.90; t(340)=8.39, p<.001; Cohen's d=0.46
FY 2017-18: Baseline M=5.3, SD=1.05; Follow-up M=6.0, SD=0.80; t(174)=9.46, p<.001; Cohen's d=0.73
FY 2016-17: Baseline M=5.4, SD=1.19; Follow-up M=5.9, SD=0.94; t(141)=5.27, p<.001; Cohen's d=0.45

School-Based Behavioral Health Intervention & Support (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 5-14	Schools	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$3,408,589	40,500
FY 2021-22	$1,808,589	26,680
FY 2022-23*	$1,953,024	26,680

**Increased budget by $145K for "You And" app update for translation to Spanish, Vietnamese, and subtitles for deaf and hard of hearing.*

SERVICES

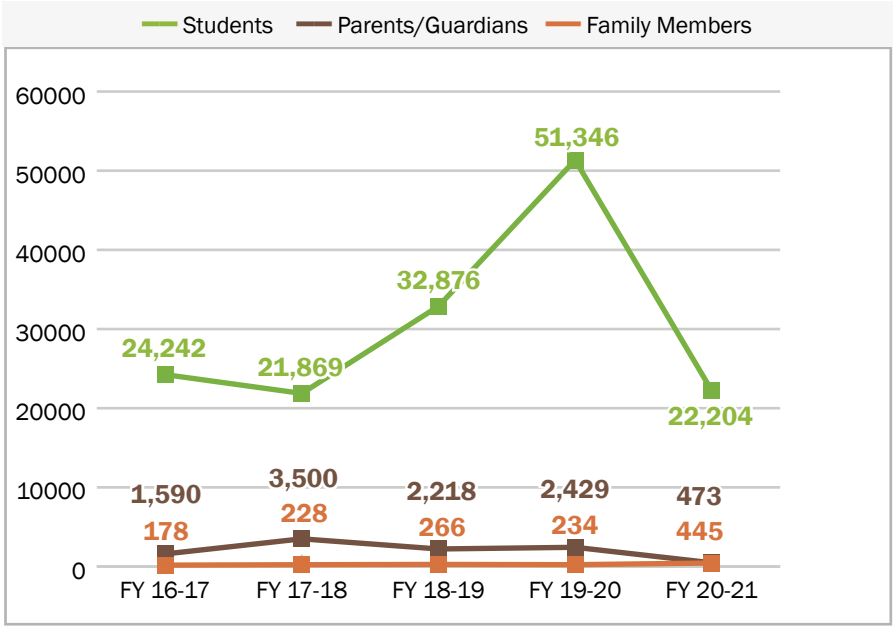
SBBHIS provides a three-tiered approach to program services aimed at preventing and/or intervening early among at risk students and their families:

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

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

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

Families Served by FY



OUTCOMES

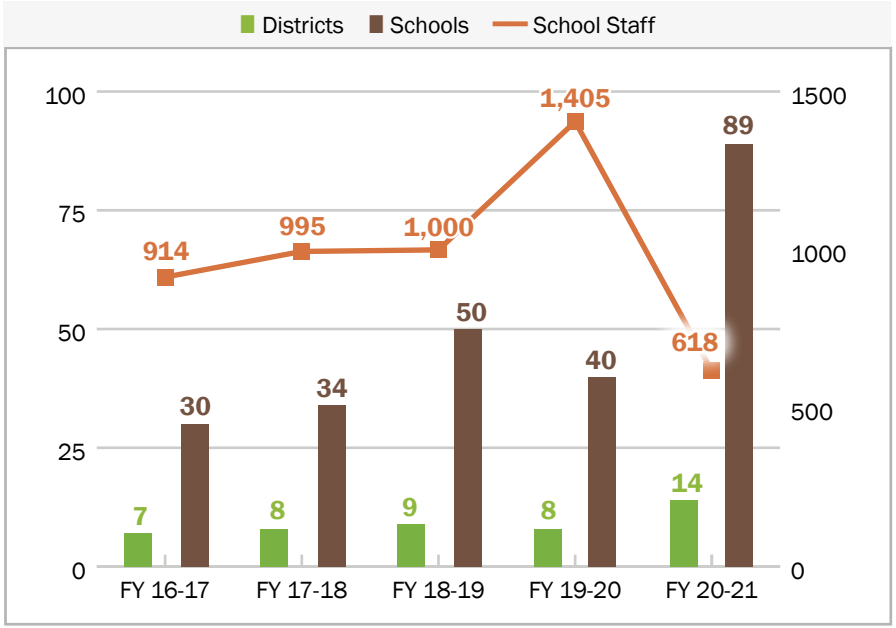
Different measures were used in each tier due to differences in services and level of student need. At each tier, the respective measure was assessed at baseline and program exit, and the change in scores was analyzed and reported according to effect size, which reflects, in part, the extent to which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

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

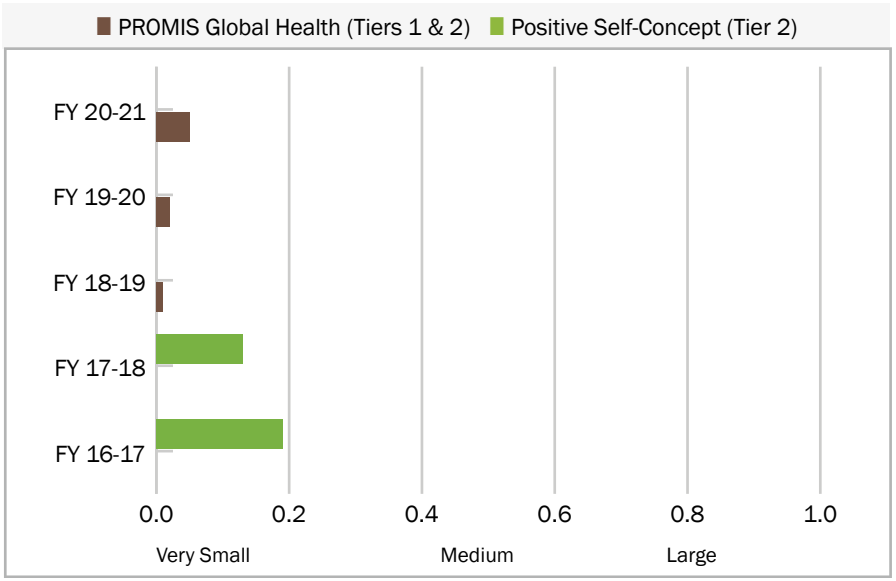
Tier 3: To assess the effectiveness in reducing prolonged suffering among Tier 3 participants, different types of disruptive behaviors (e.g., argues with adults, and interrupts or intrudes on others) were rated by the students' parents on the Child and Adolescent Disruptive Behavior Inventory (CADBI)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

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

Schools Served by FY



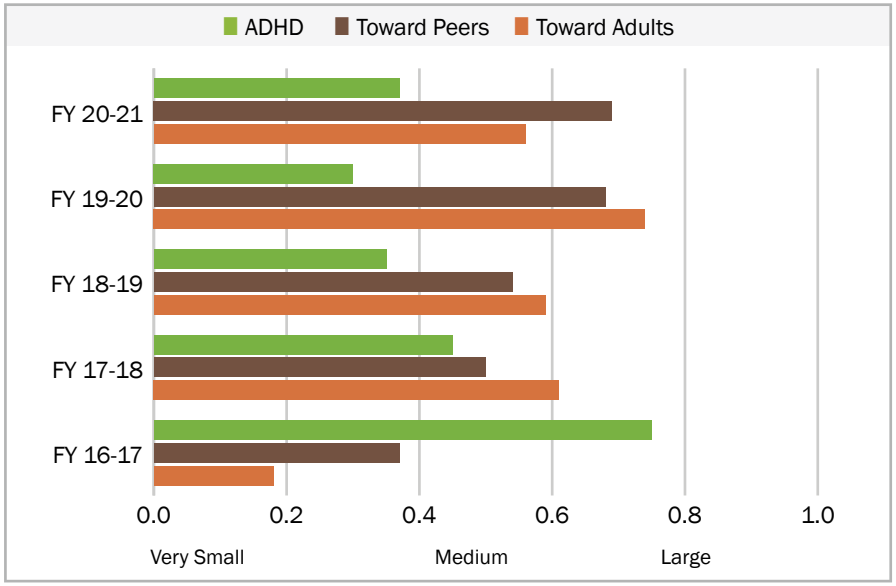
SBBHIS Improvement on Global Health *(Positive Self-Concept in prior FYs)*



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

In response to the pandemic and school closures, the program was successful in continuing to serve students by recreating their program curriculum and providing it on a virtual platform. In addition, a provider created the "Safer from Home" series for middle school students in response to the pandemic and received outstanding reviews form participants and their teachers. Finally, with the use of CARES Act funding, this same provider developed a computer and mobile interactive app, called "You And," for school age youth designed to maintain social and emotional well-being of students, their mental health, improve resiliency, develop positive coping skills, and stay connected to their peers. The content is tailored to engage four educational groupings: K-2, 3-5, Middle School and High School. Based on requests from individual schools, the provider will integrate the 6-week curriculum within the Tier 1 and Tier 2 services. From mid-year FY 2018-19 thru FY 2020-21, this program added a second provider utilizing time-limited funding which expired June 30, 2021. As a result, the UOS were decreased for FY 2021-22 based on the capacity of the one provider

SBBHIS - Impact on Disruptive Behaviors by FY



COMMUNITY IMPACT

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

REFERENCE NOTES

Tier 1/Tier 2: PROMIS Global Health:

FY 2020-21: Baseline M=23.8, SD=4.24; Follow-up M=24.1, SD=4.35; t(2280)=5.16, p<.001; Cohen's d=.05
FY 2019-20: Baseline M=24.5, SD=4.35; Follow-up M=24.6, SD=4.35; t(9853)=2.36, p=.018; Cohen's d=.02
FY 2018-19: Baseline M=24.3, SD=4.52; Follow-up M=24.2, SD=4.48; t(8084)=1.12, p=.263; Cohen's d=-.01

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

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

Tier 3: Disruptive Behavior Toward Adults:

FY 2020-21: Baseline M=22.0, SD=14.66; Follow-up M=16.3, SD=9.49; t(54)=3.76, p<.001; Cohen's d=0.56
FY 2019-20: Baseline M=19.2, SD=8.85; Follow-up M=15.0, SD=5.79; t(39)=4.19, p<.001; Cohen's d=0.74
FY 2018-19: Baseline M=20.7, SD=9.38; Follow-up M=16.2, SD=7.77; t(38)=4.35, p<.001; Cohen's d=0.59
FY 2017-18: Baseline M=20.7, SD=13.6; Follow-up M=16.3, SD=19.9; t(66)=4.46, p<.001; Cohen's d=0.61
FY 2016-17: Baseline M=13.9, SD=6.0; Follow-up M=13.2, SD=4.3; t(28)=0.90, p=<.382; Cohen's d=0.1

Tier 3: Disruptive Behavior Toward Peers:

FY 2020-21: Baseline M=21.9, SD=15.72; Follow-up M=13.6, SD=6.82; t(62)=4.65, p<.001; Cohen's d=0.69
FY 2019-20: Baseline M=20.9, SD=12.47; Follow-up M=15.0, SD=7.58; t(37)=3.69, p<.001; Cohen's d=0.68
FY 2018-19: Baseline M=20.8, SD=11.09; Follow-up M=16.4, SD=8.67; t(48)=3.65, p<.001; Cohen's d=0.54
FY 2017-18: Baseline M=21.8, SD=14.8; Follow-up M=17.4, SD=12.3; t(66)=3.96, p<.001; Cohen's d=0.50
FY 2016-17: Baseline M=15.2, SD=9.3; Follow-up M=12.6, SD=6.3; t(32)=1.90, p=.06; Cohen's d=0.37

Tier 3: ADHD/Hyperactive/Impulsive:

FY 2020-21: Baseline M=23.9, SD=14.86; Follow-up M=18.9, SD=11.63; t(58)=2.76, p<.001; Cohen's d=0.37
FY 2019-20: Baseline M=25.0, SD=14.19; Follow-up M=21.2, SD=13.5; t(36)=1.80, p<.081; Cohen's d=0.30
FY 2018-19: Baseline M=23.1, SD=13.47; Follow-up M=19.0, SD=11.91; t(46)=2.39, p<.021; Cohen's d=0.35
FY 2017-18: Baseline M=24.7, SD=15.0; Follow-up M= 20.6, SD=12.7; t(65)=3.53, p<.001; Cohen's d=0.45
FY 2016-17: Baseline M=24.2, SD=16.5; Follow-up M=15.1, SD=10.6; t(22) =3.30, p<.01; Cohen's d=0.75

Violence Prevention Education (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 6-18	Schools	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

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

SERVICES/IMPACT

The program has five different tracks designed to promote violence prevention. In FY 2018-19 VPE underwent significant changes by adding new components (i.e., Boys and Girls Restorative Practices, Threat Assessment program). In FY 17-18 the program also tailored the Anti-Bullying assembly content to different grade levels. Each track uses an evidence-based or practice-based evidence standard geared toward its specific focus, and fidelity to the Evidence-Based Practice (EBP) model is maintained by providing staff with periodic refresher trainings to ensure appropriate implementation.

- **Bullying/Cyber-Bullying:** Educates students, staff, administrators and parents on bullying and cyber-bullying prevention through: (1) presentations conducted at school assemblies in an effort to impact the overall school climate by reducing and/or preventing bullying; (2) a classroom-based curriculum focused on combating cyber-bullying and online safety; for grades K-12; (3) parent and staff trainings focused on preventing bullying at the student level. From FY 2016-17 through FY 2020-21, the majority of respondents agreed or strongly agreed that they knew or learned about bullying (61-80%) and felt empowered to stand up to bullying behavior (73-78%) after attending a student assembly. In FYs 2018-19 and 2020-21, when the post-training measure was implemented, the majority of students who took part in the cyber-bullying curriculum (72-89%) stated that they had learned a digital literacy skill.

- **Restorative Practices:** Offers a trauma-informed, research-based training for teachers to promote resilience in youth, particularly those who have been exposed to violence and varying degrees of trauma. Teachers utilize "circle practices" in the classroom to promote healthy relationships and help create calmer, more focused classrooms. The "circle practice" encourages students to strengthen relationships with their peers and teachers, thus, creating a safe and supportive environment for effective communication, expression of emotion, and exploration and acceptance of differences. Teachers who use these methods often find that the overall portion of time dedicated to managing problematic behavior is reduced, thus freeing up more time for instruction. In FY 2020-21, the majority of students agreed or strongly agreed that they had engaged in healthy habits or accepted others.

- **Safe From The Start:** Educates parents on research demonstrating how exposure to violence impacts the developing brain during the first five years of life, whether through direct physical contact or as a witness, can impact children's neurological development which may, in turn, compromise their cognitive, social and emotional development. Presentations are provided to parents at campus during and after school hours, as well as at shelters and other community organizations. Presentations are provided in English, Farsi, Korean, Spanish and Vietnamese. Across the past four fiscal years (FY 2016-17 through FY 2020-21), the majority of respondents reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training (65-100%).

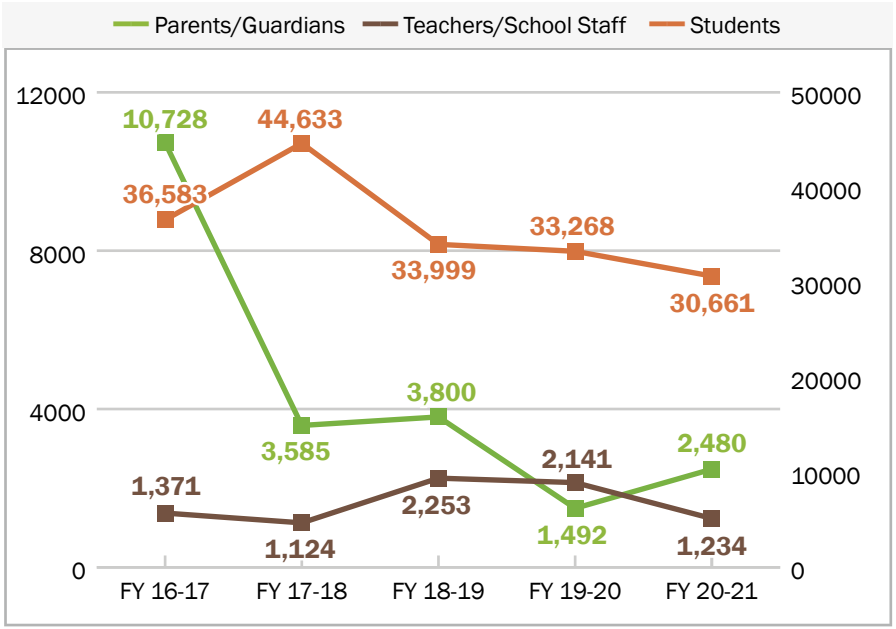
- **Threat Assessment:** Provides training to school administrators, teachers, mental health counselors, school resource officers and other school staff to assess threats and respond appropriately, and survey results indicate that those who received the simulation drills (see below) felt more confident in their ability to assess and respond to potential threats. The program consists of three components:
  - Proactive Threat Assessment Training, a full-day training covering the definition of threat, threat types and levels, how to screen and assess threats, behavioral indicators to look for, a response protocol, addressing stigma and mental health resources;
  - Threat Assessment Simulation Drills, covering situational awareness to increase confidence and a sense of empowerment during an emergency, which includes classroom and front office lockdown steps and procedures, and a post-drill debrief to reflect on shared experience, distress reactions, and the importance of self-care;
  - Community forums, facilitates discussion around the importance of violence prevention and early intervention, shares best practices for school

safety, and supports families and community members in identifying ways they can participate in violence prevention efforts, how to have conversations with children about violence, as well as how to support children in times of crisis, and access mental health services and resources.

In FYs 2018-19 and 2020-21, when the training was implemented, the majority of school staff who took part in the training (86-96%) stated that they had learned information on how to identify and/or respond to a potential threat.

- **Crisis Response Network:** A network of crisis responders trained in Crisis Incident Stress Management who mobilize and assist a school or community in times of emergency, need or threat. Pre-incident and crisis management trainings are also provided to the schools and the community. Across the past five fiscal years (FY 2016-17 through FY 2020-21), the majority of respondents agreed or strongly agreed that they learned how to recognize risk factors and practice healthy coping or support behaviors (85-100%).

VPE Persons Served



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

Gang Prevention Services (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
9-15				
Ages 9-15	Schools	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

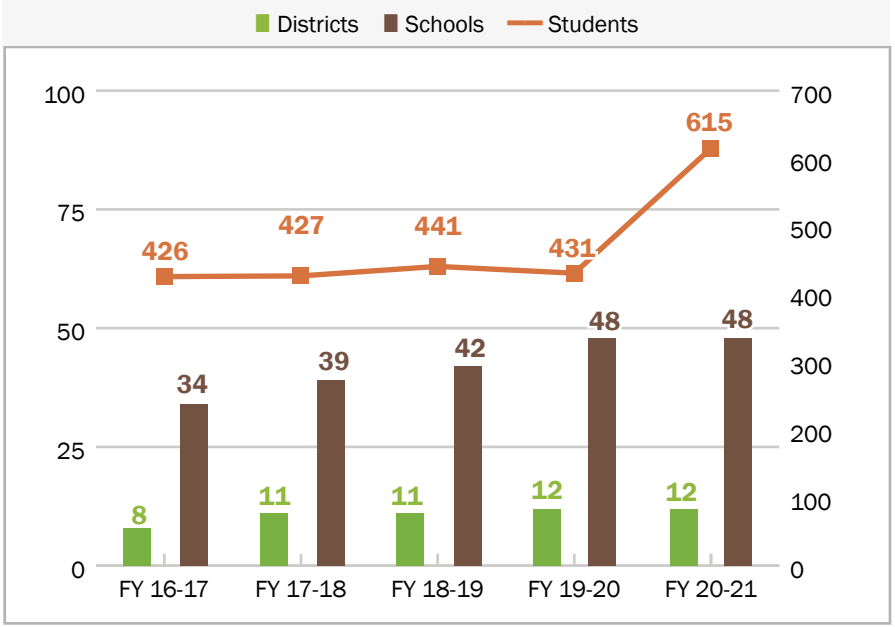
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$403,100	600
FY 2021-22	$403,100	600
FY 2022-23	$403,100	440

SERVICES

At each participating school, staff provides education to students, parents and teachers on gang prevention and offers school staff 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 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.

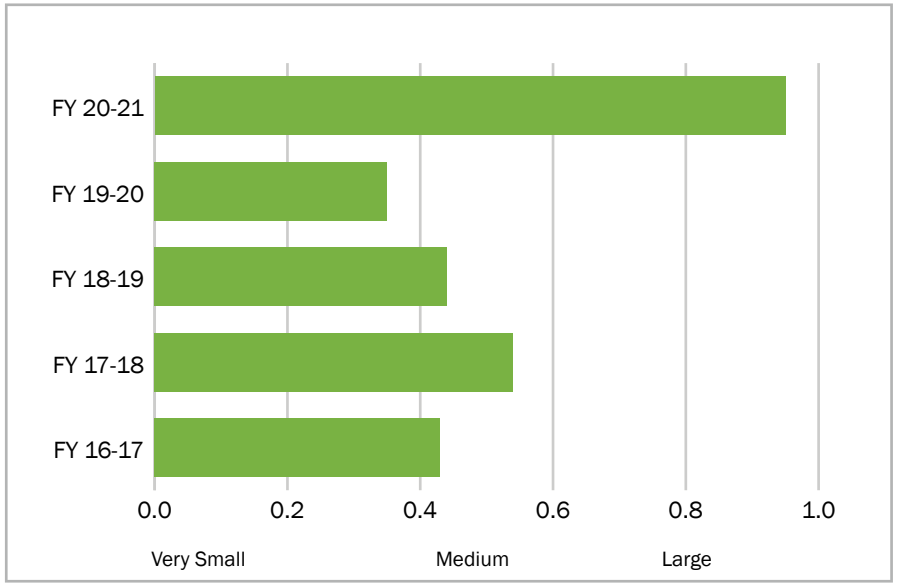
Schools & Students Served by FY



OUTCOMES

To measure the extent to which GPS increased the protective factor of health and well-being, students completed the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. The change in scores between baseline and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students served. In all four years, youth not only maintained their global health but also made small additional gains while receiving services. Thus, the program was associated with maintaining and somewhat improving this protective factor. During FY 2020-21, youth demonstrated large gains in global health, which is different than in previous years. Youth began services with lower ratings of health and made more progress while receiving services than in previous years. In addition, as a component of the Gang Reduction Intervention Program (GRIP), in FY 2020-21, 89% students increased attendance, and 83% decreased truancy. In FY 2020-21, there were no curfew sweep

GPS - Impact on PROMIS Global Health



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

REFERENCE NOTES

PROMIS Global Health:

FY 2020-21: Baseline M=22.5 SD=3.16; Follow-up M=26.2, SD=3.90; t(607)=23.07, p<.001; Cohen's d=0.95
FY 2019-20: Baseline M=24.0, SD=4.02; Follow-up M=25.7, SD=4.35; t(438)=7.40, p<.001; Cohen's d=0.35
FY 2018-19: Baseline M=23.6, SD=3.60; Follow-up M=25.5, SD=3.87; t(414)=9.02, p<.001; Cohen's d=0.44
FY 2017-18: Baseline M=22.4, SD=3.02; Follow-up M=25.0, SD=3.92; t(338)=9.85, p<.001; Cohen's d=0.54
FY 2016-17: Baseline M=24.8, SD=4.27; Follow-up M=27.0, SD=4.52; t(400)=8.68, p<.001; Cohen's d=0.43

Family Support Services (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
Ages 0-8	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

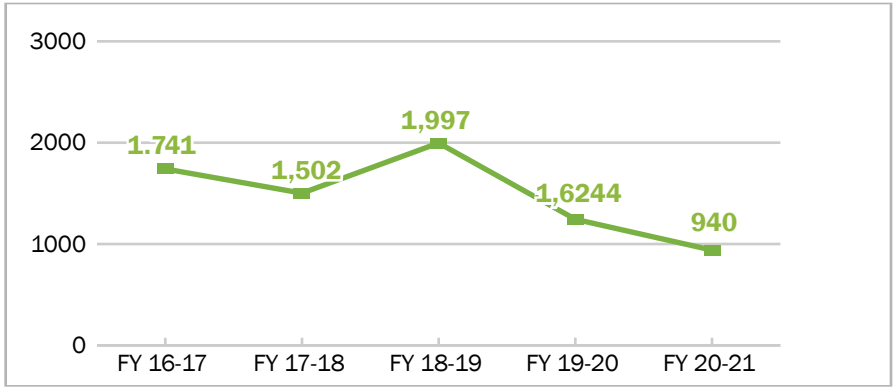
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$282,000	1,800
FY 2021-22	$282,000	1,800
FY 2022-23*	$304,996	1,800

**Increased FY 22-23 budget by $23K to pay Peer staff fair market rate.*

SERVICES

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

FSS Parents/Guardians Served



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

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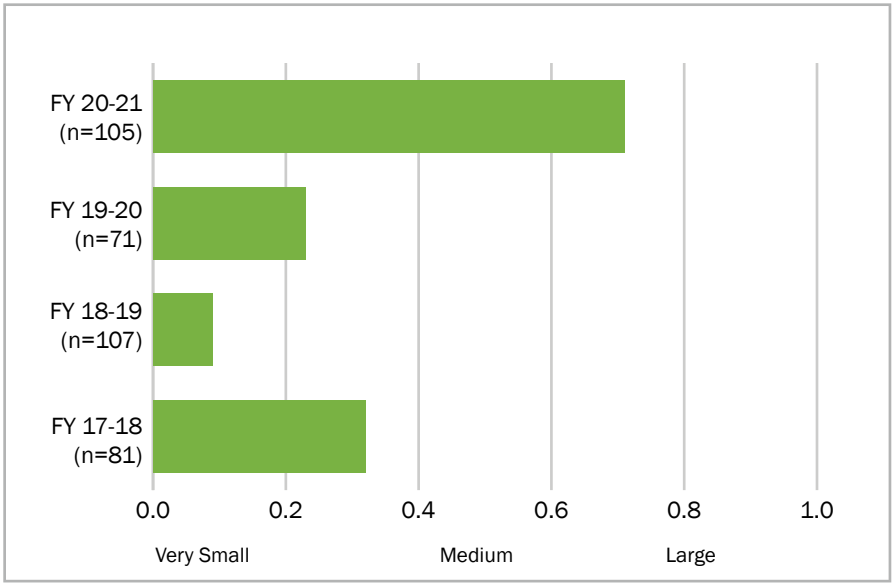
OUTCOMES

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

Across the fiscal years, parents consistently reported high levels of global health as they entered the program. While enrolled in FSS, parents made additional medium to large gains in global health in FY 2020-21. During the previous fiscal years, the improvements were small to moderate, with the exception of FY 2018-19. Thus, FSS appeared to be effective in maintaining and/or enhancing the protective factor of global health among the participants it serves.

FSS - Impact on Global Health



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to the pandemic, the number served in this program was lower in FY 2020-21. One of the main reasons for the low units was that the services were provided in the virtual format via Zoom. This format was challenging for both the participants as well as the Peer, who were conducting the group sessions. Peers expressed difficulty in successfully navigating the virtual platforms while receiving and providing the content respectively. Therefore, the number of attendees was lower than anticipated with a high rate of no shows despite participants' early interest and fewer number of groups were offered overall. Additionally, as the pandemic continued into the second year, participants also expressed "Zoom Fatigue" further impacting the low rate of attendance. Conversely, the program saw a significant increase in Peer Connector individual sessions. This is an indication of the community need for personalized individual services provided via telephone contact during the pandemic. It is also noteworthy that even though fewer individuals were served, those served received more intensive contacts. In addition, it is anticipated that demand for group program services will resume as the community continues to make progress opening-up.

COMMUNITY IMPACT

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

REFERENCE NOTES

PROMIS Global Health:

FY 2020-21: Baseline M=34.0, SD=6.49; Follow-up M=38.4, SD=6.00; t(104)=7.22, p<.001; Cohen's d=0.71
FY 2019-20: Baseline M=31.9, SD=6.78; Follow-up M=33.4, SD=4.92; t(70)=1.90, p<.061; Cohen's d=0.23
FY 2018-19: Baseline M=34.5, SD=6.20; Follow-up M=35.1, SD=7.12; t(106)=0.93, p<.353; Cohen's d=0.09
FY 2017-18: Baseline M=13.6, SD=3.33; Follow-up M=14.5, SD=2.80; t(80)=2.81, p<.001; Cohen's d=0.32
FY 2016-17: data collection began in FY 2017-18

Summary of MHSA Strategies Used by Prevention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

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

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

Underserved children, youth and families living in high-risk/need regions of the county often face challenges in accessing care due to transportation, childcare, scheduling or availability of appointments, and stigma. These programs strive to counter these challenges and increase timely access to services by providing their services throughout the county at locations that are accessible to participants, such as the person's home, school sites, family resource centers, community centers,

churches, County libraries, hospitals, shelters and County jails. They also schedule services at various times (morning, afternoons and evenings), offer childcare, and frequently provide meals as a way to encourage participation. Finally, programs provide services and materials in multiple languages.

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

MENTAL HEALTH AWARENESS AND PREVENTION				LINKAGE METRICS
Programs	**FY**	**# Referrals**	**# Linkages**	**Types of Linkages**
School Readiness	FY 2016-17	273	88	Special needs/disability services; behavioral health prevention, early intervention programs; information and referral resources; family support; recreation activities; basic needs
	FY 2017-18	670	229	
	FY 2018-19	744	176	
	FY 2019-20	930	197	
	FY 2020-21	442	165	
CSPP	FY 2016-17	224	67	Access & Linkage; MHRS Outpatient Early Intervention: Family Services
	FY 2017-18	114	105	
	FY 2018-19	253	168	
	FY 2019-20	32	18	
	FY 2020-21	0	0	
GPS	FY 2016-17	866	634	Counseling services, adult literacy programs, housing and food assistance, medical care, school supplies, enrichment activities
	FY 2017-18	1,360	1,050	
	FY 2018-19	554	496	
	FY 2019-20	694	667	
	FY 2020-21	1,581	1,339	

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

ACCESS AND LINKAGE TO TREATMENT/SERVICES

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

- OC Links 24/7
- MHRS Outreach & Engagement
- Multi-Service Center for Homeless Adults
- Jail to Community Re-Entry
- Recovery Open Access

OC Links (PEI) (CSS)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
All Ages	Telephone	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	✓ TDD/CHAT
✓ Farsi	Mandarin	Vietnamese
Khmer	✓ Spanish	Other:

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC					
Age	**%**	**Gender**	**%**	**Race/EtŠicity**	**%**
0-15	1	Female	65	African American/Black	3
16-25	12	Male	35	American Indian/Alaskan Native	<1
26-59	71	Transgender	-	Asian/Pacific Islander	9
60+	16	Genderqueer	-	Caucasian/White	47
		Questioning/Unsure	-	Latino/Hispanic	41
		Another	-	Middle Eastern/North African	-
				Another	<1

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Duplicated # of Calls/Chats**
FY 2020-21	$1,000,000	19,986
FY 2021-22	$4,000,000	35,000
FY 2022-23*	$5,380,000	37,500

**Proposed activities to FY22-23 to provide additional staff necessary to operate 24/7 program.*

SERVICES/OUTCOMES

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

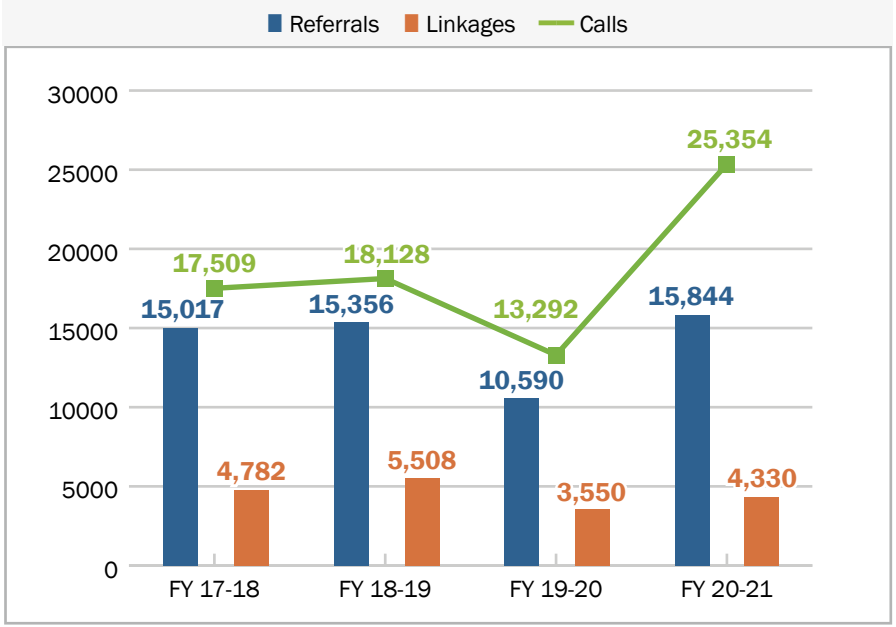
During a call or live chat, trained navigators provide screening, information, and referral and linkage directly to MHRS programs that best meet the needs of callers. Navigators make every attempt to connect callers directly to services while they are still on the line. Once the caller is linked to a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

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

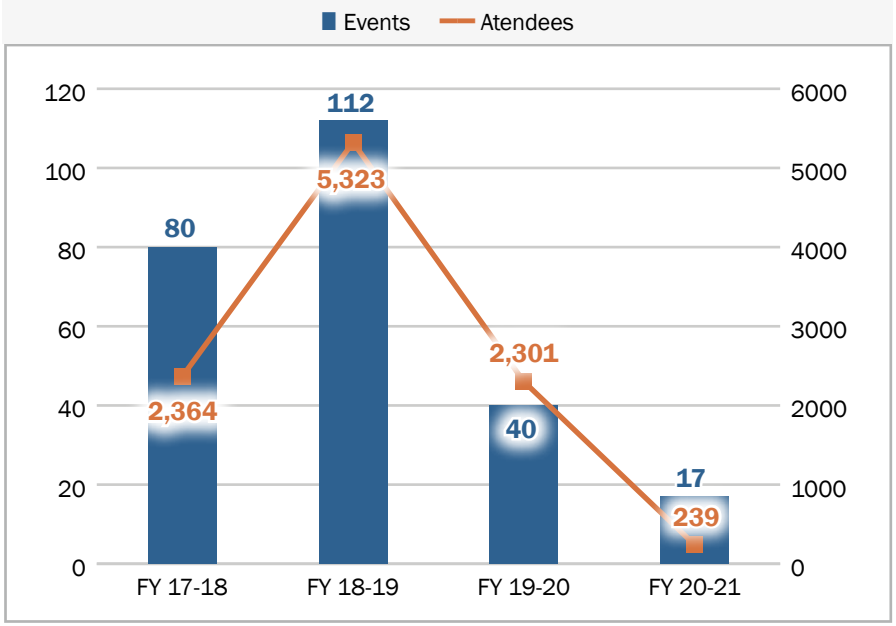
MOST COMMON LINKAGES MADE

OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE PROGRAMS, NAVIGATION AND TRAINING SERVICES, PREVENTION AND EARLY INTERVENTION SERVICES

Referrals and Linkages - OC Links

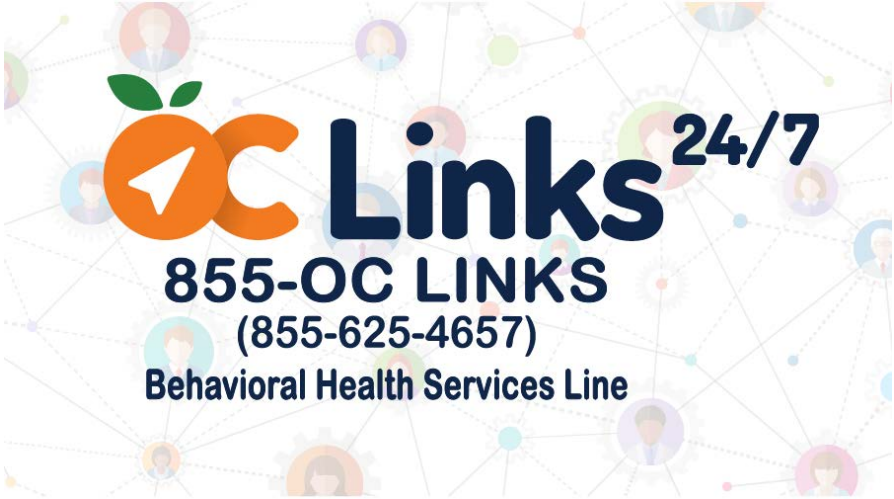


Outreach Activity - OC Links



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Increasing community awareness about OC Links and the services available through the County of Orange are a constant challenge that must continually be addressed. To better educate the public about OC Links on an ongoing basis, the team participates in community events and offers presentations to service providers and community groups. The program also provides OC Links informational cards to locations throughout the community in the threshold languages to promote services. HCA will be launching a new media campaign called "Where Wellness Begins," to get the word out about what OC Links has to offer. The multimedia campaign is anticipated to launch Spring 2022 and will include advertising in English, Spanish, and Vietnamese. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County MHRS. Challenges that arose due to COVID-19 impacted the daily work shifts and the type of outreach OC Links was able to perform. In response to the pandemic, hours of operation were expanded to cover from 8 a.m. to 8 p.m., and then in January 2021 the program permanently shifted to operate 24/7. Community outreach in the form of tabling events were also suspended. There was a small impact felt by callers who identified specific issues relating to COVID-19 and these issues were addressed by shifting work schedules to cover the additional hours. Local organizations that requested presentations were able to be accommodated by using meeting software platforms.



COMMUNITY IMPACT

The program has responded to more than 115,000 participants since opening in the Fall of 2013. OC Links serves Orange County residents by helping callers navigate a large and complex system of care and linking them to the County and/or County-contracted services best suited to meet their behavioral health needs.

Behavioral Health Outreach and Engagement (PEI)

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

AGE RANGE
0+ All Ages

PRIMARY LOCATION	
Field	Community

TARGET POPULATION		
At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC					
Age	**%**	**Gender**	**%**	**Race/EtŠicity**	**%**
0-15	<1	Female	31	African American/Black	6
16-25	2	Male	69	American Indian/Alaskan Native	<1
26-59	75	Transgender	-	Asian/Pacific Islander	17
60+	23	Genderqueer	-	Caucasian/White	47
		Questioning/Unsure	-	Latino/Hispanic	30
		Another	<1	Middle Eastern/North African	-
				Another	<1

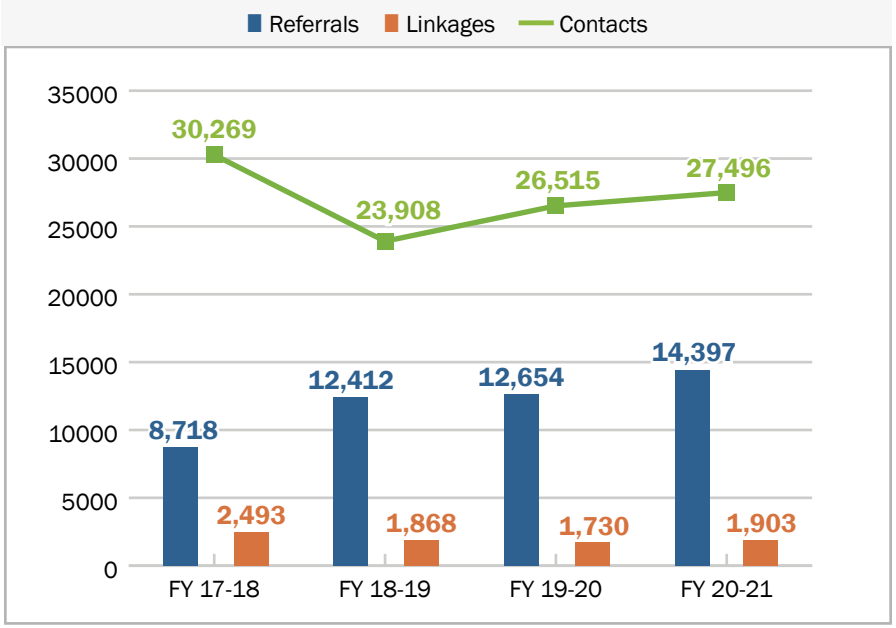
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Duplicated # of Contacts**
FY 2020-21	$2,232,523	26,358
FY 2021-22	$3,129,668	27,676
FY 2022-23*	$8,999,668	29,030

**Proposed activities to FY 22-23 to add 5 teams to increase case management service capacity for homeless individuals w/ MH and/or SUD conditions. This includes 10 MHS as field-based teams, 6 MHW IIs/Peers, 4 Housing Navigators (MHS), 1 SC I. Adding addtl $2M for MHSA portion of O&E Street Medicine program with Cal Optima.*

SERVICES/OUTCOMES

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

Referrals and Linkages - OC Links



MOST COMMON LINKAGES MADE

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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

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

COMMUNITY IMPACT

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

Multi-Service Center for Homeless Adult (CSS)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
18+					
Ages 18+	Field	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$900,000	675
FY 2021-22	$900,000	675
FY 2022-23*	$3,102,489	1,350

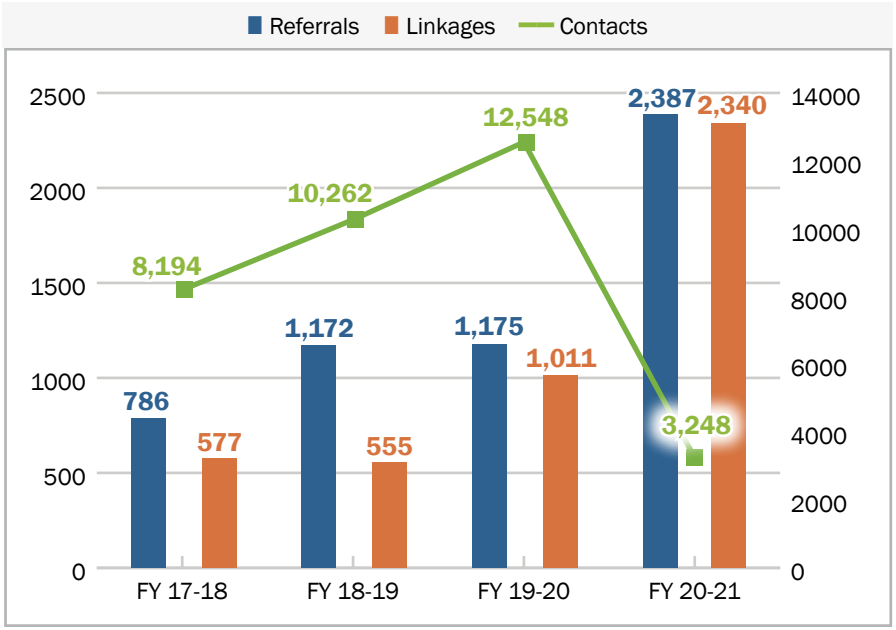
**Proposed activities to FY 22-23 includes removal of MHSA funding with end of the Courtyard Program. Increasing Salaries of counselors for this program. Expand to add a 2nd location to meet high demand.*

SERVICES/OUTCOMES

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

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

Referrals and Linkages - Multi-Service Center



MOST COMMON LINKAGES MADE

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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

Integrated Justice Involved Services (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 18+	Other (Jail)	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	✓ TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

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

**Proposed activities in FY 22-23 to move from CSS to PEI to better align with population served. Increasing original budget by $1M for assessment and diversion services for jails, $1M for Family Support Services, as well as $2.3M to open a pilot family resource center.*

SERVICES/OUTCOMES

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

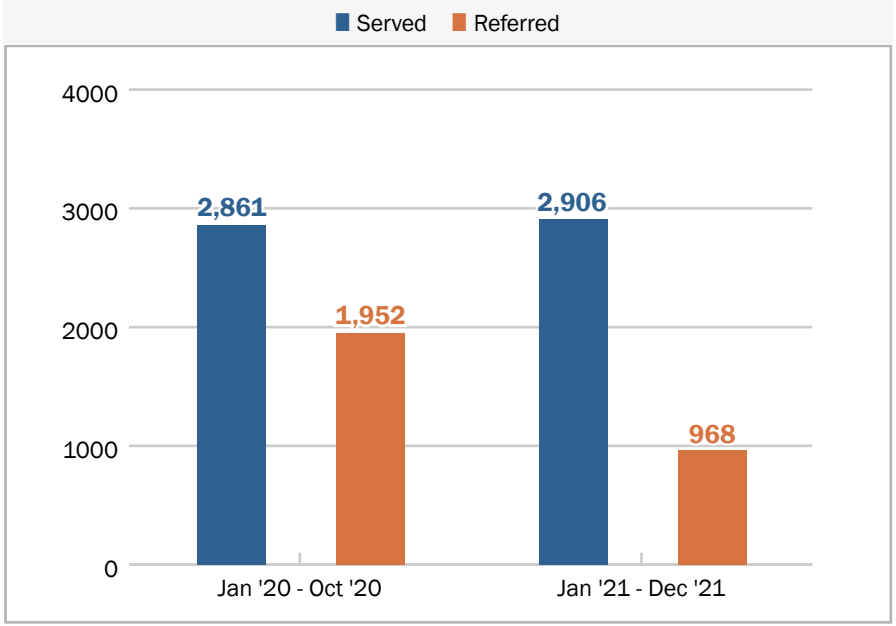
Services also include facilitation of linkage to a range of services upon release, such as counseling, medication support, housing, Medi-Cal enrollment and essential needs such as clothing and transportation. Connections with family and support systems such as peer support mentors is also facilitated.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

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

From January 2021 to December 2021, 2,906 inmates who received mental health services while incarcerated were released from Orange County jails. Of these inmates served, 968 were referred to external programs by the JCRP team. The individuals who were not referred either had directly declined or had a previous established transition arrangement.

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

Persons Served & Referred: Jail to Community Re-Entry



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

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

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

COMMUNITY IMPACT

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

Recovery Open Access (CSS)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 18+	Clinic	~~At-Risk~~	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	✓ Other: Laotian

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

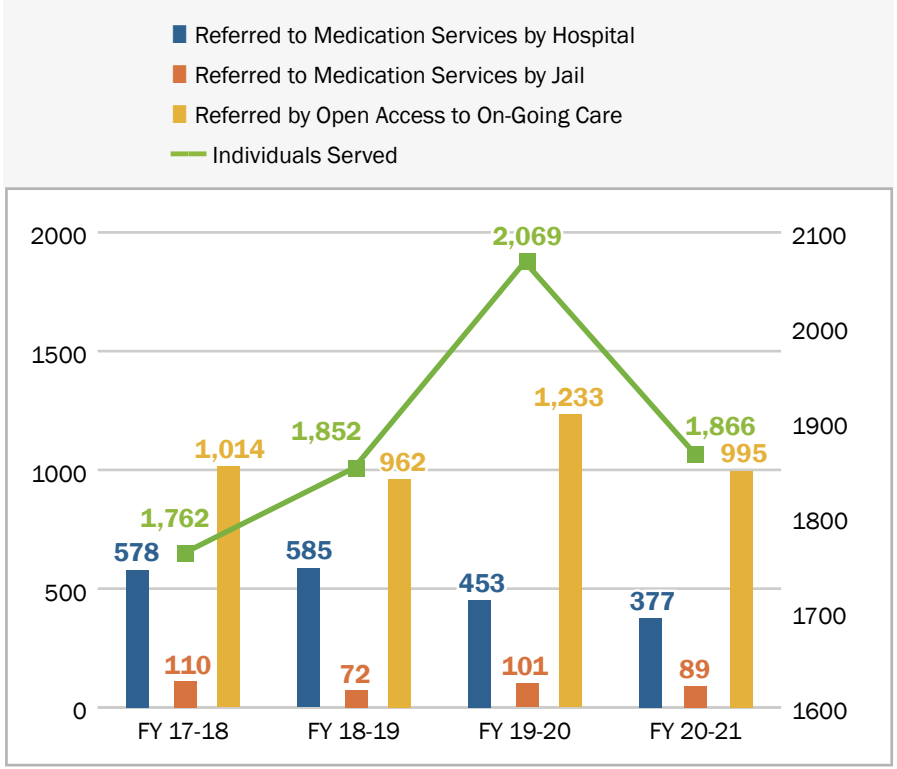
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,300,000	1,850
FY 2021-22	$2,600,000	2,000
FY 2022-23*	$3,000,000	2,000

**Proposed activities to FY 22-23 to add $700K to keep budget level for current service levels.*

SERVICES

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

Referrals and Linkages - Recovery Open Access



OUTCOMES

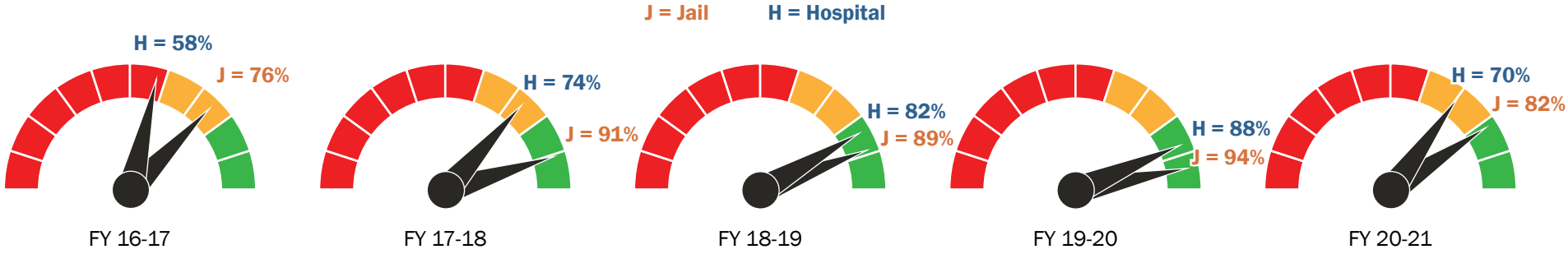
Performance of the program was measured by whether the program met or exceeded the following targets:

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

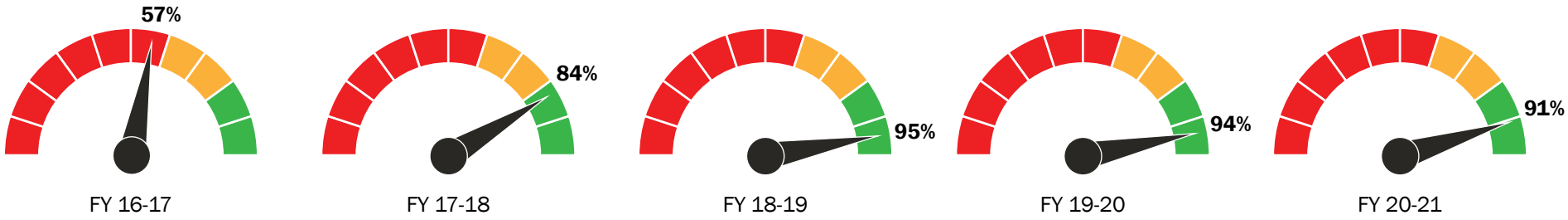
The program continued to meet its targets in FY 2020-21, except for adults discharged from hospital and referred for medication and linked to Open Access medication services within 3 business days (70%). The target was not reached due to a medical staff shortage in one region.

Additional staff has resulted in smaller caseloads, and this has allowed staff to monitor linkages more closely and follow up on missed appointments. These improvements, in addition to the implementation of a Performance Improvement Project (PIP) in October 2018 that focused on linking hospitalized clients to Open Access and outpatient services, may have contributed in the upward trend in linkages since 2016-17.

Percent Linked to Open Access Medication Services within Three Business Days by Discharge Location



Percent Linked from Open Access to Ongoing Care within Thirty Days



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

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

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

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

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

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

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

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

CRISIS PREVENTION AND SUPPORT

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

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

WarmLine (CSS)

The **WarmLine** provides emotional peer support to unserved and underserved Orange County residents who are experiencing mild to moderate symptoms of a mental health disorder or who are at risk of developing a mental health disorder, challenges at school and/or trauma exposure. The program also serves family members. Beginning July 2020, the WarmLine began providing services 24 hours a day, seven days a week, year-round. This program is supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+				
All Ages	Telephone	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

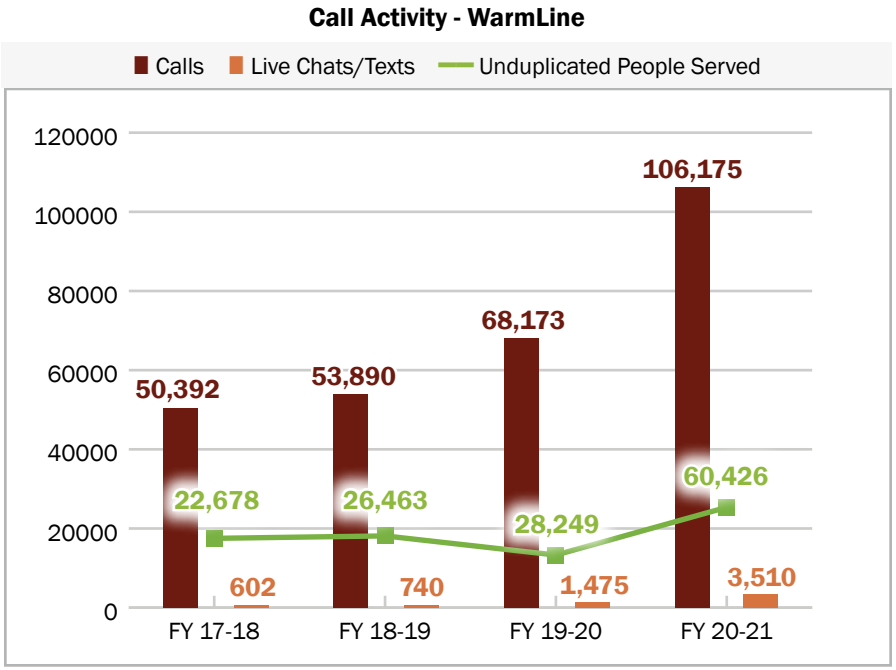
Fiscal Year	Program Budget	Call/Chat Volume
FY 2020-21	$1,116,667	36,000
FY 2021-22	$2,000,000	65,000
FY 2022-23*	$12,000,000	65,000

**Proposed activities in FY22-23 to move from PEI to CSS. Increase budget from $1.1M to $12M. Increased call volume as well as expanding to 24/7. Adding a Spanish and Vietnamese WarmLine.*

SERVICES

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

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



OUTCOMES

In FY 2020-21, the number of unduplicated callers increased, as did the number of calls and live chats/texts compared to previous years. The majority of calls were from individuals who had used the WarmLine before and calls typically lasted an average of 25 minutes. The WarmLine continues to demonstrate an increasing number of callers and amount of activity.

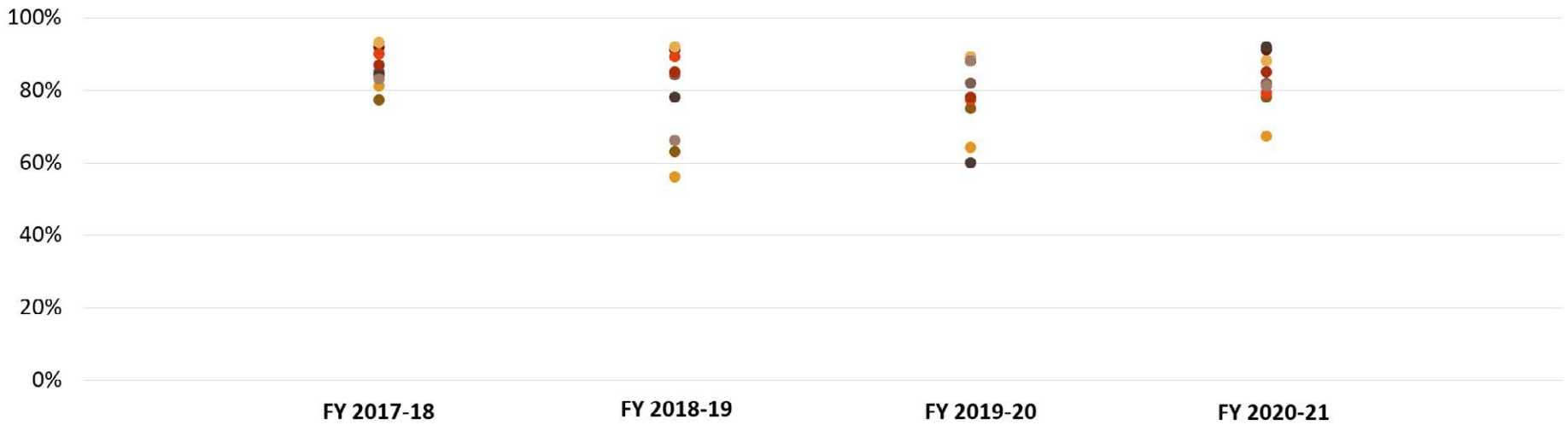
The WarmLine aims to reduce prolonged suffering from behavioral health problems, which was measured through changes in ratings on the Profile of Mood States (POMS). Callers were asked at the beginning of the call whether they felt different emotions (i.e., worried, uncertain, etc.) and then asked at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

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

COMMUNITY IMPACT

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

Percent of WarmLine Callers Reporting Improved Mood at End of Call by FY



Greater spread of dots within a fiscal year reflects greater variability of improved mood reported by callers that year

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

At the beginning of the FY 20-21, the program received additional funding which allowed for service expansion from the hours of 3 a.m.-9 a.m. to a 24/7 service. Consequently, the call volume also increased, reaching approximately 11,000 calls a month. Due to the provider's efficiency with the recruitment process, the WarmLine was fully staffed within the first two months of the service expansion. Calls to the WarmLine are influenced by current events and other factors, including global and national events, which can bring up strong emotions for the participants. WarmLine Staff reported that during the pandemic, WarmLine Mentors spent more time with each caller; average time spent with each caller increased from 16 to 24 minutes. This resulted in creating longer wait times to return voicemails as staff are not always available to answer incoming calls immediately. The ever-growing demand for services, impacted on the program's ability to cover each work shift with adequate staffing. Additionally, the volunteer pool became almost non-existent due to the pandemic; further straining staffing coverage. The program has tried different strategies including cross training all WarmLine staff to answer the calls to ensure that there are no gaps in calls coverage.

The pandemic also impacted traditional outreach services. However, NAMI has been conducting other forms of outreach to the community including social marketing strategies such as use of social media, radio/TV advertisements and marketing through partner organizations. Current language capabilities have been increased to include English, Spanish, Vietnamese, and Farsi. Callers that speak other languages can utilize a general mailbox and the language line.

Suicide Prevention Services (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
All Ages	Telephone	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

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

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

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Unduplicated # to be Served**
FY 2020-21	$1,200,000	12,147
FY 2020-22	$3,200,000	12,147
FY 2022-23*	$3,200,000	12,147

**Proposed activities to FY 22-23 add $2M to Survivor Support hotline to add additional services such as step down services and follow up care.*

SERVICES

The program currently offers a range of services that use Applied Suicide Intervention Skills Training (ASIST), which provides practical suicide intervention training for clinicians, first responders, medical providers and caregivers seeking to prevent the immediate risk of suicide. During the COVID-19 pandemic, ASIST trainings were temporarily paused since they are required to be conducted in person. In lieu of ASIST trainings, the provider offered virtual trainings for clinicians and the community at large. Additionally, the provider also offers a six-hour training with CEU's on suicide assessment, prevention and intervention.

Crisis Hotline Telephone/Chat Support:

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

TELEPHONE Hotline CALL VOLUME				
	FY 17/18	FY 18/19	FY 19/20	FY 20/21
Callers	9,200	10,137	9,886	9,771
Calls	11,607	13,536	13,613	14,092

Postvention In person/Telehealth Services:

- **Individual Counseling for Survivors after Suicide:** Children, adolescents, adults and older adults who are coping with the loss of someone to suicide can receive time-limited individual counseling either in person or via telehealth. Short-term bereavement counseling is also available to families who want to improve their functioning and communication after the loss of a family member.
- **Survivors after Suicide Bereavement Groups:** Two different bereavement groups are offered for anyone who is coping with the loss of someone to suicide. The first is an eight-week, closed format group, co-facilitated by a therapist and a survivor. The goal is to establish a safe place without stigma for survivors to share experiences, ask questions, and express painful feelings so they can move forward with their lives. The second group is a drop-in bereavement group designed to help individuals receiving individual counseling (described above), and program alumni so that they continue the healing process in the months and years following their losses.

INDIVIDUALS SERVED IN FACE-TO-FACE SERVICES			
FY 17/18	FY 18/19	FY 19/20	FY 20/21
148	140	156	81

TOTAL NUMBER OF INDIVIDUAL SESSIONS			
FY 17/18	FY 18/19	FY 19/20	FY 20/21
559	678	745	598

TOTAL NUMBER OF SAS & SOSA GROUPS			
FY 17/18	FY 18/19	FY 19/20	FY 20/21
64	91	104	148

- **Survivors of Suicide Attempts (SOSA) Support Group:** The program offers closed groups that provide a safe, non-judgmental place for people who have survived a suicide attempt to talk about the feelings that led them to attempt suicide. The goal of this group is to support their recovery and provide them with skills for coping with deep hurt. The program also provides individuals with culturally appropriate follow-up care and education.
- The FY 21-22 service expansion includes a partnership with Orange County hospitals for linkages and warm handoffs from emergency departments, intensive outpatient programs and inpatient behavioral health units to Didi Hirsch's Survivor Support Services. Services aim to target individuals who are assessed for suicidal ideation; those who may have attempted a suicide or those who are assessed to be at high risk of suicide. Services include a direct linkage of these individuals, prior to being discharged, to step-down therapeutic intervention, prevention and postvention services. These services include individual intervention and/or treatment, support groups and/or individual, couples, or family therapy for at-risk individuals with suicidal ideations. The step-down services uses evidence-based practices including Cognitive Therapy for Suicide Prevention (CT-SP), which will be provided by clinical staff. CT-SP consists of an average of 12-13 sessions includes an analysis of the suicidal event, safety plan development, skill building, psychoeducation, family intervention, and relapse prevention.

- Intervention services include one-on-one therapeutic sessions for individuals, couples and families for an average of 13 weeks per participant to reduce the risk of a suicide attempt, provided by clinicians who have specialized training in CT-SP.

- Prevention and postvention services for the target population include coping skills and support groups for individuals and family members, recognizing warning signs, how to obtain help and how to manage their own stress as a support/care provider and bereavement support.

- Follow-up services will be offered to participants upon completion of therapeutic services from Didi Hirsch and will include monitoring of safety plans, ongoing risk assessments and follow-through on referrals to community resources. The participant's individual therapist will do a check-in follow-up each month for two months post discharge. Subsequently, the specially trained Crisis Line Extended Follow-Up triage team will make follow-up calls minimally at the three-six-nine- and 12-month marks post discharge from the program. Follow-up calls by the Crisis Line Extended Care counselors will also be offered to individuals who were discharged from hospitals but did not attend the Didi Hirsch step-down care program.

Community Training/Outreach:

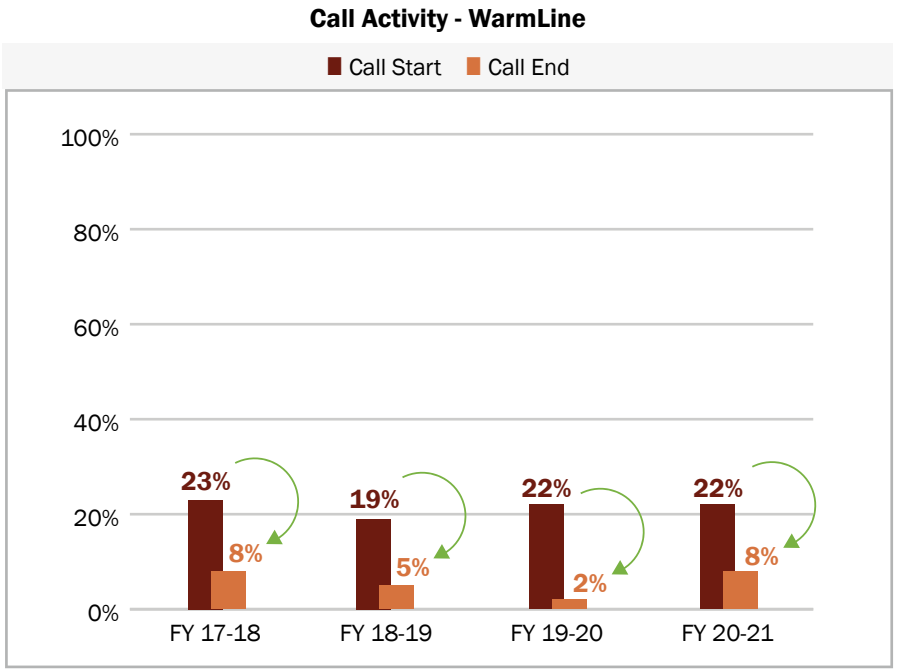
- Consistent with PEI regulations, the program trains potential first responders in ASIST and SafeTalk so that they are 1) better able to recognize signs of depression, suicidal ideation and other mental health conditions, and 2) informed about myths associated with talking about suicide, strategies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

OUTCOMES

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

Crisis Hotline Telephone Support

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



Postvention Services

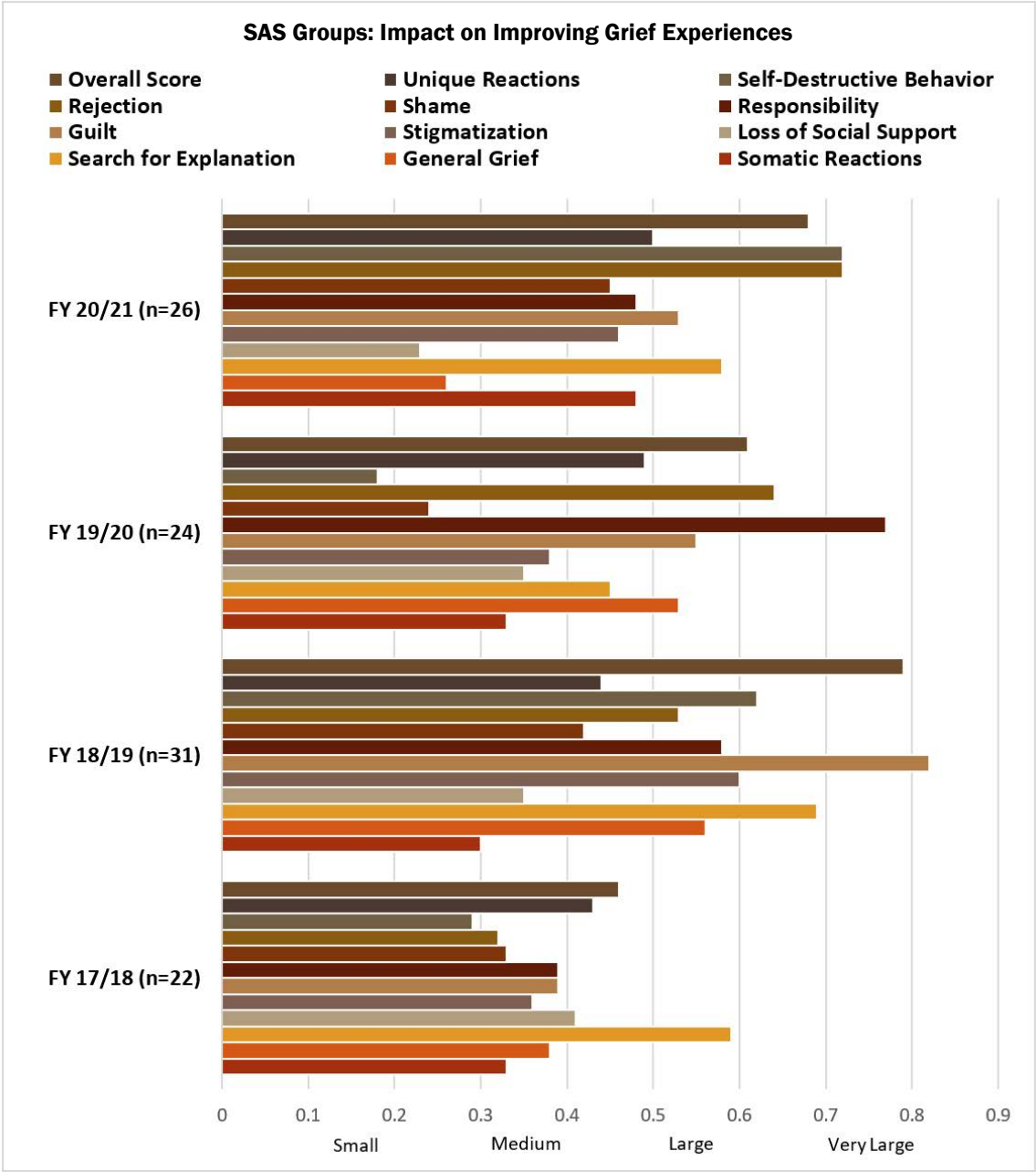
The program also provides in-person/telehealth services, which have remained relatively consistent in the numbers of people served over the past few years; with services trending towards more individual counseling sessions and fewer support groups.

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

- **Survivors of Suicide Attempts (SOSA):** SOSA participants (FY 2020-21 n=4; FY 2019-20 n=10; FY 2018-19 n=10; FY 2017-18 n=5; 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 participant's progress and adjust care plans as needed. The HCA is currently identifying ways to improve collection and/or measurement of performance outcome for this group.

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Since its inception in August 2010, the Didi Hirsch Crisis Prevention Hotline and Survivor Support Services have undergone multiple improvements and changes. Prior to FY 2020-21, Didi Hirsch provided the Crisis Prevention Hotline and Survivor Support Services under two individual HCA contracts. In FY 20-21, the Suicide Prevention and Support Services experienced a strategic operational shift integrating the existing Crisis Prevention Hotline and Survivor Support Services programs, combining the provision of these services under one agreement. While the actual services remained the same, this change allowed for more continuous support services for individuals affected by suicide.

COMMUNITY IMPACT

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

REFERENCE NOTES

Community Training/Outreach:

FY 2020-21: Baseline M=11.1, SD=3.63; Follow-up M=9.6, SD=3.43; t(25)=2.42, p=.023; Cohen's d=0.48
FY 2019-20: Baseline M=13.3, SD=3.67; Follow-up M=12.4, SD=3.80; t(23)=1.60, p<.124; Cohen's d=0.33
FY 2018-19: Baseline M=13.3, SD=3.21; Follow-up M=12.2, SD=3.83; t(30)=1.64, p<.012; Cohen's d=0.30
FY 2017-18: Baseline M=13.4, SD=5.0; Follow-up M=12.1, SD=3.6; t(21)=1.47, p=.16; Cohen's d=0.33
FY 2016-17: Baseline M=11.5, SD=4.2; Follow-up M=9.5, SD=2.7; t(19)=3.23, p<.01; Cohen's d=0.84

General Grief Reaction:

FY 2020-21: Baseline M=11.9, SD=3.98; Follow-up M=11.1, SD=3.49; t(25)=1.33, p=.196; Cohen's d=0.26
FY 2019-20: Baseline M=15.8, SD=3.65; Follow-up M=13.5, SD=3.65; t(23)=2.60, p<.016; Cohen's d=0.53
FY 2018-19: Baseline M=14.9, SD=3.77; Follow-up M=13.4, SD=3.85; t(30)=3.14, p<.012; Cohen's d=0.56
FY 2017-18: Baseline M=15.0, SD=4.1; Follow-up M=13.5, SD=3.6; t(21)=1.75, p=.10; Cohen's d=0.38
FY 2016-17: Baseline M=13.1, SD=4.4; Follow-up M=11.7, SD=4.3; t(19)=2.01, p<.05; Cohen's d=0.47

Search for Explanation:

FY 2020-21: Baseline M=15.9, SD=4.84; Follow-up M=14.2, SD=5.29; t(25)=2.91, p=.007; Cohen's d=0.58
FY 2019-20: Baseline M=18.5, SD=3.65; Follow-up M=16.6, SD=3.87; t(23)=5.10, p<.001; Cohen's d=0.45
FY 2018-19: Baseline M=18.6, SD=3.51; Follow-up M=15.8, SD=3.85; t(30)=5.10, p<.001; Cohen's d=0.69
FY 2017-18: Baseline M=17.0, SD=4.8; Follow-up M=14.2, SD=5.1; t(21)=2.77, p<.05; Cohen's d=0.59
FY 2016-17: Baseline M=15.0, SD=3.5; Follow-up M=12.6, SD=3.7; t(19)=2.70, p<.05; Cohen's d=0.60

Loss of Social Support:

FY 2020-21: Baseline M=11.7, SD=5.61; Follow-up M=12.6, SD=4.77; t(25)=1.14, p=.267; Cohen's d=0.23
FY 2019-20: Baseline M=15.5, SD=6.35; Follow-up M=13.9, SD=4.27; t(23)=1.60, p<.123; Cohen's d=0.35
FY 2018-19: Baseline M=14.7, SD=6.03; Follow-up M=13.2, SD=6.33; t(30)=1.96, p<.059; Cohen's d=0.35
FY 2017-18: Baseline M=13.1, SD=5.6; Follow-up M=11.3, SD=3.8; t(21)=1.46, p=.16; Cohen's d=0.41
FY 2016-17: Baseline M=11.6, SD=4.3; Follow-up M=11.1, SD=4.0; t(19)=0.55, p=.59; Cohen's d=0.12

Stigmatization:

FY 2020-21: Baseline M=11.6, SD=4.54; Follow-up M=10.0, SD=4.23; t(25)=2.31, p=.023; Cohen's d=0.45
FY 2019-20: Baseline M=14.9, SD=4.44; Follow-up M=13.2, SD=4.78; t(23)=1.86, p<.076; Cohen's d=0.38
FY 2018-19: Baseline M=12.5, SD=5.32; Follow-up M=10.5, SD=4.88; t(30)=3.29, p<.059; Cohen's d=0.60
FY 2017-18: Baseline M=12.9, SD=5.4; Follow-up M=10.9, SD=4.8; t(21)=1.67, p=.11; Cohen's d=0.36
FY 2016-17: Baseline M=11.2, SD=4.8; Follow-up M=9.0, SD=4.0; t(19)=3.05, p<.01; Cohen's d=0.70

Guilt:

FY 2020-21: Baseline M=15.8, SD=4.28; Follow-up M=13.3, SD=5.30; t(25)=2.32, p<.023; Cohen's d=0.53
FY 2019-20: Baseline M=18.0, SD=5.26; Follow-up M=15.7, SD=4.12; t(23)=2.63, p<.015; Cohen's d=0.55
FY 2018-19: Baseline M=17.3, SD=5.76; Follow-up M=14.7, SD=5.80; t(30)=4.57, p<.001; Cohen's d=0.82
FY 2017-18: Baseline M=16.7, SD=4.9; Follow-up M=14.6, SD=4.7; t(21)=1.81, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=14.5, SD=4.5; Follow-up M=12.1, SD=3.4; t(19)=2.55, p<.05; Cohen's d=0.58

Responsibility:

FY 2020-21: Baseline M=12.4, SD=4.30; Follow-up M=11.0, SD=4.49; t(25)=2.42, p=.023; Cohen's d=0.77
FY 2019-20: Baseline M=15.6, SD=5.64; Follow-up M=12.9, SD=5.30; t(23)=3.75, p<.001; Cohen's d=0.77
FY 2018-19: Baseline M=13.2, SD=5.17; Follow-up M=11.2, SD=4.79; t(30)=3.22, p<.003; Cohen's d=0.58
FY 2017-18: Baseline M=13.9, SD=4.8; Follow-up M=12.0, SD=4.7; t(21)=1.84, p=.08; Cohen's d=0.39
FY 2016-17: Baseline M=10.1, SD=3.4; Follow-up M=9.1, SD=2.9; t(19)=1.65, p=.12; Cohen's d=0.37

Shame:

FY 2020-21: Baseline M=10.1, SD=6.28; Follow-up M=9.1, D=4.92; t(25)=2.17, p<.039; Cohen's d=0.45
FY 2019-20: Baseline M=13.9, SD=6.23; Follow-up M=13.1, SD=5.66; t(23)=1.16, p<.259; Cohen's d=0.24
FY 2018-19: Baseline M=14.4, SD=4.40; Follow-up M=12.5, SD=4.99; t(30)=2.31, p<.027; Cohen's d=0.42
FY 2017-18: Baseline M=14.3, SD=4.8; Follow-up M=12.8, SD=5.2; t(21)=1.53, p=.11; Cohen's d=0.33
FY 2016-17: Baseline M=13.2, SD=4.0; Follow-up M=12.1, SD=3.5; t(19)=1.47, p=.16; Cohen's d=0.33

Rejection:

FY 2020-21: Baseline M=13.2, SD=5.29; Follow-up M=12.1, SD=5.16; t(25)=3.69, p<.001; Cohen's d=0.72
FY 2019-20: Baseline M=17.5, SD=6.58; Follow-up M=15.0, SD=5.13; t(23)=2.95, p<.007; Cohen's d=0.64
FY 2018-19: Baseline M=114.6, SD=5.24; Follow-up M=12.5, SD=5.57; t(30)=2.96, p<.006; Cohen's d=0.53
FY 2017-18: Baseline M=14.7, SD=5.8; Follow-up M=13.2, SD=5.6; t(21)=1.51, p=.15; Cohen's d=0.32
FY 2016-17: Baseline M=11.8, SD=4.8; Follow-up M=11.1, SD=4.6; t(19)=0.89, p=.39; Cohen's d=0.20

Self-Destructive Behavior:

FY 2020-21: Baseline M=8.8, SD=2.62; Follow-up M=7.7, SD=2.69; t(25)=3.65, p=.001; Cohen's d=0.72
FY 2019-20: Baseline M=10.9, SD=3.62; Follow-up M=10.3, SD=2.77; t(23)=0.84, p<.407; Cohen's d=0.18
FY 2018-19: Baseline M=11.1, SD=4.07; Follow-up M=8.5, SD=3.02; t(30)=3.21, p<.003; Cohen's d=0.62
FY 2017-18: Baseline M=10.5, SD=4.2; Follow-up M=9.6, SD=3.7; t(21)=1.34, p=.19; Cohen's d=0.29
FY 2016-17: Baseline M=8.0, SD=3.5; Follow-up M=8.1, SD=3.1; t(19)=-0.17, p=.87; Cohen's d=0.04

Unique Reactions:

FY 2020-21: Baseline M=13.7, SD=3.49; Follow-up M=3.72, SD=4.82; t(25)=2.42, p<.023; Cohen's d=0.50
FY 2019-20: Baseline M=14.9, SD=3.49; Follow-up M=13.5, SD=4.08; t(23)=2.37, p<.026; Cohen's d=0.49
FY 2018-19: Baseline M=14.9, SD=2.87; Follow-up M=13.8, SD=3.74; t(30)=2.33, p<.027; Cohen's d=0.44
FY 2017-18: Baseline M=13.4, SD=3.5; Follow-up M=12.0, SD=3.9; t(21)=2.00, p=.06; Cohen's d=0.43
FY 2016-17: Baseline M=12.8, SD=2.6; Follow-up M=10.5, SD=2.7; t(19)=4.92, p<.001; Cohen's d=1.10

Overall Score:

FY 2020-21: Baseline M=140.6, SD=34.21; Follow-up M=122.6, SD=37.12; t(25)=3.47, p=.002; Cohen's d=0.68
FY 2019-20: Baseline M=168.9, SD=34.98; Follow-up M=150.2, SD=35.36; t(23)=2.96, p<.006; Cohen's d=0.61
FY 2018-19: Baseline M=158.4, SD=33.09; Follow-up M=138.4, SD=38.56; t(30)=4.33, p<.001; Cohen's d=0.79
FY 2017-18: Baseline M=154.8, SD=38.4; Follow-up M=136.3, SD=33.6; t(21)=2.16, p<.05; Cohen's d=0.46
FY 2016-17: Baseline M=132.6, SD=32.6; Follow-up M=116.7, SD=30.7; t(19)=3.28, p<.01; Cohen's d=0.74

Mobile Crisis Assessment (CSS)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+ All Ages	Telephone	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Total Evaluations
FY 2020-21	$9,135,858	7,689
FY 2021-22	$9,135,858	8,837
FY 2022-23*	$10,585,858	10,241

**Proposed activities to FY 22-23 to add $450K to right size to actual spending and maintain same level of service as well as funds for satellite location. Add $1M in budget for the OCSD Behavioral Health Bureau to provide case management for individuals and their families following law enforcement response.*

SERVICES

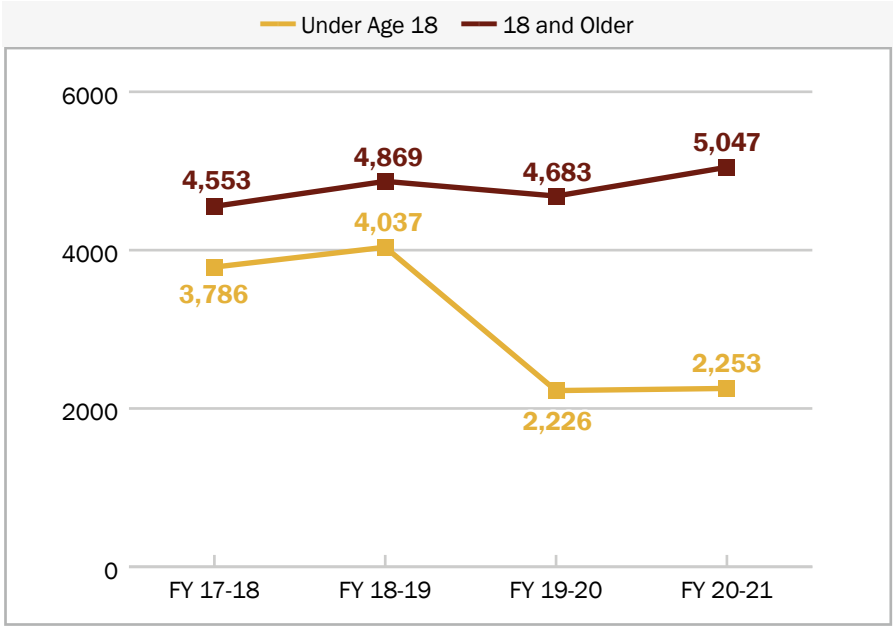
This multi-disciplinary program provides prompt response in the county when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training and are designated to conduct evaluations and risk assessments that are geared to the individual's age and developmental level.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

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

There are currently 27 clinician postions on the children's crisis assessment team (CAT) serving youth under age 18, and 47 clinicians on the TAY/Adult/Older Adult team serving individuals ages 18 and older. The teams are also staffed with Service Chiefs who are responsible for overseeing the day-to-day operations of the program. The HCA currently has 17 PERT collaborations across Orange County, including the Orange County Sheriff's Department and police departments in the cities of Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Seal Beach, Tustin, University of California at Irvine and Westminster.

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

Crisis Evaluations Completed by Age



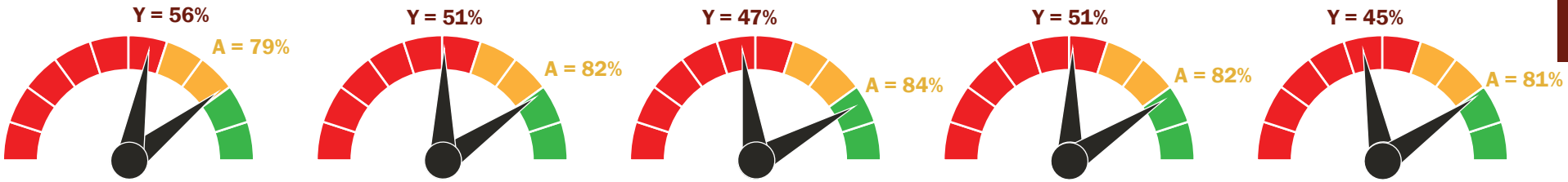
OUTCOMES

The program is evaluated by the timeliness with which the teams are able to respond to calls, with the goal of a dispatch-to-arrival time that is 30 minutes or less at least 70% of the time. While the TAY/Adult/Older Adult team has continued to meet this goal each year, the Children's team did meet the goal.

In addition to dispatch-to-arrival times, the teams also evaluate the percentage of individuals who are placed on a psychiatric hold as a result of the risk assessment versus the percentage of individuals served who can be linked with safe alternatives to inpatient services in the community. Consistent with prior years, children continued to be hospitalized less than half the time (44%, 40%, 42%, 47% and 46% in FYs 2016-17 through 2020-21). Between FY 2016-17 and 2019-20, TAY, adults and older adults were hospitalized less than half of the time (48%, 45%, 46% and 46%). In FY 2020-21, TAY, adults and older adults did not meet this goal, with 54% hospitalized.

Dispatch-to Arrival Rate by FY

Y = Youth Under Age 18 **A = Adults 18 and Older**



FY 16-17 FY 17-18 FY 18-19 FY 19-20 FY 20-21

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

While the Children's team has continued to evaluate the impact of call location on response time, the response to the COVID-19 impact lead to changes in the dispatching process for clinicans, where they would be dispatched from home. The HCA will continune to monitor call volume and the impact on response time.

COMMUNITY IMPACT

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

Crisis Stabilization Units (CSS)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
13+				
Ages 13+	Clinic	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	✓ Other: Tagalog

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$6,700,000	7,227
FY 2021-22	$10,000,000	7,949
FY 2022-23*	$14,000,000	8,743

**Proposed activities in FY22-23 to add County-operated CSU to MHSA funding.*

SERVICES

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

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

COMMUNITY IMPACT

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

In-Home Crisis Stabilization (CSS)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0+					
All Ages	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,935,480	1,187
FY 2021-22	$2,935,480	1,320
FY 2022-23*	$3,435,480	1,468

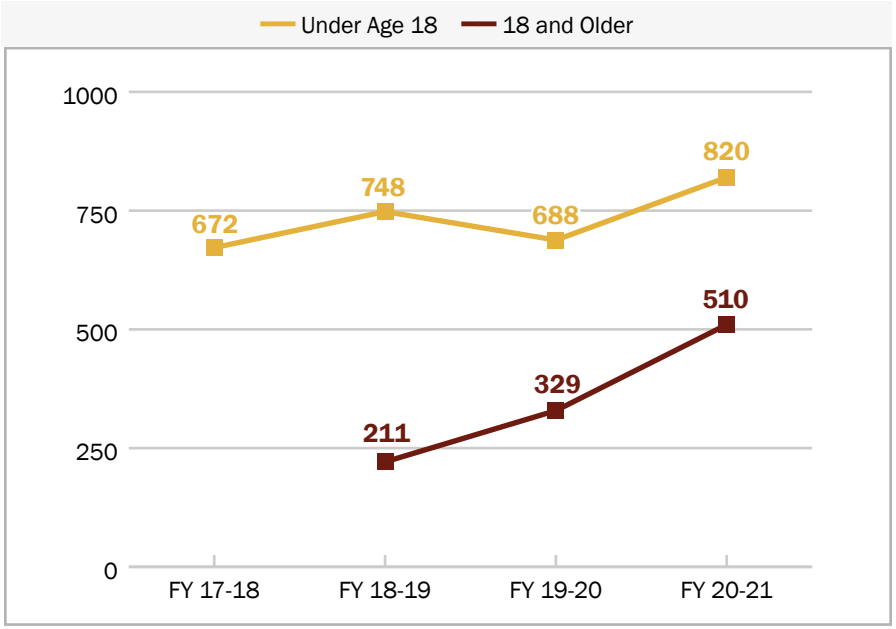
**Proposed activities in FY 22-23 to increase budget by $500K in order to have staffing salaries competitive to hire and retain staff. Add additional clinician staff as well.*

SERVICES

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

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

Enrollments by Age and FY



OUTCOMES

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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

COMMUNITY IMPACT

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

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

Y = Youth Under Age 18 **A = Adults 18 and Older**

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

Crisis Residential Services (CSS)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
12+				
Ages 12+	Residential	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

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

SERVICES

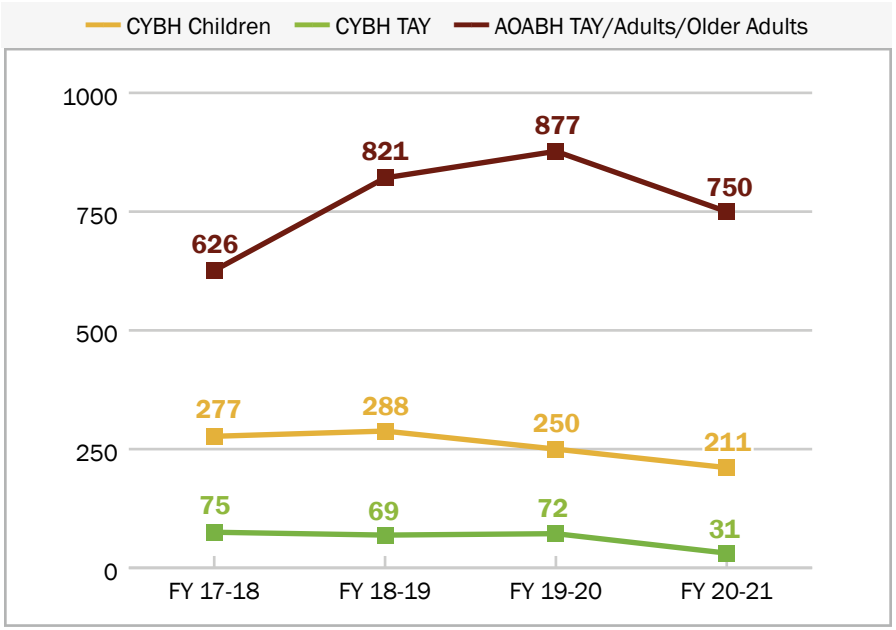
CRS has several sites across the county tailored to meet the needs of different age groups:

- **Children** ages 12 to 17 receive services at three sites operated by Children Youth and Behavioral Health (CYBH; i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, although children can remain in treatment for up to six weeks if needed.
- **TAY** between the ages of 18-25 receive services at a site operated by CYBH with six beds. Services generally last for three weeks, although youth can remain in treatment for up to six weeks if needed. TAY may also receive services at the TAY/Adults sites operated by Adult and Older Adult Behavioral Health (AOABH).
- **TAY/Adults** ages 18 and older receive services at three sites operated by AOABH (2 sites in Orange, 1 in Mission Viejo) with a total of 36 beds, four of which are Americans with Disabilities Act (ADA)-compliant. Stays last an average of 7 to 14 days.
- **Older Adults** ages 50 and older receive services at a newly renovated Older Adult CRS operated by AOABH in Anaheim (6 beds, 2 of which are ADA-compliant). Stays last an average of 7 to 14 days.

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

To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other ongoing behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual; etc.). Children also have the option to participate in a weekly graduate drop-in group. As an essential service the CRPs remained fully operational throughout the COVID-19 pandemic and implemented practices to keep clients and staff safe, including the use of PPE, COVID-19 testing and reducing the census as necessary to allow for isolation and quarantine. The planned budget increase for the Children's CRP for FY 2022-23, is to increase psychatric services onsite at all three locations and increase support for system involved youth residing in Orange County.

Admissions by Age Group and FY

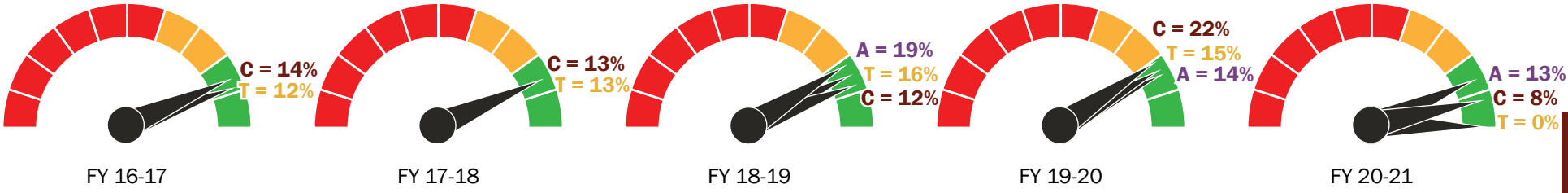


OUTCOMES

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

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

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



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

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

An ongoing, primary challenge has been the increased demand for Crisis Residential Services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and opened the Silver Treehouse on September 1, 2020, that exclusively addresses the needs of older adults in behavioral health crisis. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care, and children periodically showed an increased demand for services throughout the past two calendar years and, at times, either had to be placed on a waitlist or diverted to other crisis services such as in-home crisis. The HCA is examining these trends to determine projected need for Children's Crisis Residential Services over the course of the next three-year period. As part of this, the HCA is considering how the CCRP level of care fits into the continuum of crisis residential services for youth.

COMMUNITY IMPACT

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

MHRS Disaster Response (PEI)

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+				
All Ages	Telephone	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

Funding is contained within the Outreach for Increasing Recognition of Early Signs of Mental Illness program. The number of requests for services and/or individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year.

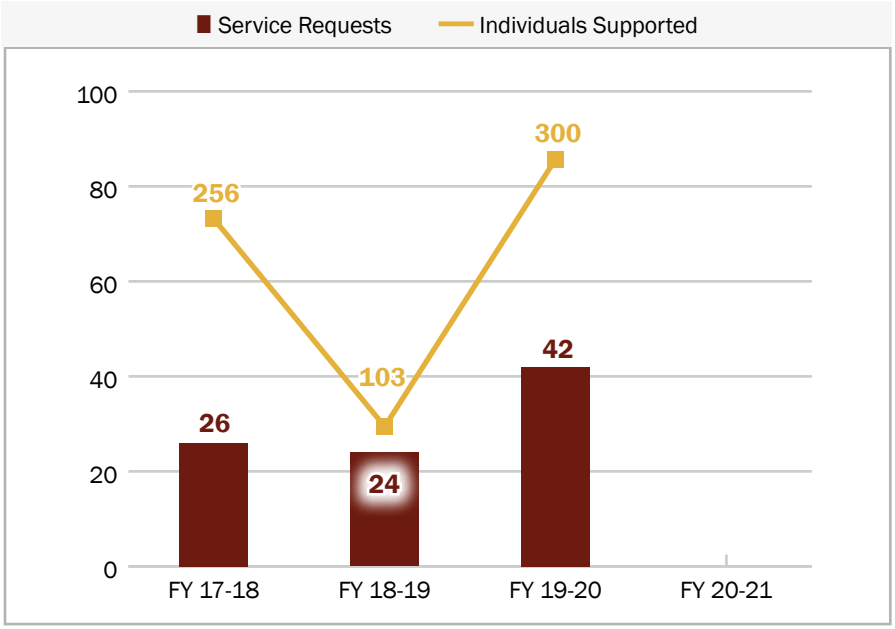
SERVICES

MHRSDR provides Critical Incident Stress Management (CISM) group debriefings, CISM one-on-one debriefings, CISM briefings and education on grief, stress reactions and self-care. In addition, the team provides Psychological First Aid training to community members. The number of requests for services and/or individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year. During FY 2020-21, as in the previous year, several scheduled meetings, exercises, activities and trainings were canceled or modified due to COVID-19. MHRSDR continued to focus its efforts to assist with many activities to support the County's response to the pandemic. More specifically, the team helped with:

- Providing emotional support and crisis intervention for community members receiving a vaccination at the Orange County COVID-19 Point of Dispensing (POD) sites. MHRSDR maintained a stable presence for 19 weeks at 5 locations to check in on individuals, answer questions and provide referrals to County Behavioral Health services
- Redeployment of team members to the Joplin Youth Center (May 2020 to August 2020), where they provided outreach and engagement, case management, crisis intervention and referral and linkage to homeless individuals
- Response and deployment of team members based on two requests from the State to support the California Medical Assistance Teams (CALMAT) stationed at the Fairview Alternate Care Site
- Coordination and oversight of supportive services provided to the vulnerable homeless population residing in motels during the COVID-19 crisis
- Planning of the 2021 Orange County Crisis Response Conference in collaboration with OC Department of Education, Waymakers and the Trauma Intervention Program
- Development of a presentation titled Response and Recovery: The Emotional Impact of COVID-19 for community members, including health care workers
- Facilitation of 5 trainings to 177 individuals throughout FY 2020-21, including a new training titled Supporting Staff During COVID-19: Tips and Resources for Supervisors and Disaster Response training for volunteers at the Orange County COVID-19 POD sites.
- Coordination of Personal Protective Equipment (PPE) distribution

In addition, MHRSDR Team members received training in Complex Trauma- The Connection Between COVID-19 and Civil Unrest, Avoiding COVID-19 Burnout, Resiliency in Public Service and Coping with the Journey of Grief and Mourning.

Critical Incident Stress Management Activity by FY



COMMUNITY IMPACT

MHRSDR staff served a critical role in responding to the COVID-19 pandemic, supporting both essential workers and vulnerable individuals. Recently the team was asked to create a presentation regarding the emotional impact of COVID-19, particularly on those in the health care field. The presentation received positive feedback in the community. Several agencies, including the Emergency Operations Center and the OC Health Care Coalition, have requested the presentation as a way to address mental health wellness and resiliency among staff.

Summary of MHSA Strategies Used by Suicide and Crisis Prevention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

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

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

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

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

CRISIS PREVENTION AND SUPPORT SERVICES				LINKAGE METRICS
Programs	**FY**	**# Referrals**	**# Linkages**	**Types of Linkages**
WarmLine	FY 2016-17	4.663	See note*	OC Links, mental health services, Family Support Service, Patients' Rights Advocacy, suicide prevention programs
	FY 2017-18	2,139		
	FY 2018-19	2,189		
	FY 2019-20	2,629		
	FY 2020-21	3,214		
Suicide Prevention Services (Survivor Support Services only)	FY 2016-17	471	226	Early Intervention, Private/Community Outpatient, Outpatient Clinic-Based, Outpatient Crisis Services, Supportive Services
	FY 2017-18	692	220	
	FY 2018-19	983	119	
	FY 2019-20	526	32	
	FY 2020-21	488	35	
In Home Crisis Stabilization (Adult team)	FY 2016-17	-	See note*	Lower level of outpatient behavioral health care service
	FY 2017-18	-		
	FY 2018-19	206	141	
	FY 2019-20	434	208	
	FY 2020-21	498	35	

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

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

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

OUTPATIENT TREATMENT

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

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

School-Based Mental Health Services (PEI)

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

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
11-15	Field	Clinic	At-Risk	Mild-Moderate	~~Severe~~
Ages 11-15					

PROGRAM SPECIALIZATIONS

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

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

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

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

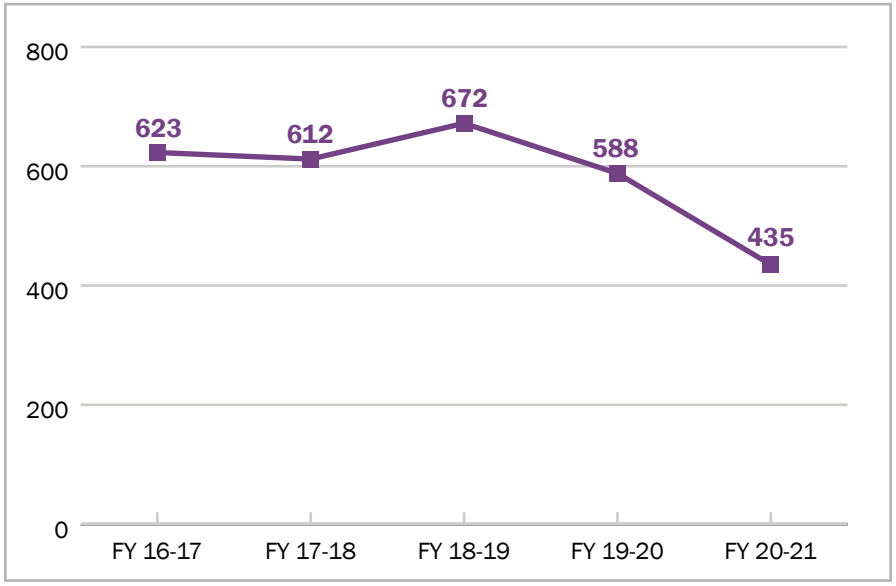
PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

SERVICES

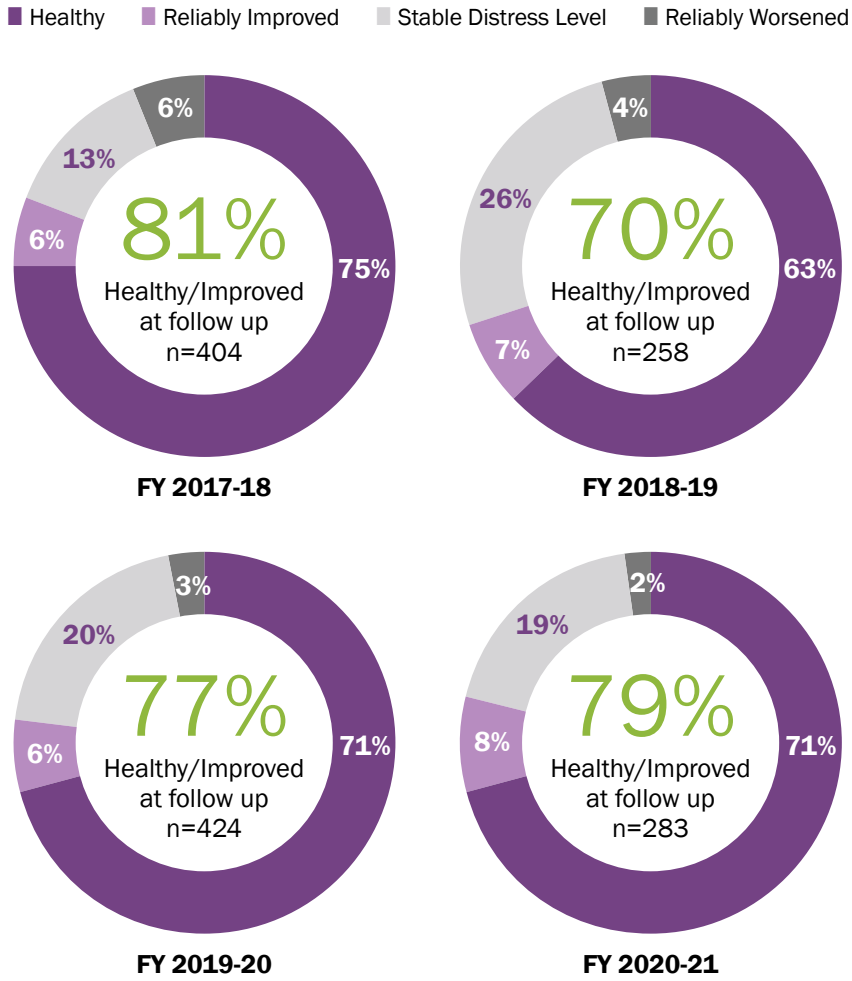
SBMHS provides a range of services to develop protective factors and create resilience in youth to better meet new academic and social challenges. This includes educating parents about these challenges and how they can assist their transitioning youth. Services include assessment, individual counseling,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

Students Served in SBMHS



OUTCOMES

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



CHALLENGES, BARRIERS AND SOLUTIONS

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

As a Medi-Cal Certified program, SBMHS can look to expand staffing and increase their capacity to serve additional students as the need arises.

COMMUNITY IMPACT

The SBMHS program has provided services to more than 15,773 students since its inception in August 2011. In FY 2020-21, the program collaborated with Orange County Department of Education's Regional Mental Health Coordinators and school districts to expand program reach in schools lacking mental health support.

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

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
12-25					
Ages 12-25	Field	Clinic	At-Risk	Mild-Moderate	~~Severe~~

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

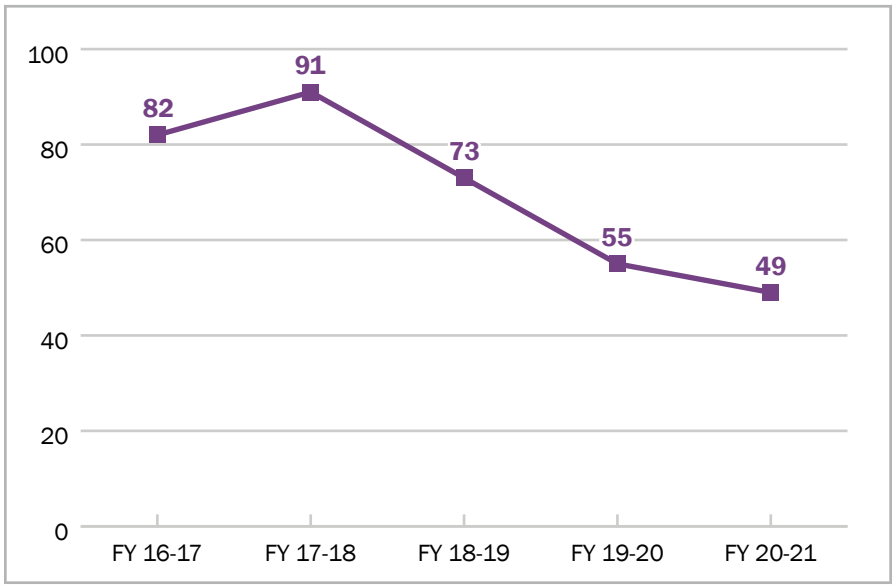
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

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

SERVICES

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

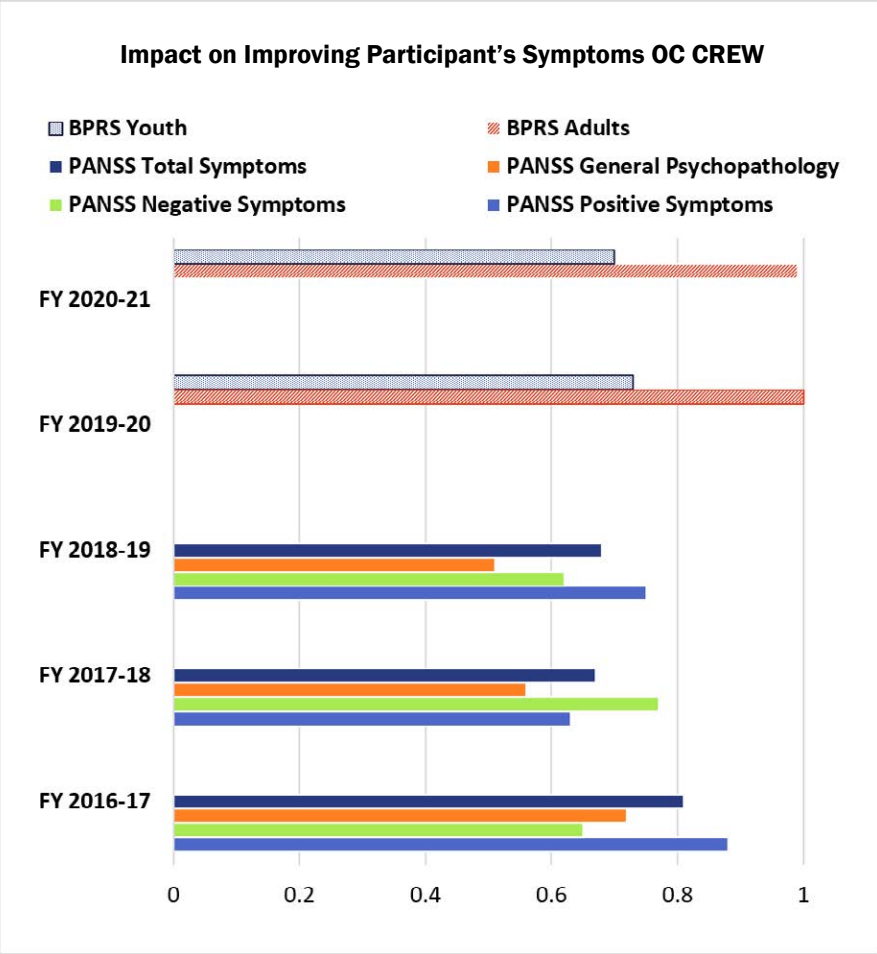
Youth Served in OC CREW



OUTCOMES

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

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

In FY 2021-22, in addition to the program participating in the EPLHCN Statewide Collaboration, in partnership with the University of California, Irvine, the program piloted early psychosis screening and assessment services. In FY 2022-23, these services will be expanded and integrated into a larger effort to transform care for these youth and their families (see “Clinical High Risk for Psychosis Services: Improving Early Identification and Increasing Access to Care” in Special Projects). Additionally, a Medi-Cal Certified program, OC CREW can look to expand staffing and increase their capacity to serve additional participants as the need arises.

COMMUNITY IMPACT

OC CREW has provided services to more than 684 participants since its inception in the Spring of 2011. By providing field-based services the program is able to reach, serve and impact individuals who are reluctant to seek behavioral health treatment for fear of being stigmatized, have limited resources to access clinical-based care or experience functional limitation due to their mental health symptoms. In FY 2020-21, the program is actively participating in the Early Psychosis Learning Care Network (EPLHCN) Statewide Collaborative and is preparing to launch the next phase of this project in FY 2021-22. The next phase includes collecting participant and provider data that will be used to further evaluate program effectiveness.

REFERENCE NOTES

Brief Psychiatric Rating Scale (BPRS):

Children:

FY 202-21: Baseline M=53.0, SD=17.77; Follow-up M=40.9, SD=16.27; t(10)=2.33, p<.05; Cohen's d=0.70

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

Adult:

FY 202-21: Baseline M=53.2, SD=19.52; Follow-up M=41.8, SD=13.83; t(12)=3.25, p<.01; Cohen's d=0.99

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

PANSS:

Positive Symptoms:

FY 2018-19: Baseline M=16.7, SD=6.68; Follow-up M=11.7, SD=5.94; t(54)=5.53, p<.001; Cohen's d=0.75

FY 2017-18: Baseline M=16.1, SD=7.0; Follow-up M=10.8, SD=7.9; t(50)=4.47, p<.001; Cohen's d=0.63

FY 2016-17: Baseline M=15.9, SD=7.0; Follow-up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88

Negative Symptoms:

FY 2018-19: Baseline M=19.0, SD=7.66; Follow-up M=14.0, SD=7.2; t(54)=4.62, p<.001; Cohen's d=0.62

FY 2017-18: Baseline M=17.9, SD=7.1; Follow-up M=12.0, SD=7.4; t(48)=5.42, p<.001; Cohen's d=0.77

FY 2016-17: Baseline M=17.2, SD=8.3; Follow-up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65

General Psychopathology:

FY 2018-19: Baseline M=34.9, SD=11.40; Follow-up M=27.8, SD=10.65; t(54)=3.75, p<.001; Cohen's d=0.51

FY 2017-18: Baseline M=33.5, SD=11.6; Follow-up M=24.7, SD=14.2; t(50)=3.95, p<.001; Cohen's d=0.56

FY 2016-17: Baseline M=32.2, SD=11.9; Follow-up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72

Total Symptoms:

FY 2018-19: Baseline M=70.6, SD=23.29; Follow-up M=53.0, SD=21.15; t(54)=5.06, p<.001; Cohen's d=0.68

FY 2017-18: Baseline M=68.2, SD=24.0; Follow-up M=48.6, SD=29.6; t(50)=4.72, p<.001; Cohen's d=0.67

FY 2016-17: Baseline M=65.3, SD=25.0; Follow-up M=42.7, SD=27.4; t(50)=5.74, p<.001; Cohen's d=0.81

Early Psychosis Learning Health Care Network (INN)

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

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

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Unduplicated # to be Served**
FY 2020-21	$500,000	N/A
FY 2021-22	$561,234	N/A
FY 2022-23	$310,000	N/A

SERVICES

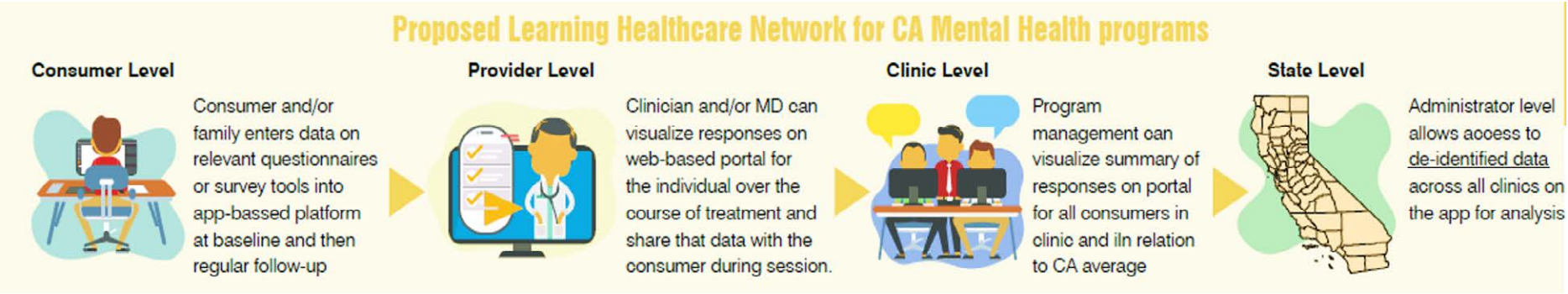
During the initial year of implementation (2020), OC CREW program staff, participants and family members participated in voluntary focus groups to provide feedback on the selection of EP outcome measures. Focus group results from all participating counties, as well as a detailed description of project activities within the first year of implementation are available in the MHSA INN Annual Project Report.

In 2021 during the second year of implementation, OC CREW staff participated in EPI-CAL Site onboarding. Orange County, along with other participating counties, also provided retrospective data, which were being cleaned and prepped for use in a planned integrated evaluation of cost and utilization. Finally, County staff discussed plans and timeline for the Fidelity Assessment, and arranged for trainings and consultations to begin in 2022 to help support staff in strengthening and reinforcing best practices or evidence-based care for those with a first episode psychosis.

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

OUTCOMES

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



OC Parent Wellness Program (PEI)

The **Orange County Parent Wellness Program** (OCPWP) provide services to at-risk and stressed families with children under age 18, including pregnant females and partners affected by the pregnancy or birth of a child within the past 12 months, families that have been reported to Child Protective Services (CPS) for allegations of child abuse or neglect, or families with a young child between the ages of 0 and 8 years who are exhibiting mild to moderate behavioral health symptoms that may negatively impact their readiness for school. Referrals come from a variety of sources including self-referrals, hospitals, schools, behavioral health outpatient facilities, and the Social Services Agency (SSA). Eligibility criteria for families referred by SSA is that the most recent child abuse and/or neglect allegation(s) was found to be inconclusive, unfounded or unsubstantiated.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0+					
All Ages	Field	Clinic	At-Risk	Mild-Moderate	~~Severe~~

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

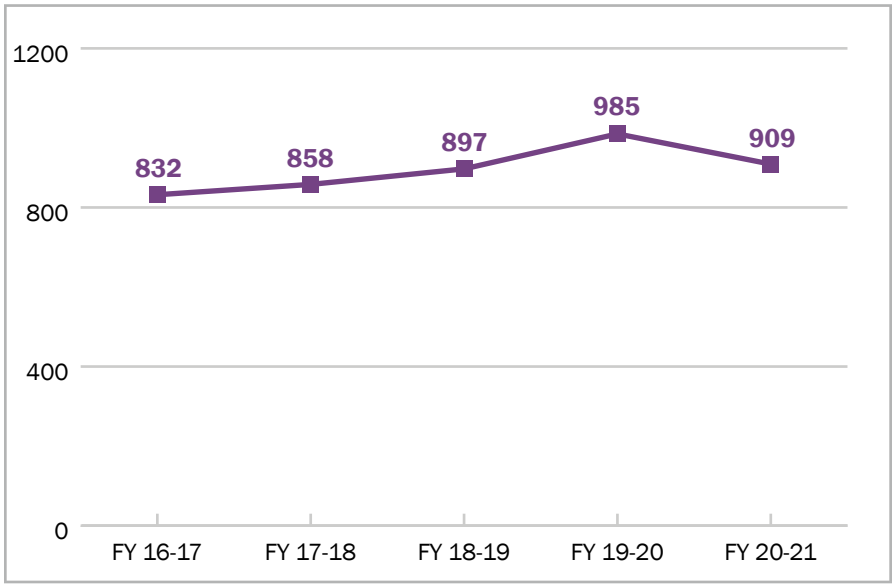
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$3,738,072	900
FY 2021-22	$3,738,072	900
FY 2022-23	$3,738,072	900

SERVICES

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

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

Persons Served in OCPWP

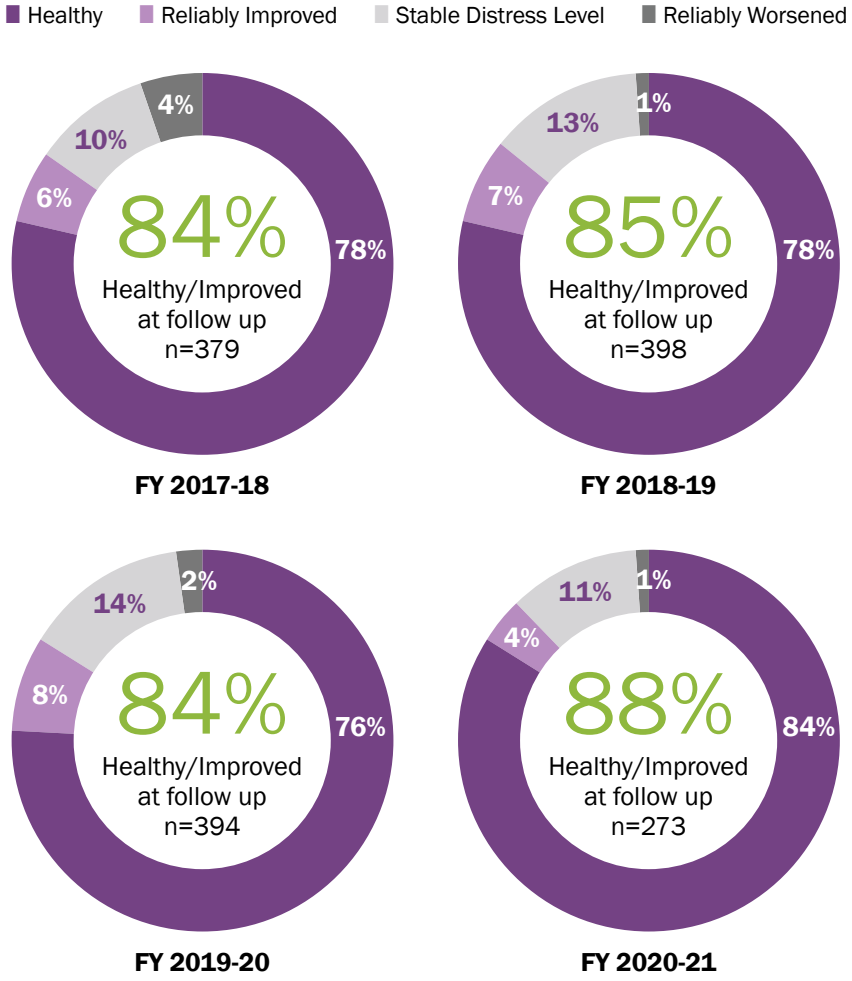


OUTCOMES

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

Across the five fiscal years, anywhere from 77% to 88% of enrolled parents reported healthy or reliably improved levels of distress, as measured by the OQ®, since starting services. Thus, services were associated with preventing symptoms of a mental health condition from becoming severe and disabling for the overwhelming majority of parents served. For the parents who report a significant worsening in their distress, program staff have been streamlining procedures to quickly identify these individuals earlier in the course of treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists.

For parent participants with young children, the program also aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed using the PARCA-SE. In FY 2020-21, the PARCA-SE was discontinued; however, between FY 2016-17 and 2019-20, parents consistently reported increased levels of confidence in their parenting skills between intake and follow up. Thus, services appeared to be effective in maintaining and/or enhancing the protective factor related to parental self-efficacy among those parents in the at-risk families served in the program.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

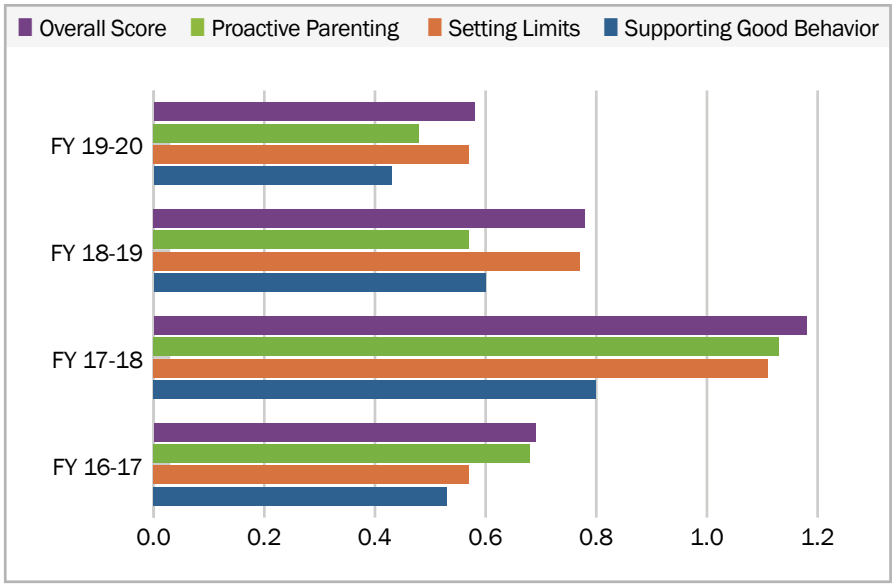
In FY 2020-21, OC Parent Wellness Program received 1,195 referrals and enrolled 909 participants into services. During this period the program experienced staffing vacancies due to the COVID-19 pandemic. As a result of the pandemic, in-person services were transitioned to telehealth thus reducing travel time for staff. This allowed existing staff to increase their capacity to serve more participants and continue to meet the needs of the community during the pandemic. Additionally, staff participated in Mothers and Babies course, an evidence-based curriculum focused on both the prevention and treatment of major depression during the prenatal and postpartum periods, post training consultation groups and offered this intervention weekly. Offering the weekly group intervention provided additional support to participants in between individual sessions. The program continues to make strides toward becoming more father-inclusive by engaging expectant and new fathers.

OCPWP continues to maintain its strong collaborative relationships with community partners and with the increase in referrals, the program required three mental health specialists to screen program referrals for suitability. When appropriate, they immediately schedule an initial Intake session with a therapist to ensure timely access to care.

COMMUNITY IMPACT

Since its inception the OC Parent Wellness Program has worked with more than 8,094 parents. The program also provides community education on Maternal Mental Health risks and community supports and Triple P, a parenting education program.

Improvement on Out-of-Home-Placement Days - OCPCP



REFERENCE NOTES

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

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

PARCA-SE Supporting Good Behavior:

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

PARCA-SE Setting Limits:

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

PARCA-SE Proactive Parenting:

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

PARCA-SE Overall Score:

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

Community Counseling & Supportive Services (PEI)

Community Counseling and Supportive Services (CCSS) serves residents of all ages who have, or are at risk of developing, a mild to moderate behavioral health condition and limited or no access to behavioral health services. The majority are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. Beginning FY 2020-21, OC ACCEPT merged with CCSS and expanded its capacity to provide specialized expertise working with individuals identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives. CCSS is designed to help participants address the early symptoms of depression, anxiety, alcohol and/or drug use, suicidal thoughts, violence and Post Traumatic Stress Disorder (PTSD), as well as the confusion, isolation, grief and loss, high-risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness and lack of familial support frequently experienced by individuals identifying as LGBTIQ. Participants are referred to the program by family resource centers, medical offices, community-based organizations, County-operated and County-contracted programs and self-referral.

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
0+ All Ages	Clinic	At-Risk	Mild-Moderate	~~Severe~~

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	✓ Other: ASL

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

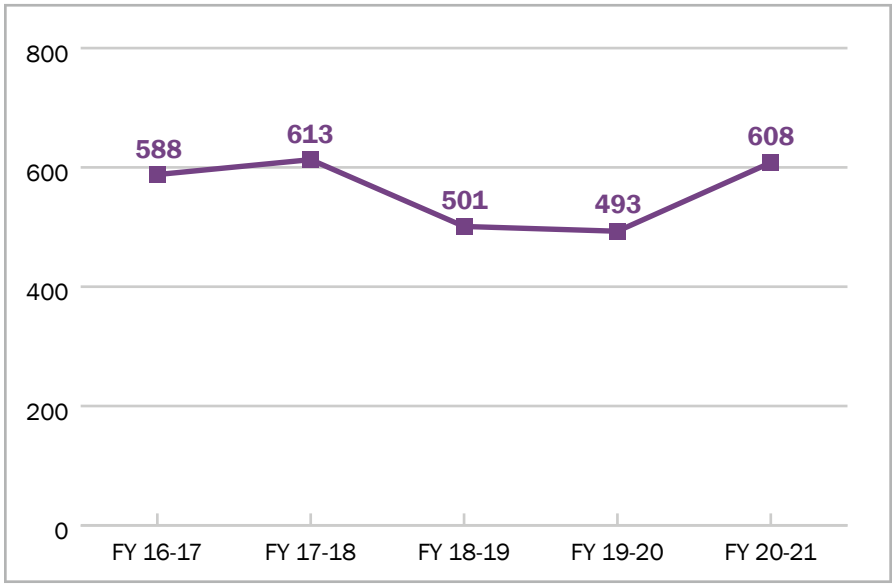
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

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

SERVICES

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

People Served in CCSS

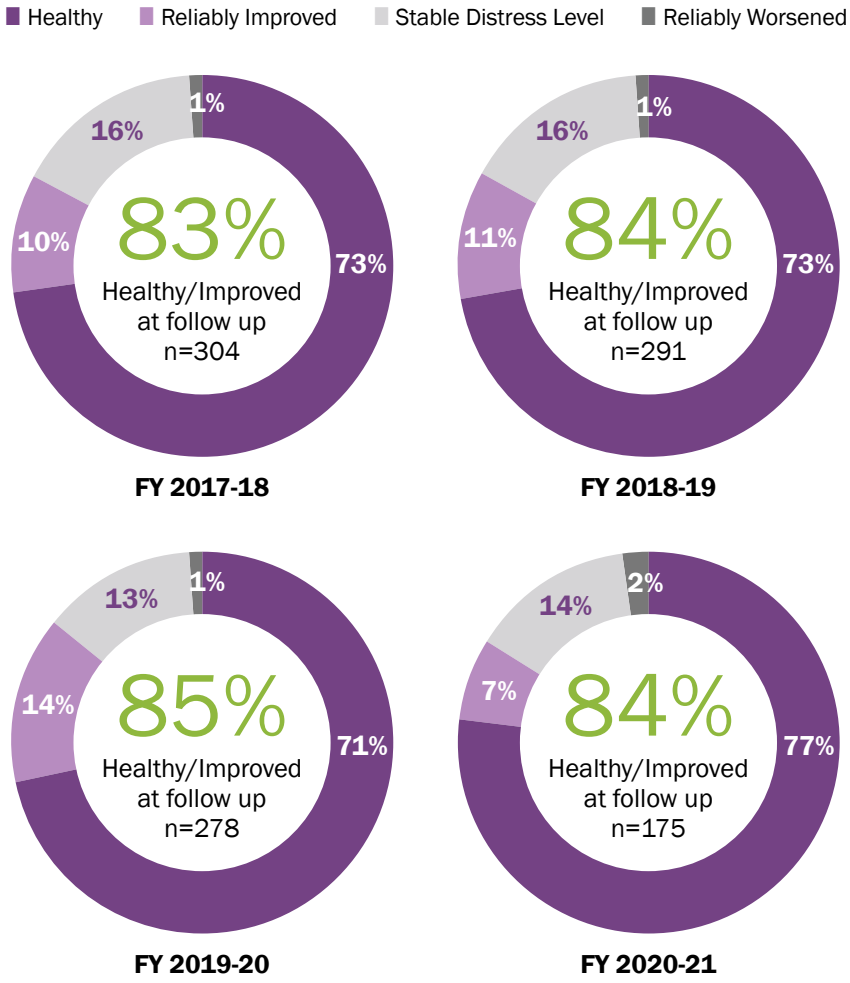


OUTCOMES

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

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

Overall, this improvement in scores between intake and follow-up suggests that the services of CCSS were associated both with preventing symptoms of a mental health condition from becoming severe and disabling, as well as with a clinically meaningful reduction in suffering among those who had reported clinically-elevated distress levels upon enrolling. In addition, for the individuals who report a significant worsening in their distress, program staff have streamlined procedures to quickly identify these individuals earlier in the course of treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists.



CHALLENGES, BARRIERS AND SOLUTIONS

In fiscal 2020-21, as a result of the COVID-19 pandemic, in-person services transitioned to a virtual and telephonic platform. The pandemic initially impacted the number of referrals received. In response to program outreach efforts, referrals slowly increased and exceeded last FY's numbers. To address timely screening of referrals made to the program, a universal Intake Coordinator (IC) system was piloted. The universal IC system involved cross training all P&I IC's to screen referrals made to any P&I program, regardless of their primary assignment. Previously, CCSS has two dedicated IC's and when they were unavailable to screen a new referral, other CCSS clinicians would help screen the callers. Now, if the dedicated CCSS IC's are unavailable, there are five additional IC's trained to screen new callers for services. This allows clinicians to focus on providing direct client care. The program continues to have over 90% of clinicians that are bilingual in two of the County's threshold languages thereby increasing the program's ability to serve monolingual communities. In this next FY, the program plans on increasing outreach and resume trainings to collaborative partners and community members.

COMMUNITY IMPACT

CCSS continues to collaborate with community-based organizations to provide culturally responsive services to ethnic minorities, deaf-and-hard-of-hearing, and LGBTIQ communities. Since inception, CCSS has provided services to more than 3,201 individuals, 582 of whom were part of its LGBTIQ service. Additionally, in FY 2020-21, 803 individuals (of 1,144 referred to the program) were screened by the Intake Coordinator who is responsible in linking all screened to the appropriate level of care that addresses their specific need in a timely manner.

Early Intervention Services for Older Adults (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
					
Ages 50+	Field	Community	At-Risk	Mild-Moderate	~~Severe~~

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

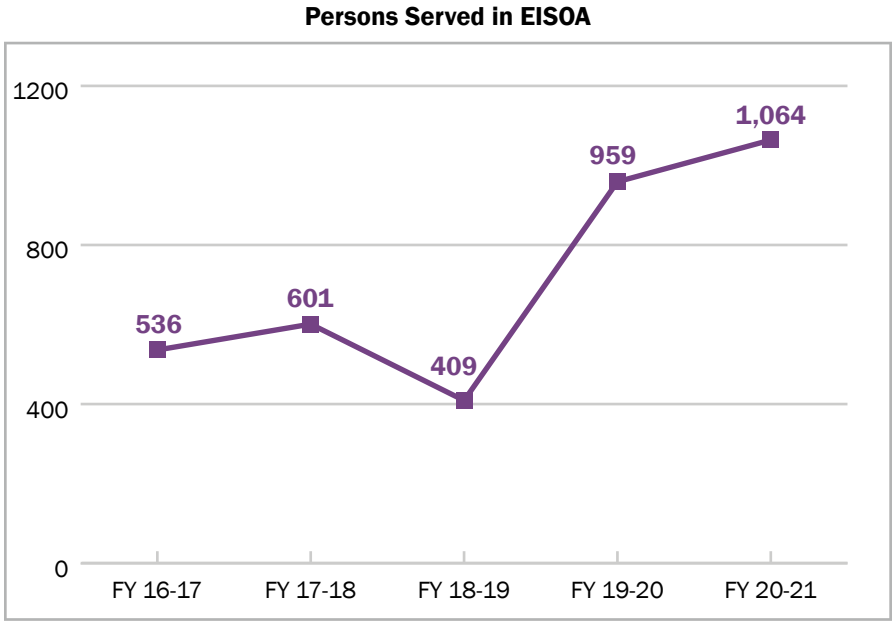
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,469,500	1,300
FY 2021-22	$2,469,500	1,300
FY 2022-23	$3,000,000	1,300

SERVICES

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

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

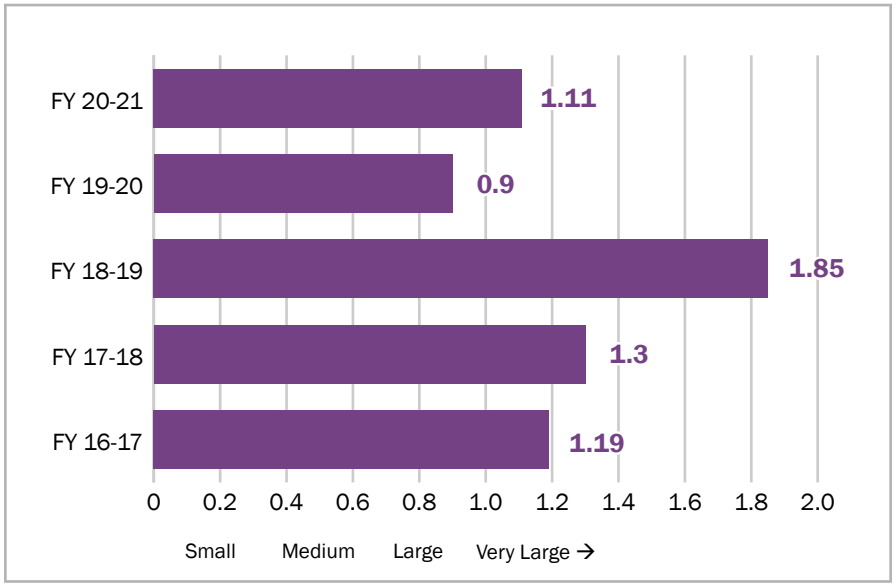


OUTCOMES

Larger numbers of older adults were served in FY 2019-20 and FY 2020-21 relative to previous years due to an increase in funding allocation for these services. The dip in older adults served in FY 2018-19 was due to a change in the program's admission and discharge criteria that occurred in the second half of FY 2017-18 and affected participant recruitment and engagement the following fiscal year.

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

Improvement of Depressive Symptoms Among Clinically-Distressed Older Adults - EISOA



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to the increased risk the COVID-19 pandemic posed for the older adult population, additional supports were provided through CARES Act funding during the 2020 calendar year. Rental assistance and essential items such as masks, toiletries, cleaning supplies, nutritional drinks, clothing, prepared meals, fresh food and pet supplies were delivered, allowing participants to remain safely in their homes while still ensuring their basic needs were met. Program staff remained in contact with the participants telephonically to provide emotional support during this time, and computer devices, hot spots/Wi-Fi and training were provided to those who did not have access to technology.

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

COMMUNITY IMPACT

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

REFERENCE NOTES

FY 2020-21: Baseline M=9.1, SD=4.41; Follow-up M=4.3, SD=3.83; t(713)=29.41, p<.001; Cohen's d=1.11
FY 2019-20: Baseline M=9.2, SD=5.19; Follow-up M=4.8, SD=4.29; t(488)=19.75, p<.001; Cohen's d=0.90

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

OC4Vets (PEI)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
					
All Ages	Field	Community	At-Risk	Mild-Moderate	~~Severe~~

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	22	Female	40	African American/Black	12
16-25	10	Male	60	American Indian/Alaskan Native	<1
26-59	56	Transgender	-	Asian/Pacific Islander	5
60+	13	Genderqueer	-	Caucasian/White	45
		Questioning/Unsure	-	Latino/Hispanic	24
		Another	-	Middle Eastern/North African	-
				Another	13

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,695,957	519
FY 2021-22	$2,400,000	530
FY 2022-23	$2,520,000	542

SERVICES

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

- **Referral Path 1:** Adult veterans who have not yet integrated into the Department of Veterans Affairs (VA) system, do not have access to the VA system, are unaware of their need for behavioral health services, or are seeking alternative services to the VA system.

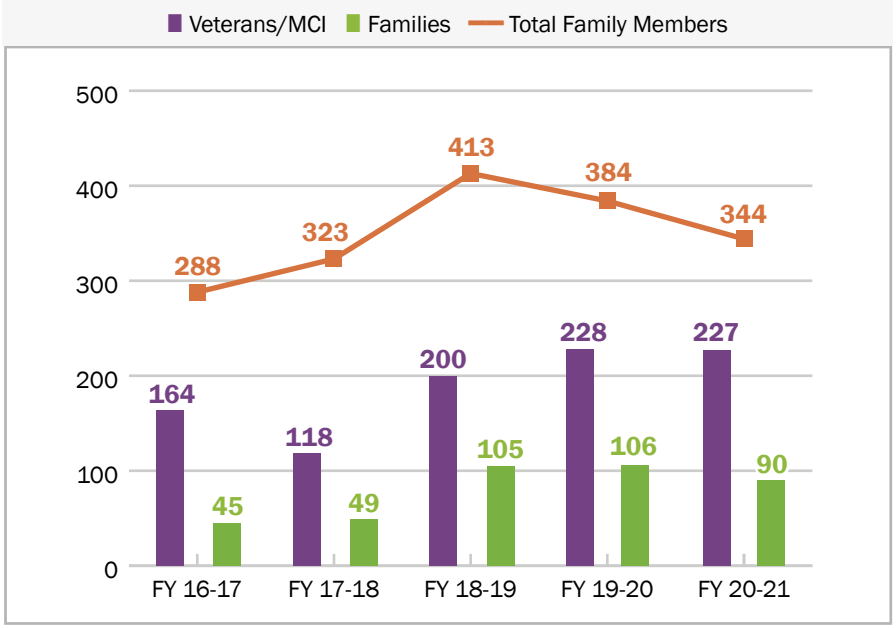
- **Referral Path 2:** Veterans and military connected adults who would benefit from partnering with peer navigators. Peer navigators have an understanding of military culture and are veterans themselves who work with program participants to identify their behavioral health needs, overcome barriers that may limit access to care and connect to ongoing treatment.

- **Referral Path 3:** Veterans and military connected adults engaged with the Orange County Courts (i.e., Veterans Treatment, Military Diversion, Family), many of whom exhibit mental health symptoms related to trauma exposure.

- **Referral Path 4:** Military connected students in local community colleges who would benefit from a military connected behavioral health clinician located on campus. The clinician also provides outreach and engagement on Orange County campuses using veteran-specific events and support groups to encourage discussion of barriers to a successful transition to college and civilian life. Services are provided on campus, in areas that are comfortable and accessible to the veterans, such as the campus Veterans Resource Center and virtually for groups and individual services.

- **Referral Path 5:** Military connected families who would benefit from working with trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family, such as Post Traumatic Stress Disorder (PTSD), traumatic brain injury (TBI), substance use and other conditions. Services are inclusive of the entire family unit, which allows for more effective family communication, functioning and support. Services can be provided via telehealth.

Participants Served in Veteran's Programs

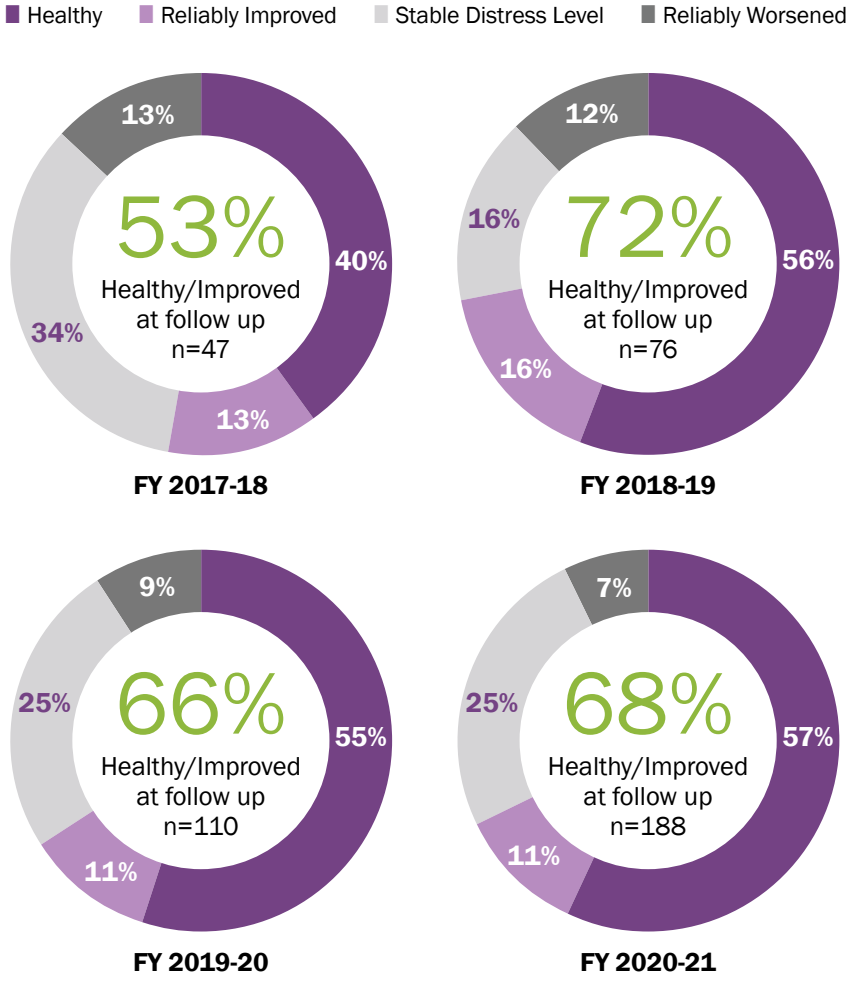


OUTCOMES

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

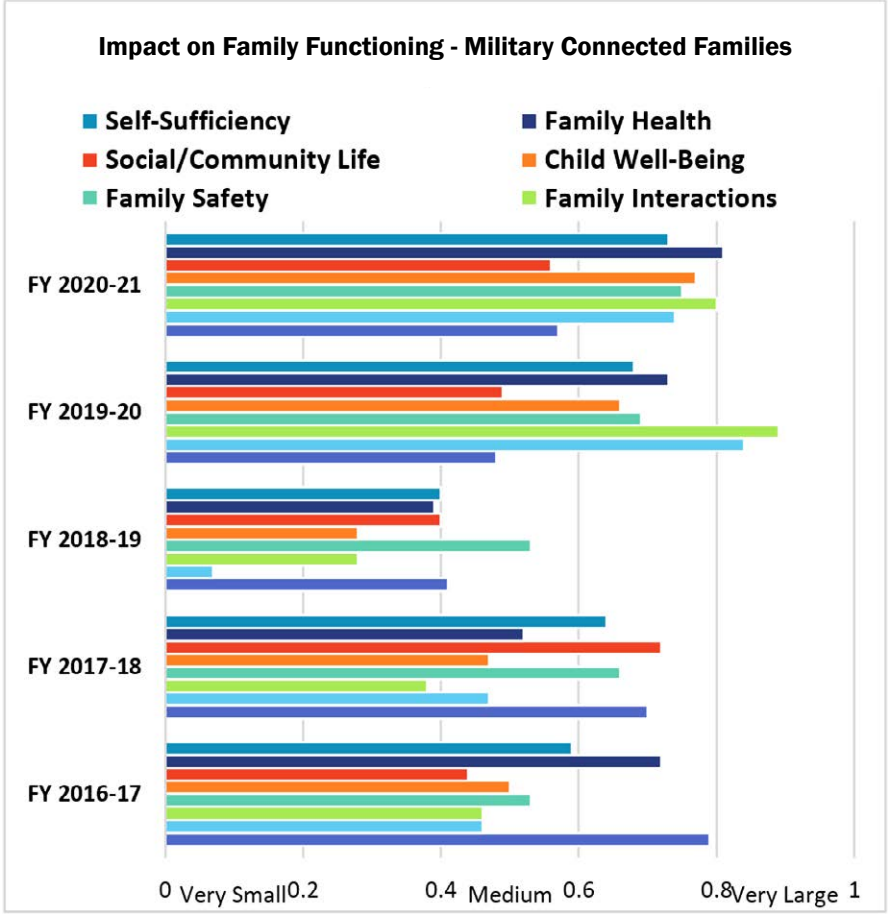
After noting the low completion rate of measures in FY 2016-17, OC Health Care Agency (HCA) staff provided guidance and course corrective actions to providers to ensure data were collected reliably and consistently. Steps have been taken to encourage more timely completion of forms, including providing training on administration timing and procedures, how to incorporate the results into care planning, and continuous support and follow up. As a result, an increasing number of completed forms have been returned over the past few years (i.e., 35, 47, 76, 110, and 188 from FY 2016-17 through FY 2020-21, respectively).

Overall results from the OQ® suggest that OC4Vets services help prevent participant's symptoms from becoming severe and disabling, with the proportion of OC4Vets participants reporting a healthy or reliably improved level of distress at follow up increasing from 40-46% in FYs 2016-17 and 2017-18 to 55-56% in the past three fiscal years. Moreover, in FY 2020-21, this is largely accounted for by more veterans enrolled in community-based programs reporting healthy distress levels at follow up (59% community-based veterans and 59% of military connected families, compared to 47% of college student veterans). Before FY 2019-20, the onset and/or worsening of mental health conditions specifical-



ly among military connected families was assessed using the North Carolina Family Assessment Scale (NCFAS). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results were reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time was clinically meaningful for the families served in the program. Depending on the construct measured, program services were associated with small to medium/large improvements, with larger improvements generally noted in environment (e.g., housing stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health), and greater effects observed in FY 2016-17 and FY 2017-18 compared to FY 2018-19. The difference in effects observed in FY 2018-19 compared to previous fiscal years may be due to capacity issues, including understaffing within agencies and staff turnover, as well as reduced leverage funding from partners, resulting in increased referrals outside of the project to link families to needed support. Beginning in FY 2019-20, military connected families began to complete the OQ® to 1) standardize data collection and reporting across program referral paths and 2) allow for more direct assessment of clinical improvement given that this is an early intervention program.

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



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

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

COMMUNITY IMPACT

OC4Vets has provided services to more than 1,400 veterans, military connected adults, and military connected youth in the community since July 2012, more than 340 veterans in college since its inception in October 2011, and more than 1,206 individual family participants since July 2015. Program staff has developed strong collaborations with a number of agencies that serve Orange County's veteran population, including the Veteran's Service Office with OC Community Resources (OCCR), Workforce Investment Office with OCCR, Office on Aging, Veterans Affairs Administration, the Tierney Center at Goodwill, and the Los Alamitos Joint Forces Training Base OC Superior Courts, OC Family Court, Veterans Resource Centers at local community colleges, and Orange County schools to best meet the needs of Orange County's veterans and their families.

REFERENCE NOTES

NCFAS

Environment:

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

Parental Capabilities:

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

Family Interactions:

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

Family Safety:

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

Child Well-Being:

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

Social/Community Life:

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

Self-Sufficiency:

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

Family Health:

FY 2019-20: Baseline M=30.4, SD=2.9; Follow-up M=32.2, SD=2.9; t(54)=5.1, p<.001; Cohen's d=0.69
FY 2018-19: Baseline M=3.1, SD=.39; Follow-up M=2.9, SD=.54; t(31)=2.18, p=.04; Cohen's d=0.39
FY 2017-18: Baseline M=3.0, SD=.53; Follow-up M=2.8, SD=.60; t(39)=3.65, p=.001; Cohen's d=0.59
FY 2016-17: Baseline M=2.9, SD=.54; Follow-up M=2.6, SD=.60; t(48)=4.03, p<.001; Cohen's d=0.58

Summary of MHSA Strategies Used by Early Intervention Programs

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

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

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

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

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

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

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

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

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

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

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

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

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

EARLY INTERVENTION PROGRAMS: SPECIALIZED SERVICES				LINKAGE METRICS
Programs	**FY**	**# Referrals**	**# Linkages**	**Types of Linkages**
CCSS	FY 2016-17	424	204	Behavioral health services; legal services, advocacy; health care benefits/services LGBTIQ individuals also referred/linked to food/nutrition, housing
	FY 2017-18	371	185	
	FY 2018-19	139	97	
	FY 2019-20	197	131	
	FY 2020-21	298	99	
EISOA	FY 2016-17	9,028	3,957	Social support; basic needs; community events; ancillary services; education; Behavioral Health Outpatient Services; legal/financial; medical; employment; family support; peer support, housing support
	FY 2017-18	10,880	6,191	
	FY 2018-19	5,156	3,054	
	FY 2019-20	9,779	5,567	
	FY 2020-21	12,325	6,058	

EARLY INTERVENTION PROGRAMS: CHILD, YOUTH, PARENT FOCUSED				LINKAGE METRICS
Programs	**FY**	**# Referrals**	**# Linkages**	**Types of Linkages**
SB MHS	FY 2016-17	397	49	Basic needs items; behavioral health outpatient services; PEI programs; crisis services; health education, disease prevention, wellness, physical fitness services
	FY 2017-18	391	44	
	FY 2018-19	293	59	
	FY 2019-20	455	110	
	FY 2020-21	213	13	
OC Parent Wellness	FY 2016-17	809	261	Family support services, legal services, advocacy; basic needs (i.e., donated items, financial assistance); recreation; behavioral health outpatient; behavioral health recovery
	FY 2017-18	600	155	
	FY 2018-19	540	226	
	FY 2019-20	461	243	
	FY 2020-21	373	94	
OC CREW	FY 2016-17	104	28	Behavioral health outpatient services; residential treatment; other PEI programs; resources; information and referral resources; legal services and advocacy; employment services and resources; recreational activities; special needs and disability service
	FY 2017-18	64	22	
	FY 2018-19	37	24	
	FY 2019-20	25	13	
	FY 2020-21	21	14	

EARLY INTERVENTION PROGRAM: OC4VETS				LINKAGE METRICS
Programs	**FY**	**# Referrals**	**# Linkages**	**Types of Linkages**
Veterans/Military Connected Adult referral path	FY 2016-17	363	216	Housing resources, advocacy; behavioral health outpatient services; employment services, resources; veteran entitlement programs; transportation services; other PEI programs; financial assistance; legal services, advocacy; food and nutrition assistance; health care services; behavioral health crisis response; senior services; health education, disease prevention, wellness, and physical fitness; recreation; family support services
	FY 2017-18	155	96	
	FY 2018-19	305	136	
	FY 2019-20	341	122	
	FY 2020-21	337	56	
College Veterans referral path*	FY 2016-17	133	83	Transportation services; food & nutrition assistance; housing resources, advocacy; employment services, resources; adult education; legal services, advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs; health care services; health education, disease prevention, wellness & physical fitness; special needs, disability services; veteran entitlement programs
	FY 2017-18	249	10	
	FY 2018-19	85	58	
	FY 2019-20	196	185	
	FY 2020-21	230	193	
Military Families referral path	FY 2016-17	217	106	Basic needs (i.e., food, clothing); housing; mental health; early intervention services; domestic violence prevention; legal services; financial services; employment services; education benefits; recovery and support services
	FY 2017-18	278	157	
	FY 2018-19	300	168	
	FY 2019-20	405	238	
	FY 2020-21	489	340	
BH Peer Support referral path	FY 2019-20	1,726	458	Recovery support services; housing assistance; outpatient behavioral health
	FY 2020-21	2,298	1,049	

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

EARLY INTERVENTION TREATMENT PROGRAMS*	TARGET POPULATION SPECIALIZATION/FOCUS						
Programs	**Children/ Youth**	**Parent/ Families**	**Adults**	**Older Adults**	**Trauma-Exposed Individuals**	**LGBTIQ**	**Monolingual/ Ethnic Communities**
CCSS	X	X	X	X	X	X	X
School-Based Mental Health Services	X	X			X		X
Early Intervention Services for Older Adults		X		X	X		X
OC Parent Wellness Program	X	X	X		X		X
First Onset of Psychiatric Illness (OC CREW)	X	X			X		X
OC4Vets	X	X	X		X		

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

Children and Youth Clinic Services (CSS)

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

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

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

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 0-21	Clinic	~~At-Risk~~	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

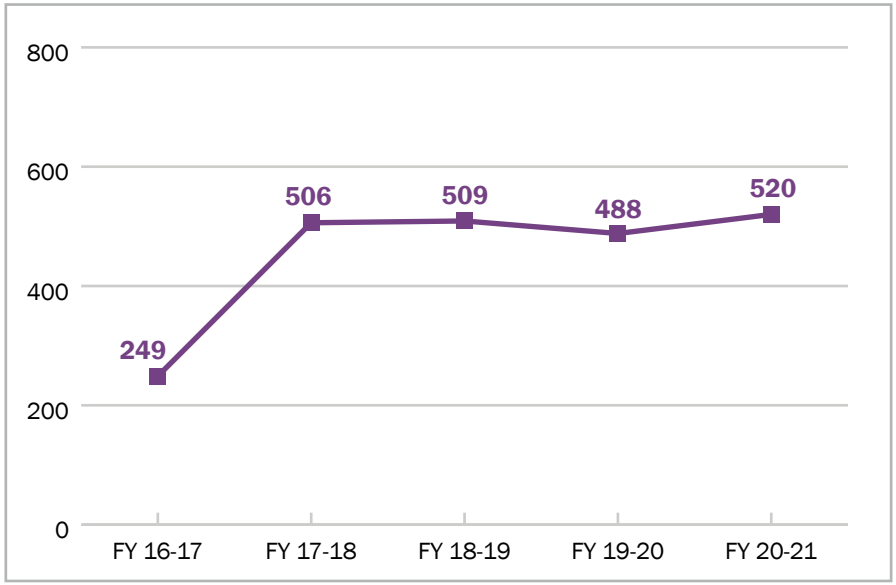
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,500,000	400
FY 2021-22	$2,500,000	500
FY 2022-23	$2,500,000	500

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

SERVICES

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

Youth Served in Clinic Expansion



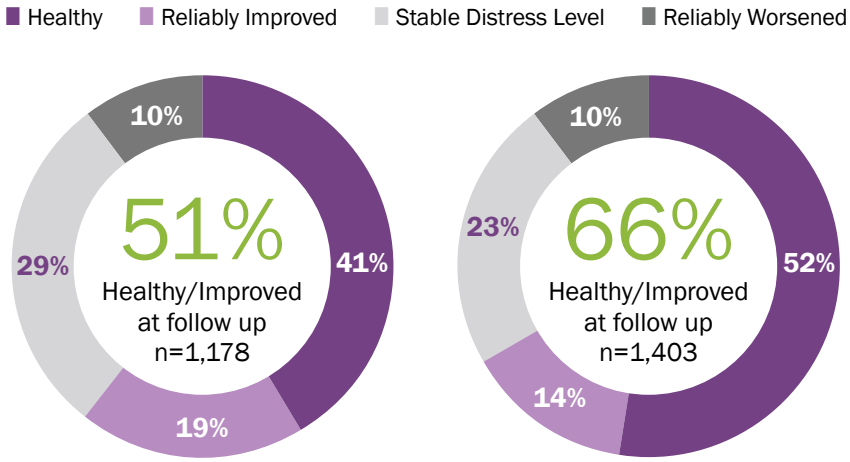
OUTCOMES

Outcome data for the Children and Youth Clinic Services program were collected and analyzed for FY 2020-21. The Youth Outcome Questionnaire (YOQ) is used to assess change in clinical symptoms and distress over time. The YOQ is a 64-item measure of clinical distress, intrapersonal distress, somatic, interpersonal, social problems, behavioral dysfunction, and critical items, such as suicidality. Youth complete the Self-Report YOQ (SR 2.0), and caregivers complete the Parent-Proxy YOQ (2.0) at intake, every six months, and at discharge from services. During FY 2020-21, 51% of youth rated themselves as healthy or improved, 29% stably distressed, and 10% worsened at follow-up. Parents rated their children as 66% healthy or improved, 23% stably distressed, and 10% worsened at follow-up.

The outcome data results suggest that the Children and Youth Clinic Services program has been successful at reducing clinical symptoms and distress in children and youth. Although the percentages of 51% and 66% may not appear that significant, the fact that most of the clients served by these providers present with severe mental and behavioral health conditions must be considered. It should also be noted that the data sets used for this analysis included clients who had not completed treatment. Going forward, the County will work with the contract providers to separate this part of the data in an effort to yield analyses that are more meaningful.

FY 20-21	CHILD REPORT		PARENT REPORT	
Distress Category	**# of Clients**	**%**	**# of Clients**	**%**
Healthy	486	41%	736	52%
Reliably Improved	229	19%	196	14%
Stable Distressed	342	29%	325	23%
Reliably Worsened	121	10%	146	10%

FY 2020-21 CYBH Contract-Operated Outpatient Programs



Youth Self-Report Clinical Symptoms & Distress

Parent-Report Clinical Symptoms & Distress

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The Children and Youth Expansion Services program will face a variety of challenges in FY 2021-22. Increased incidents of depression and anxiety are being identified by providers at all the clinics throughout Orange County. As children and youth deal with the adverse impact of the COVID-19 pandemic, providers are seeing more mental health problems with high acuity requiring more intensive levels of intervention. Overcoming barriers to access that children and their parents face such as childcare, public transportation, unemployment, and hybrid school schedules will be of paramount importance to the program. Some of the solutions providers have developed include implementation of audio/video technology to provide telehealth services for children and their families who cannot, or who do not yet feel safe to receive services in the clinics. Another solution providers are using is to make changes to both clinic procedures and the physical environment that allows for adequate social distancing, screening for health symptoms, and increased outreach to clients by providing resource information on children's mental health and daily living needs such as where and how to obtain vaccinations, transportation, housing and food. As COVID-19 restrictions begin to relax, an increasing number of children and youth will begin to return to the clinics for in-person services. Outpatient clinic staff will shift accordingly to meet this need.

COMMUNITY IMPACT

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

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

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0-20	Field	Community	At-Risk	~~Mild-Moderate~~	Severe
Ages 0-20					

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

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

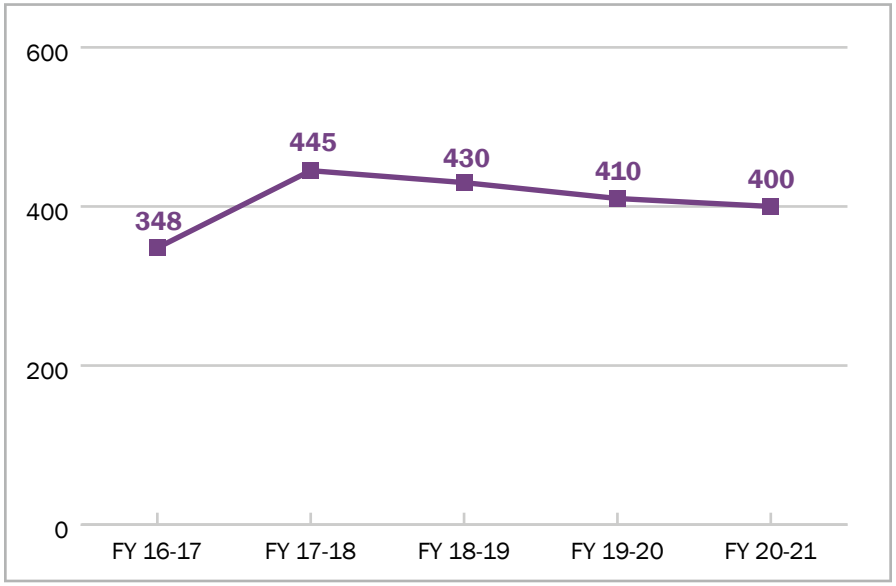
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,000,000	525
FY 2021-22	$1,000,000	550
FY 2022-23	$1,500,000	600

SERVICES

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

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

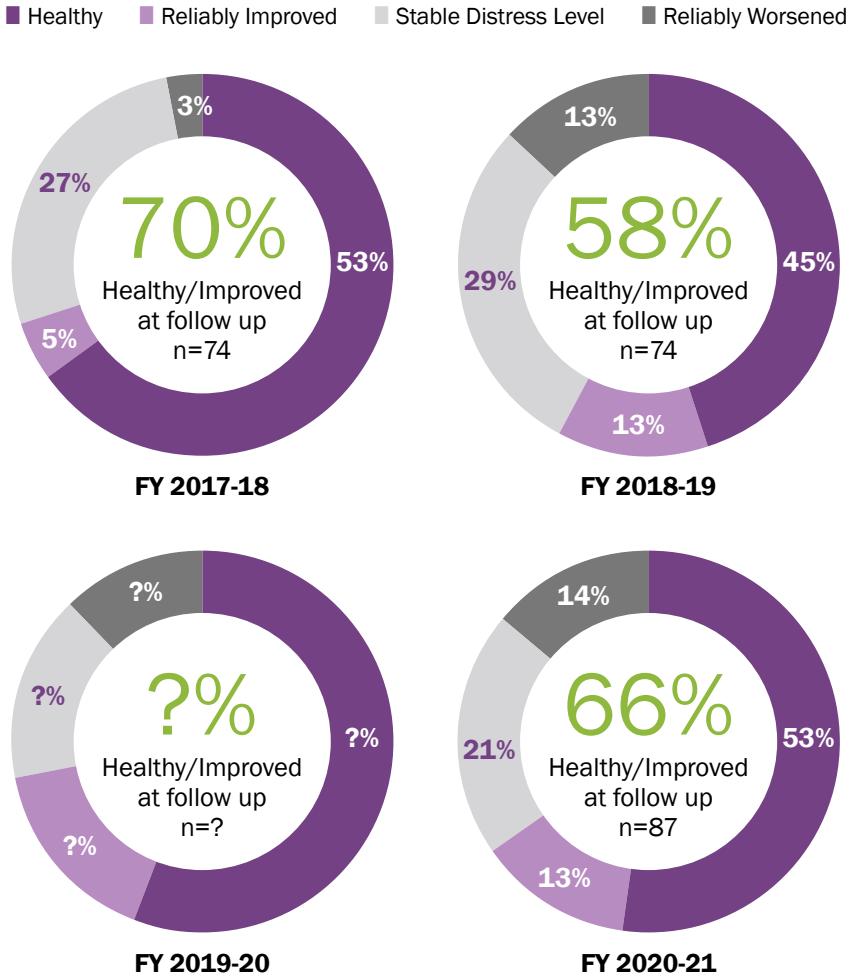
Youth with Co-Occurring Medical Conditions



OUTCOMES

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

Overall, the program's services appear to be associated with preventing symptoms of mental illness from becoming severe and disabling and with meaningfully reducing suffering among those who report clinically elevated distress during program enrollment. However, in FY 2019-20, the proportion of youth who reported a healthy or reliably improved level of distress at follow-up decreased, and the proportion of those reporting a reliable worsening of symptoms increased, relative to prior fiscal years. In FY 2020-21, the program returned to higher proportions of youth reporting healthy or reliably improved levels of distress at follow-up.



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

Beginning in March 2020, the program was faced with the COVID-19 public health emergency and needed to adapt the in-person treatment model to ensure safety requirements were met. The shift was made to providing services in a telehealth format which allowed the program to continue to provide services for their clients. The program noted increased engagement for some families, saving them travel time to the program which could often take three hours via public transportation. Some challenges were experienced with younger participants around engagement and a noted decrease in the length of sessions provided via telehealth. The program has been exploring new ways to engage participants through the telehealth format. While telehealth became a prevalent treatment modality since the start of March 2020, the program has continued to provide services in person at the clinic location and on the specialty medical units to support the needs of the client's and their families. Throughout FY 2020-21 telehealth services continued to be provided and evaluated to support clients' needs with the changing landscape of COVID-19.

COMMUNITY IMPACT

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

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

Starting in FY 2017-18, **Services for the Short-Term Residential Therapeutic Program** (S-STRTP; previously a track in the former Youth Core Services program called STRTP) was established to serve Wards and Dependents of the Court ages six to 17 and Non-Minor Dependents (NMD) ages 18 up to 21 who need the highest level of behavioral health care in a trauma-informed residential setting. Residential costs are paid through the foster care system, and the HCA contracts with the S-STRTP facilities to provide Medi-Cal Specialty Mental Health Services (SMHS) to eligible youth and NMDs placed under the Assembly Bill 403 mandate. All referrals to the program are made by Child Welfare or Probation with approval from the Interagency Placement Committee (IPC), which includes staff from Child Welfare, Probation and the HCA. The HCA is contracted for 144 beds with eight STRTP providers who have 21 facilities across the county:

- All eight providers have obtained Medi-Cal Certification and DHCS Mental Health Program Approval
- Six of these providers have obtained Permanent S-STRTP Licensure from CDSS
- Two providers are provisionally licensed and are awaiting permanent licensure

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
6-20				
Ages 6-20	Residential	~~At-Risk~~	~~Mild-Moderate~~	Severe

PROGRAM SPECIALIZATIONS

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

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

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

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

SERVICES

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

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

OUTCOMES

In FY 2020-21, the S-STRTP served 165 unduplicated clients with the goal of transitioning the youth to lower levels of care at the time of discharge. The average length of stay for these youth is 263 days (8.8 months), much longer than the intended six-month timeline for the S-STRTP. This is indicative of the intensive clinical needs of the youth served in the S-STRTP, and the need for extended intensive treatment in order to stabilize and transition them to lower levels of care and longer-term family-based placements. Of the 165 youth served, 118 have since been discharged as follows:

- Eighteen transferred to higher level of care (I.e., incarceration, hospitalization, etc.)
- Twenty had no discharge destination due to extended Absence Without Leave (AWOL)
- Nineteen were transferred to another STRTP
- Thirty-four were transitioned into a lower level of care placement (i.e., resource family homes, transitional housing program, etc.)
- Twenty-seven were reunited with family or relatives

Outpatient Recovery (CSS)

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

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
18+					
Ages 18+	Clinic	Field	~~At-Risk~~	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

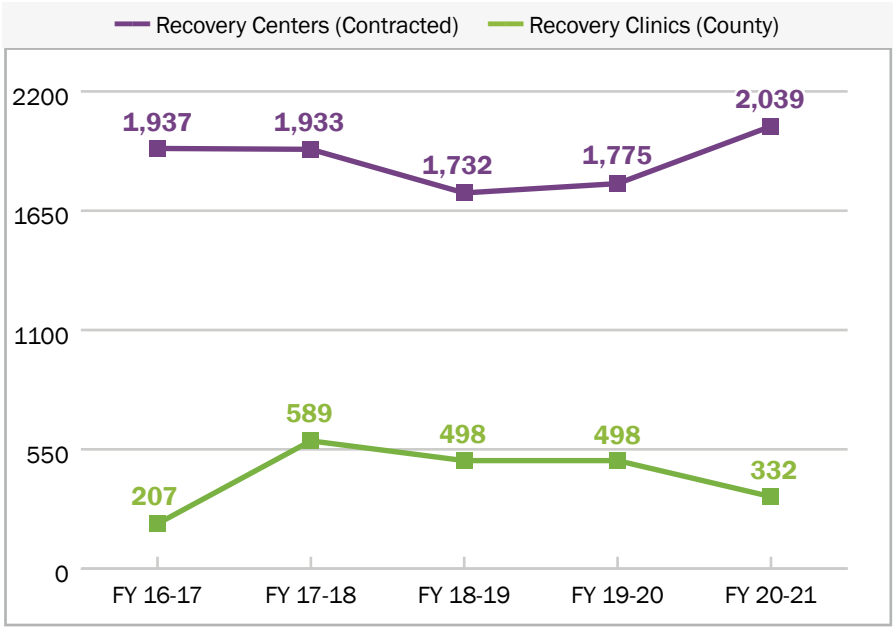
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$6,158,531	2,500
FY 2021-22	$5,858,531	2,500
FY 2022-23	$8,162,173	2,500

SERVICES

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

Persons Served - Recovery Services



OUTCOMES

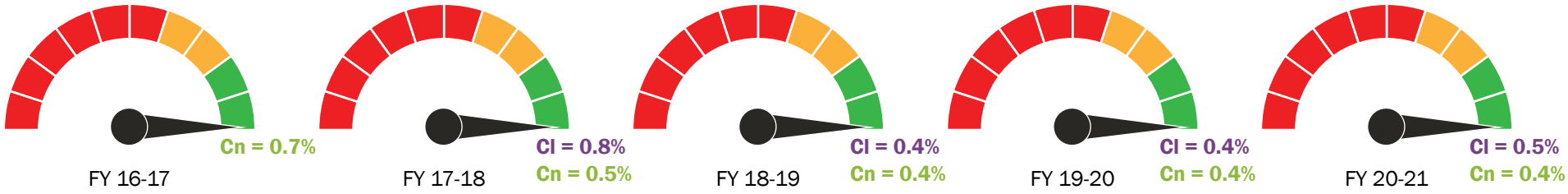
The Outpatient Recovery program monitors performance by whether the program met or exceeded the following targets:

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

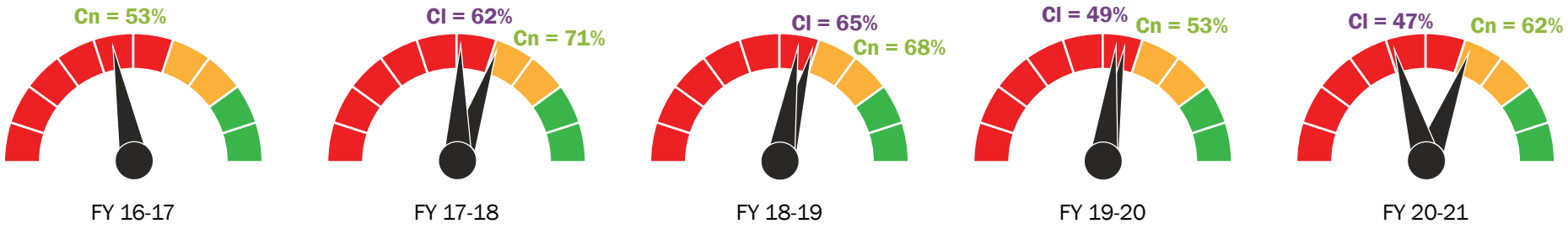
The program has met these goals across sites and fiscal years, with the exception of the number of discharges to lower level of care in FY 2016-17.

Percent Hospitalized During Enrollment in Recovery Services

Cl = Clinics Cn = Centers



Percent Discharged from Recovery Services to Lower Level of Care



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

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

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

Due to challenges with receiving appropriate referrals, the HCA has diligently worked on collaborating with referral sources and providing them with education on when, in the individual's recovery journey, it is most appropriate to refer clients to the program. In addition, the HCA has increased peer support provided in this program and hired 17 peers whose main focus is to assist individuals with transitions to different levels of care.

COMMUNITY IMPACT

The needs of the individuals accessing the Recovery Centers and Clinics are uniquely met through services focused on reintegration into the community and overall independence. Individuals and their families are educated about the system of care, exposed to community resources and encouraged to set and meet new goals beyond those achieved at the program. Through obtaining employment, pursuing education and/or participating in meaningful activities, individuals who graduate have a better understanding of the tools they can use to support and maintain their recovery after discharge.

Older Adult Service (CSS)

Older Adult Services (OAS) serves individuals ages 60 years and older who are living with serious and persistent mental illness (SPMI), experience multiple functional impairments and may also have a co-occurring substance use disorder. Many of the older adults served in this program are homebound due to physical, mental, financial or other impairments. They are diverse and come from African American, Latino, Vietnamese, Korean and Iranian communities. OAS accepts referrals from all sources.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
60+	Field	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe
Ages 60+					

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	-	Female	40	African American/Black	4
16-25	-	Male	59	American Indian/Alaskan Native	1
26-59	1	Transgender	-	Asian/Pacific Islander	17
60+	99	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	-	Latino/Hispanic	12
		Another	1	Middle Eastern/North African	1
				Another	27

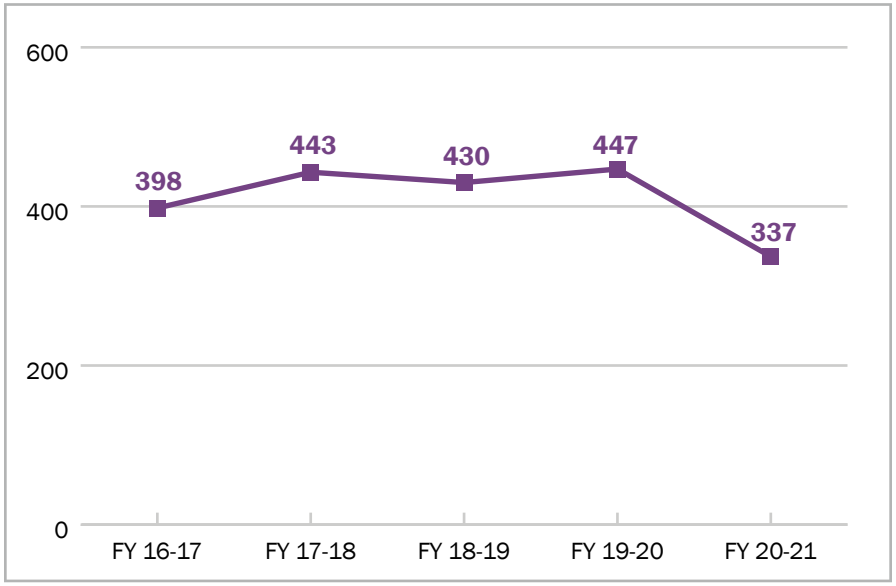
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,168,135	530
FY 2021-22	$2,168,135	530
FY 2022-23	$2,168,135	530

SERVICES

OAS provides case management, referral and linkages to various community resources, geriatric psychiatry, vocational and educational support, substance use services, nursing services, crisis intervention, medication monitoring, pharmacist consultation, peer counseling, therapy services (individual, group, and family), and psychoeducation for participants, family members and caregivers. Evidence-based practices include Cognitive Behavioral Therapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavioral Therapy (DBT), problem-solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care.

Older Adults Served in OAS



OUTCOMES

One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary care, which is quantified as the number of nursing assessments completed. During FY 2020-21, due to COVID-19, there were no nursing assessments completed because nurses did not have face-to-face assessments with clients. Of the older adults served each of the prior fiscal years, 49%, 19%, 21% and 26% had an assessment completed in FYs 2016-17 through 2019-20, respectively. This reduction since 2016-17 is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. As a result, staff were spread out over multiple offices, which affected program operations and service delivery. The program moved to a new location in March 2019 and nursing assessments increased. However during COVID-19, nursing assessments were abbreviated due to the lack of face-to-face interviews with participants. The nurse was not able to obtain vital signs and interviewed new participants on the phone prior to the appointment with the psychiatrist for past medical conditions, current and past medications, education on diet and nutrition, sleep hygiene, PCP information, labs and allergies.

OAS clinicians increased the frequency of home visits during the pandemic. In addition to providing case management, they assisted clients to utilize telehealth appointments with their psychiatrist and PCP.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

OAS continues to encounter ongoing issues collecting outcome measures that evaluate the program's performance (i.e., selection of a feasible measure of symptom reduction, adequate completion rates, etc.). Program staff has continued meeting to identify metrics appropriate for the target population being served such as implementing the PHQ-9 every six months. Future Plan Updates will report these outcomes once implemented. With the move to a new location, OAS staff can now offer evidence-based practice groups and education for participants and their family members in a clubhouse atmosphere. During COVID-19, older adults became even more vulnerable since they were sheltering at home. OAS was able to obtain a small amount of CARES ACT funding to provide participants with sanitation packages, hygiene items, nutrition drinks, home delivered healthy meals, needed food items for companion animals and other essential items. Because of their co-morbid medical issues and mental health symptoms, they were not able to stand in line at food banks or go to multiple grocery stores for essential items. OAS staff were able to deliver items and simultaneously provide mental health services while practicing social distancing.

COMMUNITY IMPACT

OAS collaborates with the Public Health Services Senior Health Outreach and Prevention Program (SHOPP), Council on Aging, Social Services Agency (Adult Protective Services), community senior centers, adult day health care, Alzheimer's Association, Ageless Alliance, local police departments, OC Probation Department, hospitals and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face, which can include ensuring the safety of seniors, reaching out to homebound seniors in need of mental health services, coordinating joint home visits with the HCA Public Health nurses to ensure that participant's mental and physical health needs are addressed, and providing educational events for older adults and professionals on issues relevant to seniors, such as medication management, health- and mental health-related matters and community services.

Telehealth/Virtual Behavioral Health Care (CSS)

The **Telehealth/Virtual Behavioral Health Care** program was new to the Three-Year Plan and intended to provide telehealth and/or virtual behavioral health care options for individuals 13 years and older living with serious mental health conditions, and for parents and caregivers of children of all ages. Due to the use of CARES Act funding that supported the transition of many MHSA-funded programs into providing telehealth and virtual mental health services, program implementation was paused in FY 2020-21.

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Unduplicated # to be Served**
FY 2020-21	-	-
FY 2021-22*	$2,500,000	TBD
FY 2022-23	$3,000,000	TBD

SERVICES

Through one or more applications and/or telehealth providers, this program is intended to offer a range of tele-mental health care including, but not limited to, individual therapy, crisis intervention, telepsychiatry and/or peer support. Digital solutions that offer psychoeducation, navigation to needed resources, and training and coaching in relaxation skills, meditation, mindfulness, etc. may also be identified. This program may offer standalone services to individuals and/or provide adjunctive supports to individuals engaged in face-to-face behavioral health services. The services provided through this program will be evidence-supported or established practices. In contrast, the Help@Hand Innovation project will support 1) the identification, development and/or evaluation of new and/or emerging technologies, and 2) the identification and development of administrative processes necessary to create a 'digital mental health system of care' capable of responding to rapid changes in technology and/or its regulatory environment.

In response to considerable feedback from consumers, clients, family members and service providers during the 2021 CPPP, this program will also address a key barrier to engaging in virtual care, namely gaps in understanding how to use technology safely, efficiently and effectively. As such, this program will also include a robust training and technical assistance (TA) piece that will include, but not be limited to:

- Needs assessment to determine whether/how to replace/upgrade outdated provider devices
- Development of tipsheets, brief video tutorials available on-demand online, drop-in scheduled "Appy Hours," and multi-session courses on digital literacy and digital mental health literacy topics
- Partnership with local agencies and community organizations as needed to develop and adapt materials and training that are culturally responsive and linguistically appropriate
- Accelerated development and implementation of in-person training and TA for consumers, family members, prioritizing in-person training/TA for those most in need
- Ongoing market surveillance scan of digital MH solutions

In response to community feedback, the HCA will also strive to provide training on digital literacy basics to individuals and groups most in need of in-person training by the end of Summer 2021. This would allow those with the greatest gaps in digital knowledge an opportunity to receive hands-on assistance while in-person gatherings and meetings are permitted since it is still unknown whether there will be new safer-at-home orders in the fall/winter.

Summary of MHSA Strategies Used by Clinic Expansion

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

Recovery and resilience are promoted by ensuring that a strong support network is in place to improve the lives of individuals served in these programs and their families. This is achieved by working closely with the individuals and family members, when appropriate, using a strengths-based approach to help develop skills that further improve their functioning, maintain independence and decrease isolation, as well as by communicating and collaborating with the various providers involved in their care (i.e., medical teams and other health care providers, community resources, school staff, wraparound team, Social Services Agency, schools, etc.). STRTP providers also help foster recovery and resilience by creating a space that provides physical and emotional safety for the youth, sensitively conducting screenings and assessments to identify the trauma-related reactions and risk of the children and youth they serve, and educating caregivers on how their own trauma histories may be impacting their current behaviors and relationships, particularly with their children, and helping the adults develop skills and tools to support their children in recovery.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

Operating from a strengths-based view rather than an illness-based view helps reduce some of the stigma associated with mental health conditions. Staff also recognize the importance of providing services and supports in a manner that takes into account and accepts the individual's differences and unique life circumstances, including culture, ethnicity, gender identity, sexual orientation and socioeconomic status. In the co-occurring physical health/mental health program, several unique opportunities are available since the program is located at a teaching hospital. For example, Spanish-speaking clinicians are encouraged to participate in a monthly Spanish-speaking clinicians' meeting aimed at discussing and training in topics and issues related to the provision of mental health services in Spanish, as well as cultural and linguistic factors specific to the Hispanic population. Post-doctoral fellows regularly attend seminars that provide education and training on research and evidence-based practices that consider cultural and diversity factors that impact mental health and psychosocial functioning. The program also regularly educates medical providers on issues related to mental health to increase understanding and reduce stigma. In addition, older adults may hesitate to access services due to stigma related to being an older adult. They may fear losing their independence or being removed from their homes, forced to take medications and/or forced to live in a nursing home due to their age. They may also feel shame due to their belief that, as adults, they should not need anyone's help to live their lives. OAS staff are trained and encouraged to take whatever time is needed to develop trust with participants and facilitate engagement into services.

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

Lack of transportation and stigma are some of the primary barriers to care for these participants, which are mitigated by bringing services directly to individuals and their families out in the community, including co-locating services at schools, medical offices, hospitals, etc., rather than relying on them to travel to a behavioral health clinic. Program staff also teach participants how to use public transportation and provide bus passes. These programs also provide services in multiple languages through bicultural/bilingual staff, or a language line translation service as needed, to assist those who speak other languages, thus reducing language barriers that may impeded engaging in services. In addition, for older adults hesitant to enroll in OAS, staff from another program (OAS SHOPP) are dedicated to conducting outreach and engagement with referred individuals to OAS and recognize that it may require several friendly home visits before an older adult engages in OAS services.

Discontinued Program - Integrated Community Services (CSS)

Integrated Community Services (ICS), which serves individuals ages 18 and older living with chronic primary medical care and mild to severe mental health needs, will no longer be funded through MHSA/CSS. Instead the program has been transitioning over to CalOptima, with funding provided through Medi-Cal and other non-MHSA sources.

FY 2020-21 TO FY 2022-23 PROGRAM BUDGET		PROJECTED UNDUPLICATED # TO BE SERVED	
Actual FY 2019-20 Budget	$1,648,000	FY 2019-20	600
Proposed FY 2020-21 Budget	-$1,197,000	FY 2020-21	600
Proposed FY 2021-22 Budget	-$1,197,000	FY 2021-22	600
Proposed FY 2022-23 Budget	-$1,197,000	FY 2022-23	0

Full Service Partnership Programs (CSS)

A Full Service Partnership (FSP) is designed to provide intensive, community-based outpatient services to a county's most vulnerable individuals, and the OC Health Care Agency has established eligibility criteria to ensure that the FSPs reach Orange County residents who are experiencing disparities in access to behavioral health care. Thus, the target population includes individuals of all ages who are living with a SED or SMI; unserved or underserved; and are homeless, at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment, culturally or linguistically isolated, and/or have complex medical needs. Orange County has four distinct FSP programs organized by the MHSA-defined age groups (i.e., Children, TAY, Adult, Older Adult). In addition to tailoring services and supports to the members' age and developmental stage, three (i.e., Children, TAY, Adult) offer additional tracks for individuals with more specialized needs and providers within these specialized tracks often serve individuals across multiple age groups. The most common age groups spanned are Children/TAY and Adult/Older Adult, although there are some exceptions (see tables below). All FSP services – even those affiliated with the Courts and OC Probation – are voluntary.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0+	Field	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe
All Ages					

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	13	Female	41	African American/Black	7
16-25	35	Male	58	American Indian/Alaskan Native	1
26-59	43	Transgender	1	Asian/Pacific Islander	11
60+	9	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	-	Latino/Hispanic	38
		Another	-	Middle Eastern/North African	1
				Another	4

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$53,766,876	3,521
FY 2021-22	$53,766,876	3,591
FY 2022-23	$57,466,876	3,661

IDENTIFIED UNSERVED/UNDERSERVED TARGET POPULATIONS FOR CHILDREN/TAY FSP PROGRAMS	Children 0-15	TAY 16-17	TAY 18-25	Adult 26-29	Older Adult 60+
Children/youth (mostly 12-15 years) and their parents/caregivers (Project RENEW) Referrals from: County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, Children's CAT	■	■			
TAY who have minimal family involvement (STAY Process) Referrals from: County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT, AOT		■	■		
Court-referred youth and their parents/caregivers (CCFSP) Referrals from: Juvenile Court (Recovery, Girls, Boys, Grace); Truancy Response Program	■	■	■		
Criminal-Justice Involved youth and their parents/caregivers (YOW) Referrals from: County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, Children's CAT	■	■	■		
Youth with significant/chronic physical illness and their families (Project HEALTH) Referrals from: Hospitals, physicians, specialty medical clinics, County and County-contracted clinics	■	■	■		
Culturally/linguistically-isolated Asian/Pacific Islander youth/families (Project FOCUS) Referrals from: County and County-contracted outpatient clinics, primary care physicians, emergency departments, SSA, inpatient units, schools, CYBH CAT	■	■	■	** See note*	

*** Beginning in FY 2017-18, the provider continued offering services to TAY who aged out of the program when they turned 26 because there is currently no similar specialized FSP for adults.*

IDENTIFIED UNSERVED/UNDERSERVED TARGET POPULATIONS FOR ADULT/OLDER ADULT FSP PROGRAMS	Children 0-15	TAY 16-17	TAY 18-25	Adult 26-29	Older Adult 60+
FSP-eligible adults who are homeless or at risk of homelessness (TAO) Referrals from: Jails, OC Probation, general community			■	■	■
LPS conservatorship, returning from long-term care, court-involved (STEPS) Referrals from: Long-term care facilities, Collaborative Courts, general community			■	■	■
Voluntarily agreed/court-ordered to participate in AOT FSP Referrals from: Assisted Outpatient Treatment (AOT) Assessment and Linkage Team (see Appendix X for details)			■	■	■
Criminal-Justice Involved Referrals from: Jails, OC Probation, general community			■	■	■
Court-Involved (WIT/Whatever It Takes) Referrals from: Collaborative Courts			■	■	■
FSP-eligible adults at risk of losing permanent housing (Home First) Referrals from: County outpatient clinics and programs, private providers, property managers, general community			■	■	■
FSP-eligible older adults (also tend to have health/mobility issues) (OASIS) Referrals from: Hospitals, Adult Protective Services, outpatient clinics, senior centers, jail, OC Links, family members, CAT, general community				■	■

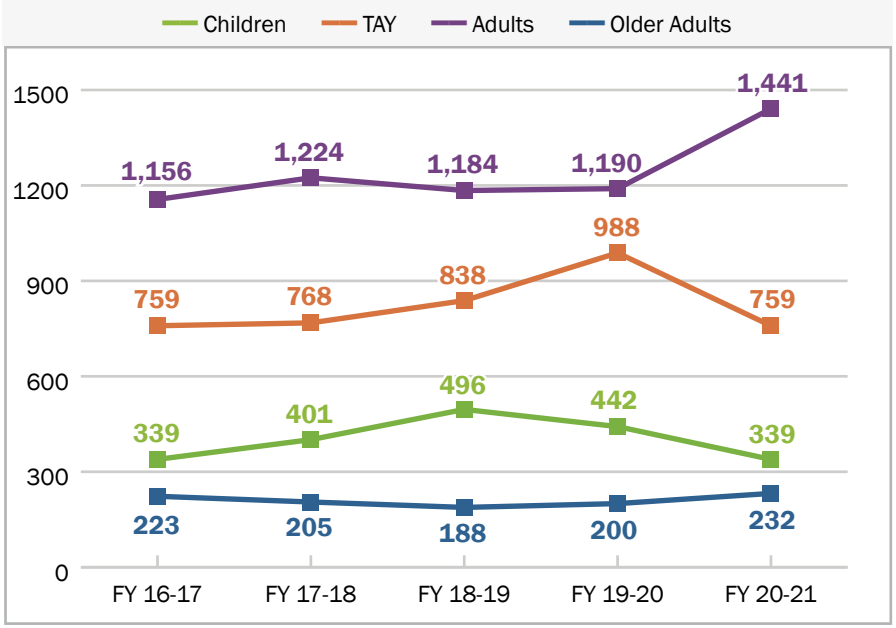
SERVICES

The FSP programs use a coordinated team approach to provide "whatever it takes," including 24/7 crisis intervention and flexible funding to support people on their recovery journeys. They follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally competent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can include Marriage and Family Therapists, Clinical Social Workers, Personal Services Coordinators, Peer Mentors, Youth Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Clinical Dietitians, Licensed Clinical Supervisors, Psychiatrists and/or Nurses who are committed to the recovery model and the success of their participants. Working together, the teams provide intensive services that include counseling, case management and peer support, which are described in more detail below.

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

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

FSP Members Served by Age and FY



Some providers also have employment and/or housing coordinators who assist and support their participants in these essential elements of recovery. Employment coordinators, or when dedicated coordinators are not available, PSCs and other staff, lead numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. FSP housing coordinators (and/or PSCs) also assist individuals with

finding and maintaining safe, suitable housing, as reducing homelessness is one of the target outcomes for the FSPs.

Peer Recovery Specialists/Coaches and Parent Partners are key members of the FSP teams and play an integral role in promoting wellness and resilience. By sharing their lived experience and learned skills, peer staff support recovery, empowerment and community integration. In addition, Parent/Family Partners work closely with parents, legal guardians, caregivers, significant others and other family members to provide suggestions on how they can best support the participant. Parent Partners also assist with the psychoeducational process to close the generational gap and shift how parents and caregivers view mental health, as well as provide respite care.

Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and has been central to the Children and TAY FSP program providers' approach to service and care planning. In addition, the Adult FSP program providers have been working on increasing family inclusion at all levels of treatment and at social events, and several providers offer a monthly family support group to provide families with information, education, guidance and support for their own needs, as well as to enable them to assist their family member's recovery.

OUTCOMES

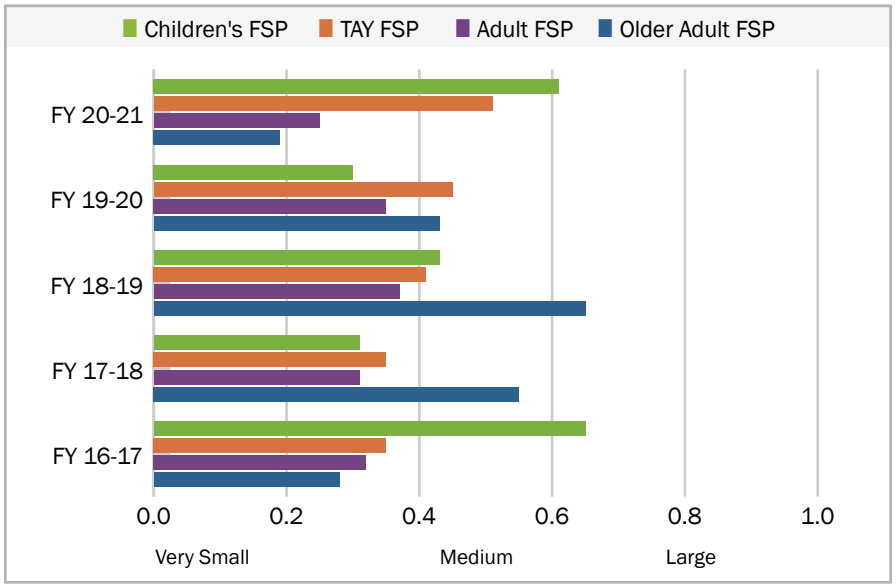
The programs evaluated changes on outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance by comparing functioning in the 12 months prior to enrolling in the FSP to functioning during the fiscal year being evaluated. With the exception of school performance, all results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP program.

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

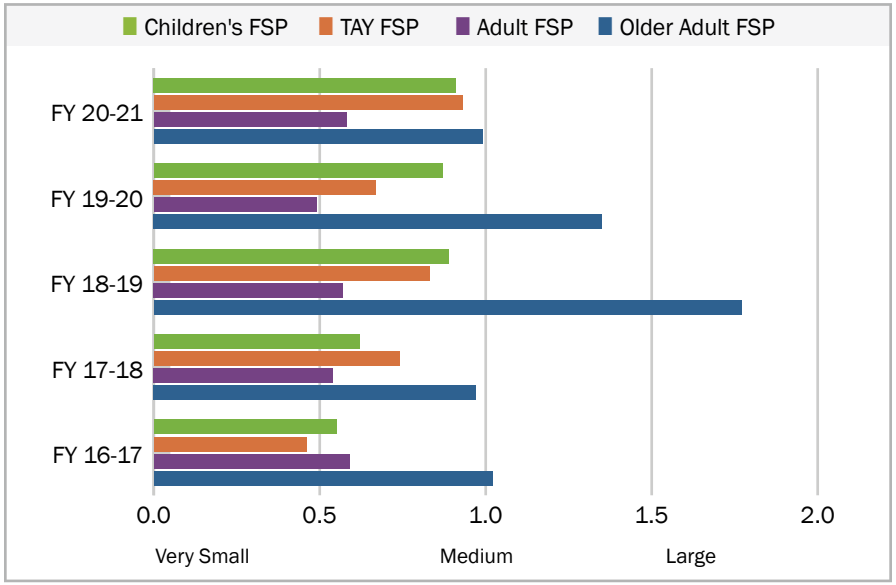
Across fiscal years, the FSPs generally made a small impact on decreasing the amount of time participants spent in a psychiatric hospital, with TAY, adult and older adult participants having spent, on average, about 4-5 weeks in the hospital during the year prior to enrolling in an FSP compared to about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

In addition, FSPs demonstrated medium to large decreases in the average number of mental health-related emergency interventions that participants experienced across each of the fiscal years, further suggesting that they experienced recovery while receiving FSP services. This effect was particularly pronounced for older adults, with the average number of events essentially dropping to zero.

FSP Improvement on Psychiatric Hospitalization Days



FSP Improvement on MH Emergency Interventions



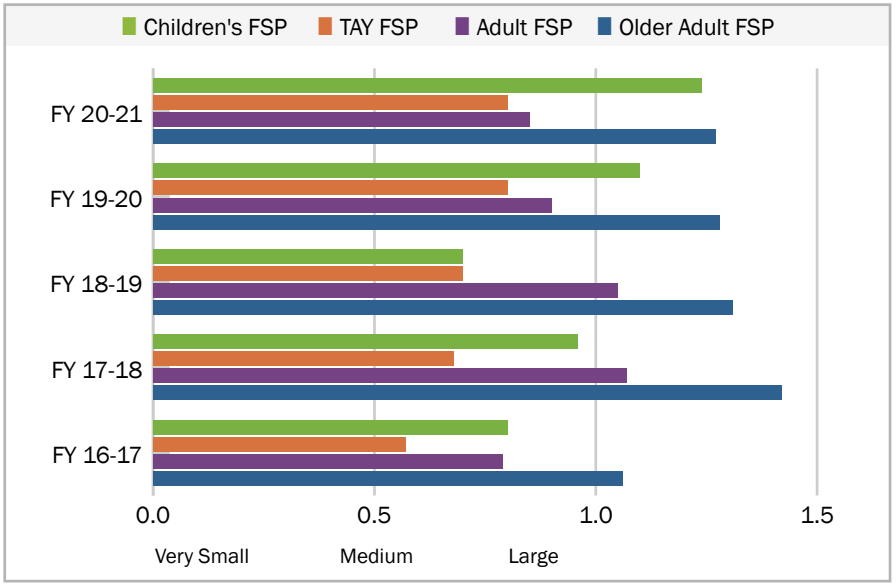
Homelessness and Living Situation: Another goal of the FSPs is to prevent and reduce unsheltered homelessness, emergency shelter stays and, for children, out-of-home placements. For TAY, Adults and Older Adults, the FSPs also strive to increase the number of days they are able to live in the community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

The FSP programs continued to improve the housing circumstances of their participants as evidenced by the generally large reduction (moderate for TAY) in the average number of days spent homeless during each of the past FYs. Improvements were most pronounced for adult and older adults, who typically experienced greater homelessness prior to FSP enrollment. Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc. In the last two fiscal years, there were large reductions in unsheltered homeless days for children, as well.

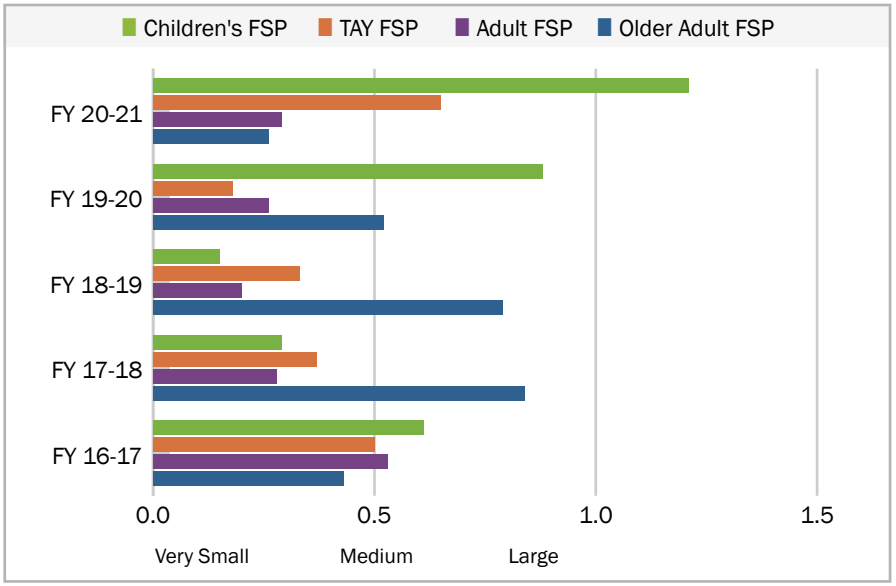
The impact of FSPs on reducing days spent in emergency shelter varied across age group and fiscal year. Children, TAY and adults generally experienced small to moderate decreases while enrolled in the FSP over the past several FYs.

Efforts to relocate a large number of homeless adults living in the Flood Control Channel and Santa Ana Civic Center area during FYs 2017-18 and 2018-19 likely contributed to the reduced impact on this outcome as the TAO Central FSP provider worked to place adults living in these areas in emergency shelters temporarily. In support of this speculation, when homeless adults served by this provider are removed from the analysis, the remaining adults experienced moderate reductions (0.48) in emergency shelter use during FY 2018-19, which is consistent with findings from FY 2016-17. In contrast, older adults FSP demonstrated the opposite pattern (i.e., shifting from a moderate impact in FY 2016-17 to a large impact in the past two FYs), which may be attributable to a few participants who had very long emergency shelter motel stays while receiving services in FY 2016-17 before transitioning to permanent living placements in FY 2017-18. In FY 2019-20, fewer children had stayed in emergency shelters pri-

FSP Improvement on Unsheltered Homeless Days



FSP Improvement on Emergency Shelter Days

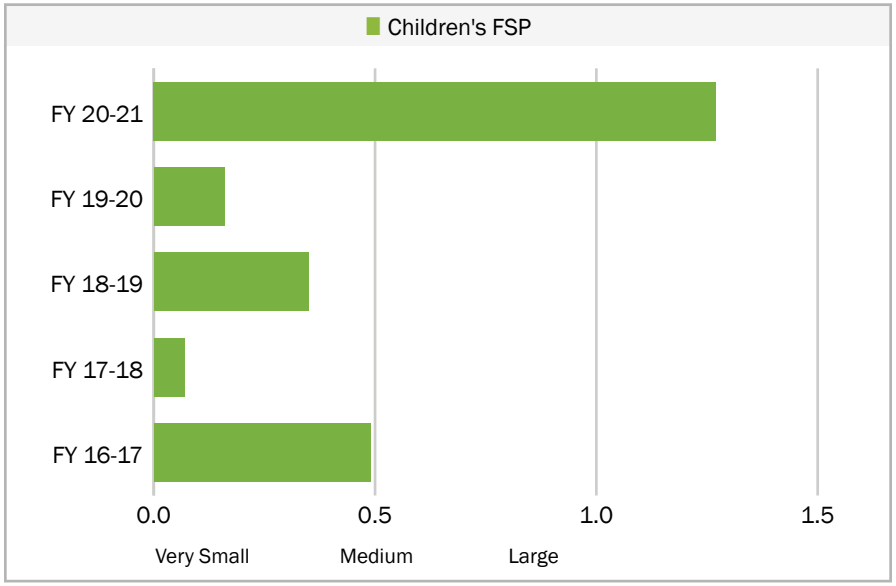


or to enrolling in the FSP compared to prior fiscal years, those that had reported unusually long shelter days, resulting in a large decrease once the FSP was able to provide housing for these children and their families. Thus, unique factors across the past four FYs may account for the fluctuating impact on emergency shelter use rather than true changes in the FSPs' ability to improve this outcome. Finally for FY 2020-21, we saw a large increase in the Emergency Shelter Day Category which in part may be due to the COVID-19 housing assistance, relieve and moratoriums on evictions during this time. The HCA will continue to track and evaluate this data as we move into the next fiscal year.

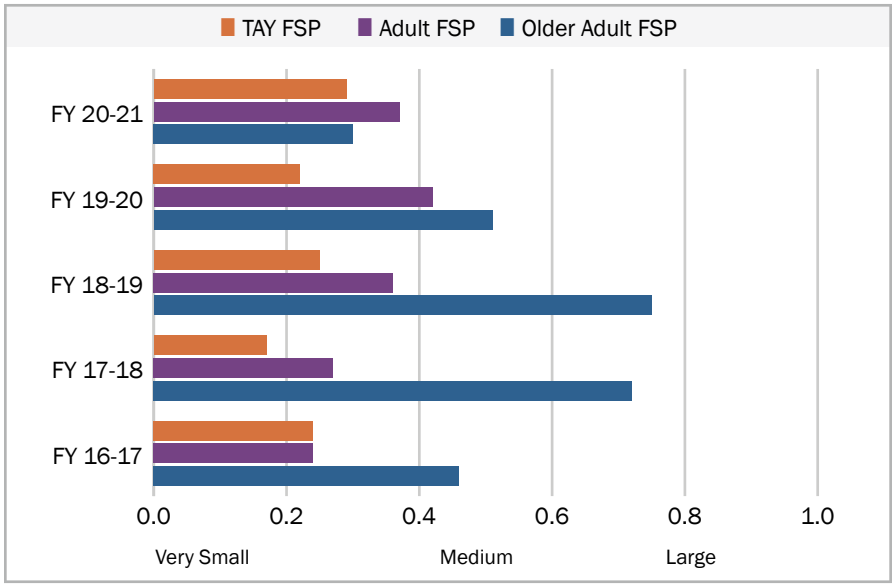
For children the goal is to reduce out-of-home placements, which are defined as placement in a group home or residential treatment facility. It should be noted that a very small number of children are affected by an out-of-home placement either prior to enrolling in the FSP or during the fiscal year being evaluated (i.e., n= 20 in FY 2016-17, n= 14 in FY 2017-18, n= 17 in FY 2018-19, n= 10 in FY 2019-20, & n=12 in FY 2020-21). Thus, it is difficult to draw firm conclusions on the overall efficacy of FSPs in reducing out-of-home placements for children, although the average number of days children were placed out-of-the-home did decrease during all three fiscal years when compared to the year prior to their enrollment in the FSP.

While TAY and adults experienced a small increase in the average number of days spent living independently across FYs, older adults demonstrated moderate to large increases. Thus, the Older Adult FSP appears to be relatively effective at helping support independent living, which is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement. These improvements appear to be the result of changes implemented in FY 2017-18 when the increased impact was first observed. During this time the provider implemented a more collaborative, structured approach where the treatment team collectively discussed and problem-solved ways to engage members who were at high risk of hospitalization and/or incarceration. In addition to weekly contact with personal service coordinators, teams increased contact with the older adults by including visits with life coaches, therapists or

FSP Improvement on Out-of-Home-Placement Days



FSP Improvement on Independent Living Days



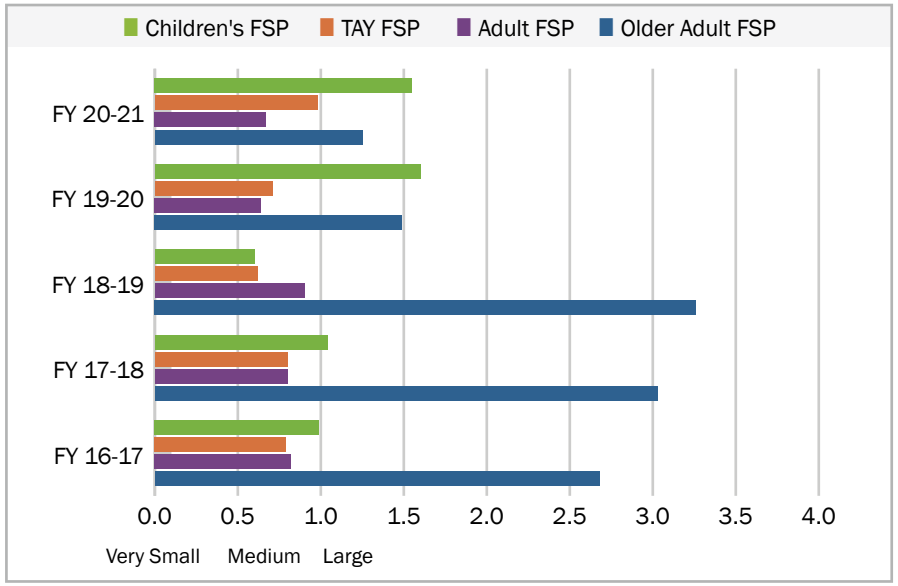
housing coordinators or members of the medical team. In addition, staff has worked diligently to increase the number of groups offered and created new and more interesting group topics and events based on client interests and needs. As a result, the program has seen a significant increase in group participation over the past fiscal years. These improvements are thought to have positively impacted overall functioning and not just independent living, as evidenced by improvements across all outcomes during the past two FYs relative to FY 2016-17.

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. Adults and Older Adults generally experienced medium to very large decreases in arrests during all fiscal years compared to the year prior to FSP enrollment. TAY outcomes tended to fluctuate across the fiscal years between small to large. Children experienced small to medium reductions in incarcerations days across the fiscal years. The HCA is currently exploring possible underlying reasons for these shifts in incarceration patterns among TAY and children.

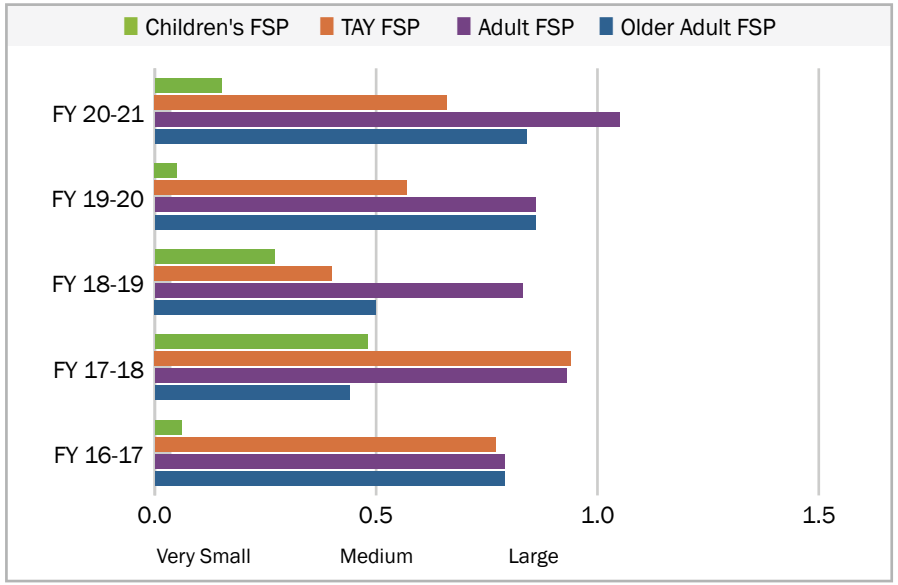
Employment: The TAY and Adult FSPs also examined days employed, which is vital to recovery, but can be difficult to attain for those struggling with the combination of serious mental illness, substance use disorders, homelessness and/or a legal history. Per guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-housework, work experience, non-paid work experience and other gainful employment activity.

Compared to the year prior to FSP enrollment, the FSPs had a small impact on employment for TAY in FYs 2019-2020 and 2020-21. The FSPs had no impact in FY 2016-17 and a small impact in FYs 2017-18 and 2018-19 on employment for adults and TAY who were at least 16 years old at the start of the fiscal year (and therefore eligible to work the duration of the reporting period). Thus, increasing employment activity in a meaningful way continues to be a particularly challenging area for the FSPs.

Improvement on Arrests

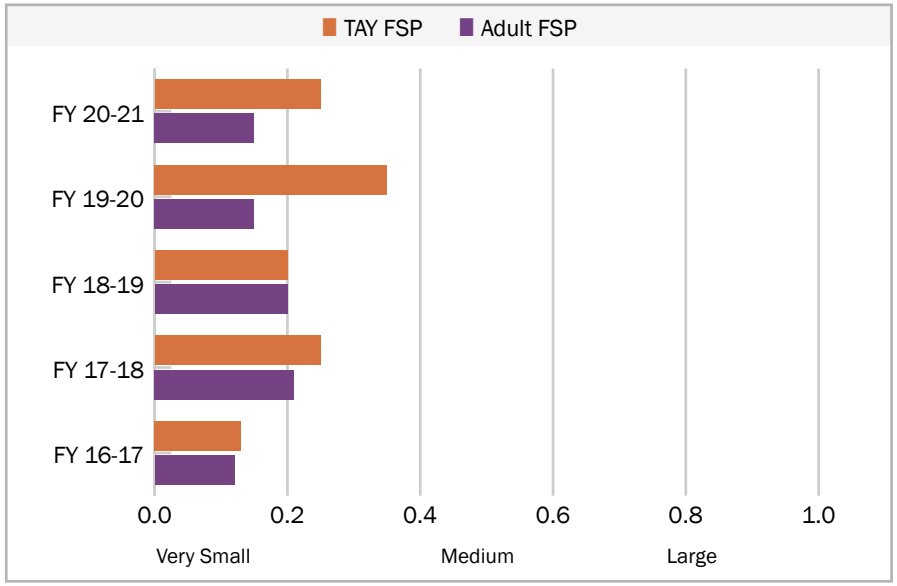


Improvement on Incarceration Days

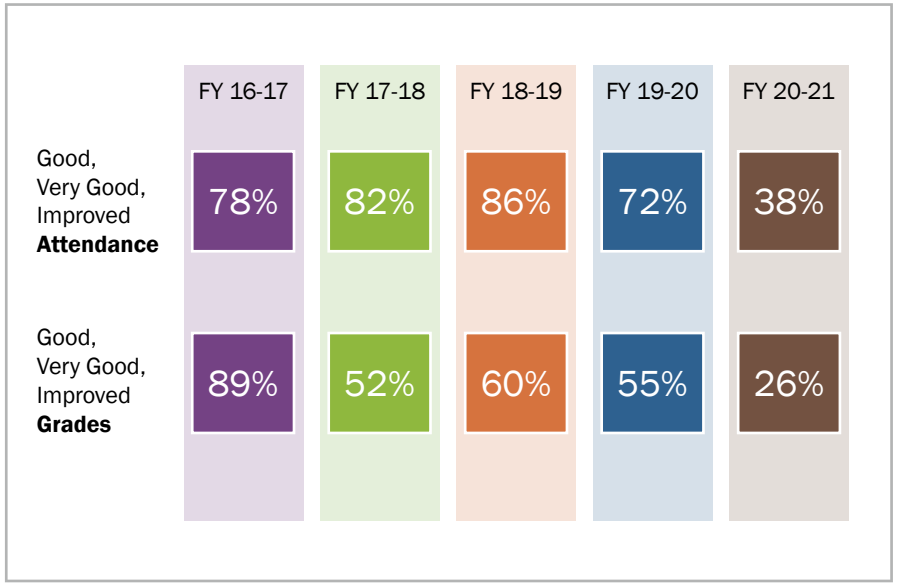


School Performance: The Children's FSPs examined the proportion of children who (1) maintained good/very good school attendance or grades and/or who (2) improved their attendance or grades while enrolled in the FSP. During FY 2020-21, 38% of children reported good/improved attendance and 26% reported good/improved grades, representing a decline from previous years. This represents a substantial decrease from prior fiscal years that is likely attributable to the impact of the pandemic of school performance. While the findings generally suggest that the FSPs are successful in maintaining or improving school performance among the children served, the HCA will continue to monitor the FSPs' impact on grades.

Improvement on Employment Days



School Performance - Children/Youth FSP



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. In FY 2020-21 the HCA created an FSP track that assists individuals and families who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless. To address the shortage of permanent supportive housing, the HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, the HCA has partnered with Orange County Community Resources, housing developers and other community partners to apply for federal and state housing funding, including No Place Like Home.

Employment has also continued to be an ongoing and significant challenge despite the recovering job market. FSP programs can encounter difficulties identifying employers who are flexible enough to employ individuals (or their parents/guardians) who may need time away from work to support their (child's) recovery. Yet employment serves as a critical component of recovery by helping increase peoples' connection with their community, providing a sense of purpose and increasing self-sufficiency. Drawing upon these principles, as well as CBHDA's expanded definition of employment, the programs are working to increase individuals' participation in meaningful, employment-related activities such as volunteer work and enrollment in educational/training courses as a way to enhance vocational skills, gain experience, and increase their confidence in being able to succeed in the workforce. Over the years, the Adult FSP program has worked to secure additional community opportunities and created internal opportunities for volunteer work. Nevertheless, more than any other target outcome, the program continues to struggle with supporting individuals in sustaining employment in a consequential way. With the COVID-19 pandemic, there were limited job opportunities. Over the next year, FSP program staff will explore employment resources and review referrals and linkages to employment services to see if opportunities exist to increase referrals and better support linkage to these services.

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

To address an increase of co-occurring substance use issues among TAY and adult participants, the FSP programs are offering more co-occurring groups; working to partner with community substance use treatment programs to expand resources, including residential programs that specialize in co-occurring treatment; and creating their own co-occurring supports and interventions to fill identified service gaps. FSP staff also work collaboratively with Housing and Supportive Services staff to help individuals with co-occurring issues maintain their housing. The Adult FSP providers that serve justice-involved individuals are working to have more staff trained in MRT in order to provide more MRT groups and have increased collaboration with Correctional Health Services to support linkage by providing in reach services and coordinating for transportation upon release.

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

The Adult Housing FSP provider began providing services in Fall 2020. The provider effectively engages individuals who have come from homelessness and provides intensive and comprehensive treatment and support that focuses on preventing loss of housing while increasing housing sustainability.

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

COMMUNITY IMPACT

Since program inception dates, the FSPs have served more than 2,100 children (approximately 18%), nearly 4,000 TAY (approximately 35%), more than 4,600 adults (approximately 40%) and nearly 700 older adults (approximately 6%). The FSP programs provide a strong base in participant-driven services that build on individual strengths using a "whatever it takes" approach and field-based services that break down barriers to accessing treatment. With the continued implementation of co-occurring services, the programs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detoxification centers. In addition, providers that work collaboratively with the Courts, Probation Department, Public Defender's Office, District Attorney's Office, and/or County Counsel continue to prioritize developing treatment approaches that reduce recidivism in the criminal justice system.

The FSP programs also work closely with various providers and other community groups to support participants on their recovery journeys. This includes the Social Security Administration, Social Services Agency, primary care physicians and other medical providers, hospitals, board and care homes, room and boards, recovery residences, housing providers, shelters, Family Resource Centers, legal resources, food banks, vocational trade programs, LGBTIQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policymakers, community based organizations and community clinics. By establishing such depth and breadth to their network of collaborators, the FSPs continue to be a leading force for mental health recovery in the community.

REFERENCE NOTES

Psychiatric Hospitalization Days:

Children:

FY 2020-21: Prior M=16.8, SD= 15.1; Since M= 3.7, SD 17.6; t(84)=5.67, p<.001, Cohen's d= 0.61, -78%
FY 2019-20: Prior M=14.8, SD= 37.7; Since M= 4.5, SD 12.5; t(82)=2.4, p<.02, Cohen's d= 0.30, -70%
FY 2018-19: Prior M=9.9, SD= 11.6; Since M=3.8, SD 7.0; t(90)=4.0, p<.001, Cohen's d=0.43, -62%
FY 2017-18: Prior M= 7.7, SD= 6.7; Since M=3.8, SD= 8.9; t(75)=2.67, p<.01, Cohen's d=0.31, -51%
FY 2016-17: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t(70)=5.05, p<.001, Cohen's d=0.65, -83%

TAY:

FY2020-21: Prior M=20.1, SD=30.5; Since M=3.3, SD=17.7; t(255)=8.0, p<.001, Cohen's d=0.51, -84%
FY2019-20: Prior M=17.2, SD=23.8; Since M=5.2, SD=17.6; t(245)=-7.0, p<.001, Cohen's d=.45, -70%
FY 2018-19: Prior M=23.0, SD=42.1; Since M=6.7, SD=19.8; t(265)=-6.14, p<.001, Cohen's d=0.41, -71%
FY 2017-18: Prior M=28.6, SD= 52.1; Since M=8.6, SD=26.8; t(274)=5.59, p<.001, Cohen's d=0.35, -70%
FY 2016-17: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246)=-5.03, p<.001, Cohen's d=0.35, -63%

Adults:

FY 2020-21: Prior M=38.0, SD=69.5; Since M=18.7, SD=42.0; t(588) = 5.87, p<.001, Cohen's d=.25, -51%
FY2019-20: Prior M=37.7, SD=65.9; Since M=13.8, SD=31.6; t(599)=8.06, p<.001, Cohen's d=.35, -63%
FY 2018-19: Prior M=36.7, SD=65.1; Since M=13.2, SD=29.7; t(556)=8.08, p<.001, Cohen's d=0.37, -64%
FY 2017-18: Prior M=34.0, SD=59.7; Since M=14.4, SD=31.9; t(559)=6.92, p<.001, Cohen's d=0.31, -58%
FY 2016-17: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t(542)=6.78, p<0.001, Cohen's d=0.32, -62%

Older Adults:

FY 2020-21: Prior M=28.5, SD=52.3; Since M=15.5, SD=38.4; t(56) = 1.39, p =.170, Cohen's d=0.19, -46%
FY 2019-20: Prior M=36.3, SD=67.9; Since M=8.7, SD=24.4; t(55)=2.89, p <.05, Cohen's d=.43, -76%
FY 2018-19: Prior M=37.2, SD=70.4; Since M=7.6, SD=24.0; t(52)=3.53, p <.001, Cohen's d=0.65, -80%
FY 2017-18: Prior M=39.4, SD=76.1; Since M=5.0, SD=12.8; t(57)=3.41, p<.001, Cohen's d=0.55, 87%
FY 2016-17: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t(58)=1.84, p=0.07, Cohen's d=0.28, -58%

Mental Health Emergency Interventions:

Children:

FY 2020-21: Prior M=2.2, SD=1.9; Since M=0.2, SD=1.1; t(151)=11.3, p<.001, Cohen's d=0.91, -91%
FY 2019-20: Prior M=2.1, SD=2.0; Since M=0.3, SD=1.0; t(169)=11.8, p<.001, Cohen's d=0.87, -86%
FY 2018-19: Prior M=1.8, SD=1.7; Since M=0.3, SD=.78; t(241), p<.001, Cohen's d=0.89, -83%
FY 2017-18: Prior M=1.8, SD=1.9; Since M=0.5, SD=1.1; t(158)=7.61, p<.001, Cohen's d=0.62, -72%
FY 2016-17: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t(82)=4.57, p<.001, Cohen's d=0.55, -78%

TAY:

FY2020-21: Prior M=2.4, SD=2.9; Since M=0.2, SD=0.7; t(483)=17.7, p<.001, Cohen's d=0.93, -92%
FY 2019-20: Prior M=2.4, SD=3.4; Since M=0.3, SD=1.0; t(460)=13.3, p<.001, Cohen's d=0.67, -88%
FY 2018-19: Prior M=2.6, SD=3.3; Since M=0.3, SD=.7; t(500)=15.12, p<.001, Cohen's d=0.83, -88%
FY 2017-18: Prior M=2.7, SD=3.6; Since M=0.4, SD=3.6; t(365)=12.14, p<.001, Cohen's d=0.74, -85%
FY 2016-17: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t(295)=7.7, p<.001, Cohen's d=0.46, -74%

Adults:

FY 2020-21: Prior M=2.5, SD=2.8; Since M=0.79, SD=1.5; t(742) = 15.1, p<.001, Cohen's d=.58, -68%
FY 2019-20: Prior M=2.3, SD=2.3; Since M=0.81, SD=2.0; t(700)=13.00, p<.001, Cohen's d=.49, -65%
FY 2018-19: Prior M=2.5, SD=2.4; Since M=0.8, SD=1.7; t(658)=14.43, p<.001, Cohen's d=0.57, -67%
FY 2017-18: Prior M=3.2, SD=3.7; Since M=1.0, SD=2.0; t(809)=14.88, p<.001, Cohen's d=0.54, -68%
FY 2016-17: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t(629)=13.10, p<.001, Cohen's d=0.59, -69%

Older Adults:

FY 2020-21: Prior M=2.2, SD=2.4; Since M=0.08, SD=0.27; t(77) = 7.38 , p<.001, Cohen's d= 0.99, -96%
FY 2019-20: Prior M=2.5, SD=2.4; Since M=0.01, SD=0.12; t(73)=8.68, p<.001, Cohen's d=1.35, -100%
FY 2018-19: Prior M=2.1, SD=1.7; Since M=0, SD=0.0; t(66)=10.25, p<.001, Cohen's d=1.77, -100%
FY 2017-18: Prior M=3.2, SD=4.6; Since M=0, SD=0.0; t(121)=7.58, p<.001, Cohen's d=0.97, -100%
FY 2016-17: Prior M=1.7, SD=1.6; Since M=0.2, SD=0.5; t(79)=8.07, p<.001, Cohen's d=1.02, -89%

Homeless Days:

Children:

FY2020-21: Prior M=87.6, SD=99.9; Since M=0.0; SD=0.0; t(11)= 3.04, p<.011, Cohen's d=1.24, -100%
FY 2019-20: Prior M=81.5, SD=109.3; Since M=0.0; SD=0.0; t(17)= 3.2, p<.006, Cohen's d=1.10, -100%
FY 2018-19: Prior M=56.0, SD=94.7; Since M=1.9; SD=7.1; t(25)=2.87, p<.001, Cohen's d=0.70, -97%
FY 2017-18: Prior M=88.8, SD=101.8; Since M=7.3, SD=19.7; t(23)=3.86, p<.01, Cohen's d=0.96, -92%
FY 2016-17: Prior M=96.4, SD=129.7; Since M=17.1, SD=51.7; t(19)=-3.0, p<.01, Cohen's d=0.80, -82%

TAY:

FY 2020-21: Prior M=94.6, SD=101.6; Since M=11.3, SD=48.3; t(115)=8.1, p<.001, Cohen's d=0.80, -88%
FY 2019-20: Prior M=77.8, SD=91.4; Since M=11.7, SD=41.3; t(132)=8.4, p<.001, Cohen's d=.80, -85%
FY 2018-19: Prior M=92.8, SD=113.9; Since M=15.1, SD=33.2; t(146)=8.51, p<.001, Cohen's d=0.70, -84%
FY 2017-18: Prior M=101.6, SD=118.8; Since M=21.9, SD=46.1; t(168)=8.13, p<.001, Cohen's d=0.68, -78%
FY 2016-17: Prior M=102.3, SD=124.93; Since M=26.3, SD=55.79; t(154)=-6.69, p<.001, Cohen's d=0.57, -74%

Adults:

FY 2020-21: Prior M=158.9, SD=129.0; Since M=34.1, SD=74.1; t(807) = 23.4, p<.001, Cohen's d=.85, -79%
FY 2019-20: Prior M=159.8, SD=127.8; Since M=30.9, SD=71.3; t(669)=22.4, p<.001, Cohen's d=.90, -81%
FY 2018-19: Prior M=179.9, SD=134.1; Since M=30.6, SD=70.0; t(640)=25.4, p<.001, Cohen's d=1.05, -83%
FY 2017-18: Prior M=178.7, SD=132.0; Since M=25.2, SD=60.7; t(666)=26.17, p<.001, Cohen's d=1.07, -86%
FY 2016-17: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t(611)=18.68, p<.001, Cohen's d=0.79, -75%

Older Adults:

Y 2020-21: Prior M=200.8, SD=136.3; Since M=24.9, SD=66.6; t(133) = 13.8, p<.001, Cohen's d=1.27, -88%
FY 2019-20: Prior M=204.9, SD=133.8; Since M=25.7, SD=70.4; t(119)=13.3, p<.001, Cohen's d=1.28, -87%
FY 2018-19: Prior M=216.4, SD=140.0; Since M=27.8, SD=76.1; t(124)=13.89, p<.001, Cohen's d=1.31, -87%
FY 2017-18: Prior M=217.5, SD=136.2; Since M=27.7, SD=67.2; t(128)=14.99, p<.001, Cohen's d=1.42, -87%
FY 2016-17: Prior M=205.4, SD=138.5; Since M=37.6, SD=84.5; t(134)=12.14, p<.001, Cohen's d=1.06, -82%

Emergency Shelter Days:

Children:

FY 2020-21: Prior M= 98.9, SD=115.9; Since M=0.0, SD=0.0; t(16)=3.52, p=.003, Cohen's d=1.21, -100%
FY 2019-20: Prior M= 88.2, SD=112.9; Since M=7.7, SD=20.6; t(22)=3.4, p=.003, Cohen's d=0.88, -91%
FY 2018-19: Prior M= 43.8, SD=79.6; Since M=25.4; SD=45.1; t(83)=1.7, p=.094, Cohen's d=0.19,-37%
FY 2017-18: Prior M=62.4, SD=100.4; Since M=27.5; SD=55.7; t(48)=1.99, p=.05, Cohen's d=0.29, -56%
FY 2016-17: Prior M=72.9, SD=108.9; Since M=14.8; SD=35.4; t(31)=-2.97, p<.01, Cohen's d=0.61, -80%

TAY:

FY 2020-21: Prior M= 76.6, SD=101.5; Since M=8.5, SD=44.5; t(144)=7.3, p<.011, Cohen's d=0.65, -89%
FY 2019-20: Prior M= 54.2, SD=85.7; Since M=32.6, SD=75.3; t(205)=2.6, p<.011, Cohen's d= 0.18, -40%
FY 2018-19: Prior M= 96.0, SD=109.5; Since M=28.7, SD=57.2; t(215)=-.041, p<.05, Cohen's d=0.61, -51%
FY 2017-18: Prior M=69.3, SD=101.3; Since M=29.2, SD=54.5; t(155)=4.38, p<.001, Cohen's d=0.37, -58%
FY 2016-17: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t(162)=-5.90, p<.001, Cohen's d=0.50, -73%

Adults:

FY 2020-21: Prior M=76.8, SD=111.2; Since M=37.3, SD=72.7; t(489) = 6.41, p<.001, Cohen's d=.29, -51%
FY 2019-20: Prior M=66.5, SD=102.6; Since M=32.6, SD=67.0; t(385)=5.03, p<.001, Cohen's d=.26, -51%
FY 2018-19: Prior M=62.7, SD=103.3; Since M=36.8, SD=63.9; t(406)=4.01, p<.001, Cohen's d=0.20, -41%
FY 2017-18: Prior M=68.4, SD=102.6; Since M=33.9, SD=53.6; t(430)=5.66, p<.001, Cohen's d=0.28, -50%
FY 2016-17: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t(341)=9.18, p<.001, Cohen's d=0.53, -75%

Older Adults:

FY 2020-21: Prior M=118.8, SD=132.9; Since M=70.1, SD=110.8; t(120) = 2.82, p<.05, Cohen's d=0.26, -41%
FY 2019-20: Prior M=118.2, SD=130.8; Since M=40.0, SD=73.6; t(109)=5.27, p<.001, Cohen's d=.52, -66%
FY 2018-19: Prior M=138.1, SD=139.4; Since M=25.2, SD=60.6; t(87)=6.89, p<.001, Cohen's d=0.79, -82%
FY 2017-18: Prior M=120.2, SD=136.9; Since M=12.8, SD=34.4; t(95)=7.27, p<.001, Cohen's d=0.84, -89%
FY 2016-17: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t(102)=3.96, p<.001, Cohen's d=0.43, -63

Independent Living Days:

TAY:

FY2020-21: Prior M=11.0, SD=52.9; Since M=38.3, SD=98.7; t(836)= -7.8, p<.001, Cohen's d=-0.29, 248%
FY 2019-20: Prior M=8.5, SD=43.3; Since M=25.23, SD=77.2; t(910)=-6.4, p<.001, Cohen's d=-0.22, 196%
FY 2018-19: Prior M=10.2, SD=49.0; Since M=33.1, SD=89.6; t(787)=-6.69, p<.001, Cohen's d=-0.25, 225%
FY 2017-18: Prior M=14.6, SD= 60.8; Since M=29.9, SD=81.2; t(743)=-4.57, p<.001, Cohen's d=-0.17, 105%
FY 2016-17: Prior M=17.9, SD= 65.01; Since M=43.4, SD=96.66; t(747)=-6.46, p<.001, Cohen's d=-0.24, 142%

Adults:

FY 2020-21: Prior M=37.6, SD=96.3; Since M=93.6, SD=131.2; t(1440) = -14.0, p<.001, Cohen's d=-.37, 149%
FY 2019-20: Prior M=34.5, SD=89.4; Since M=94.9, SD=136.7; t(1187)=-13.9, p<.001, Cohen's d=-.42, 175%
FY 2018-19: Prior M=38.3, SD=95.2; Since M=89.8, SD=133.4; t(1111)=-11.81, p<.001, Cohen's d=-0.36, 134%
FY 2017-18: Prior M=38.7, SD=95.8; Since M=75.7, SD=127.1; t(1144)=-9.01, p<.001, Cohen's d=-0.27, 96%
FY 2016-17: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t(1153)=-9.10, p<.001, Cohen's d=-0.24, 86

Older Adults:

FY 2020-21: Prior M=46.2, SD=107.6; Since M=95.8, SD=145.4; t(231) = -4.57, p<.001, Cohen's d=-0.30, 108%
FY 2019-20: Prior M=55.4, SD=113.9; Since M=145.3, SD=161.9; t(199)=-7.12, p<.001, Cohen's d=-.51, 162%
FY 2018-19: Prior M=58.6, SD=116.1; Since M=190.1, SD=156.2; t(181)=-9.95, p<.001, Cohen's d=-0.75, 224%
FY 2017-18: Prior M=70.0, SD=125.3; Since M=198.1, SD=152.3; t(190)=-9.82, p<.001, Cohen's d=-0.72, 183%
FY 2016-17: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t(219)=-7.41, p<.001, Cohen's d=-0.46, 124%

Out-of-Home Placement Days:

Children:

FY 2020-21: Prior M=114.4, SD=127.0; Since M=0.0; SD=0.0; t(11)=3.12, p=.010, Cohen's d=1.27, -100%
FY 2019-20: Prior M=45.5, SD=95.1; Since M=27.4; SD=50.9; t(9)=0.50, p=.63, Cohen's d=0.16, -40%
FY 2018-19: Prior M=92.8, SD=135.44; Since M=55.2, SD=93.1; t(16)=1.38, p=.19, Cohen's d=0.35, -41%
FY 2017-18: Prior M=51.8, SD=74.3; Since M=44.0, SD=66.2; t(13)=0.27, p=.79, Cohen's d=0.07, -15%
FY 2016-17: Prior M=72.9, SD=102.2; Since M=55.9, SD=104.1; t(19)=.643m, p=0.53, Cohen's d=0.49, -23%

Arrests:

Children:

FY 2020-21: Prior M= 2.4, SD=3.0; Since M=0.7, SD=1.2; t(29)=3.0, p<.006, Cohen's d=1.55, -71%
FY 2019-20: Prior M=2.0, SD=1.7; Since M=0.2, SD=.5; t(28)=6.5, p<.001, Cohen's d=1.60, -90%
FY 2018-19: Prior M=2.3, SD=.4; Since M=0.4, SD=.8; t(61)=3.69, p<.001, Cohen's d=0.60, -83%
FY 2017-18: Prior M=2.5, SD=2.6; Since M=0.1, SD=0.4; t(24)=4.48, p<.001, Cohen's d=1.04, -72%
FY 2016-17: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6)=1.86, p=.11, Cohen's d=0.99, -78%

TAY:

FY 2020-21: Prior M= 2.2, SD=2.0; Since M=.3, SD=.7; t(320)=16.7, p<.001, Cohen's d= 0.98, -100%
FY 2019-20: Prior M=2.5, SD=3.6; Since M=.3, SD=.8; t(308)=10.3, p<.001, Cohen's d=0.71, -88%
FY 2018-19: Prior M=2.1, SD=3.0; Since M=0.4, SD=.84; t(220)=7.9, p<.001, Cohen's d=0.62, -81%
FY 2017-18: Prior M=2.2, SD=3.1; Since M=0.1, SD=0.5; t(216)=9.81, p<.001, Cohen's d=0.80, -95%
FY 2016-17: Prior M=2.1, SD=3.0; Since M=0.4, SD=.83; t(270)=10.21, p<.001, Cohen's d=0.79, -81%

Adults:

FY 2020-21: Prior M=2.1, SD=2.9; Since M=.4, SD=0.9; t(671) = 15.12, p<.001, Cohen's d=.67, -83%
FY 2019-20: Prior M=2.1, SD=3.0; Since M=.4, SD=0.9; t(613)=13.72, p<.001, Cohen's d=.64, -81%
FY 2018-19: Prior M=2.0, SD=1.7; Since M=0.4, SD=0.8; t(554)=19.84, p<.001, Cohen's d=0.90, -82%
FY 2017-18: Prior M=1.9, SD=1.9; Since M=0.3, SD=0.8; t(586)=18.26, p<.001, Cohen's d=0.80, -84%
FY 2016-17: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t(598)=17.58, p<.001, Cohen's d=0.82, -86%

Older Adults:

FY 2020-21: Prior M=1.6, SD=1.5; Since M=0.05, SD=.23; t(56) = 7.83, p<.001, Cohen's d=1.25, -97%
FY 2019-20: Prior M=1.6, SD=1.5; Since M=0; SD=0.0; t(43)=7.0, p<.001, Cohen's d=1.49, -100%
FY 2018-19: Prior M=1.3, SD=0.6; Since M=0, SD=0.0; t(39)=14.58, p<.001, Cohen's d=3.26, -100%
2017-18: Prior M=1.4, SD=0.7; Since M=0, SD=0.0; t(32)=12.34, p<.001, Cohen's d=3.03, -100%
FY 2016-17: Prior M=1.4, SD=0.8; Since M=0, SD=0.0; t(31)=10.71, p<.001, Cohen's d=2.68, -100%

Incarceration Days:

Children:

FY2020-21: Prior M=57.7, SD=66.9; Since M=45.2; SD=64.6; t(24)= 0.75, p=.46, Cohen's d=0.15, -22%
FY 2019-20: Prior M=33.3, SD=47.8; Since M=37.7; SD=76.1; t(22)=-.25, p=.81, Cohen's d=-.05, 13%
FY 2018-19: Prior M=43.0, SD=69.4; Since M=22.1; SD=42.6; t(52)=1.93, p=.059, Cohen's d=0.27, -48%
FY 2017-18: Prior M=75.4, SD=97.4; Since M=29.8; SD=42.6; t(21)=2.07, p=.05, Cohen's d=0.48, -60%
FY 2016-17: Prior M=28.7, SD=39.1; Since M=34.2; SD=67.9; t(9)=.194, p=.851, Cohen's d=-0.06, 19%

TAY:

FY2020-21: Prior M=104.0, SD=98.4; Since M=31.1, SD=70.0, t(305)=11.1, p<.001, Cohen's d=0.66, -70%
FY 2019-20: Prior M=83.5, SD=96.6; Since M=24.4, SD=48.2, t(290)=9.3, p<.001, Cohen's d=0.57, -71%
FY 2018-19: Prior M=99.7, SD=102.4; Since M=44.9, SD=82.5, t(215)=5.9, p<.001, Cohen's d=0.4, -55%
FY 2017-18: Prior M=114.1, SD=107.4; Since M=22.5, SD=42.9, t(210)=12.19, p<.001, Cohen's d= 0.94, -80%
FY 2016-17: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1, t(217)=10.31, p<.001, Cohen's d=0.77, -79%

Adults:

FY 2020-21: Prior M=130.3, SD=112.3; Since M=18.7, SD=42.5; t(678) = 24.67, p<.001, Cohen's d=1.05, -86%
FY 2019-20: Prior M=117.9, SD=107.0; Since M=26.0, SD=49.9; t(620)=20.04, p<.001, Cohen's d=.86, -78%
FY 2018-19: Prior M=105.6, SD=102.2; Since M=24.5, SD=48.3; t(555)=18.03, p<.001, Cohen's d=0.83, -77%
FY 2017-18: Prior M=103.8, SD=97.6; Since M=17.3, SD=38.3; t(585)=20.38, p<.001, Cohen's d=0.93, -83%
FY 2016-17: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t(623)=19.24, p<.001, Cohen's d=0.79, -80%

Older Adults:

FY 2020-21: Prior M=109.4, SD=114.0; Since M=11.1, SD=34.4; t(46) = 5.33, p<.001, Cohen's d=0.84, -90%
FY 2019-20: Prior M=106.9, SD=111.1; Since M=12.6, SD=44.1; t(32) = 4.54, p<.001, Cohen's d=0.86, -88%
FY 2018-19: Prior M=71.4, SD=91.2; Since M=19.3, SD=48.9; t(37)=2.98, p<.05, Cohen's d=0.5, -73%
FY 2017-18: Prior M=46.6, SD=75.0; Since M=11.5, SD=39.5; t(29)=2.28, p<.05, Cohen's d=0.44, -75%
FY 2016-17: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t(29)=3.72, p<.01, Cohen's d=0.79, -88%

Employment Days:

TAY:

FY2020-21: Prior M=31.3, SD=78.2, Since M=61.2, SD=113.9; t(948)=-7.5, p<.001, Cohen's d=-0.25, 96%

FY 2019-20: Prior M=28.2, SD=75.3, Since M=68.2, SD=114.7; t(897)=-10.2, p<.001, Cohen's d=-0.35, 142%

FY 2018-19: Prior M=39.8, SD=87.3; Since M=62.9, SD=109.5; t(848)=-5.74, p<.001, Cohen's d=-0.20, 58%

FY 2017-18: Prior M=40.5, SD=89.5; Since M=70.8, SD=115.3; t(764)=-6.88, p<.001, Cohen's d=-0.25, 75%

FY 2016-17: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624)=3.30, p<.001, Cohen's d=-0.13, 36%

Adults:

FY 2020-21: Prior M=21.3, SD=66.2; Since M=37.3, SD=96.1; t(1440) = -5.60, p<.001, Cohen's d=-.15, 75%

FY 2019-20: Prior M=28.6, SD=76.4; Since M=45.5, SD=103.6; t(1181)=-4.92, p<.001, Cohen's d=-.15, 59%

FY 2018-19: Prior M=26.6, SD=74.4; Since M=49.4, SD=106.0; t(1111)=-6.50, p<.001, Cohen's d=-0.20, 85%

FY 2017-18: Prior M=25.8, SD=70.9; Since M=50.5, SD=108.2; t(1144)=-6.91, p<.001, Cohen's d=-0.21, 96%

FY 2016-17: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t(1150)=-4.58, p<.001, Cohen's d=-0.12, 53%

Program of Assertive Community Treatment (PACT) (CSS)

The **Program of Assertive Community Treatment** (PACT) is the County-operated version of a Full Service Partnership program. Like the FSPs, it utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes," field-based outpatient services to persons ages 14 and older who are living with serious emotional disturbance (SED) or serious mental illness (SMI). Individuals enrolled in the PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services. The main difference from an FSP is that the PACT specifically targets individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the past year. The PACT accepts referrals from County-operated and, in the case of children, County-contracted outpatient clinics. The PACT staffing is separated into teams that provide age and developmentally targeted services (Children/youth ages 14-21, TAY ages 18-25, adults ages 26-59, older adults ages 60 and older). Youth ages 18-21 are served by the Child/Youth team or the TAY team based on their level of caregiver involvement and developmental age.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
14+	Field	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe
Ages 14+					

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	3	Female	47	African American/Black	4
16-25	21	Male	53	American Indian/Alaskan Native	1
26-59	66	Transgender	-	Asian/Pacific Islander	16
60+	10	Genderqueer	-	Caucasian/White	46
		Questioning/Unsure	-	Latino/Hispanic	28
		Another	-	Middle Eastern/North African	1
				Another	5

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$10,599,650	1,430
FY 2021-22*	$10,699,650	1,430
FY 2022-23	$10,699,650	1,430

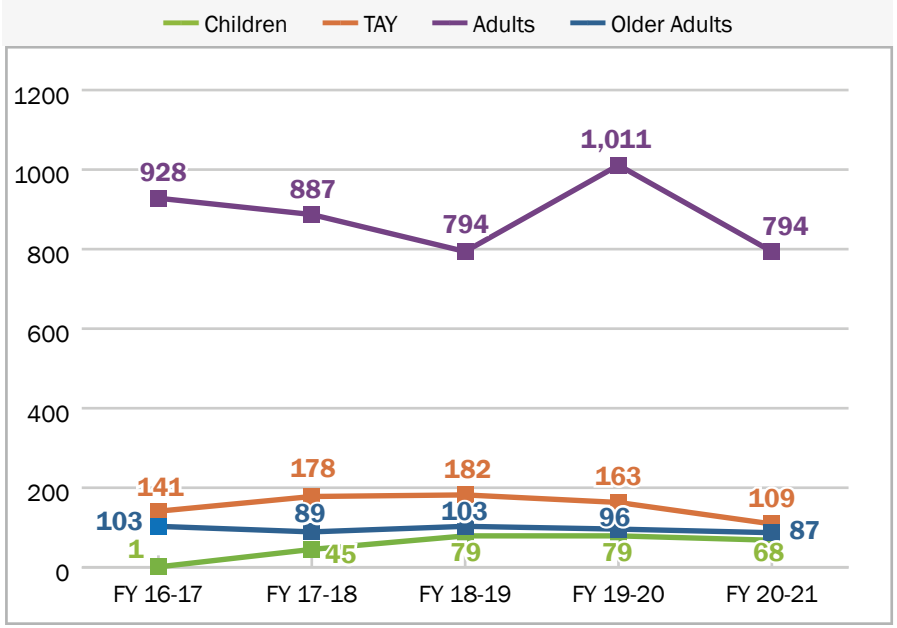
SERVICES

The PACT is staffed by multidisciplinary teams that provide an individualized treatment approach offering intensive, age-appropriate services out in the community. The teams include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance use services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused Cognitive Behavioral Therapy. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family members, which can include family therapy, is provided.

The PACT also provides intensive case management. Team members offer peer and/or caregiver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community resources such as NAMI, Family Resource Centers and the Wellness Centers to help facilitate their recovery and maintain their gains after being discharged from the program.

As needed, the PACT uses flexible funding to support the needs of participants and/or their families and is intended to cover the costs of services and supports not otherwise reimbursable, as well as items such as incentives, stipends, tickets/admission fees, food, refreshments, and ancillary supports such as child care or family involvement, etc. so that the participant may fully engage in the recovery-focused activity.

PACT Members Served by Age and FY

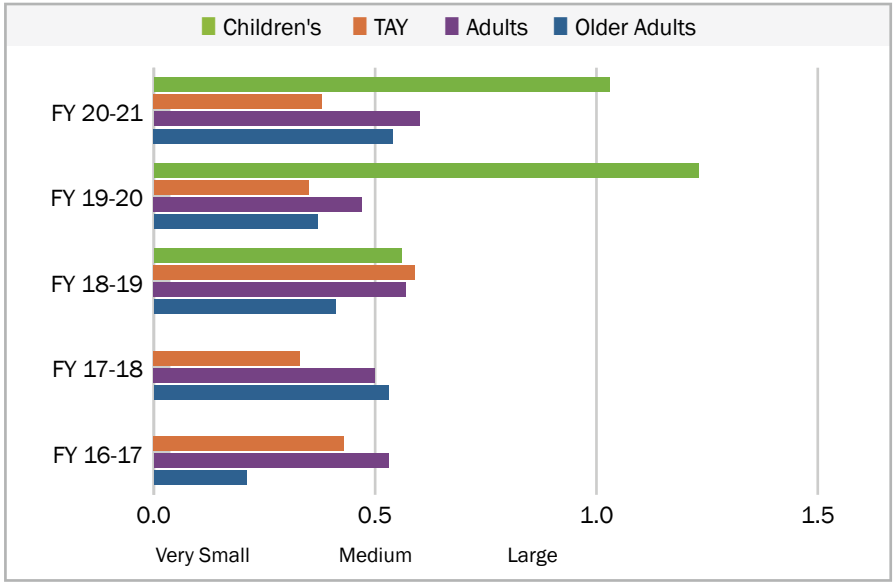


OUTCOMES

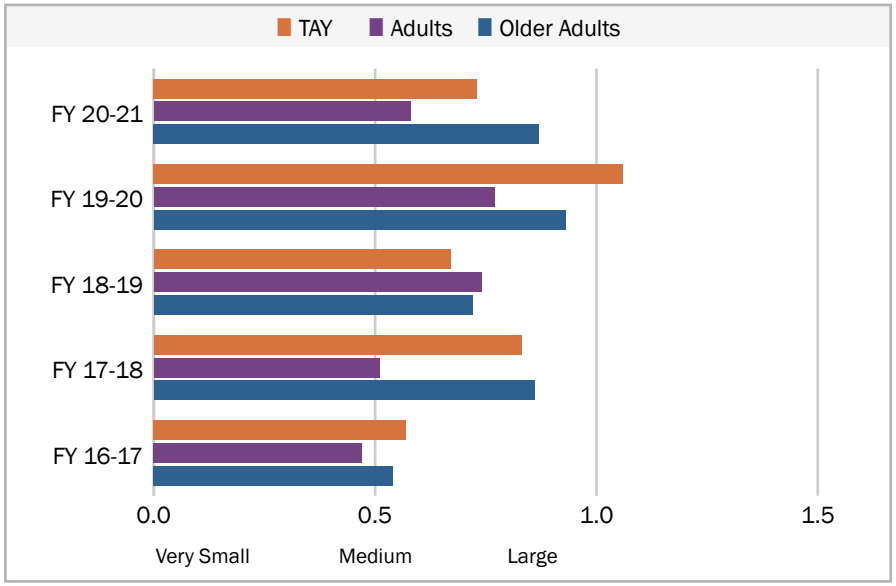
Using the same approach as the FSPs, the PACT evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. For children/youth under age 18, the PACT also evaluated grades and school attendance. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the PACT. For all functional measures other than employment or education, only individuals who reported that they experienced the functional outcome (i.e., hospitalization, homelessness, incarceration) either before or after enrollment were included in the outcomes analysis. All TAY and adults were included in the employment analysis and all children/youth were included in the school attendance/grades evaluation.

Psychiatric hospitalizations: Adults experienced a moderate reduction in psychiatric hospitalization days during each of the fiscal years reported here, as did children/youth in FY 2018-19, the first full year in which the team serving this younger age group was fully operational. In FY 2019-20 and 2020-21, children/youth demonstrated large reductions in psychiatric hospitalization days. In contrast, TAY and older adults demonstrated variable effectiveness, ranging from small to moderate, in reducing days spent in the hospital while served in the PACT. Older adults continue to face challenges with discharge placement options that can accommodate complex medical or physical needs of consumers, which has led to longer hospitalization stays during some years. TAY, on the other hand, experienced a moderate decrease in days hospitalized in FY 2018-19, an improvement from the two prior years, but in FY 2019-20 and 2020-21, there was less improvement. The HCA will continue to monitor the rates in future years to see if this improved reduction continues for TAY.

PACT Improvement on Psychiatric Hospital Days



PACT Improvement on Unsheltered Homeless Days

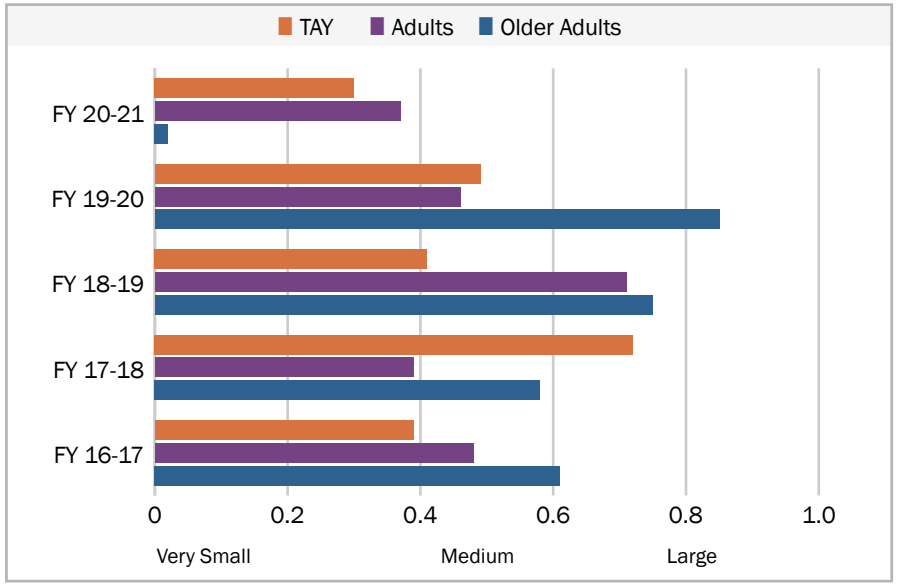


Homelessness: Because individuals who are homeless and living with SED/SMI are largely referred to FSP services, the number of individuals in the PACT who experience unsheltered homelessness tends to be lower than those who are in an FSP. In FY 2020-21, there were two youth that experienced unsheltered homeless days, for a total of 140 days. One of these youth had four homeless days prior to enrollment in PACT. Prior to FY 2020-21, there were no youth enrolled in PACT that experienced unsheltered homeless days.

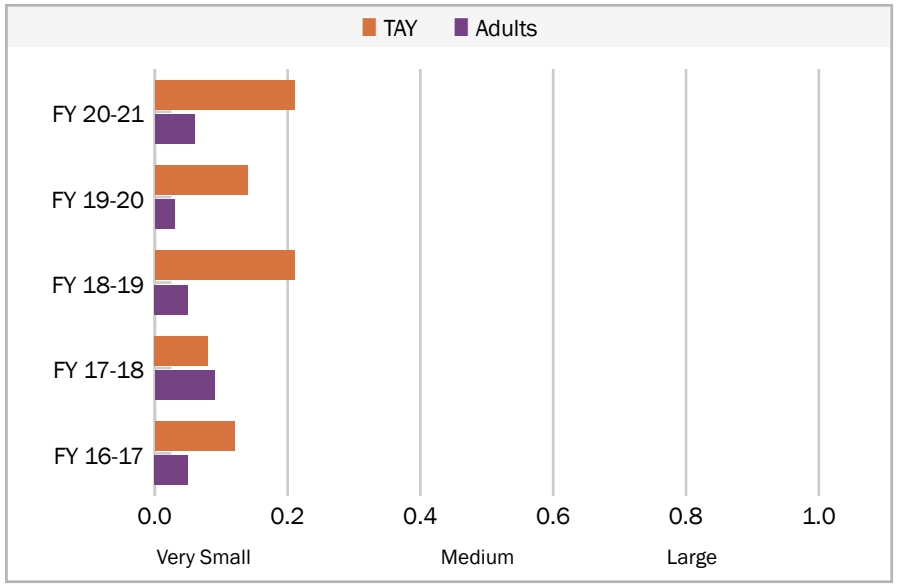
TAY, adults and older adults experienced moderate to large decreases in days spent homeless over each of the past five fiscal years (i.e., average days spent homeless while enrolled in the PACT generally ranged from 1.5-2.5 weeks for TAY except FY 2019-20 which averaged 30 days; 7-9 weeks for adults, 7-10 weeks for older adults). The number of TAY and older adults affected by homelessness tends to be much lower than the number of adults affected, thus the differences across the age groups may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in overall program efficacy. The HCA will continue to monitor trends in homelessness for the PACT participants over time.

Incarcerations: During, FY 2020-21, TAY and adults showed decreases in incarcerations days than in previous years. There was a substantial reduction in the impact on incarceration days for older adults in FY 2020-21. This is due to one client having 364 incarceration days while enrolled in PACT. In prior fiscal years, TAY, adults and older adults generally experienced moderate to large decreases in days spent incarcerated (i.e., average days incarcerated while enrolled in the PACT was typically 1-2.5 weeks across all age groups). Similar to findings on days spent homeless, the number of TAY and older adults who were incarcerated tended to be much lower than the number of adults. Thus, the differences across age groups and fiscal years may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in program efficacy. The HCA will continue to monitor trends in incarceration for the PACT participants. Very few children/youth reported incarcerations prior to or during enrollment in

PACT Improvement on Incarceration Days



PACT Improvement on Employment Days



the PACT. There were no incarceration days in FY 2020-21. During FY 2019-20, two clients were incarcerated prior to enrollment for a total of 168 days (one for 28 days, one for 140 days). There were no incarceration days during enrollment in the PACT. In FY 2018-19, the first year in which the child/youth team was fully implemented, two of the 79 children/youth experienced incarceration (one for 121 days prior to enrollment and no days in FY 2018-19; the other reported for 30 days prior to enrollment and 19 days after).

Employment: Across all fiscal years, the PACT showed minimal to no impact on improving employment, with an exception in 2020-21 and 2018-19 where small increases were noted for TAY. As with the FSP programs, the PACT continues to struggle with making progress on this functional domain.

Education: In FY 2020-21, 55% of youth had good, very good, or improved school attendance. Across the prior four fiscal years, the majority (74-82%) of children/youth demonstrated good, very good or improved school attendance while enrolled in the program compared to prior to enrollment. In FY 2020-21, 83% of youth had good, very good, or improved grades while enrolled in PACT, which is similar to the FY 2016-17 rate of 89%, but a decline from the three most recent fiscal years (41-53%). These findings are consistent with educational outcomes among FSP participants.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

CYBH has experienced significant turnover in the past year, leading to longer waitlists. With a small number of staff in the program, enrolling new clients can take longer. Another ongoing challenge has been the reluctance of the children/youth to use existing work/vocational programs. Instead, they prefer to seek employment on their own with coaching from program staff. In the two years since the program began, many clients have obtained employment, suggesting that this challenge may decrease as clients stabilize and take advantage of the vocational support provided by the program. In the future, the HCA would like to offer services to children/youth and their families in additional threshold languages but will need staff that speak the languages to meet this need. During the COVID-19 pandemic, the Children/Youth team had difficulty engaging youth who were already rather isolated. The team brainstormed several creative virtual group ideas to engage youth, delivered supplies to their homes, and sent out information on the upcoming groups. This resulted in some of the largest and most engaging groups the team has facilitated to date and youth shared positive feedback about their experience with the groups. As soon the team was able to, they resumed in-person services but for those clients still uncomfortable with in person services, continued to be made telehealth made available. If client did not have the technology necessary to engage in telehealth services, iPads were provided to them.

The TAY, Adult and Older Adult teams have experienced some new challenges during the COVID-19 pandemic. While the teams never stopped providing services to the clients, the methods of delivery were constantly changing to maintain safety for the clients and the staff providing the services. The programs have been able to increase their use of telehealth services through WebEx to continue face-to-face services for clients who have adequate technology. For clients who do not have access to technology, the programs have received telepresence machines where the participant is able to come into the program and be in one room while their clinician is in another room. Some older adults are not comfortable using telehealth services as they feel it is not a trustworthy way

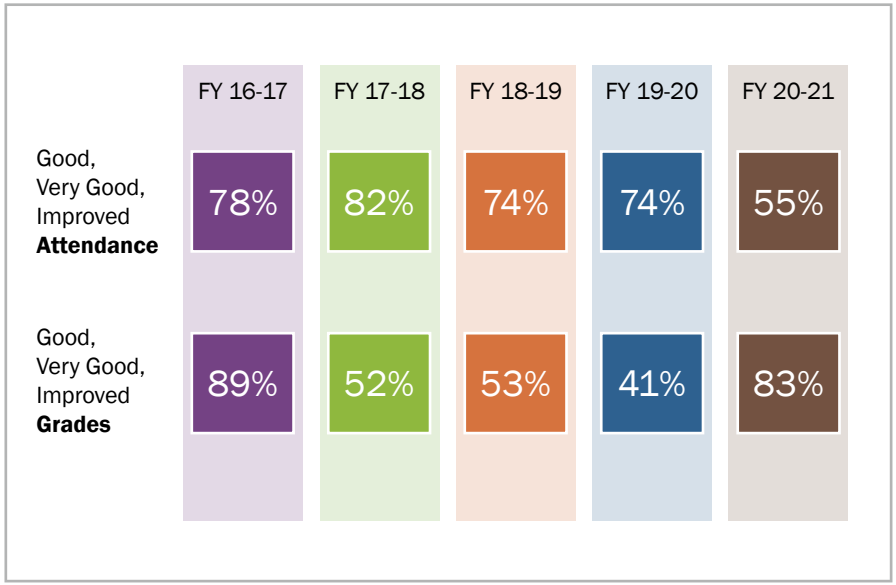
of talking to their clinician. They are able to access services over the phone or in person.

Finding safe and affordable housing continues to be a challenge for the Older Adult PACT due to clients having limited supplemental Social Security Income and housing resources. This issue has increased especially during the COVID-19 pandemic as most shelters, Assisted Living Facilities, and Board and Care facilities are closed or are not accepting new clients. Most Older Adult PACT clients are scared and fearful of going to shelters as they are more vulnerable and are at higher risk in regard to COVID-19. There has been an increase in Older Adult PACT referrals for individuals who are homeless, at risk of evictions, and struggling to find placement which often exacerbates their mental health condition resulting in frequent hospitalizations. The PACT clinicians are addressing these challenges by increasing their visits with clients to provide additional support and continue to utilize life coaches and peer mentors to expand the list of available housing resources.

The challenges of medication adherence and follow through with medical and other appointments have improved by utilizing peer mentors and life coaches to assist with appointments. The Older Adult PACT clinicians are also using County resources such as iPhones to assist clients in connecting with their primary care doctors and psychiatrists during the COVID-19 pandemic to address their physical and mental health needs.

New challenges that Older Adult PACT participants face during the COVID-19 pandemic are social isolation, food insecurity, and a lack of sanitizing supplies that can have a tremendous impact on their mental and physical health. The Older Adult team has addressed these issues by increasing the frequency of case management visits and bringing clients food and supplies from the food bank.

School Performance - Children/Youth PACT



COMMUNITY IMPACT

The PACT teams in Orange County target high-risk underserved populations, which include monolingual Asian/Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with serious mental illness. The program has shown a modest reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these

REFERENCE NOTES

Psychiatric Hospitalization Days:

Children:

FY 2020-21: Prior M=21.5, SD= 17.8; Since M= 5.7, SD 10.9; t(60)=7.5, p<.001, Cohen's d= 1.03, -74%
FY 2019-20: Prior M=20.1, SD= 16.0; Since M=5.8, SD 9.9; t(51)=8.0, p<.001, Cohen's d= 1.23, -71%
FY 2018-19: Prior M=29.0, SD=27.4; Since M=16.5, SD=10.8; t(7)=1.4, p<0.21; Cohen's d=0.56, -44%
FY 2017-18: None reported
FY 2016-17: None reported

TAY:

FY 2020-21: Prior M=33.4, SD=53.7; Since M=8.8, SD=38.4; t(101) = 3.8, p<0.001, Cohen's d=.38, -74%
FY 2019-20: Prior M=38.1, SD=61.1; Since M=11.2, SD=49.6; t(126)=3.92, p<0.001; Cohen's d=.35, -71%
FY 2018-19: Prior M=42.2, SD=68.2; Since M=7.6, SD=30.6; t(113)=5.6, p<0.001; Cohen's d=0.59, -84%
FY 2017-18: Prior M=46.4, SD=62.8; Since M=16.8, SD=61.1; t(82)=2.97, p<.01; Cohen's d=0.33, -64%
FY 2016-17: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t(92)=4.12, p<0.001; Cohen's d=0.43, -73

Adults:

FY 2020-21: Prior M=50.2, SD=81.4; Since M=11.6, SD=37.5; t(681) = 11.43, p<0.001, Cohen's d=0.60, -77%
FY 2019-20: Prior M=53.3, SD=84.0; Since M=12.9, SD=42.1; t (671) = 11.39, p<0.001, Cohen's d=.47, -76%
FY 2018-19: Prior M=47.4, SD=78.3; Since M=7.4, SD=24.7; t(590)=12.12, p<0.001; Cohen's d=0.57, -84%
FY 2017-18: Prior M=48.7, SD=77.8; Since M=10.0, SD=35.7; t(659)=11.86, p<.001; Cohen's d=0.50, -79%
FY 2016-17: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t(687)=12.59, p<0.001; Cohen's d=0.53, -81

Older Adults:

FY 2020-21: Prior M=54.3, SD=82.5; Since M=10.3, SD=48.5; t(58) = 3.91, p <.05=01, Cohen's d=0.54, -81%
FY 2019-20: Prior M=45.0, SD=69.1; Since M=14.6, SD=61.7; t(55)=2.78, p<0.05; Cohen's d=.37, -67%
FY 2018-19: Prior M=40.7, SD=75.5; Since M=8.6, SD=32.9; t(63)=3.07, p=0.003; Cohen's d=0.41, -79%
FY 2017-18: Prior M=38.4, SD=74.8; Since M=4.3, SD=17.3; t(69)=3.73, p<.001; Cohen's d=0.53, -89%
FY 2016-17: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t(52)=1.64, p=0.11; Cohen's d=0.21, -44%

Homeless Days:

Children:

FY 2020-21: Sample size too small for statistical analyses

FY 2019-20: None reported

FY 2019-20: One reported

FY 2018-19: None reported

TAY:

FY 2020-21: Prior M=133.4, SD=120.0; Since M=23.2, SD=63.8; t(13) = 2.68, p<0.019, Cohen's d=0.73, -83%

FY 2019-20: Prior M=155.4, SD=119.2; Since M=31.0, SD=68.5; t(21)=4.73, p<0.001, Cohen's d=1.06, -80%

FY 2018-19: Prior M=71.8, SD=89.8; Since M=11.2, SD=29.8; t(16)=2.53, p=0.022; Cohen's d=0.67, -84%

FY 2017-18: Prior M=73.2, SD=59.2; Since M=19.9, SD=42.7; t(16)=3.36, p<.01; Cohen's d=0.83, -73%

FY 2016-17: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t(17)=3.37, p<0.01; Cohen's d=0.57, -74

Adults:

FY 2020-21: Prior M=159.3, SD=138.1; Since M=59.0, SD=107.7; t(245) = 8.96, p<0.001, Cohen's d=0.58, -63%

FY 2019-20: Prior M=163.6, SD=137.5; Since M=48.6, SD=90.3; t(261)=12.07, p<0.001; Cohen's d=.77, -70%

FY 2018-19: Prior M=165.4, SD=131.0; Since M=52.4, SD=93.1; t(207)=10.47, p<0.001; Cohen's d=0.74, -68%

FY 2017-18: Prior M=152.6, SD=136.1; Since M=65.8, SD=104.7; t(227)=7.62, p<.001; Cohen's d=0.51, -57%

FY 2016-17: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t(242)=7.97, p<0.001; Cohen's d=0.47, -54%

Older Adults:

FY 202-21: Prior M=180.7, SD=133.8; Since M=45.0, SD=110.0; t(20) = 4.0, p<.001, Cohen's d=0.87, -75%

FY 2019-20: Prior M=174.05, SD=144.53; Since M=55.1, SD=113.87; t(20)=4.16, p<0.001, Cohen's d=.93, -68%

FY 2018-19: Prior M=174.6, SD=152.5; Since M=69.0, SD=115.1; t(30)=3.50, p<=0.002; Cohen's d=0.72, -60%

FY 2017-18: Prior M=187.0, SD=141.5; Since M=49.6, SD=102.3; t(33)=4.96, p<.001; Cohen's d=0.86, -74%

FY 2016-17: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t(30)=2.81, p=<0.01; Cohen's d=0.54, -57%

Incarceration Days:

Children:

FY 2020-21: Sample size too small for statistical analyses

FY 2019-20: None reported

FY 2019-20: See narrative for number of days for two youth who reported having been incarcerated

FY 2018-19: See narrative for number of days for two youth who reported having been incarcerated

TAY:

FY 202-21: Prior M=75.1, SD=121.2; Since M=30.5, SD=78.9; t(16) = 1.20 p <.249, Cohen's d=.30, -59%

FY 2019-20: Prior M=64.4, SD=105.9; Since M=13.4, SD=35.3; t(25)=2.28, p <.05; Cohen's d=.49, -79%

FY 2018-19: Prior M=50.9, SD=94.6; Since M=14.1, SD=32.6; t(13)=1.38, p=0.19; Cohen's d=.41, -72%

FY 2017-18: Prior M=35.5, SD=36.0; Since M=7.3, SD=15.2; t(19)=3.02, p=.07; Cohen's d=0.72, -79%

FY 2016-17: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t(29)=2.48, p<0.05; Cohen's d=0.39, -58%

Adults:

FY 202-21: Prior M=70.7, SD=93.5; Since M=24.6, SD=71.0; t(165) = 4.77, p<0.001, Cohen's d=0.37, -65%

FY 2019-20: Prior M=57.33, SD=82.6; Since M=15.4, SD=42.6; t(201)=6.27, p<0.001, Cohen's d=.46, -73%

FY 2018-19: Prior M=61.7, SD=83.4; Since M=7.1, SD=21.9; t(176)=8.29, p<0.001; Cohen's d=0.71, -89%

FY 2017-18: Prior M=55.6, SD=83.9; Since M=18.1, SD=50.3; t(200)=5.38, p<.001; Cohen's d=0.39, -67%

FY 2016-17: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t(216)=6.38, p<0.001; Cohen's d=0.48, -70

Older Adults:

FY 2020-21: Prior M=41.3, SD=53.6; Since M=39.0, SD=108.9; t(10) = 0.56, p<.957, Cohen's d=0.02, -5%

FY 2019-20: Prior M=86.96, SD=91.88; Since M=7.27, SD=24.03; t(14)=3.04, p<0.05, Cohen's d=.85, -92%

FY 2018-19: Prior M=78.3, SD=99.3; Since M=12.6, SD=25.5; t(13)=2.40, p=0.032; Cohen's d=0.75, -84%

FY 2017-18: Prior M=59.3, SD=85.1; Since M=9.2, SD=22.7; t(12)=1.93, p=.08; Cohen's d=0.58, -84%

FY 2016-17: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t(10)=3.24, p<0.01; Cohen's d=0.61, -69%

Employment Days:

Children:

Not assessed for children

TAY:

FY 202-21: Prior M=17.7, SD=48.5; Since M=35.0, SD=76.7; t(108) = -2.2, p=.034, Cohen's d=-.21, 98%
FY 2019-20: Prior M=27.2, SD=71.0; Since M=40.4, SD=86.0; t(136)=-1.63, p=.105, Cohen's d=-.14, 49%
FY 2018-19: Prior M=26.8, SD=69.3; Since M=46.8, SD=98.4; t(96)=-2.04, p=0.044; Cohen's d=-0.21, 75%
FY 2017-18: Prior M=26.2, SD=72.9; Since M=33.7, SD=82.7; t(90)=-0.73, p=.47; Cohen's d=-0.08, 29%
FY 2016-17: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t(92)=-0.68, p=0.50; Cohen's d=-0.12, 22%

Adults:

FY 202-21: Prior M=18.6, SD=62.8; Since M=24.0, SD=76.8; t(793) =-1.76, p=0.080, Cohen's d=-0.06, 29%
FY 2019-20: Prior M=24.1, SD=71.0; Since M=27.0, SD=75.1; t(722)=-.94, p=0.349, Cohen's d=-.03, 12%
FY 2018-19: Prior M=29.7, SD=77.9; Since M=34.33, SD=83.1; t(640)=-1.20, p=0.231; Cohen's d=-.05, 15%
FY 2017-18: Prior M=30.2, SD=81.0; Since M=40.0, SD=93.6; t(718)=-2.41, p<.05; Cohen's d=-0.09, 33%
FY 2016-17: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t(753)=-1.55, p=0.12; Cohen's d=-0.05, 21%

Summary of MHSA Strategies Used by FSP/PACT

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

Central to all of Orange County's intensive outpatient treatment programs is the emphasis placed on helping individuals move forward in their recovery. The PACT and FSP provider staff work with participants using a strengths-based model to customize their individualized, client- and family-centered treatment plans, aligned with participant's wants and needs, and matched to their level of functioning. Many of the adult providers utilize tools from the Recovery Centered Clinical System, which focuses on exploring identity, defining hopes and dreams, making choices, reducing harm and making connections. All participants are encouraged to broaden their resources and support systems by increasing their social contacts, improving family relationships when appropriate, and having meaningful roles in the community. Team members strive to instill hope in the participants with whom they work, identify their and their families' strengths, maintain a non-judgmental stance, and have empathy for their and their families' struggles. Integral to these efforts are Peer Specialists, Peer Coaches and Parent Partners who share their lived experience, serve as positive models, encourage empowerment, facilitate community integration, and build, enhance and maintain resilience.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

FSP and the PACT program staff also recognize that providing quality services begins with taking into consideration the culture, values, preferences and needs of the individuals and families they serve and, as such, strive to hire bilingual and bicultural staff. All staff participate in ongoing trainings related to ethnicity, religious observations, gender identity and sexual orientation. These trainings provide staff with an overview of how to incorporate culturally responsive approaches in their interactions with participants, and enable staff to better connect with unserved, underserved and culturally and linguistically isolated individuals through conversations that fit with the individuals' and their families' values and worldview. For example, some of the perspectives that the provider serving the Asian and Pacific Islander (API) population considers when providing services to participants include the medical and spiritual aspects of mental health, somatic symptoms and the chance to improve education or employment outcomes through mental health services. They also hire staff who are sensitive to the fact that the children and youth they serve may have values and perspectives that are different from those of their parents/guardians and staff actively work to bridge any cultural divide. Thus, through training and/or experience, staff understands the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities and draws upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination. In addition to providing valuable direct services and supports to participants, Peer Specialists also serve as inspirational role models, which can be powerful in reducing mental health-related stigma among the people and families served.

STRATEGIES TO IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

Individuals and families referred to the PACT and FSP programs often face issues that may keep them from seeking services. These can include language/cultural barriers; recent immigration to the United States; anxiety about their legal status and the possibility of being deported; homelessness, high risk of homelessness, or housing instability; lack of financial or other resources; lack of food or childcare, transportation challenges; criminal justice involvement and mistrust of "the system;" difficulty navigating the very large mental health system; lack of open program space; stigma related to having a mental health condition; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals.

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

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

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

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

To overcome these wide-ranging challenges, the PACT teams operate under the "whatever it takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or wherever participants are comfortable meeting to overcome barriers to access or engagement. The teams also carry smaller caseloads so individuals and their families can be seen more frequently and have their needs met in a timely manner. Moreover, many of the PACT therapists are bilingual and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

The teams serving adults and older adults also offer a streamlined referral and linkage process to (1) allow direct referrals into the PACT, and/or to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these operational changes, individuals are linked to services more quickly and feel supported through the process. In addition, some clinicians are specifically assigned to engage individuals who are referred from hospitals, and homeless shelters and the MHSA housing programs.

The Child/Youth team, implemented in June 2017, has worked to increase timely access to its services by presenting to providers about the PACT services and eligibility criteria. Once referred, Child/Youth therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in detail and establish rapport with the youth and parent. Like the other teams, the Child/Youth team also works with hospital staff, child welfare, Probation Officers and others involved with the youth and family to engage them in their program services.

The PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from the PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. Although this transition can be difficult and may take several visits, program staff appreciate the value of this process in allowing individuals to continue moving forward on their recovery journeys.

FY 2020-21 TO FY 2022-23 PROGRAM BUDGETS: COMBINED AND BY FSP AGE GROUP					
Budget by FY	**Combined***	**Children**	**TAY**	**Adult**	**Older Adult**
Actual FY 2019-20 Budgets	$53,530,226	$11,054,575	$8,184,468	$21,592,093	$2,683,249
Proposed FY 2020-21 Budgets	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899
Proposed FY 2021-22 Budgets	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899
Proposed FY 2022-23 Budgets	$53,766,876	$11,054,575	$8,184,468	$21,592,093	$3,219,899

**Combined budget amount includes administrative fees, which are not included in budgets for each age group*

FY 2020-21 TO FY 2022-23 PROJECTED UNDUPLICATED TO BE SERVED: COMBINED AND BY FSP AGE GROUP					
	Combined*	**Children**	**TAY**	**Adult****	**Older Adult**
FY 2019-20	3,676	410	1,020	2,052	194
FY 2020-21	3,521	430	1,070	1,825	196
FY 2021-22	3,591	430	1,120	1,835	196
FY 2022-23	3,661	450	1,070	1,845	196

*** Includes numbers to be served by AOT Assessment and Linkage Team, which also serves TAY and older adults*

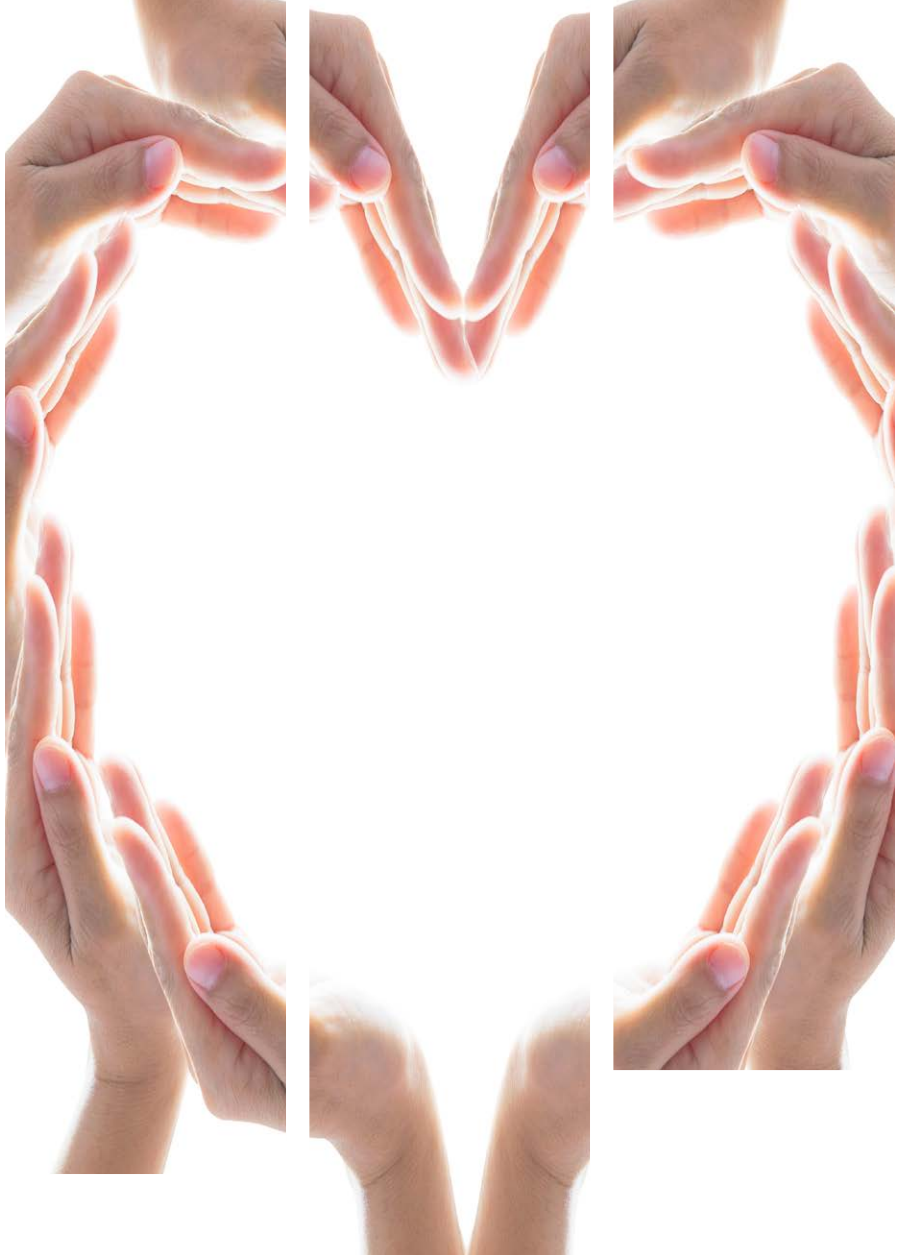
PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC: COMBINED AND BY FSP AGE GROUP							
Age Group	**% Combined**	**Gender**	**% Combined**	**% Children**	**% TAY**	**% Adult**	**% Older Adult**
0-15	13	Female	41	42	43	38	47
16-25	35	Male	58	56	53	62	53
26-59	43	Transgender	1	2	4	-	-
60+	9	Genderqueer	-	-	-	-	-
		Questioning/Unsure	-	-	-	-	-
		Other	-	-	-	-	-

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC: COMBINED AND BY FSP AGE GROUP					
Race/Ethnicity	**% Combined**	**% Children**	**% TAY**	**% Adult**	**% Older Adult**
African American/Black	7	5	5	9	9
American Indian/Alaskan Native	1	1	1	1	1
Asian/Pacific Islander	11	19	11	9	6
Caucasian/White	38	13	22	52	64
Latino/Hispanic	38	59	56	23	13
Middle Eastern/North African	1	1	1	1	1
Other	4	2	4	5	6

SUPPORTIVE SERVICES

Supportive Services provides a broad array of supports generally designed to augment and expand an individual's gains made in treatment programs, particularly those within Outpatient Treatment, Crisis Prevention and Support Services, and Residential Treatment. These programs, which are funded by CSS and PEI serve individuals of all ages and are further subdivided into the following categories:

- Peer Support
- Family Support
- General Support
- Housing Support



Peer Mentor and Parent Partner Support (CSS)

Peer Support programs are staffed with individuals who have lived experience with mental health and/or substance use recovery, and their family members (i.e., parent partners of child/youth participants). While Orange County includes peers and parent partners as part of the service delivery teams of many of its behavioral health programs (i.e., FSPs, PACT, Veteran-Focused Early Intervention Outpatient, Suicide Prevention Services, etc.) the programs described here are different in that the full scope of services they offer are provided exclusively by peers and their family members. By sharing their lived experience, peers and parent partners are able to help support and encourage participants in their own recovery journeys.

The **Peer Mentor and Parent Partner Support** program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services of a Peer Specialist. Peer Specialists may include peer or youth mentors and/or parent partners who work with participant's family members who would benefit from the supportive services of a parent mentor. Individuals referred to this program can receive support with linkage to services and/or with achieving one or more recovery goals.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
All Ages	Field	Clinic	~~At-Risk~~	Mild-Moderate	Severe

PROGRAM SPECIALIZATIONS

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$4,249,888	2,638
FY 2021-22	$4,249,888	2,771
FY 2022-23	$5,124,888	2,884

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	21	Female	42	African American/Black	5
16-25	32	Male	57	American Indian/Alaskan Native	1
26-59	39	Transgender	1	Asian/Pacific Islander	8
60+	8	Genderqueer	-	Caucasian/White	28
		Questioning/Unsure	-	Latino/Hispanic	51
		Another	-	Middle Eastern/North African	2
				Another	5

SERVICES

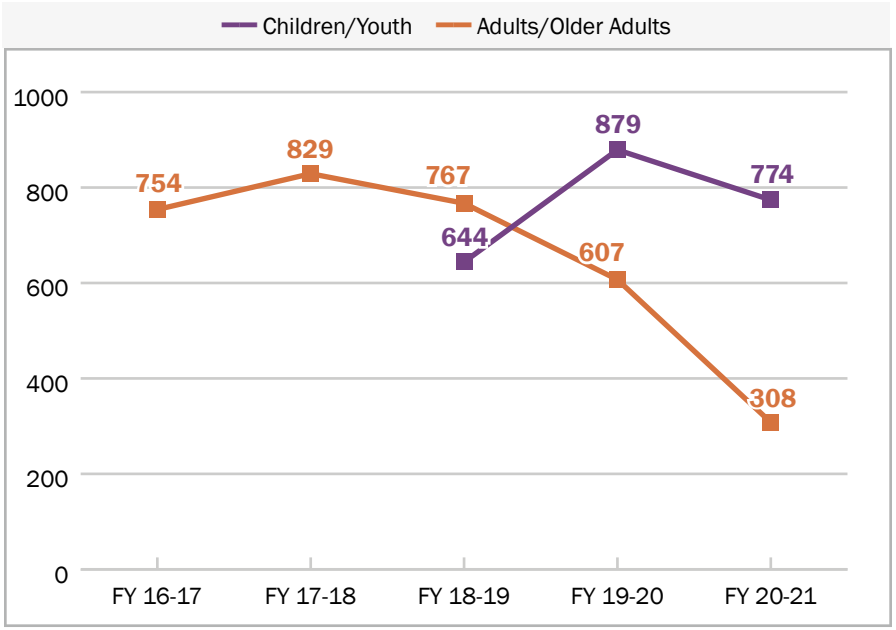
Through this program, Peer Specialists work with participants to help them achieve identified goals. By sharing their lived experience, Peer Specialists are often able to provide the encouragement and support a person needs to engage in ongoing services and achieve their personal goals. The support provided is customized depending on the individuals' needs and personal recovery goals, and can include the following:

- **Support in linking to services that may involve activities such as:**
  - Accessing behavioral health or medical appointments
  - Accessing community-based services such as food pantries or emergency overnight shelters as needed
  - Re-integrating into the community following discharge from inpatient care, hospitalization, emergency department visits and/or incarceration/in-custody stays

- **Support in building skills that may involve activities such as:**
  - Learning independent living skills, such as how to use and navigate the public transportation system
  - Increasing socialization activities such as attending groups or activities at the Wellness Centers and/or facilitating or assisting with groups
  - Managing and preventing behavioral health crises
  - Obtaining identification cards or driver's licenses
  - Learning skills to find, obtain and/or sustain housing placements, which may include landlord negotiations, housekeeping, food shopping and preparation, financial management, medication management, transportation, medical care, arranging utilities, phone, insurance and access to community supports and services[1]

Referrals for support with linkage to services are provided by: 1) Therapists working with individuals who need additional support when transitioning between behavioral health services and/or levels of care; 2) Staff in a Crisis Stabilization Unit (CSU), Royale Therapeutic Residential Center or crisis services program connecting individuals into ongoing outpatient care; and/or 3) Therapists or Personal Service Coordinators working with an individual as they re-integrate into their community following a recent hospitalization, incarceration/juvenile detention, or shelter stay (i.e., Orangewood, etc.). Referrals for support with achieving one or more recovery goals are provided by: 1) BHS therapists working with an individual, and perhaps their families, on their treatment goals within an outpatient clinic and/or community setting; and/or 2) BHS Outreach & Engagement (O&E) team and 3) Housing Navigators working with individuals in need of housing sustainability assistance after being placed as part of Orange County's Whole Person Care plan.

Persons Served - Peer Mentor & Parent Partner Support



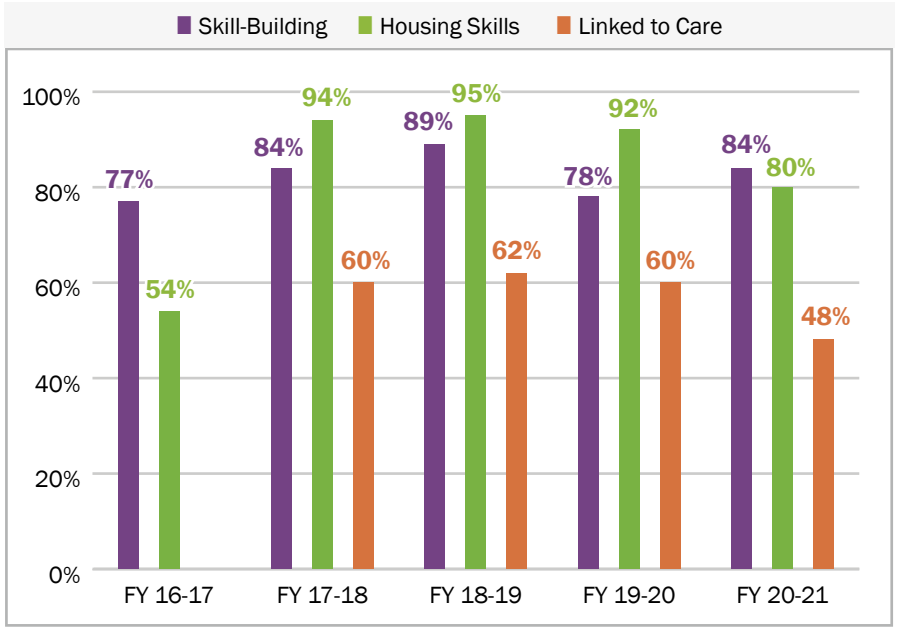
[1] This area is the focus of the provider supporting Orange County's Whole Person Care plan.

OUTCOMES

Across the three fiscal years reported here, adults and older adults engaged in outpatient care were largely successful in achieving their skill-building goals with the support of their peer. The most common types of goals included learning to navigate the public transportation system, obtaining identification cards or driver's licenses, completing housing applications, and increasing socialization activities.

Since the first full year of implementation, between 80%-95% of individuals supported by the Whole Person Care provider achieved their housing-related goals. In FY 2020-21, 84% of individuals met their skill-building goals, which is consistent with previous years. A little over half of adults and older adults were successfully linked to behavioral health and/or medical appointments with the support of their peer.

% Participants Achieving Target Goals - Peer Mentor & Parent Partner Support



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The utilization of peer mentors within clinical programs is a relatively new strategy in Orange County and, as with any new program concept, it can take time to promote its services. Educating the various referral sources about Peer Mentoring services is a high priority, and staff provides frequent presentations throughout the county about the services they offer. In addition, homelessness continues to be an issue with regard to the peers' ability to maintain contact with the participants and increased efforts have been made during the initial contact to obtain as much identifying information from the participant as possible on how to best reach them. Initial results from these front-end efforts have been promising.

COMMUNITY IMPACT

Peer Mentoring has provided services to approximately 3,000 adults and older adults since services began in November 2015, and 644 children and youth since services were first added for this age group in FY 2018-19. The program recognizes that building County and community partnerships is a priority. In addition to the strong ongoing partnerships with referral sources such as the County and County-contracted clinics and the County Crisis Stabilization Unit, the program also partners with the Wellness Centers, the Council on Aging, NAMI and housing agencies.

Wellness Centers (CSS)

Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on their recovery, which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0+					
All Ages	Field	Community	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	✓ Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC					
Age	**%**	**Gender**	**%**	**Race/EtŠicity**	**%**
0-15	-	Female	46	African American/Black	5
16-25	10	Male	52	American Indian/Alaskan Native	1
26-59	81	Transgender	-	Asian/Pacific Islander	14
60+	9	Genderqueer	-	Caucasian/White	43
		Questioning/Unsure	-	Latino/Hispanic	22
		Another	2	Middle Eastern/North African	1
				Another	14

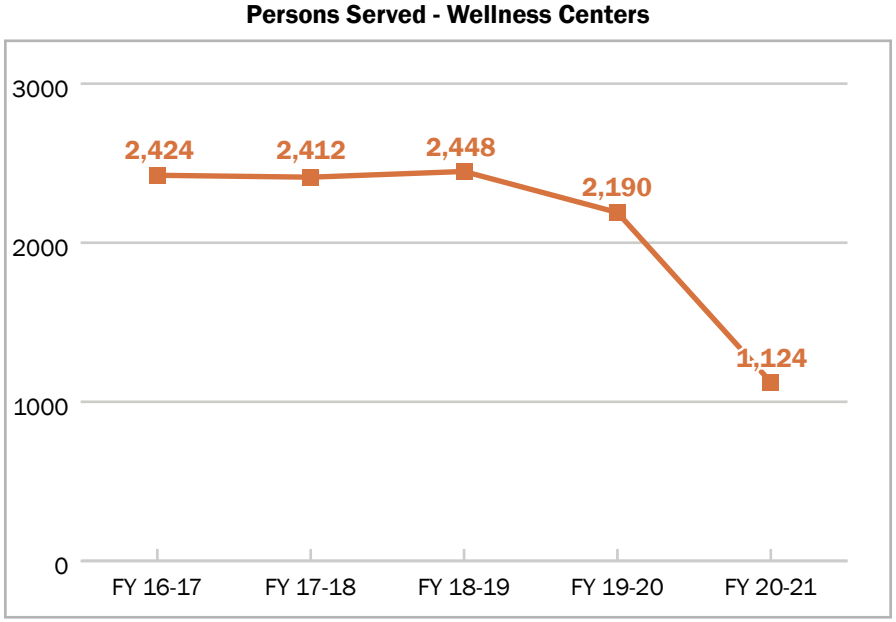
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Unduplicated # to be Served**
FY 2020-21	$3,354,351	2,550
FY 2021-22	$3,354,351	2,600
FY 2022-23	$3,924,351	2,600

SERVICES

Wellness Centers are grounded in the Recovery Model and provide a support system of peers to assist members in maintaining their stability while continuing to progress in their personal growth and development. The programs are culturally and linguistically appropriate while focusing on personalized socialization, relationship building, assistance with maintaining benefits, setting educational and employment goals, and giving back to the community via volunteer opportunities.

Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer support in a non-judgmental environment. A wide variety of weekend, evening and holiday social activities are provided for members to increase socialization and encourage (re)integration into the community. The ultimate goal is to reduce reliance on the mental health system and to increase self-reliance by building a healthy network of support which may involve the members' family, friends or significant others.

The Wellness Centers utilize Member Advisory Boards (MABs) composed of members who develop or modify programming and evaluate the successes or failures of groups, activities and classes. They also use a community town hall model and member Satisfaction and Quality of Life surveys to make decisions about programming and activities.



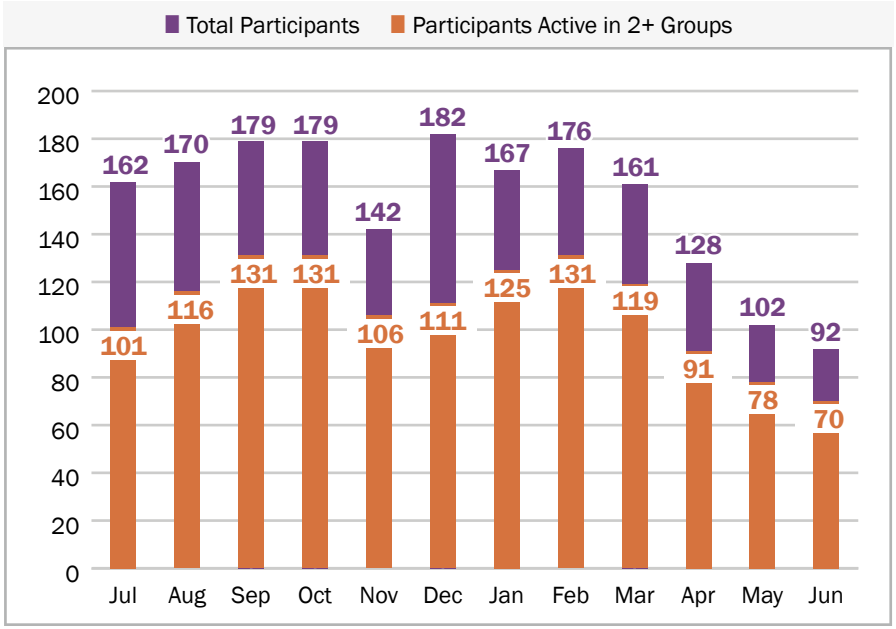
OUTCOMES

The Wellness Centers monitor their success in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two interrelated ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, during FY 2020-21, 61-76% of members participated in two or more tele-groups/activities each month. In FY 2019-20, In FY 2019-20, the Centers met this goal with 72-89% of members participating in two or more groups/ activities each month during FY 2019-20. This is comparable to FY 2016-17 through FY 2018-19 (see Appendix VII for graphs). Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. During FY 2020-21, 273 adults (24%) participated in community integration activities. This is lower than previous years due to the impact of COVID-19. In FY 2019-20, 1,638 adults (75%) participated in community integration activities, which is lower than the rates in FY 2016-17 through FY 2018-19, (84%, 84% and 97%, respectively) and was directly attributable to the COVID-19 pandemic that began in the last quarter of the fiscal year.

The onset of the COVID-19 pandemic significantly limited and reduced in-person attendance for groups and activities in the Wellness Centers, and brought about an urgent need to quickly develop alternative methods to continue to provide as many services as possible that these programs offer. The programs used this as a creative opportunity, and developed and implemented Tele-Groups, which provided on-line or virtual groups and activities through media such as Zoom and other platforms, and offered as many groups and activities as possible to continue to provide services to its members. While the creation of Tele-Groups continued services to the greatest extent possible, many members still did not have internet access to attend, but did offer the ability to connect via telephone as well. This new technology also proved beneficial for those individuals that may not have always been able to attend in-person services due to transportation or other barriers, and allowed them to participate in services where they may not have been able to before.

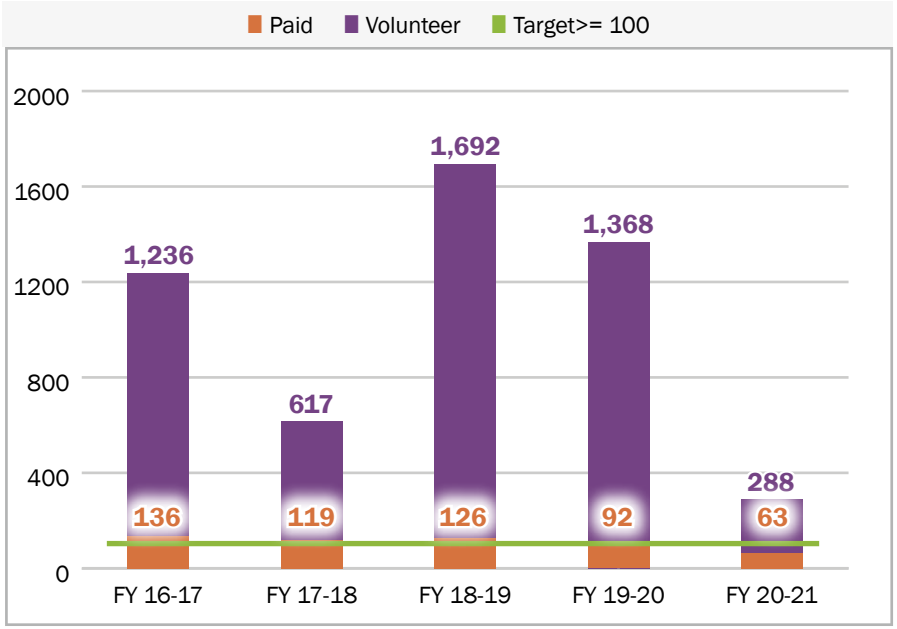
The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 153, 219, 146 and 141 adults enrolled in education classes in FY 2019-20, FY 2018-19, FY 2017-18, and FY 2016-17, respectively. Thus, school enrollment remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes. To assist members in furthering their education in ways that may not require a long term school commitment, members are encouraged and have been completing online courses that are shorter in duration and which issue a certificate of completion at the end of the course. This has been well received by members and serves to build confidence by achieving shorter term goals and often leads to more interest by members in furthering their education.

Monthly Consumer Participation in Tele-Groups Wellness Centers - FY 20/21



In contrast, 351 adults in FY 2020-21, 1,460 adults in FY 2019-20, 1,818 adults in FY 2018-19, 736 adults in FY 2017-18, and 1,372 adults in FY 2016-17 were involved in employment, primarily due to the large proportion in volunteer positions. Initially the pandemic led to fewer employment opportunities due to business closures, but as the community rebounded and adapted to workplace restrictions, many job opportunities began to develop, with even higher wages being offered than ever before. Although new opportunities presented themselves for gainful employment, there remained an overall hesitation for a significant number of members to actively pursue employment and go back into enclosed environments until more progress was made in combatting the pandemic and reducing new cases and spread of the virus. Although facing challenges, the programs continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.

Wellness Centers - Annual Employment



CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to 2 hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel. With the centers operating in the west, central and south regions of the county, access has improved. The south county center is particularly challenging when it comes to public transportation, as the majority of bus routes are no longer in operation in that region. To assist individuals with accessing and utilizing the south center, the HCA has authorized the utilization of its Transportation program to assist those individuals with the most challenging transportation needs to get to the south center.

An additional challenge that surfaced for each of the Wellness Centers during FY 2020-21 was the onset of the Covid-19 pandemic, which resulted in program closures for in-person services and a transition to remote group operations via Zoom, Webex and other platforms. All three Centers were impacted in daily attendance, as many members do not have the ability to participate in remote groups. However, daily participation did increase over time, and in late FY 2020-21 all the programs transitioned to hybrid programming, which offers both in-person services at reduced capacities to comply with state and local guidelines, as well as continued remote services. This had a significant impact on participation in the programs, and daily attendance continues to increase. Many members are still hesitant to participate in in-person services due to the pandemic, especially among older adults, however, members who have chosen to participate in in-person services have expressed gratitude to be able to attend the programs and join in face-to-face groups and activities, as well as reconnect with members that they had lost touch with during program closures and the need to limit interactions in the community.

COMMUNITY IMPACT

Since their respective programs' inceptions, over 6,300 adults have received services at Wellness Center Central, with an average daily attendance of 66 members, six days per week; more than 850 adults at Wellness Center South, with an average daily attendance of 29 members, six days per week; and nearly 1,800 members at Wellness Center West, with an average daily attendance of 47 members per day, six days per week.

Continuum of Care for Veterans and Military Families (INN)

The **Continuum of Care for Veterans and Military Families** Innovation project integrates military family culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. It seeks to expand general service providers' knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population. The target population served includes active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
0+					
All Ages	Field	Clinic	At-Risk	Mild-Moderate	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
Farsi	Mandarin	Vietnamese
Khmer	✓ Spanish	Other:

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC					
Age	**%**	**Gender**	**%**	**Race/EtŠicity**	**%**
0-15	55	Female	50	African American/Black	15
16-25	10	Male	50	American Indian/Alaskan Native	-
26-59	35	Transgender	-	Asian/Pacific Islander	10
60+	-	Genderqueer	-	Caucasian/White	45
		Questioning/Unsure	-	Latino/Hispanic	30
		Another	-	Middle Eastern/North African	-
				Another	-

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP		
Fiscal Year	**Program Budget**	**Unduplicated # to be Served**
FY 2020-21	$962,445	250
FY 2021-22	$962,445	100
FY 2022-23	-	-

SERVICES

Peer Navigators with lived military experience are co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military family culture awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project is also staffed with clinicians who, with the ongoing support of peer navigators, provide counseling and trauma-informed care utilizing evidence-based practices. Additional services include referral and linkage to County and community programs.

Continuum of Care for Veterans and Military Families was implemented July 1, 2018. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Innovation funds for this project will end in March 2023.

OUTCOMES

During FYs 2019-20 and 2020-21, community outreach events were significantly impacted due to stay home orders and social distancing requirements in response to the COVID-19 pandemic. In FY 2020-21 staff conducted 47 community outreach events, compared to the 17 events held in FY 2019-20. In FY 2020-21, Peer Navigators, clinicians, and collaborative partners provided 589 trainings related to military family culture to FRC staff, which included specialty trainings on military legal issues, domestic violence and housing. This is an increase from the 256 trainings provided in FY 2019-20. In the upcoming year, the program will further expand on trainings to include e-Learns, brief micro-learning sessions that will be available online to FRC staff.

In FY 2020-21, 70 military-connected families (n=245 individual family members) were served, which is an increase from FY 2019-20 (47 military-connected families; n=175 individual family members). A total of 1,636 case management session were provided to families, in contrast to the 1,728 sessions provided in FY 2019-20. Due to their lived experience and extensive training, the Peer Navigators were able to identify needs and appropriately refer military-connected families to resources, thereby increasing the likelihood that families would receive needed services in a timely manner.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

A significant challenge in this program involves the collaboration with FRCs due to their unique population needs and variation in operations across the different sites. FaCT FRCs include over 100 funded and unfunded community partners, adding complexity to the collaboration, training and partnership elements of this program. To address this challenge, program staff continue to attend FRC meetings, virtually and in person, and work closely with FRC staff to address the unique culture and needs of each site. The program has also developed brief online trainings on various topics to increase FRC staff's access to information about military family culture, based on their specific needs. The pandemic brought additional challenges. Many families continue to struggle with complex issues and need support with both individual clinical services and basic needs at a time when most agency resources are scarce. In response, the lead agency Director developed a clinical referral decision tree to assist staff in finding programs to which they can refer clients for clinical support. Program staff continue to diligently work on identifying new sources for basic needs support and utilize grants to provide rental assistance to families. In addition, all staff continue to work together to closely coordinate care to serve families more efficiently. This resulted in a system where the Peer Navigators work with families who are more stable, allowing clinicians the time to dedicate to families experiencing a crisis. Lastly, many families are not computer literate and have difficulty accessing virtual sessions. The COC staff was able to train FRC staff on more effective ways to connect with these families which resulted in more virtual interactions. They also utilize mailed materials and telephonic services as needed.

COMMUNITY IMPACT

In year three (FY 2020-21), program staff integrated into four new FRCs. The Peer Navigators delivered Military and Veteran Family Culture trainings to new and existing FRC staff along with the FaCT community partners. These trainings were well received by both the FRC staff and the FaCT partner staff. In addition, these trainings increased the interest of community partner administrators in being trained on how to best identify, engage and serve military families, theryby increasing the military cultural competency of their agencies. During the project, the COC team conducted Lunch and Learn focus groups with FRC staff and partners to gather feedback about the successes and challenges in working with the COC team, discuss desired e- learn topics, and revise existing e-learns. This process helped ensure that FRCs had a part in creating content that would meet the needs of their respective communities. The FRC staff has reported that the peer mentoring portion of the project has been invaluable in providing awareness of veteran and military-connected family culture. Through their facilitation of Peer Mentoring training sessions within the FRCs, the Peer Navigators have assisted the FRCs in increasing their military cultural competency to better serve military connected families throughout Orange County.

Summary of MHSA Strategies Used by Supportive Services Programs: Peer Service

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

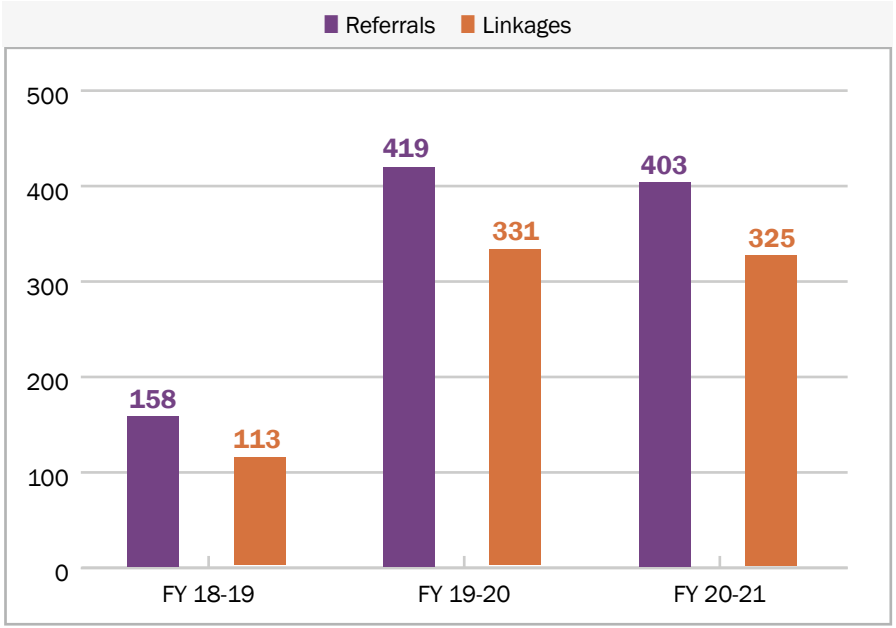
In one-on-one services, peers, parent partners and peer navigators focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on their recovery journey. The activities in which participants engage are designed to enhance their resourcefulness and well-being in emotional, physical, spiritual and social domains, thus allowing them to re-integrate successfully into their communities. In addition, the Wellness Centers provide a safe and nurturing environment where each individual can achieve their vision of recovery while in a setting that promotes acceptance, dignity and social inclusion. Peer navigators in the Continuum of Care project also have specific experience and knowledge of military culture and train FRC staff on military culture and identifying military-connected families, which has increased military cultural awareness among non-veteran serving organizations.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

The programs strive to make their services available to all eligible Orange County residents in a manner that is sensitive and responsive to participant's diverse backgrounds. Cultural competence is an essential part of the development, recruitment and hiring of staff. Within the clinic settings where the peer mentors and parent partners work, peers/partners strive to reduce stigma and discrimination by drawing upon their cultural strengths and providing services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. In addition, peers/partners encourage participants and other staff working in the clinics/programs to use recovery language. They normalize seeking mental health treatment by sharing their own lived experiences and by discussing how any other individual would seek treatment for a physical illness. Peers/partners also demonstrate empathy, caring and concern to bolster participant's self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, doctors, etc.

In addition, the Wellness Centers reduce stigma and discrimination by providing a warm, welcoming and accepting environment, and serving all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members, and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. The Wellness Centers also offer a variety of groups such as Diversity Plus and the

Wellness Centers - Annual Employment



MOST COMMON LINKAGES MADE

LEGAL SERVICES, MENTAL HEALTH CARE, TRANSPORTATION, HOMELESS SERVICES, AFFORDABLE HOUSING, PRIMARY/DENTAL CARE, CLOTHING, JOB PLACEMENT, FOOD AND NUTRITION, JOB PLACEMENT, FOOD/NUTRITION, OTHER SERVICES (I.E., CHILD SUPPORT, FINANCIAL, UTILITY ASSISTANCE, ETC.)

LGBTIQ group that are specifically designed for their widely diverse membership. Groups related to arts and crafts are extremely valuable to members as it provides an opportunity to express their emotions and feelings in constructive ways, and the Annual Art Fair offers members the opportunity to have their artwork, poetry, or photography memorialized in the annual MHSA Calendar, wherein a panel of peer judges selects art to be displayed in each month of the calendar.

Employment preparation, offered both by the Centers and peer mentors/parent partners, also helps participants focus on their experiences, skills and what they have to offer, rather than on their mental health condition, and many members have been ultimately hired to be peer mentors in these programs. Socialization activities held in the community help to develop confidence in participants that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear.

Finally, military-connected families seeking FRC resources have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer navigators also connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood.

The programs conduct outreach to potential referral sources in order to increase awareness of and access to their services. For example, the Wellness Center distributes flyers and monthly activity calendars to all County and County-contracted programs, and frequently staffs booths at behavioral health and other community events. The Peer Mentoring/Parent Partner program has proactively built relationships with leadership at County and County-contracted outpatient clinics by conducting presentations to inform staff of the referral process, services provided, and to share success stories. Sharing data on linkage rates and successful goal completion as a result of using peer mentoring services has had a large influence on increasing referrals to the program.

Referred individuals may face barriers to engaging in services due to housing, transportation, childcare, challenges with scheduling and/or symptoms of a mental health condition may prevent members from engaging in peer mentoring services and/or Center activities. Utilizing peer staff with lived experience with behavioral health issues is key to operating programs of this nature as these staff can relate on a much deeper level with individuals because they have often walked in their shoes. Peer staff are from a variety of cultures, ethnicities and backgrounds, and have the ability to serve members in all threshold languages

Homelessness is another factor that can affect access to peer mentoring program services, in particular, as mentors can lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. Peers proactively address this potential challenge at their first meeting by making a significant effort to learn about where a participant may be staying and how to contact them to minimize losing contact with them once their initial meeting has ended.

Finally, to meet the specific, complex needs of military families, the collaboration of nonprofit community organizations supporting the Continuum of Care project provided specialty services to families with domestic violence, housing and legal needs. Providing access to these services directly within the FRCs enables peer navigators to connect with participants while they are seeking other support services and provide them with timely access to behavioral health support and treatment, as well as other needed services. The project also trains FRC staff on how best to meet the needs of military-connected families so that they feel competent and willing to identify and serve this target population. FRCs also serve as a new point of entry into behavioral health and supportive services for military families. The support offered by a military-connected peer increases family member's access to needed services, especially behavioral health care, which they may be reluctant to seek on their own due to the stigma associated with mental health conditions.

Transportation (CSS, PEI)

The **Transportation** program serves adults ages 18 and older, who have a serious mental illness or substance use disorder, and who need transportation assistance to and from necessary County behavioral health or primary care appointments or select supportive services (particularly housing-related). Individuals are referred by their MHRS treatment provider, following an assessment of their transportation needs and history of scheduled appointments missed due to transportation issues. Based on the community planning process for the Three-Year Plan, this program was to be expanded to support participants with additional transportation needs. However, due to the lingering impact of COVID-19, exploration of expanding services to youth and families with children, including those who must be transported in child safety seats, and to support services that help address social determinants of health, may be postponed.

General Support programs provide supplementary services designed to improve recovery by helping participants meet essential needs such as transportation assistance and/or develop skills. At present, all programs in this subset are for adults 18 and older and are funded through CSS. However, the transportation program, described below, will be expanded to include assistance for children (while accompanied by their parent/caregiver).

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 18+	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe

PROGRAM SPECIALIZATIONS

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

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,150,000	1,575
FY 2021-22	$1,300,000	1,650
FY 2022-23	$1,050,000	1,650

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS

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

SERVICES

Transportation services are offered Monday through Friday for most behavioral health programs, and seven days per week for the County's CSU's and Royale Therapeutic Residential Center. 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 a driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin. Individuals can also stop and get their prescriptions filled as necessary. Transportation services have also been authorized for use by both CSS and PEI field outreach teams for a one-time use to link participants served in the field to their initial behavioral health appointments. In addition, Transportation services are also used to link participants being discharged from the County and County-contracted Crisis Stabilization Units or Royale Therapeutic Residential Center to their follow-up appointments at either of the County's Open Access clinics. CSU's and RTRC, staff make the transportation arrangements on behalf of clients, and those clients will be assessed at their permanent clinical homes for future authorization for the use of Transportation Services and the ability to make their own arrangements.

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

A survey on transportation needs conducted at the four large County adult outpatient clinics (Santa Ana, Anaheim, Westminster and Mission Viejo) indicated that over 40% of missed clinic appointments were a direct result of transportation issues. These issues included, but were not limited to, lack of a car or money for gas or a bus, inability to navigate the public transportation system, the time it takes to use public transportation system, anxiety surrounding using public transportation or riding with others, and reliance on others to get rides to and from appointments. By providing reliable pick-up and drop-off at their requested destinations, participants have been better able to engage in treatment consistently, thus allowing them to pursue their recovery.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

By offering free transportation, the program makes behavioral health and medical treatment equally accessible to individuals in need of care regardless of their socioeconomic means.

STRATEGIES TO IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

The program facilitates timely access to needed behavioral health and medical services for participants with significant transportation-related barriers to care by providing them with the means to attend these appointments.

PROGRAM UTILIZATION (OUTCOMES)

The contract began July 1, 2018, with the first ride on July 12, 2018. The total number of rides provided in its first year of operations was 22,202.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

One of the biggest challenges for this program is for participants to remember to schedule their transportation service 24-hours in advance of their appointment times. The purpose of this is to allow the transportation provider to schedule its fleet of drivers the night before for their appointments the next day. With the high demand for transportation services on a daily basis (Monday-Friday), in all regions of the county, it has been very challenging for drivers to get to their scheduled pick-up/drop-off locations on time without the 24-hour notice. In an effort to ensure drivers can be at the right place at the right time, the transportation provider has identified the highest utilized areas, and increased its driver fleet in those areas during known times when there is a high need, which has resulted in minimizing any delays for pick-ups/drop-offs. To assist with the high demand for these services, additional drivers have been added to the taxi fleet that has enabled the transportation provider to meet the high demands despite not always getting a 24-hour notice for service. Finally, BHS programs will continue to identify ways to leverage transportation assistance provided by other partners and agencies (i.e., CalOptima, etc.) so that efforts are not being duplicated unnecessarily.

Supported Employment (CSS)

The **Supported Employment** (SE) program serves Orange County residents 18 and older who are living with serious mental illness, may have a co-occurring substance use disorder and require job assistance to obtain competitive or volunteer employment. Participants are referred to the program from County and County-contracted Outpatient and Recovery programs, FSPs and select PEI and Innovation programs. Participants must be engaged in behavioral health services during their entire enrollment in the program and have an assigned Plan Coordinator or Personal Services Coordinator who will collaborate with the SE team to assist with behavioral issues that may arise while participating in the program.

AGE RANGE	PRIMARY LOCATION		TARGET POPULATION		
18+	Field	Community	~~At-Risk~~	~~Mild-Moderate~~	Severe
Ages 18+					

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
✓ Arabic	✓ Korean	✓ TDD/CHAT
✓ Farsi	✓ Mandarin	✓ Vietnamese
✓ Khmer	✓ Spanish	✓ Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	-	Female	40	African American/Black	6
16-25	20	Male	60	American Indian/Alaskan Native	1
26-59	71	Transgender	-	Asian/Pacific Islander	10
60+	9	Genderqueer	-	Caucasian/White	43
		Questioning/Unsure	-	Latino/Hispanic	35
		Another	-	Middle Eastern/North African	1
				Another	4

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

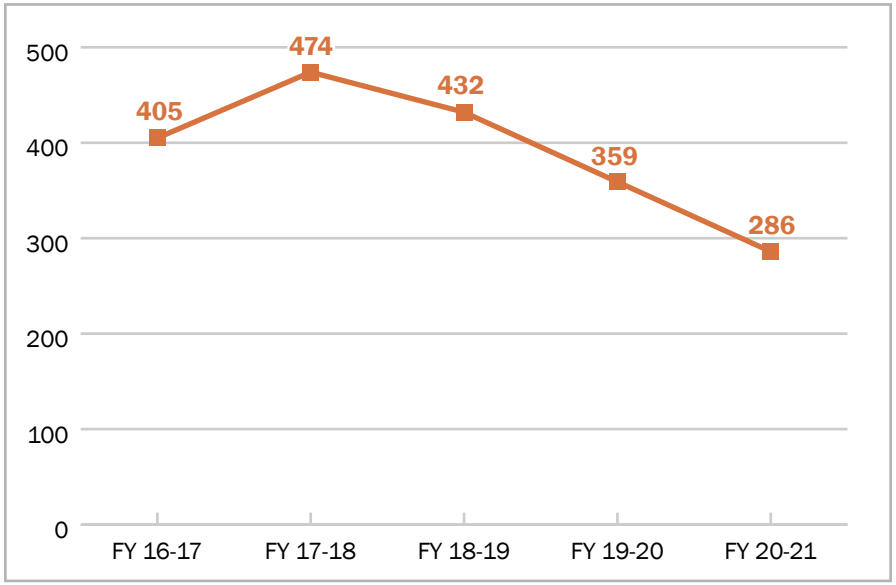
Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,371,262	360
FY 2021-22	$1,371,262	360
FY 2022-23	$1,371,262	360

SERVICES

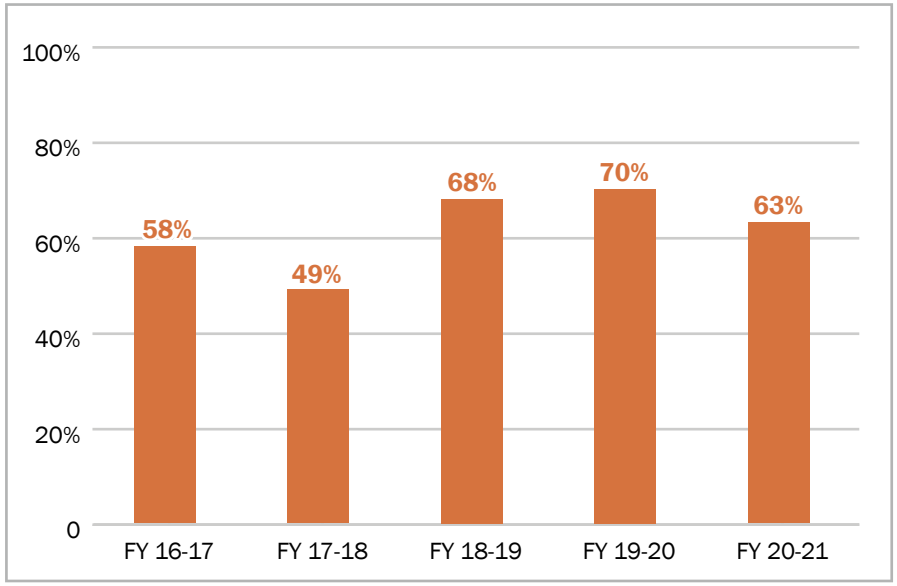
The Supported Employment program Individual Employment Plans are developed by the employment team with the participant and closely follow the evidence-based Individual Placement & Support employment model to provide services such as volunteer or competitive job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling and peer support services.

Employment Specialists (ES) and Peer Support Specialists (PSS) work together as an Employment Team. The ES assists participants with employment preparation including, but not limited to, locating job leads, assisting with application submissions and assessments, interviewing, image consultation and transportation issues. The ES also provides one-on-one job support, either by telephone or at the participant's workplace, to ensure successful job retention. The PSS are individuals with lived experience with behavioral health and substance use challenges, and who possess skills learned in formal training, and/or professional roles, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency. The PSS work with participants to develop job skills, and assist the ES in helping the participant identify areas of need for development, and may use techniques such as role modeling, field mentoring, mutual support, and others that foster independence and promote recovery. For those who may not yet be ready for competitive employment, the program offers volunteer opportunities at places of business around the county as a way for them to gain work-related skills and confidence.

Persons Served - Supported Employment



Graduation Rate - Supported Employmemt



OUTCOMES

Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. A total of 63% met this benchmark during FY 2020-21, which was a slight decrease from FY 2019-20 (70%) and FY 2018-19 (68%). However, the overall graduation rate trend continues to increase. This is notable, as improving employment outcomes for adults in the BHS system of care continues to be challenging for many other programs.

STRATEGIES TO INCREASE RECOVERY/RESILIENCE

Securing meaningful employment represents a significant step toward recovery and re-integration into the community. Staff strives to build working relationships with prospective employers, educate employers to understand mental health conditions and combat stigma, and serves as the main liaison between the employers and program participants. The ES maintains ongoing, open communication with participant treatment teams to promote positive work outcomes. The PSS provide training and support to participants using the principles of hope, equality, respect, personal responsibility and self-determination. While it is sometimes a concern among the target population that they might lose their benefits such as SSI/SSDI if they become employed, they also recognize that this may be a final step to gaining full independence.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

Helping participants find and maintain good jobs in the community is, in and of itself, an act of reducing stigma and discrimination. More and more program participants are requesting assistance in disclosing their barriers to employers. This opens up many opportunities for staff to have a supportive onsite presence that fosters collaboration and education between the participants and their employers and co-workers. The program promotes participant's successes in maintaining employment and highlights welcoming employers who provide individuals with mental health challenges, the opportunity to integrate into the community via competitive employment. This effort is carried out through media exposure via news publication, newsletters and presentations of success stories at community meetings.

STRATEGIES TO IMPROVE TIMELY ACCESS TO SERVICES FOR UNDERSERVED POPULATIONS

The Supported Employment program engages in a number of activities to encourage timely access to its services. First, SE staff regularly present at County and County-contracted clinics to encourage referrals to the program. From the day the participant enrolls, the program strives to foster an environment of empathy and hope, which contributes to their ongoing program participation. ES and PSS staff provide person-centered supports in line with the evidence-based model of Individual Placement and Support so that they can support participants in finding and keeping a good job in a supportive work environment. The team is highly mobile and can meet individuals in their communities to provide supported services. The employment team also collaborates with the referring treatment provider to discuss the participant's progress, success stories and/or any significant behavior that prompts need for clinical interventions. In addition, services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

During FY 2020-21, referrals to both the north and south programs have been low due to the pandemic, and hesitancy for some participants to join the workforce until there is further decline in the number of covid cases is a primary reason even though there is ample opportunity for employment and an abundance of jobs available. As the pandemic begins to subside, it is anticipated referrals will again increase to expected levels.

COMMUNITY IMPACT

The Supported Employment program has provided services to more than 3,500 adults since its inception in August 2006. The program has established a strong presence within Orange County through its collaboration with County and County-contracted clinics and other behavioral health programs, as well as its numerous presentations at job fairs, the Wellness Centers, and local MHSA steering committee meetings.

Year-Round Emergency Shelter (CSS)

Year-Round Emergency Shelter (formerly called Short-Term Housing Services) serves adults experiencing homelessness with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. Individuals referred to the program are actively participating in services at an Adult and Older Adult Behavioral Health County or County-contracted outpatient clinic, PACT or Assembly Bill (AB) 109 program.

Housing Support programs serve Orange County adults who are experiencing homelessness and living with a serious mental health condition. They range from providing short-term emergency shelter to permanent supportive housing and are designed to meet individuals where there are at and support them in their recovery.

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
18+				
Ages 18+	Residential	At-Risk	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

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

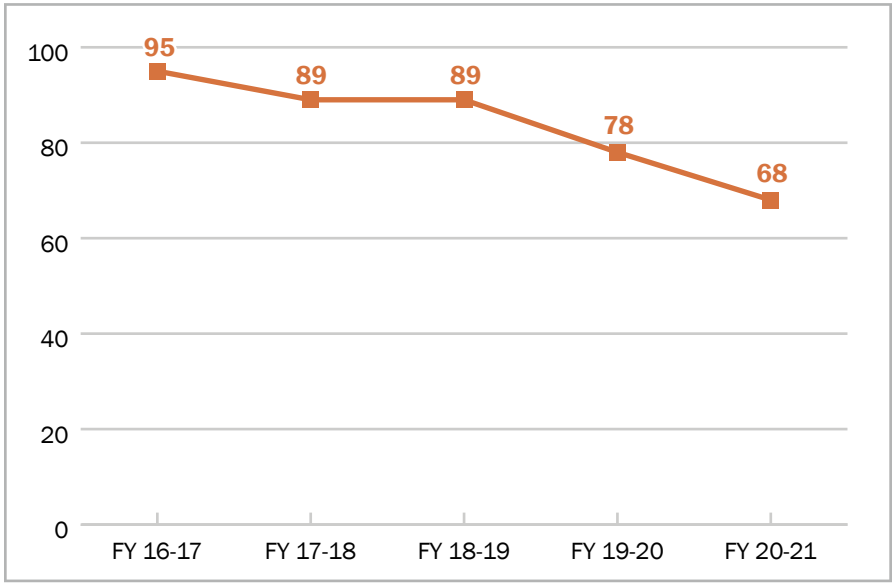
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$1,367,180	90
FY 2021-22	$1,367,180	90
FY 2022-23	$1,367,180	90

SERVICES

This program has MHSA-dedicated beds within five existing shelters. In addition to daily shelter, the program provides basic needs items (i.e., food, clothing, hygiene goods), as well as case management and linkage to services designed to assist individuals in their transition out of the shelter and into a more stable housing situation. The estimated length of stay for each episode of shelter housing is 120 days. Extensions are considered on a case-by-case basis.

Persons Served - Short-Term Housing



OUTCOMES

As reported below, the program has been successful in reaching its goals:

SHORT TERM HOUSING SERVICES METRICS	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
Average Length of Stay (ALOS) is 120 Days or Less	ALOS = 82 days	ALOS = 58 days	ALOS = 80 days	ALOS = 69 days
% Who Found Permanent or Transitional Housing within 120 Days is > 25%	40%	33%	53%	35%

SERVICE CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

Due to COVID-19 facilities experienced times when they were not accepting referrals due to covid positive cases. This limited the amount of available beds. During these incidents facilities followed Public Health Services guidelines in order to resume intakes as quickly as possible. The program continues proving the participants with in-person support and virtual activities to increase receptiveness to staying in the shelter. The program addressed other important needs, including supportive services such as transitional or permanent housing assistance and linkage to needed community support services in coordination with the Plan Coordinator from the outpatient clinic. Some facilities allowed pets and partners to stay in the shelter with participants and permitted MHRS Outreach and Engagement staff into the shelter. This allowed participants to receive support from the outreach worker with whom they had already built rapport, which could help facilitate their engagement into behavioral health services now that they were in a more stable environment.

Homeless Bridge Housing (CSS)

Homeless Bridge Housing offers interim housing for adults who have been matched to a permanent housing opportunity. The program also serves adults experiencing homelessness who are in the beginning stages of obtaining permanent housing. Adults (including women with children) are eligible if they are homeless, are living with a serious mental illness, and may have a co-occurring substance use disorder. Referrals for the Homeless Bridge Housing Services are accepted on an ongoing basis by Adult and Older Adult Behavioral Health (AOABH) Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at an AOABH outpatient clinic.

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
Ages 18+	Residential	At-Risk	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	-	Female	51	African American/Black	8
16-25	2	Male	46	American Indian/Alaskan Native	3
26-59	96	Transgender	3	Asian/Pacific Islander	7
60+	2	Genderqueer	-	Caucasian/White	78
		Questioning/Unsure	-	Latino/Hispanic	30
		Another	-	Middle Eastern/North African	-
				Another	11

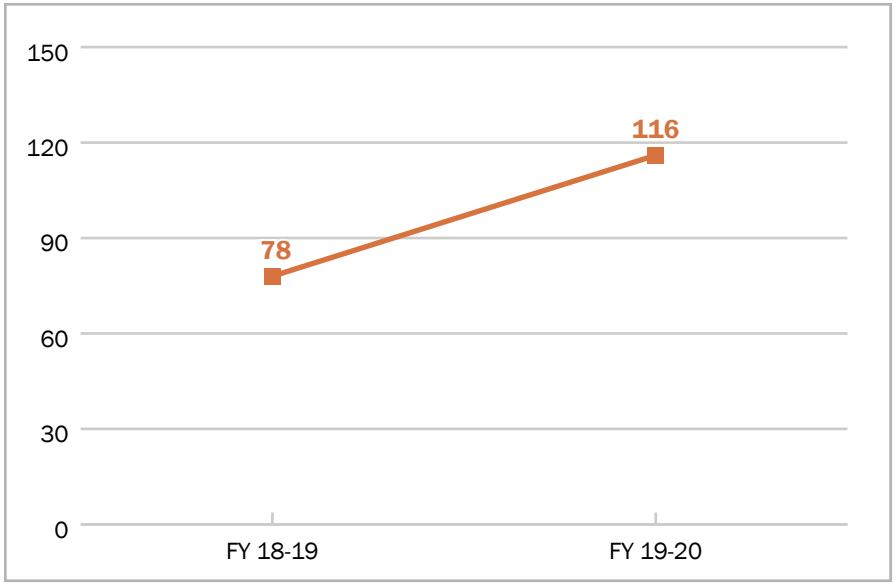
BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$2,000,000	80
FY 2021-22	$2,000,000	80
FY 2022-23	$2,000,000	80

SERVICES

The program provides housing coordination and navigation to assist participants in acquiring permanent housing. The provider also provides life skills and independent living skills training to support the participant's transition to independent living. The provider assists participants in obtaining housing opportunities that include Continuum of Care certificates, housing vouchers, locating rental units, negotiating leases and securing other housing options. The estimated length of stay is 18 months. Participants who are not able to find housing within the 18-month period are able to stay in Bridge Housing Services and continue to look for permanent housing as long as they are actively working towards their housing goals.

Persons Served - Bridge Housing



OUTCOMES

Homeless Bridge Housing tracks a number of measures to monitor its performance in supporting adults living with serious mental illness find permanent housing. The program continues to successfully reach all measurable outcomes.

BRIDGE HOUSING FOR THE HOMELESS METRICS	FY 2018-19	FY 2019-20	FY 2020-21
Average # of potential landlords contacted per month (Target: > 15)	27	39	16
% of participants with CoC certificates who moved into permanent housing within 1 year (Target: > 50%)	100%	74%	50%
% of participants w/out CoC certificates who moved into permanent housing within 18 months (Target: > 50%)	In progress* (16% housed in 12 months)	41%	35%
% of participants who secured work or entitlements w/in 6 months of intake (Target: > 50%)	60%	78%	18%
Persons Served – Bridge Housing	78	116	85

** Services launched in July 2018 so the 18-month mark had not yet passed by the end of FY 2018-19.*

MHSA/CSS Housing Program (CSS)

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the MHSA/CSS Housing Program facilitates the creation of long-term, independent supportive housing for transitional aged youth, adults and older adults with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness or risk of homelessness. Additional eligibility requirements can vary at each location due to requirements of other funding partners. The program funds development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. COSR primarily helps cover the difference between what a resident is able to pay and the cost of operating the unit during the time the resident is working on obtaining entitlement and/or employment income. Behavioral health and other supportive services are located on- and off-site to ensure access to a continuum of services that help residents adjust to and maintain their independent housing.

AGE RANGE	PRIMARY LOCATION	TARGET POPULATION		
18+				
Ages 18+	Residential	At-Risk	~~Mild-Moderate~~	Severe

LANGUAGE CAPACITY OF DIRECT SERVICE PROVIDERS		
Arabic	Korean	TDD/CHAT
✓ Farsi	Mandarin	✓ Vietnamese
Khmer	✓ Spanish	Other:

PROGRAM SPECIALIZATIONS

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

PROPORTION TO BE SERVED BY DEMOGRAPHIC CHARACTERISTIC

Age	%	Gender	%	Race/EtŠicity	%
0-15	-	Female	58	African American/Black	8
16-25	5	Male	41	American Indian/Alaskan Native	<1
26-59	64	Transgender	<1	Asian/Pacific Islander	5
60+	31	Genderqueer	-	Caucasian/White	38
		Questioning/Unsure	1	Latino/Hispanic	11
		Another	-	Middle Eastern/North African	2
				Another	37

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

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	$293,678	-
FY 2021-22	$356,046	-
FY 2022-23*	$42,431,440	-

**Proposed increase for FY 2022-23 adjusts for housing projects*

Original funding allocations for this program included:

- A one-time State allocation of $8 million in FY 2006-07 to develop permanent supportive housing for individuals with serious mental illness who were receiving services in the Full Service Partnership programs. Funds were used to develop 34 housing units in two developments
- A one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation (i.e., MHSA Housing Program) and used for 10 housing developments that created an additional 194 new units of PSH in Orange County

The table below provides details about these projects, which resulted in the development of 194 new PSH MHSA units for eligible tenants and their families.

HOUSING PROJECTS FUNDED BY ONE-TIME ALLOCATIONS

Project	Year	1-Bedroom Units	1-Bedroom Units	1-Bedroom Units	MHSA Units	Total Units (w/ MHSA)	TOTAL
Alegre Apartments	2015	11	0	1	11	104	$2,912,200
Avenida Villas	2014	24	4	1	28	29	$6,519,200
Capestone Apartments	2014	19	0	1	19	60	$4,445,468
Cotton's Point Seniors	2014	15	0	1	15	76	$2,022,400
Depot at Santiago	2018	10	0	1	10	70	$1,615,320
Diamond Apartments	2009	15	9	1	24	25	$1,583,222
Doria Apartments, Phase I	2011	10	0	1	24	25	$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
Oakcrest Heights	2016	14	1	1	15	70	$3,222,974
TOTAL					194	672	$37,895,786

MHSA SPECIAL NEEDS HOUSING PROGRAM (SNHP)

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an ongoing and persistent need for housing for individuals living with serious mental illness and who are homeless or at risk of homelessness. As such, multiple CSS transfers to the SNHP operated by the California Housing Finance Agency's (CalHFA) occurred over several years totaling $95.5 million:

- $5 million in FY 2016-17 following local community planning input
- $35 million total in FY 2017-18 upon directive by the Board of Supervisors
- $25 million total in FY 2018-19
- $30.5 million total in FY 2019-20

On May 19, 2020, the Board approved allocating $15.5 million to the 2020 Supportive Housing Notice of Funding Availability (OCCR 2020 NOFA) and $20.5 million to the Orange County Housing Finance Trust (Trust).

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The HCA recognizes that the demand for safe housing for individuals living with a mental health condition and their families is far outpacing current availability. Thus, staff continually look to identify new opportunities for developing housing for this vulnerable population, which includes staying apprised of other funding opportunities and leveraging resources with other community and County partners.

COMMUNITY IMPACT

Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals living with serious mental illness by improving housing stability, employment and mental and physical well-being. In addition, these MHSA units are integrated in larger housing developments that provide non-MHSA units of critically needed affordable housing in Orange County.

HOUSING PROJECTS FUNDED BY SNHP/TRUST/OCCR 2020 NOFA								
Project	**City**	**Estimated Completion**	**SNHP Units**	**NPLH Units**	**Trust**	**OCCR 2020 NOFA**	**Total MHSA Units**	**Total Units**
Altrudy Seniors	Yorba Linda	2022	10	10	0	0	10	10
Francis Xavier	Santa Ana	2022	13	9	0	0	13	17
Legacy Square	Santa Ana	2022	10	16	0	0	16	93
Villa St. Joseph	Orange	2023	18	18	0	0	18	50
The Groves Senior Apartments	San Juan Capistrano	2022	10	0	0	0	10	75
Mountain View	Lake Forest	2023	8	0	0	0	8	71
Casa Paloma	Midway City	2022	24	0	0	0	24	49
Asent	Buena Park	2022	28	0	0	0	28	58
Orchard View Gardens	Buena Park	2023	8	0	5	0	13	66
Santa Angelina Senior Community	Placentia	2023	16	21	5	0	21	65
Center for Hope	Anaheim	2022	0	34	16	4	34	72
Cartwright Family Apartments	Irvine	2023	10	0	0	0	10	60
Lincoln Avenue Apartments	Buena Park	2023	10	0	0	0	10	55
Westview	Santa Ana	2023	0	26	0	26	26	85
North Harbor Village	Santa Ana	2022	0	0	14	0	14	90
Huntington Beach Senior Housing	Huntington Beach	2023	0	21	0	21	21	43
Paseo Adelanto	San Juan Capistrano	2023	0	0	10	14	24	41
Meadows Senior Apartments	Lake Forest	2023	0	0	7	0	7	65
Crossroads at Washington	Santa Ana	2023	0	0	15	0	15	86
Anaheim Midway	Anaheim	2023	0	0	8	0	8	86
TOTAL			165	155	94	75	330	1036

Summary of MHSA Strategies Used by Supportive Services Programs: Supportive Housing Services

STRATEGIES TO PROMOTE RECOVERY/RESILIENCE

These programs address the basic needs of adults experiencing homelessness, such as food, shelter and physical safety. This creates a safe environment in which participants can make progress toward their recovery while securing and/or maintaining permanent housing. Staff uses Motivational Interviewing to engage participants and help them identify their own needs and challenges. This evidence-based therapeutic approach facilitates independence through self-discovery, and helps individuals become more ready for independent or supportive housing.

STRATEGIES TO REDUCE STIGMA AND DISCRIMINATION

While in the shelter or bridge housing, staff works with residents to prepare them to accept permanent housing so they can smoothly transition to housing from the streets and end their episodes of homelessness. Program staff also conducts community outreach to educate and engage prospective landlords with the goals of improving access to housing options, reducing misconceptions about people living with a mental health disorder, reducing the possibility of discrimination from landlords, and helping to facilitate acquisition of permanent housing.

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

Staff 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. Behavioral health programs provide their services on-site or off-site, promoting easy access to services. In addition, most housing sites are located near public transportation routes to enhance residents' access to transportation, as many residents do not own a car.

Discontinued Program - Mentoring for Children and Youth (CSS)

Mentoring for Children and Youth served youth ages 0-25 living with a serious emotional disturbance and receiving behavioral health services at a County or County-contracted outpatient clinic. Youth were referred by their therapist if the therapist determined that the child could benefit from additional mentoring and socialization experiences out in the community. Parents of participating youth also received parent mentoring services. After consideration of multiple factors including challenges with the ability to demonstrate program efficacy, the program is being discontinued beginning in FY 2021-22. Youth and parents will continue to receive peer/parent partner support through the Peer Mentoring and Parent Partner Support program.

FY 2020-21 TO FY 2022-23 PROGRAM BUDGET		PROJECTED UNDUPLICATED # TO BE SERVED	
Actual FY 2019-20 Budget	$500,000	FY 2019-20	225
Proposed FY 2020-21 Budget	-$500,000	FY 2020-21	230
Proposed FY 2021-22 Budget	-$500,000	FY 2021-22	230
Proposed FY 2022-23 Budget	-$500,000	FY 2022-23	0

WORKFORCE EDUCATION & TRAINING

Workforce Education and Training (WET) is intended to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members how to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and that is capable of providing consumer and family-driven services.

WET Component Overview

The mission of the Mental Health Services Act (MHSA) Workforce Education and Training component is to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings to County staff and contracting community partners that promote well-being, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern Counties Regional Partnership (SCRP) of WET Coordinators.

Following the passage of Proposition 63, the state provided each county with a one-time funding allocation to develop its WET infrastructure. Orange County's (OC) allocation of $8,948,100 was exhausted in FY 2013-14. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET. Counties are allowed to transfer CSS funds to WET, as well as Capital Facilities and Technological Needs (CFTN) and the Prudent Reserve, so long as the total amount of the transfers within a fiscal year do not exceed 20% of the county's most recent five-year average of its total MHSA allocation. Orange County continues to fund WET programs, described in greater detail below, to serve the OC behavioral health workforce, mental health consumers and their family members.

WET programs continue to reach a large audience. While FY2019-20 saw a decrease in trainings provided and attendance due to the COVID-19 global pandemic, WET identified new strategies to engage with and provide necessary trainings to staff, contract providers, and community members virtually during FY 2020-21. More than 9,000 individuals and/or community members participated in WET trainings during FY 2020-21 (9,201). In FY 2019-20, approximately 6,740 individuals and/or community members attended WET trainings and activities. Attendance in previous fiscal years found that 10,831 and 6,258 individuals attended WET trainings and activities between FYs 2018-19 and 2017-18, respectively.

The WET component currently funds the following major training and program areas:

- **Workforce Staffing Support**
- **Training and Technical Assistance**
- **Mental Health Career Pathways**
- **Residency and Internship Programs**
- **Financial Incentive Programs**

STATEWIDE WET PROGRAM

The FY 2019-20 state budget included approximately $40 million to fund county MHSA WET programs statewide. To secure these funds, county behavioral health agencies must collectively provide a 33% match or $13.2 million by 2025. County contributions must also be transferred to a third-party entity and used for WET purposes to fund pipeline/career awareness, scholarships, stipends and loan repayment programs. The County Behavioral Health Directors Association (CBHDA) has proposed that CalMHSA act as this entity and ensures contributions are returned to the county for WET purposes. In addition, CBHDA was authorized by its Board to calculate a suggested contribution for each county based on the current MHSA allocation formula. Based on the current MHSA allocation formula, the suggested contribution for OC's share of the match is $904,713. Orange County transfered the full amount of its suggested contribution in FY 2020-21.

Workforce Staffing Support

The Workforce Staffing Support (WSS) program performs three functions: (1) Workforce Education and Training Coordination; (2) Consumer Employment Specialist Trainings and One-on-One Consultations; and (3) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the OC behavioral health workforce, consumers, family members and the wider OC community. During FY 2020-21, WSS provided trainings to a total of 1,698 individuals including County staff, County-contracted staff, and general community members. This was a decrease from previous fiscal years where between 2,000 to 3,000 individuals were provided trainings. This is mostly attributed to the impact of the COVID-19 global pandemic. Additionally, during the beginning of the fiscal year, WET was still developing best practices to help with facilitating trainings using virtual platforms.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$1,710,584
FY 2021-22	$1,761,902
FY 2022-23	$1,814,758

**Proposed increase to FY 22-23 for expanded Workforce Support. This will allow for various additional trainings.*

STAFFING DESCRIPTIONS/OUTCOMES

Workforce Education and Training Coordination:

Orange County regards coordination of workforce education and training as a key strategy to promoting recovery, resilience and culturally competent services. Multidisciplinary staff members design and monitor WET programs, research pertinent training topics and content, and provide and coordinate trainings. As noted in the graph, WET provided a large number of in-person professional development trainings between FYs 2017-18 and 2018-19. Toward the latter half of FY 2019-20, all trainings had to shift to virtual platforms to accommodate the restrictions associated with in-person trainings due to the COVID-19 pandemic. Restrictions from the COVID-19 pandemic were still in effect at the start of FY2020-21. At that time, WET was actively determining how to effectively provide trainings using online technology.

Training topics from FY 2020-21 included Law and Ethics, Case Management Strategies, Clinical Supervision: A Lens on Multicultural Diversity, Cognitive Behavioral Therapy and Relapse Prevention Strategies, Effecting Change through Motivational Interviewing, Recovery Practices for BHS Service Chiefs and Supervisors: Supervision for Peer Specialists, and Trauma-Informed Care Approaches for Working with Individuals with Substance Use Disorders. Two video series were also developed and launched during FY 2020-21, one focusing on responses to trauma during the pandemic and another focused on resiliency in public service. WET also hosts several trainings at the start of the fiscal year focused on how to best engage with staff, community members, and clients using virtual platforms called Own the Room: Virtual Crash Course.

In FY 2018-19 the OC Health Care Agency (HCA) transitioned to a new Learning Management System (LMS) where employees have access to over 70 online, on-demand trainings to develop professional soft skills like leadership or technical skills in using software like Microsoft Suite. In FY 2019-20, live virtual instruction trainings were offered due to the global COVID-19 pandemic. Some of these trainings were recorded and offered to staff at a later date on the LMS. In FY 2020-21, all trainings continued to be provided using virtual means. Some trainings that were conducted live were recorded and launched online for those unable to attend the initial training.

Consumer Employment Specialist Trainings/One-on-One Consultations:

As part of WSS, Consumer Employment Support (CES) Specialists work with Behavioral Health Services, contract providers and community partners to educate

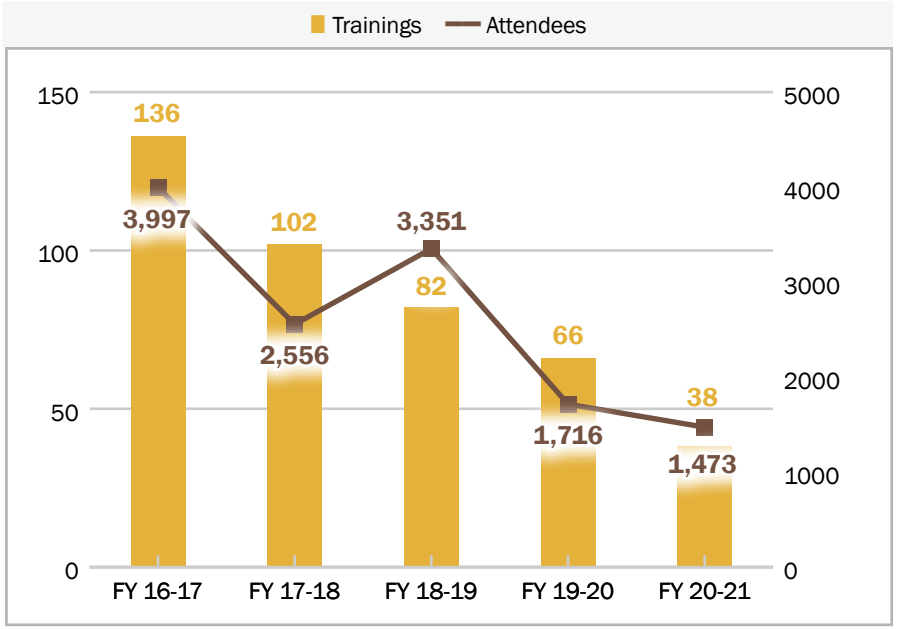
consumers on disability benefits. One of the Consumer Specialists provides educational and outreach services exclusively in American Sign Language (ASL). The specialists provided training on topics such as Ticket to Work, Reporting Overpayment, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to consumers who requested more in-depth guidance. Additional services for those who are deaf and hard of hearing include advocacy/education, group or individual consultations, and information/referral to resources.

Liaison to Regional Workforce Education and Training Partnership:

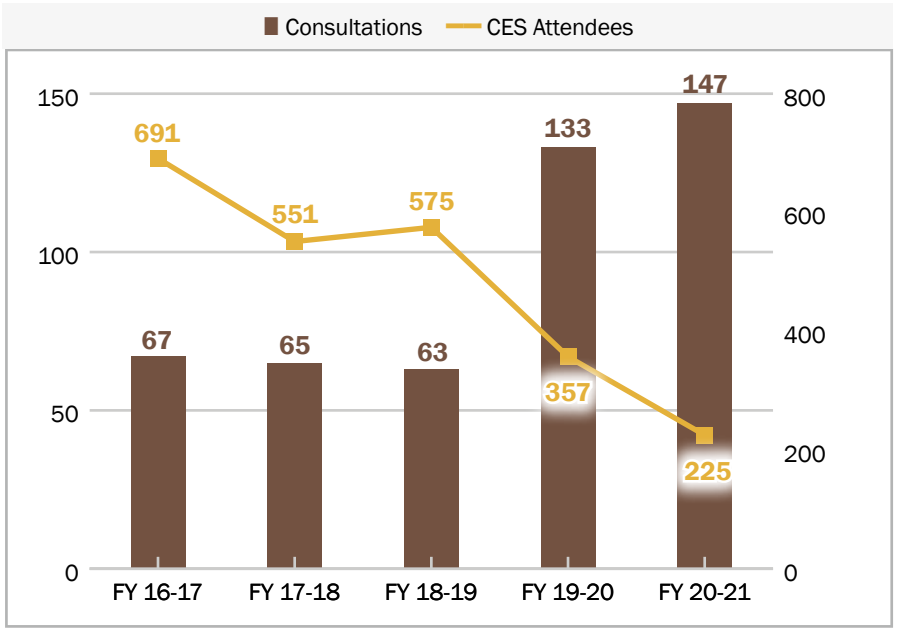
The Liaison represents OC by coordinating regional educational programs; disseminating information and strategies about consumer and family member employment throughout the region; and sharing strategies that increase diversity in the public mental health system workforce. They are also responsible for disseminating OC program information to other counties in the region; and coordinating regional actions that take place in OC such as Trauma-Informed trainings, cultural humility trainings, and support for building our Mental Health First Aid trainer capacity. Furthermore, through the SCRP, the OSHPD (now called HCAI) WET grant will be implemented. The focus areas are Staff Retention, Workforce Recruitment and Workforce Development/Pipeline programs.

- **Staff Retention Programs:** The loan repayment program will provide financial assistance to public mental health (PMHS) professionals identified within the 10 counties of the Southern Region partnership. This is a benefit to help with retention of hard-to-fill positions. Applicants will apply for the program through the OSHPD (now called HCAI) centralized application. Applications will be reviewed and selected on the basis of high need and hard-to-fill positions as designated by each County, with an emphasis on selecting applicants that enhance the diversity within the PMHS, such as individuals that possess an ability to provide services in HCA's threshold languages and based on years of services in the PMHS. The award amounts are up $10,000 per awardee in order to provide flexibility to determine the most effective use of the program funds within their individual counties. Recipients will be

CES Professional Development



CES 1:1 Consultations



required to complete a work obligation of 1-2 years depending on the award amount and complete an annual follow-up survey for up to three years regarding employment status and satisfaction within the PMHS.

Other retention strategies identified under the OSHPD/HCAI WET grant is staff training in evidence-based practices and in staff wellness programs. When staff are well trained in current interventions, they will be able to more adequately perform their job duties and will have more job satisfaction. This will include training in such topics as Trauma Informed Care, Cognitive Behavioral Therapy, Seeking Safety, Motivational Interviewing, and other EBP's. In addition to this professional development training staff will also be provided with staff wellness programs which will aid in reducing job stress and a reduction of job burnout. Training and programs in self-care, trauma informed care, and vicarious trauma strategies will be provided to staff in the PMHS.

- **Workforce Recruitment and Capacity Building:** The stipend program will assist in building a diverse workforce through recruitment of qualified interns. This program will provide financial support to graduate level students completing clinical training related to their degree program. Eligible programs will include a doctoral degree in psychology or master's degrees in either Marriage & Family Therapy, Clinical Social Work, Professional Clinical Counseling, or Psychiatric Mental Health Nurse Practitioner. Applicants will apply through the OSHPD (now called HCAI) centralized application and then be selected by county representatives based on the specific county needs. To be eligible, students must be participating in a practicum or internship within the County or contracted county provider system, be in advanced standing in their degree program and express an interest in future employment within the County or contracted provider system. Priority will be placed on students that possess threshold language skills, students that have consumer or family member experience, and students that will enhance the overall diversity within the PMHS. The stipend award will be $6,000 per student with a one-year work commitment with the stipend funds disbursed during the internship or traineeship time period.

- **Workforce Development and Pipeline Programs:** The pipeline program will have two components. First a peer employment program will be supported by offering training stipends and training to peers interested in peer employment. This focused support is to enhance peer employment within the County and contract provider system of care. Mentorship and support programs will be provided to foster successful employment for peers. The second component of the pipeline programs will include outreach and educational programs focused on high school and undergraduate students to provide information and guidance regarding careers in behavioral health. Sponsored activities may include marketing/social media, career fairs, mental health career seminars, mentorship programs, and career counseling support to assess for career readiness and to encourage the pursuit of a career in the PMHS. Specific outreach in Orange County will be to the Deaf community at the Orange County Department of Education's Deaf program schools such as University High School.

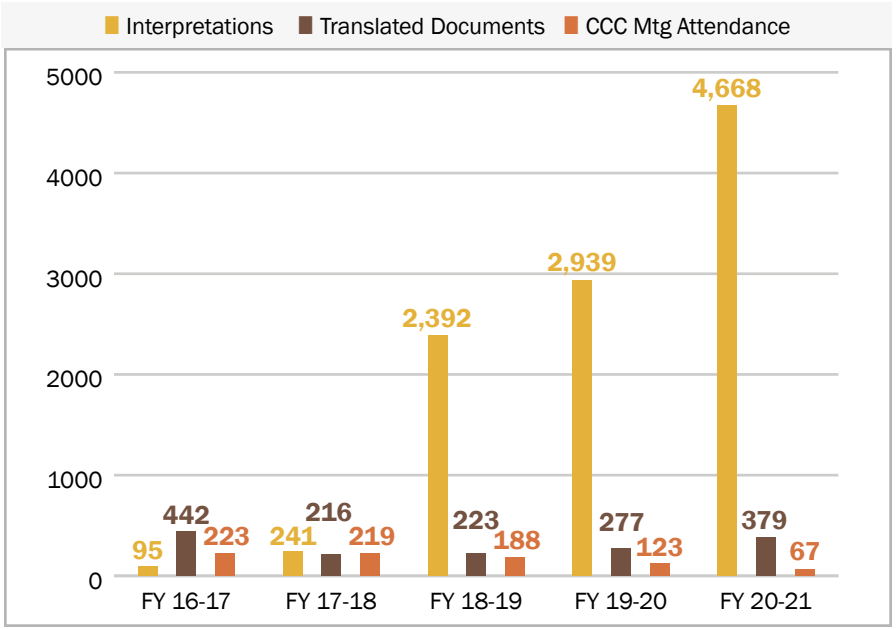
Multicultural Development Program

The Multicultural Development Program (MDP) consists of staff with language proficiency and culturally responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also coordinates requests and provides translation/interpretation services through in-house staff and a contracted provider. During FY 2020-21, there was a continued increase in the number of interpretation services provided in Spanish, Vietnamese, Arabic, Farsi and ASL both onsite and over the phone. This increase appeared, in part, to be related to an increase in COVID-19-related document translation requests.

Program staff translated, reviewed and field-tested a total of 379 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2020-21, which was more than the previous fiscal years.1 In addition, a Licensed Marriage Family Therapist serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language interpretation support is provided at trainings and community meetings.

In FY 2020-21, the Ethnic Services Manager facilitated the Cultural Competence Committee (CCC) meetings. The CCC consists of multi-ethnic partners and multi-cultural experts in OC who meet to provide input on how to incorporate cultural sensitivity and awareness into the Behavioral Health Services (BHS) system of care and how to provide linguistically and culturally appropriate behavioral health information, resources and trainings to underserved consumers and family members. In FY 20-21, the name of the committee changed to the Behavioral Health Equity Committee (BHEC) to provide a more comprehensive description of the work being done in the committee. Furthermore, a governing structure was developed and steering committee membership was formed. Attendance and interest in CCC (now called the BHEC) increased, especially after social injustice events occurred in our nation.

WET: Multicultural Development Activities



[1] The total number of interpretations (on-site & telephone) only reflect services that are coordinated through MDP, not Agency-wide. These numbers are reflective of the services provided by MDP and vendor services.

Training and Technical Assistance

The Training and Technical Assistance (TTA) program offers trainings on evidence-based practices, consumer and family member perspective, multicultural competency for mental health providers, and mental health training for law enforcement. The number of trainings offered in this area fluctuates from year to year depending on the number of professional development requests from HCA staff and community members. Additionally, the TTA program not only hosts several behavioral health trainings each year, but also provides CE units to other departments in the HCA requesting trainings for their clinical or medical staff. Examples of requested trainings include The Pandemic: What is Reveals About Inequities in Medicine, Expanding Treatment Options for the Growing Mental Health Pandemic, PCIT without ISMs, and Translating Culturally Responsive Leadership Into Action. In FY 2020-21, TTA provided 42 trainings for 6,699 attendees. The increase in the number of individuals and/or community members who engaged in TTA trainings is largely due to the launch of the new Cultural Competency training in September 2020. It was required that all HCA staff and contract providers completed the training during Fall 2020. In FY 2019-20, TTA provided 78 trainings for 3,642 attendees, 89 trainings for 5,711 attendees were provided in FY 2018-19, and in FY 2017-18, 88 trainings were facilitated to 2,573 attendees.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$1,223,390
FY 2021-22	$1,282,434
FY 2022-23	$1,465,794

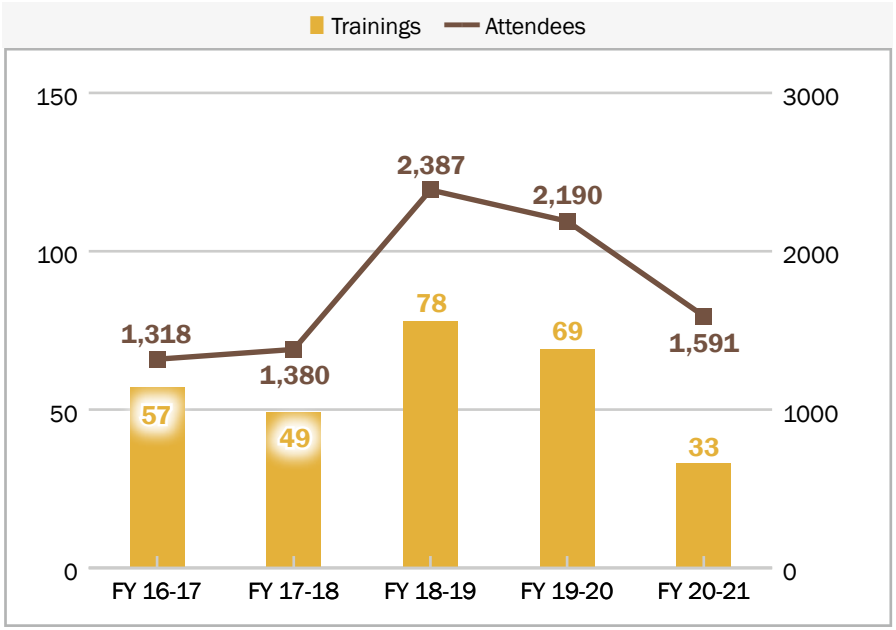
**Proposed increase for FY22-23 to support the Workplace Wellness Advocate program by providing resources. $30k for additional training.*

TRAINING DESCRIPTIONS / OUTCOMES

Evidence-Based Practices:

Trainings on Evidence-Based Practices were conducted to help behavioral health providers stay current on best practice standards in their field. County and contracted staff, community partners, consumers and their family members attended evidence-based training on topics. During FY 2020-21, training topics focused on, but were not limited to, Mental Health First Aid, Eye Movement Desensitization and Reprocessing (EMDR), Meeting of the Minds conference, Cognitive Behavioral Therapy for Insomnia and Other Sleep Disorders, Coordinating for a Successful Reentry System for Individuals with Behavioral Health Disorders, Moral Reconation Therapy, and Promoting Wellness & Resiliency: Community Resiliency Model.

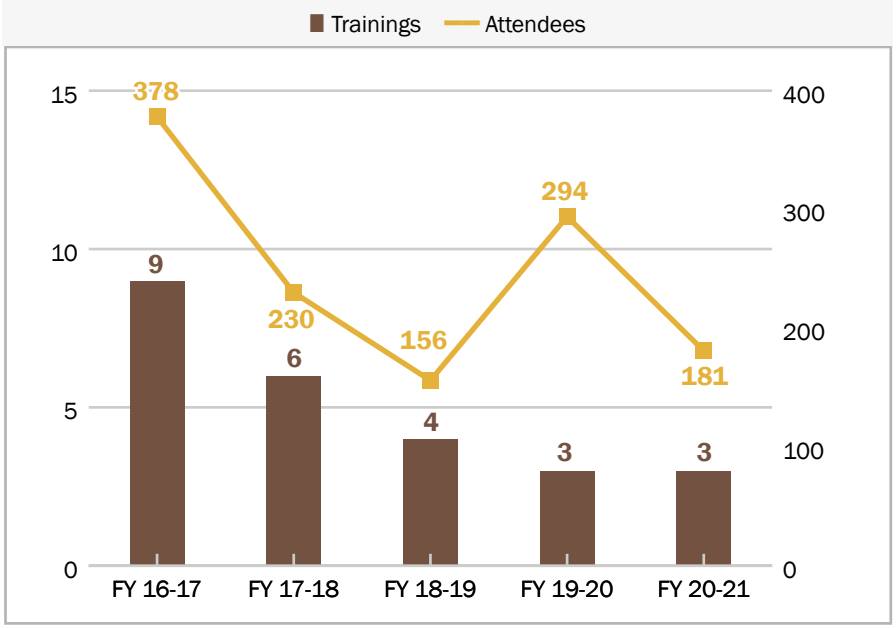
WET: Evidence-Based Practices



Consumer and Family Member Perspective:

Consumers and their family members sat on a panel where they shared their lived experience with County and County-contracted behavioral health personnel. Panel members presented on their lived experiences to help reduce stigma and raise awareness of behavioral health conditions. Over the past three years, fewer requests have been made for these trainings. During FY 2020-21, WET included consumer and family member perspectives using of peer specialists and highlighted key principles of recovery which includes the consumer perspective. These concepts were interwoven into most trainings.

WET: Consumer & Family Member Perspectives

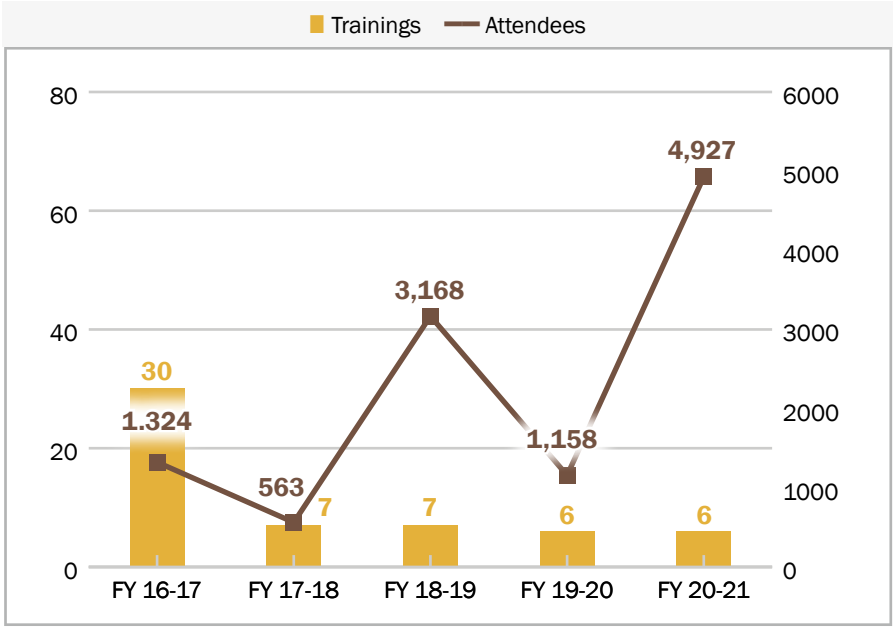


Cultural Competence:

Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Law & Ethics, What the Pandemic Reveals about Inequities in Medicine, Translating Culturally Responsive Leadership Into Action, and Addressing Unconscious Bias in the Workplace. Beginning in FY 2018-19, WET established an online Cultural Competency training for all BHS staff. Each year, new and existing staff are required to take this training as part of their professional development and per state regulations. Due to the establishment of this new annual training, the total number of attendees increased significantly during FY 2020-21.

Crisis Intervention Training (CIT), which is now being funded through PEI, is reported in Outreach to Increase Recognition of the Early Signs of Mental Illness.

WET: Cultural Competence



Mental Health Career Pathways

Mental Health Career Pathways offers courses through the Recovery Education Institute (REI), which prepares individuals living with mental health conditions and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff have personal lived experience.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$1,223,390
FY 2021-22	$1,282,434
FY 2022-23	$1,066,663

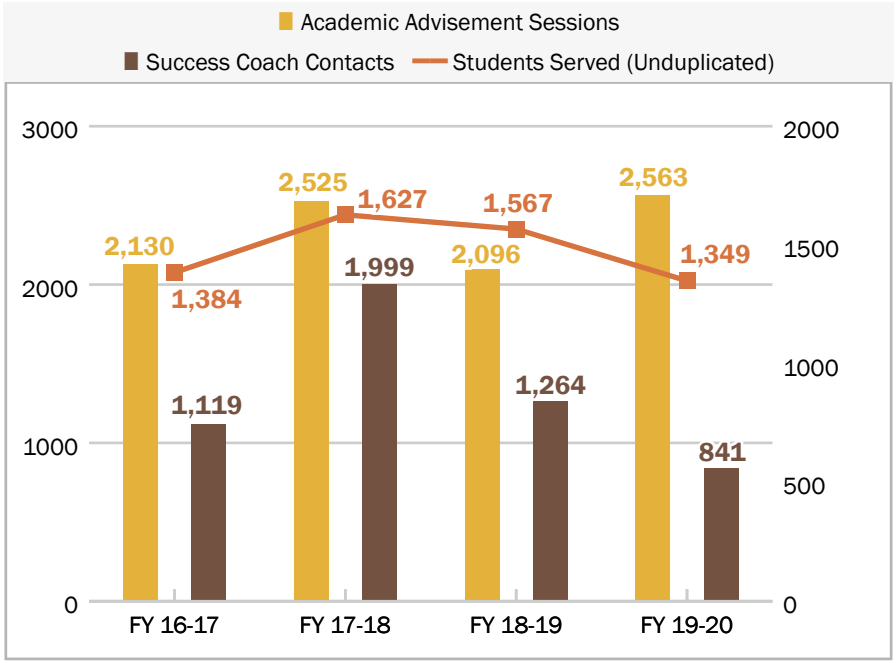
**Proposed activities for FY 22-23 to increased budget $20K Collaborate with OCDE's Deaf program to market the behavioral health field for deaf students due to severe shortage of deaf and ASL fluent behavioral health workers.*

PROGRAM DESCRIPTION/OUTCOMES

Similar to previous fiscal years, during FY 2020-21 REI provided 150 trainings to 460 active students. Of the 138 newly enrolled students, 88% identified themselves as living with a behavioral health condition, 5% identified as a family member of someone living with a behavioral health condition, and 7% identified as both. These percentages are similar to what was reported in previous fiscal years. In FY 2019-20 REI provided a total of 153 trainings to 499 active students, while in FY 2018-19, REI provided 161 trainings to 567 students. Of the 210 newly enrolled students during FY 2019-20, 76% identified themselves as living with a behavioral health condition, 10% identified themselves as a family member of someone living with a behavioral health condition, and 13% identified as both. Additionally, of the 274 newly enrolled students in FY 2018-19, 72% identified themselves as living with a behavioral health condition, 10% identified themselves as family members of those living with a behavioral health condition and 18% identified as both. In FY 2017-18, REI provided 156 trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. During FY 2020-21, students continued to engage in Academic Advisement and Success Coaching sessions. This was due to changes in service modalities. Due to the COVID-19 global pandemic the program provided more accessibility to resources. REI distributed Chromebooks to students to enable

REI Student Mentoring



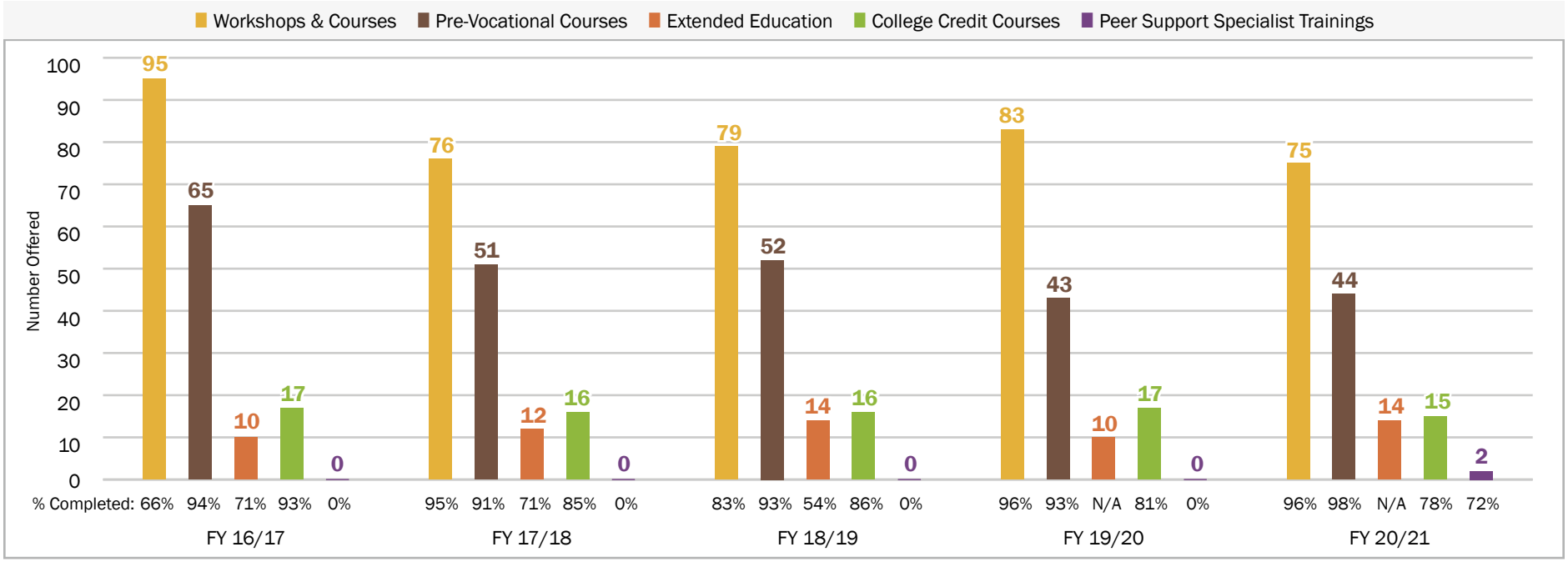
them to utilize online courses and academic advisement sessions. Students had immediate access to advising sessions, rather than having to travel to campus to seek guidance. Also, another shift was offering monthly course schedules, rather than semester-based schedules. Therefore, students had up-to-date information regarding advisement hours and workshop courses that were available.

In addition, REI offers a wide variety of trainings, including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence (see "Workshops & Classes" in table below). REI collaborates with adult education programs, links students to local community colleges for prerequisite classes, and provides accredited college classes and certificate courses onsite.

REI also offers a series of pre-vocational workshops to prepare students to enter the workforce. These workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers English as a Second Language and General Education Development classes for students to benefit their employment opportunities. A high percentage of students completed the REI workshops and classes between FY 2020-21 and FY 2017-18 (see "Workshops" and "Pre-Vocational Courses" below). This increase in completion rates from FY 2017-18 is due to an administrative efficiency created when WET consolidated classes and workshops and staff were better able to track course completion rates.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental health conditions and evidence-based practices to name a few. To receive certification, students must complete nine 3-unit courses and a 2-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies (see "College Credit Course" below). During FY 2020-21, there was a slight increase in the number of students who completed the certificate program, compared to the previous fiscal year as schools started re-opening. Also, REI offered a new Peer Support Specialist (PSS) training to prepare students for a career as a peer support specialist. This 16-week peer support specialist training offers students with lived experience skills to help others navigate and process the recovery journey. As it was first launched in FY 2020-21, REI offered 2 cohorts and 11 students completed the PSS training. This 16-week course teaches students the core competencies in being a Peer Support Specialist and prepares them for the workforce in public mental health.

Number of REI Workshops & Courses Offered



REI WORKSHOPS & COURSES	FY 2017-18[2]	FY 2018-19	FY 2019-20	FY 2020-21
Workshops & Classes	76 offered 95% completion rate	79 offered 83% completion rate	83 offered 96% completion rate	75 offered 96% completion rate
Pre-Vocational Courses	51 offered 91% completion rate	52 offered 93% completion rates	43 offered 93% completion rate	44 offered 98% completion rate
Extended Education[3]	12 offered 71% completion rate	14 offered 54% completion rate	10 offered	14 offered
College Credit Course	16 offered 85% completion rate	16 offered 86% completion rate	17 offered 81% completion rate	15 offered 78% completion rate
Peer Support Specialist Trainings	-	-	-	2 offered 72% completion rate

[3] In FY 2019-20, WET discontinued calculated Completion Rates for Extended Education courses. Since the Extended Education courses are structured in an open entry and exit format, there is no specific "Completion" date for these courses. Students can join or exit a course at any point during the semester, for any reason. Therefore, completion rates were not calculated for Extended Education courses.

Residency and Internship Programs

The Residencies and Internships program trains and supports individuals who aspire to work in the public mental health system. The California Psychology Internship Council (CAPIC) matches pre-doctoral candidates with a placement site based on a set of criteria. WET requests the same number of interns each year. However, CAPIC will match based on the number of students who have enrolled and site availability. All CAPIC students were placed in a Children Youth Behavioral Health (CYBH) site during FY 2020-21., WET's Neurobehavioral Testing Unit (NBTU) closed in August 2020 due to lack of qualified and willing CAPIC students seeking placement in a neurobehavioral testing unit. In FY 2018-19, two student interns were placed at WET's NBTU and four were placed at CYBH sites. Additionally, in FY 2017-18, four student interns were placed at WET's NBTU and two were placed at CYBH sites. All interns were supervised by a licensed psychologist.

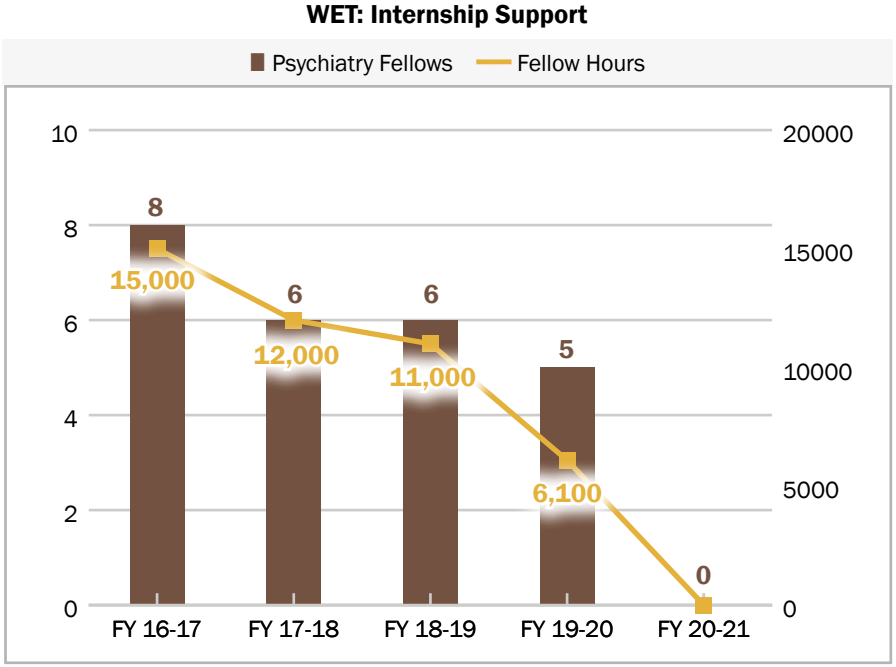
PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$170,000
FY 2021-22	$5,000
FY 2022-23	$700,000

**Proposed increase to FY 22-23 to hire clinical supervisors to support placement of student interns and hiring of pre-licensed clinicians. Funds would also be used to recruit paid interns who are deaf and/or ASL Fluent.*

PROGRAM DESCRIPTION/OUTCOMES

In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, supervised trainings were provided in the program to teach the recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented psychiatry residents and fellows into the public mental health system. The funded positions and training are one strategy the County uses to address the shortage of child and community psychiatrists working in community mental health. In FY 2020-21 CAPIC students completed fewer clinical internship hours compared to previous years. This decrease was due to one student exiting the program early as well as the inability to conduct in-person testing due to the restrictions imposed because of the COVID-19 pandemic.

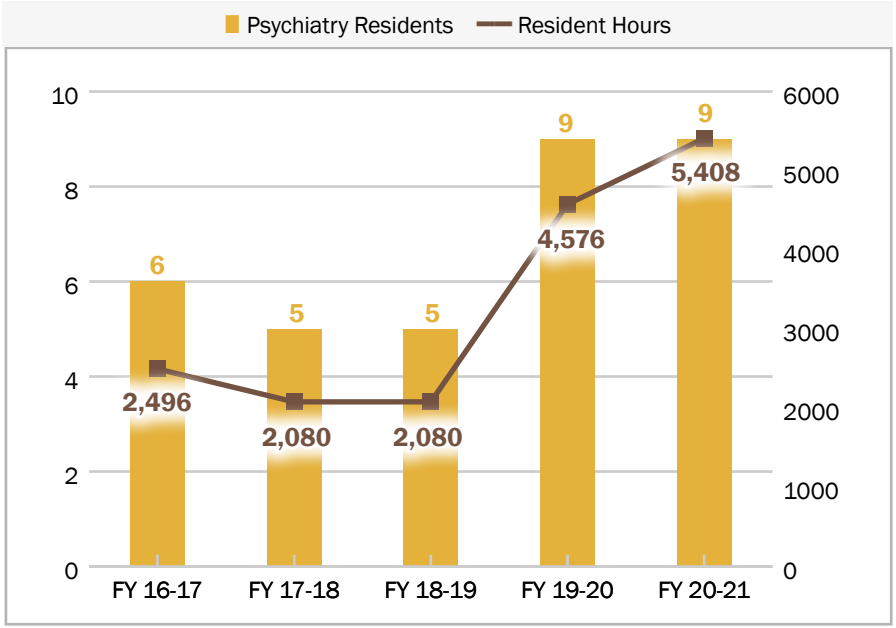
In spring 2021, WET distributed an online survey to all FY 2020-21 psychiatry residents and fellows to examine their experiences during the program. All psychiatry resident and fellow interns who responded (n=12) were satisfied with their experiences during the program. The clinical supervisors were perceived as knowledgeable, supportive, and positive. All of the interns also felt they gained the skills necessary to perform their tasks in the field (e.g., hands on experience, working with clients, utilizing clinical skills, etc.).



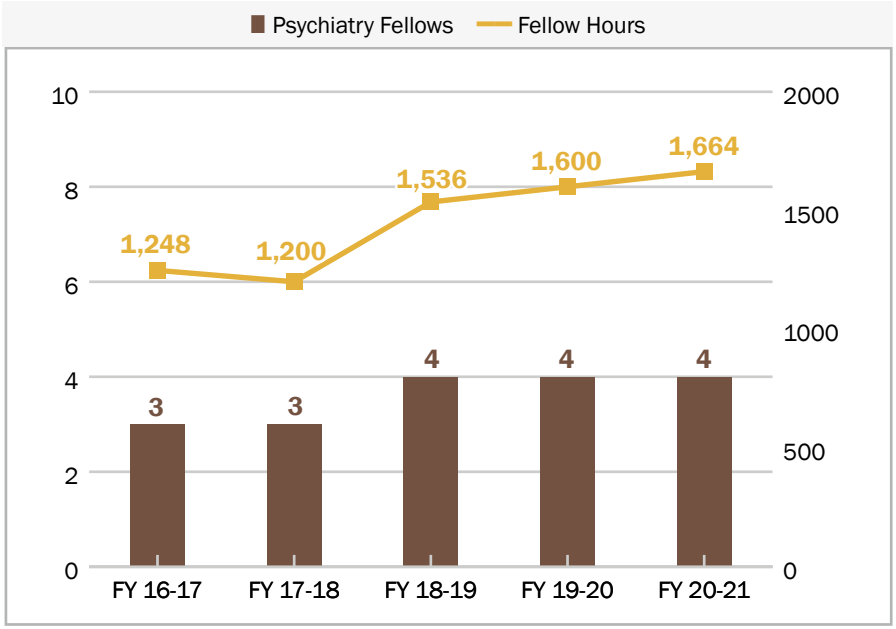
Because of the new requirements of California State Assembly Bill 93 which passed into law in 2019, Mental Health and Recovery Services (MHRS) now has greater responsibility to ensure high quality, legally and ethically defensible clinical supervision to its pre-licensed employees. In Fiscal Year 2021/2022, the WET program developed a centralized clinical supervision and internship program, that is being implemented over four phases, to better support clinical supervisors, ensure compliance with state mandates, improve clinical training, and strengthen the formation of new clinicians..

Approximately 15 clinical staff were chosen to participate in a year-long intensive training sponsored and funded by the Southern California Regional Partnership of Training Organizations (SCRP), and an additional four staff from that group continued for a further six-months in a Train-the-Trainer framework designed to bring updated clinical supervision core principles and practices to the 10 Southern California counties who are part of SCRP. These four staff make up the Clinical Supervision Program Core Team. Since beginning implementation, the WET Program has begun its own in-house clinical supervision training with the first new supervisors being trained and ready to practice by the end of August 2022. The Clinical Supervision program has created three consultation groups for current supervisors to train them on current state mandates and to increase support for them in their new role. There are currently 24 participants in these groups with training encompassing all aspects of clinical supervision including, legal and ethical issues in supervision, compliance with state mandates, models of supervision, trauma-informed supervision, multi-cultural supervision and other topics. The Core Team is also creating a training program for student interns from local universities who spend an internship year working for Health Care Agency. There will be 10-12 monthly trainings that will expose the students to different divisions and programs within MHRS, provide an overview of different therapeutic modalities, discuss the road to clinical licensure, and other salient topics. The team hopes to create a rich learning environment for the students in order to assist in future recruiting of graduates, build goodwill with the universities and community, and provide a public service for mental health in Orange County.

WET: Residency Support



WET: Fellow Support



Financial Incentive Programs

The Financial Incentives Program (FIP) is an internal program that seeks to expand a diverse bilingual and bicultural workforce by providing financial incentive stipends to BHS County employees seeking bachelor's (BA/BS) and master's (MA/MS) degrees, and to address the community psychiatrist shortage by offering loan repayment for psychiatrists working in the OC public mental health system. In FY 21/22, the WET office continued to support existing FIP contracts but did not open up the new application cycle. This program is scheduled to resume in FY 22/23 as part of the Workforce Retention strategies in addition to the loan repayment program offered through the OSHPD WET grant. The pre-approved budget and number of eligible applicants determine the exact number of students/psychiatrists who are enrolled in FIP each year. FY 2018-19 showed a decline in the number of graduate student stipends awarded. Although the county still faces a shortage of community psychiatrists, the number participating in FY 2018-19 was nearly double that of FY 2017-18.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$526,968
FY 2021-22	$646,968
FY 2022-23	$718,468

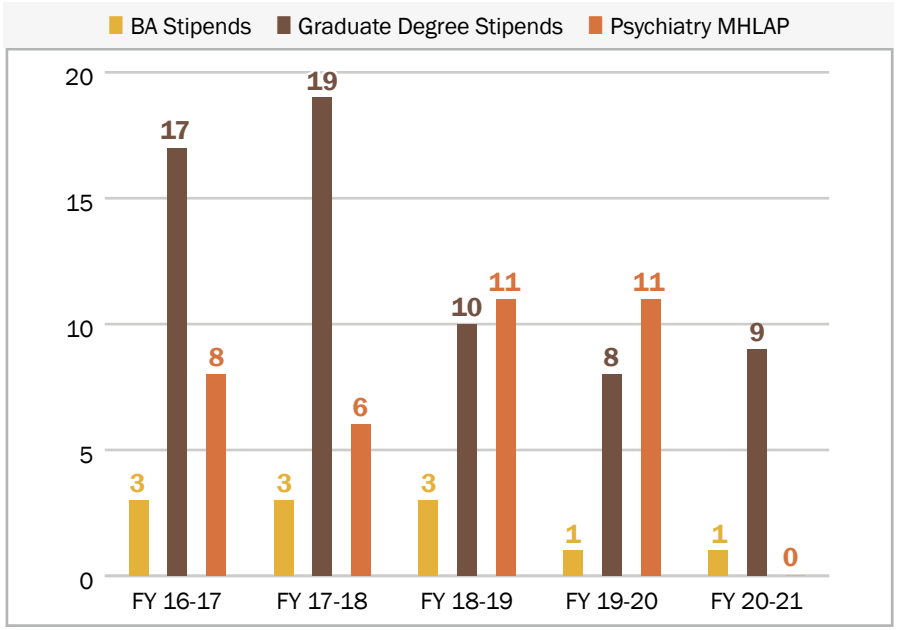
**Proposed increase to FY 22-23 to for additional tuition repayment for staff to pursue further education.*

PROGRAM DESCRIPTION/OUTCOMES

Similar to previous years, in FY 2020-21, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (70%), followed by Caucasian (20%), and Asian (10%) descent. The primary languages spoken were English (60%) and Spanish (40%). The same proportion of students enrolled during FY 2019-20 identified as Mexican/Hispanic (70%), Caucasian (20%), and Asian (10%); yet half of those enrolled spoke either English (50%) or Spanish (50%) as their primary language. In FY 2018-19, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (64%), followed by Caucasian (24%) and Asian (12%) descent. The primary languages spoken were English (35%) and Spanish (35%). Roughly one-quarter said they spoke multiple languages (29%). In FY 2017-18, stipends were provided to 22 staff. More than half of staff self-identified as Mexican/Hispanic (54.6%), followed by Asian (27.2%) or Caucasian (18.2%) descent. While over one-third indicated their primary language was English (36.3%), a large proportion indicated they spoke more than one language (45.5%).

In FY 2020-21, WET conducted an online survey with all staff who participated in FIP during that fiscal year. Out of the 10 staff enrolled in the program, five responded

WET: Financial Incentives Offered

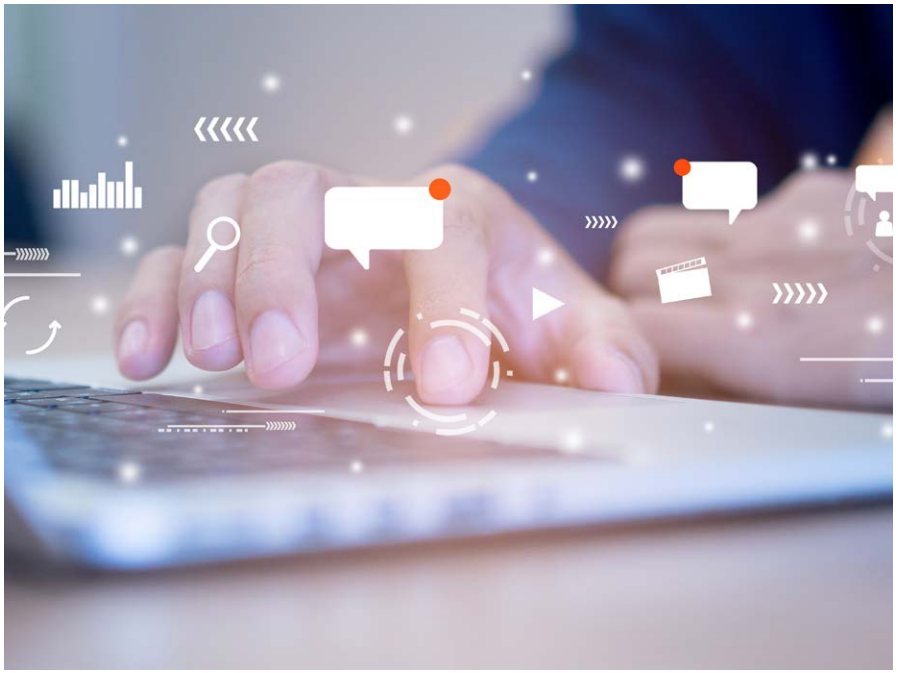


to the online survey (50% response rate). Of those who responded, the majority of participants self-identified as female (60%) and were between the ages of 26-59 (100%). A large proportion indicated their racial or ethnic background as being either Mexican/Other Latino (50%), Caucasian/White (25%), or Asian (25%). All staff indicated they were employed with the County and worked at several behavioral health locations including Adult and Older Adult Residential or Inpatient Services, Assisted Outpatient Treatment (AOT), Clinical Evaluation Guidance Unit (CEGU), Authority and Quality Improvement Services (AQIS), or Community Counseling and Supportive Services (CCSS).

Staff were asked to identify their organizational roles prior to and after participating in FIP. Prior to enrolling in the FIP program, 60% of staff indicated they were direct services providers, while 40% identified as support staff. After Participating in FIP, no staff had indicated they advanced to a new role within the Agency. In addition, staff were asked if they earned an advanced degree as a result of their participation in FIP. All staff said that FIP helped them to earn a higher educational degree or level of schooling, as well as assisted them with achieving their educational goals (100%). More specifically, prior to participating in FIP, participants either had earned their high school degree (20%) or a bachelor's degree (80%). After engaging in FIP, 60% of staff had advanced their education by earning a master's level degree.

The vast majority of staff said that FIP helped them to advance in their careers (80%). When asked to list all the ways FIP helped them, 80% of participants said the program helped them to advance their education, invest in their abilities, increase their awareness of cultural and linguistically diverse services, advance earning potentials, or develop new skills to apply with clients. The majority also said the program helped them to network with other professionals and increased their motivation to do their jobs. A smaller proportion of participants said the program helped them to develop leadership skills (60%) or encouraged them to stop out of their comfort zone (60%).

In the future, staff would like to see specific changes made to FIP to improve its effectiveness. Specifically, staff would like to participate in a mentorship or transition program (40%) or more general support from FIP after graduation (40%). Twenty percent (20%) of those who responded would also like more support during the program, more advertising about the benefits of participating in FIP, and a streamlining of the application process. Some would also like to see more colleges listed as FIP partners. While staff had recommendations for program improvements, overall, all staff who responded to the survey were satisfied with their FIP experiences, felt they were treated with courtesy and respect by staff, and would recommend the program to their colleagues. The majority also felt the program was very or extremely effective in developing a bilingual/bicultural workforce (20% and 40%, respectively). The remaining responses indicated the program was somewhat effective (20%) in developing a bilingual/bicultural workforce.



CAPITAL FACILITIES & TECHNOLOGICAL NEEDS

The Capital Facilities and TecŠological Needs (CFTN) component of the Mental Health Services Act (MHSA) was designed to enhance the existing public mental health services infrastructure. It provides resources for two types of infrastructure:

1. Capital facilities funding may be used to purchase, build or renovate land and/or facilities for the delivery of MHSA services to consumers and their families or used for MHSA administrative offices.

2. Technology funding may be used to modernize and transform clinical and administrative information systems and increase consumer and family empowerment by providing the tools for secure consumer and family access to health information. CFTN projects are now funded through transfers from CSS as allowed by the Act and accompanying regulations.

Capital Facilities

REQUIREMENTS FOR CAPITAL FACILITIES (CF) FUNDS

A county may use MHSA Capital Facility funds for the following types of projects:

- Acquire and build upon land that will be County-owned.
- Acquire buildings that will be County-owned.
- Construct buildings that will be County-owned.
- Renovate buildings that are County-owned.
- Renovate buildings that are privately-owned and dedicated, and used to provide MHSA services if certain provisions are met (i.e., renovations to benefit MHSA participants or MHSA administration's ability to provide services/programs in County's Three-Year Plan, costs are reasonable and consistent with what a prudent buyer would incur, a method for protecting the capital interest in the renovation is in place).
- Establish a capitalized repair and replacement reserve for buildings acquired or constructed with CF funds and/or the personnel cost directly associated with a CF project (i.e., project manager, with the reserve controlled, managed and disbursed by the County).

The former California Department of Mental Health (now Department of Health Care Services) outlined the following requirements for Capital Facilities funds:

- CF funds can only be used for those portions of land and buildings where MHSA programs, services and administrative supports are provided and must be consistent with the goals identified in the CSS and PEI components of the County's Three-Year Plan.
- Land acquired and built upon or construction/renovation of buildings using CF funds shall be used to provide MHSA programs, services and/or supports for a minimum of 20 years.
- All buildings through CF must comply with federal, state, and local laws and regulations, including zoning and building codes and requirements; licensing requirements, where applicable; fire safety requirements; environmental reporting and requirements; hazardous materials requirements; the Americans with Disabilities Act (ADA), California Government Code Section 11135 and other applicable requirements.
- The County shall ensure that the property is updated to comply with applicable requirements, and maintained as necessary, and that appropriate fire, disaster and liability insurance coverage is maintained.
- Under limited circumstances counties may "lease (rent) to own" a building. The County must provide justification why "lease (rent) to own" is preferable to the outright purchase of the building and why the purchase of such property with MHSA CF funds is not feasible.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$12,519,749
FY 2021-22	$16,307,384
FY 2022-23	$45,253,892

**Proposed activities in FY22-23 to increase budget $6.3M to contract vendors to get systems in compliance with state regulations. Added $7M for Population Health, addtl $1.2M for Business Intelligence, $2M Cerner upgrade. Adding $20M for additional Wellness Campus to be built. Right size Behavioral Health Training Facility budget.*

TecŠological Needs

REQUIREMENTS FOR USE OF TECHNOLOGY FUNDS

Any MHSA-funded technology project must meet certain requirements to be considered appropriate for this funding category:

- It must fit in with the state's long-term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.
- It must be part of and support the County's overall plan to achieve an Integrated Information Systems Infrastructure through the implementation of an Electronic Health Record (EHR).

CURRENT TECHNOLOGY PROJECTS

HCA Electronic Health Record (EHR):

The county Mental Health and Recovery Services (MHRS) continues to make progress on its planned trajectory of increased deployment and utilization of the Cerner based electronic health record system (EHR), and making efforts at promoting increased adoption and effective use to allow better coordination of care with access to more comprehensive data, and realize improvements in outcomes and quality. The goals and objectives of this effort support the goals of MHSA to promote well-being, recovery, and resilience. There is an ongoing effort to continue to expand to include all areas of MHRS, and to continue to implement additional functionality that supports operational efficiency, the planning and delivery of care, and to comply with all emerging laws and regulations and security and privacy guidelines. The scope of work includes a combination of software, technology infrastructure and services develop and enhance the overall system. Recent accomplishments include a wider adoption of the system such as the Substance Use and Disorder program, new functionality such as e-prescriptions for controlled substances, moving certain elements of the system to a cloud-hosted environment, upgrades of the technology infrastructure, improvements in the data-use monitoring and reporting processes, and implementation of telehealth services.

Current efforts include:

1. Transition the on-premise model of the Cerner related technology infrastructure to a remote hosted cloud environment provide by Cerner. This will provide several advantages such as high availability and scalability of the system, allow access to the system from anywhere especially as we accommodate a hybrid telecommuting work schedule for staff, increased levels of security, improved monitoring processes, support for an easier path to interoperability and data integration and sharing with other partners in the community, and transference of certain risks to the vendor.

2. Build models for our contract providers to allow secure data interfaces to the Cerner EHR, and to participate, as appropriate, in consent-based Health Information Exchanges to allow data sharing as permitted under the appropriate laws and regulations.

3. Develop and implement a technology infrastructure to support the use of data analytics and health informatics, incorporating artificial intelligence and machine learning based data science principles, to support predictive modeling, historical data trends and patterns, real time alerts and reminders and data visualizations, and allow MHRS to make more informed clinical decisions at the points-of-care and to support quality and operational improvements. This will be a continuing journey with a focus on the use of data to and help develop more effective strategic and tactical plans.

4. Continue the implementation of the EHR in other areas of MHRS, such as the Crisis Stabilization Unit.

5. Build enterprise data warehouses and data lakes and date stores to enable increased data sharing through a consent-based role-based access approach, with consideration to security and privacy. Included in this effort is an elaborate effort to ensure consistency and uniformity of terminology, development of and training on appropriate data use methods, implementing levels of classification of data to ensure appropriate governance, monitoring and prevention of breaches, and consolidation of multiple data sources into a 'single source of truth' based data source.

6. Interfaces with the state Prescription Drug Monitoring Program, as well as interfaces with University of California, Irvine to support lab orders and results.

7. Working with CalOptima to support CalAIM ECM related service delivery, documentation and claims processing and reconciliation.

8. Working with Correctional Health Services on data interfaces.

Thus far, implementation of the EHR at the County-operated outpatient clinics has gone well and user acceptance has been extremely high.

The third phase will allow the County to interface securely with its contract providers and to participate, as appropriate, in consent-based Health Information Exchanges outside County Behavioral Health Services, including with the federal EHR Meaningful Use program. Phase 3 project costs will include, but not be limited to, software licenses, network infrastructure such as servers, storage and network monitoring appliances, other EHR and data warehouse upgrades, consolidation of data from multiple sources, internal human resources, external consultants and training. Additional funds are being requested for transfer in FY 2021-22 to support the migration of the HCA EHR to the cloud

County Data Integration Project:

$1 million of the Three-Year Plan TN budget will fund a portion of the ongoing support for a System of Care Data Integration System. This system will facilitate appropriate, allowable data-sharing across County departments and with external stakeholders with the goal of delivering essential and critical services, including behavioral health care, to county residents in a more efficient and timely manner.

County Population Health/Equity and Client Engagement Project:

The County has recognized the need for the development of a system through a partnership with external vendors for supporting cohesive, integrated and comprehensive strategies for developing and implementing a population health management approach to promoting better health outcomes for the Orange County community through collaborative interventions, coordination, linkages, education, partnerships with other providers, engagement with community organizations and the individuals themselves, and ensure that the collective goals of all the stakeholders are met.

The County population health strategies will consider the socio-economic, environmental, and behavioral factors that influence and affect the health of the community, keeping in mind the diversity and equity issues that exist in the heterogeneous population within the county. The county will develop a multi-faceted approach to include not only those individuals that present themselves with specific needs across the continuum of care within the county but intends to be more iteratively proactive and address the county population in whole as part of a larger and coordinated framework of planning and delivery of services and taking accountability for improving some of the most important health issues facing the community. This will be accomplished through a deep engagement effort with the individuals and via a multisector partnership to ensure sustainability for best allocation and use of the collective resources, reduced duplication of efforts, and improved care and service coordination.

An enterprise-wide integrated system that can support these needs will enable

the County to address key aspects of health in the community, and help connect, bring access and allow coordination of programs and services to the communities of focus easily and in a seamless manner and help drive improvements.

The success of this population health and engagement project is multi-faceted. Ideally, this effort will improve the health outcomes of individual patients/clients and the population at large and address equity-driven healthcare gaps in our community through their engagement and allow the participating provider and resource community to be better informed and connected with each other in terms of planning and delivering services.

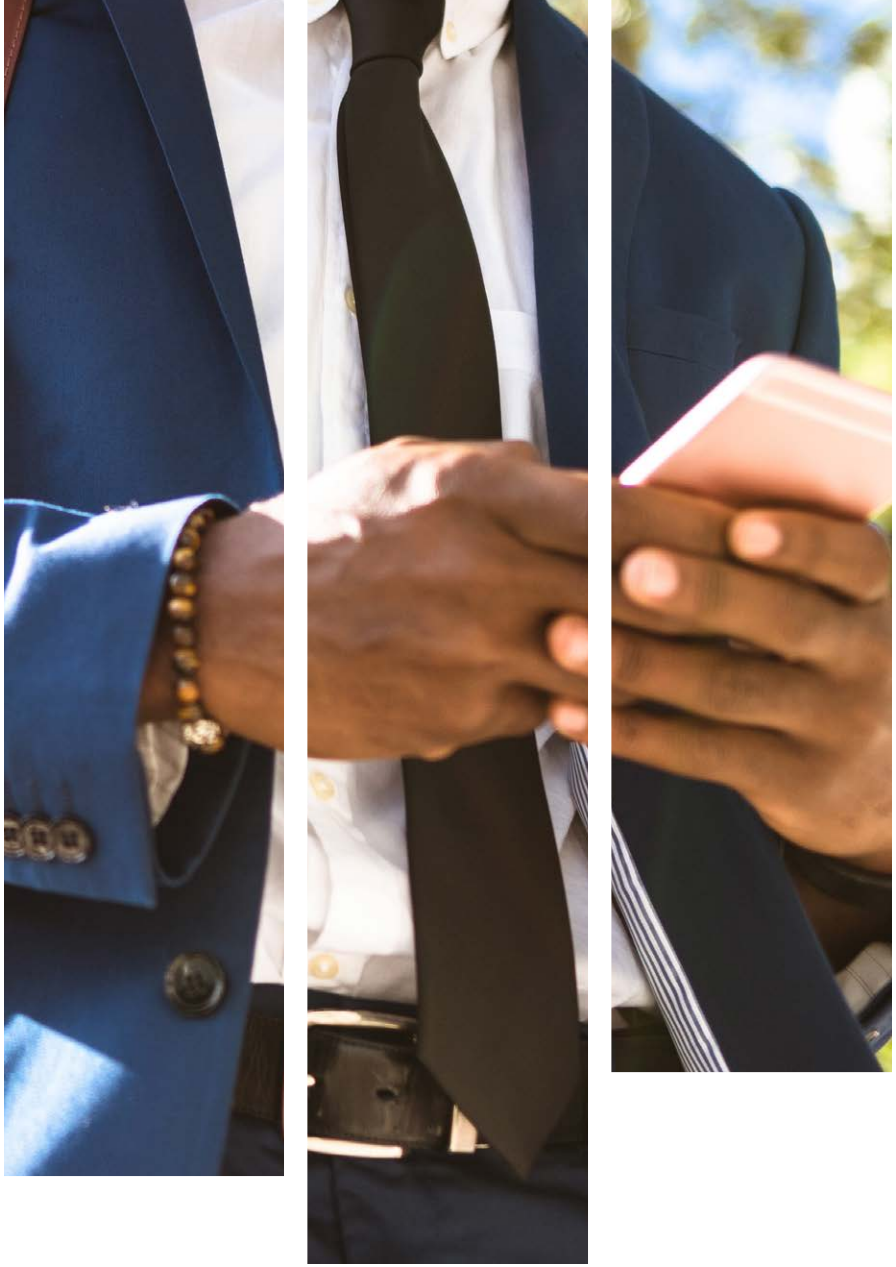
Training and Skills Development:

MHRS research staff is being provided targeted training for the use and adoption of various tools to support the development of data analytics and business intelligence.

SPECIAL PROJECTS

Orange County Special Projects are projects that are unique in scale or scope and may involve multiple services, systems and/or agencies. These programs include:

- Help@Hand
- Behavioral Health System Transformation
- Psychiatric Advance Directives
- Community Training, Screening, Clinical Care and Consultation Services for Clinical High Risk Psychosis
- Potential INN Projects



Help@Hand (INN)

Help@Hand (formerly Tech Suite) is a statewide project comprised of multiple counties and cities that leverages interactive technology-based mental health solutions (i.e., internet-based and/or mobile applications) to help improve access to care and outcomes for people across the state. The project seeks to understand how technology is introduced and works within the public behavioral health system of care. Help@Hand aims to provide diverse populations with access to mobile applications ("apps") designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and/or increase user access to mental health services when needed.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$6,000,000
FY 2021-22	$3,100,000
FY 2022-23	above carryover

SERVICES

Orange County was approved to join this Innovation project in April 2018 and began project implementation planning immediately. The HCA originally applied as a four-year project and was recently approved by the MHSOAC for a one-year, no-cost extension. Thus, the project will end for Orange County in April 2023. The primary purpose of this project is to increase access to mental health services to underserved groups, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

Help@Hand consists of several main components of which participating counties have chosen to opt in or out, based on their local needs. Orange County was approved to implement all project components, which includes:

- Technology Apps (3):
  - 24/7 Peer chat, which will offer around-the-clock, anonymous peer chat support to an individual
  - Therapy Avatar, which will offer virtual manualized evidence-based interventions delivered via an avatar in a simple, intuitive fashion (e.g., mindfulness exercises, cognitive behavioral or dialectical behavior interventions)
  - Customized Wellness Coach, which will utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users
- Marketing and Outreach
- Evaluation

Peers are integral to Help@Hand, and the vision of the peer role is to incorporate peer input, expertise, knowledge and lived experience at all levels of the project, and to support the use of identified apps through peer outreach and training. The peer component of the project holds significant importance as it:

- Creates transparency around basic cautions, clarity about user choice, and highlights that technology does not replace in-person mental health services
- Provides clarity on the project definition of peers, roles, and serves as an example of a peer staffing ladder
- Supports collaboration of peer leads across the state important to project learning, connection, and problem-solving
- Responds to county/city community stakeholder specific needs by developing digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices
- Trains the peer workforce to facilitate digital mental health literacy sessions that will keep learning at the local level and sustainable
- Trains project partners on peer culture, experience, and history supporting better project integration

- Integrates consumer expertise and voice in evaluation thus enhancing the work
- Incorporates lived experience and perspective on how possible future technology can help the project be responsive to consumer needs

Since inception, Orange County has been planning the implementation and launch of Mindstrong, a technology app that fits within the Customized Wellness Coach component. Mindstrong is a digital mental health app through which licensed therapists, psychiatrists and/or care partners (i.e., Care Team) provide access to telehealth services via phone, video or in-app texting, and virtual 24-hour crisis support. The secure smartphone app also uses innovative and proprietary algorithms to anticipate when a person may benefit from additional support, prompting someone from the Care Team to reach out proactively and provide additional, unscheduled support before the person experiences a mental health emergency. While telehealth services are an established behavioral health practice, the Mindstrong automatic notifications (i.e., biomarkers) are a new and emerging approach to care and derived from the touches, scrolls and taps a person makes throughout the day as they use their phone. These notifications may provide an early indication of changes in the moods and symptoms associated with an individual's condition that may help facilitate earlier access to care and support. The Mindstrong app and services are only available to eligible participants within specific partnered programs within Orange County. Services include telehealth, such as therapy, psychiatry and medication management; access to virtual urgent/crisis support 24 hours a day, seven days a week; secure in-app text messaging for on-demand support; proactive clinician outreach; and access to psychoeducation materials, including a personalized in-app dashboard graphing the participant's Mindstrong algorithm results.

During FY 2020-21, Orange County continued its pilot of Mindstrong within a local outpatient psychiatry clinic. Activities focused on refining project implementation on an iterative basis to adjust the processes and requirements of multiple partners (i.e., HCA, Mindstrong, outpatient psychiatry clinic). Project staff also continued their efforts in establishing a digital referral and consent process. Details about the Help@Hand Collaborative activities during FY 2020-2021 are available in the MHSA INN Annual Project Report.

OUTCOMES

Help@Hand will examine the following learning objectives:

- Detect and acknowledge mental health symptoms sooner
- Reduce stigma associated with mental illness by promoting wellness
- Increase access to the appropriate level of support and care
- Increase purpose, belonging and social connectedness of individuals served
- Analyze and collect data to improve mental health needs assessment and service delivery

Preliminary results of the Mindstrong pilot from May 26, 2020, through October 20, 2021, are listed in the table below.

REFERRALS AND ENGAGEMENT	Outputs
Total Referrals	294
Total Enrollments	223
Referral to Enrollment Conversion Rate	76%
Total Virtual Therapy Sessions	2,142
% who used virtual therapy sessions	81%
Total Virtual Urgent Sessions (i.e., crisis)	121
% after business hours and during weekends	58%
Average response time (in minutes) from request to connection	7 minutes
Number of unduplicated consumers who used urgent sessions	46
Number of urgent sessions resulting in a call to OC Crisis Assessment Team	1
Total In-App Text Messages (outside of scheduled sessions)	4,165
Average number of days/month consumers use the Mindstrong app	8 days/month
Proactive Clinician Outreach	~60 times/month

There is high utilization of digital mental health services accessed through the individual's smartphone as evidenced by the 223 enrolled consumers who are using Mindstrong services and the app an average of eight days per month. However, the case-by-case recruitment approach has limited the total number of referrals received and slowed overall enrollment. Upcoming plans for project expansion will focus on a broader referral approach.

In addition to monitoring engagement and use of Mindstrong services, an individual's level of functioning is assessed at intake and every 60 days using the Diagnostic and Statistical Manual (DSM)-5 Level 1 Symptom assessment, which assesses 13 symptom domains on a five-point scale ranging from 0 to 4, with a score of 3 or higher reflecting clinical elevation. While outcomes are typically analyzed after a consumer has been enrolled in services for six months, clinical progress among consumers who have been enrolled for at least two months (i.e., 60 or more days) are reported below as a preliminary evaluation of impact.

Of the 223 individuals enrolled, 73 (25%) have been enrolled for approximately two months or longer and completed a follow up DSM-5 assessment. Of these, 47 (64%) reported clinical elevation on one or more depression and/or anxiety symptoms. As shown in the table below, 43% to 60% of consumers who reported clinical elevation on a symptom at intake reported improvement on that symptom after enrolling in Mindstrong services, with 31% to 54% of consumers reporting clinically significant reductions and were no longer elevated at follow up. Another 25% to 50% maintained their level of functioning and did not report any worsening distress at follow up. Among those who reported worsening distress after enrolling (n=4% to 16%), Mindstrong proactively reached out to offer additional support. Notably, only one urgent session resulted in the Mindstrong Care Team calling the HCA Crisis Assessment Team, suggesting that frequent engagement with Mindstrong services, access to 24 hours a day, seven days per week virtual urgent care, and proactive outreach following a shift in clinical presentation may help prevent escalation into a psychiatric emergency necessitating an in-person intervention.

CLINICAL PROGRESS AMONG CONSUMERS ELEVATED AT INTAKE AND ENROLLED FOR 2+ MONTHS, BY SYMPTOM

Consumers Elevated at Intake, by Symptom	Significant Improvement at Follow up*	Some Improvement at Follow Up*	Maintaining at Follow Up*	Declining at Follow Up*
Depression Domain:				
No interest/pleasure, n=30	13 (43%)	3 (10%)	10 (33%)	4 (13%)
Down/Hopeless, n=26	13 (50%)	2 (8%)	10 (38%)	1 (4%)
Anxiety Domain:				
Situation /Avoidance, n=32	14 (44%)	5 (16%)	8 (25%)	5 (16%)
Nervous/Worried, n=32	10 (31%)	4 (12%)	16 (50%)	2 (6%)
Panic/Frightened, n=13	7 (54%)	0 (0%)	4 (31%)	2 (15%)

**Numbers within a row may not total to 100% due to rounding.*

CHALLENGES, BARRIERS AND SOLUTIONS IN PROGRESS

The participating cities/counties are at the forefront of innovation to understand how technology is introduced and works within the public behavioral health system of care. When faced with challenges or barriers, the collaborative offers the benefit of a shared learning experience that accelerates learning.

Throughout this process, the most significant lesson learned is that the primary focus of Help@Hand is not the implementation of apps, but rather the development of a sustainable digital mental health system of care for California (i.e., infrastructure building). As such, initial efforts should prioritize system preparation; user, program and agency readiness for change; and implementation planning. An effective work plan and checklist of pre-launch activities are essential to prioritize the necessary and required preconditions prior to the launch of an app (i.e., roadmap of involved parties and logical order/priorities for Information Technology (IT), data sharing, Compliance, clinical integration, etc.).

The initial planning phase should also include strategies for an effective communication and decision-making process. System readiness requires collaboration and ongoing communication with program managers and staff in programs where an app will be launched. It is critical to obtain feedback from clinicians and peers early on to assess interest and/or readiness to use the app services. Equally as critical is communication with vendors, checking in to ensure information, messaging and shared vision is accurate. The public behavioral health system and the private industry have their own language and communication style. As a result, it is important to frequently define terms to ensure shared understanding. Furthermore, existing technology is not necessarily geared with the County mental health plan consumer in mind, so when exploring and procuring technology, it is important to be clear in including the type of technology the target population will likely have access to, as well as language capabilities.

With regard to the planning, development and implementation of apps, it is essential for this process to be streamlined and sustainable in the future. This includes the involvement of County Counsel, Compliance and IT teams throughout the process. Additional considerations include outlining a process for procuring and learning about new apps/vendors, creating a systematic process for testing apps, and addressing potential safety, risk and liability concerns.

Behavioral Health System Transformation (INN)

The **Behavioral Health System Transformation** (BHST) project is an INN project designed to create a system that can serve all Orange County residents, regardless of insurance status, type, or level of clinical need. Its primary purpose is to promote interagency and community collaboration related to mental health services, supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention. Orange County's BHST project proposal was approved by the MHSOAC in May 2019 and local project start up began in October 2019.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	$9,477,500
FY 2021-22	$5,355,250
FY 2022-23	above carryover

SERVICES

Unlike the majority of INN projects that tend to focus on new or modified approaches to service delivery, the BHST project seeks to transform the behavioral health system of care by identifying strategies to braid public and private funding; creating a value-based system; and improving navigation of and access to needed resources. Project activities are divided into two parts:

BHST Part 1, Performance and Value-Based Contracting, addresses the plan to create a value-based system that braids public and private funding. Key steps and activities include:

- Establishing community-defined values and metrics
- Identifying braiding strategies for public and private funding
- Aligning community-defined outcomes with legal, fiscal and regulatory requirements
- Developing new provider contract templates
- Providing technical assistance to assist providers

BHST Part 2, Digital Resource Navigator, involves the development of a digital navigation tool (i.e., OC Navigator). The features, functionality and list of resources in the digital resource navigator will be developed through a participatory process that involves community members, including consumers, family members and behavioral health providers. Core features of the directory will include an optional social determinants survey, curated list of resources prioritized based on an individual's needs, and ability for providers to update resource information in real-time. Key steps and activities include:

- Identifying directory resources, features and functionality
- Directory development and testing
- Continuous review and refinement
- Project evaluation and lessons learned

Due to its focus on identifying methods to change processes and integrate policies across the public and private sectors, this project will utilize a formative evaluation. One of the key goals of a formative evaluation is to identify influences – both potential and real – on the progress and/or effectiveness of a project's implementation. Information is collected at all phases of execution and is used as part of a continuous feedback loop to improve the ultimate likelihood of successful project implementation.

Through focus groups, interviews, observational studies, and surveys of stakeholders, subject matter experts and meeting participants, the evaluation will allow Orange County to identify successful and unsuccessful strategies employed

throughout the various project activities, including inter-agency and inter-departmental meetings and workgroups. Similarly, the formative evaluation will determine whether Orange County is able to identify ways to engage a diverse group of community stakeholders successfully and elicit meaningful participation, guidance and feedback.

OUTCOMES

The BHST project does not provide direct services, as a result, there are no outcomes to report. However, during FY 2020-21, BHST Part 1 and Part 2 made significant progress in their respective key steps and activities. A full report of all project activities is described in the MHSA INN Annual Project Report.

Psychiatric Advance Directives (INN)

The Psychiatric Advance Directives (PADs) project is an INN project designed to help counties improve a consumer's access to appropriate services and quality of care while preserving the individual's life goals and mental health preferences. PADs are a means for increasing self-determination and autonomy by empowering individuals to make decisions about their own lives. PADs serve to improve positive outcomes for consumers at risk of involuntary care, homelessness, unnecessary hospitalizations, and involvement with the criminal justice systems through all stages of life.

In June 2021, the MHSOAC approved Orange County, along with four other counties, to participate in this statewide project. The proposed project will engage the expertise of ethnically and culturally diverse communities, threshold populations, consumers, peers with lived experience, consumer and family advocacy groups, and disability rights groups. The project proposes to meet several unmet needs throughout the state, including, but not limited to:

- Provide standardized training to increase understanding of the existence and benefits of PADs by communities and stakeholders.
- Develop and implement a standardized PAD template, ensuring that individuals have autonomy and are the leading "voice" in their care, especially during a mental health crisis.
- Utilize peers to facilitate creation of PADs so that shared lived experience and understanding will lead to more open dialogue, trust, and improved outcomes.
- Develop and implement a standardized training "tool-kit" to enable PAD education, policy, and practice fidelity from county to county.
- Align mental health PADs with medical Advance Directives, with a focus on treating the "whole person" throughout the life course.
- Utilize a technology platform for easy access to training, materials, creation, storage, and review of PADs.
- Create a fully functioning cloud-based PADs Technology Platform, for ease of use by consumers, law enforcement, or hospitals for in-the-moment use.
- Use legislative and policy advocacy, with consumer voices in the lead, to create a legal structure to recognize and enforce PADs, so that consumer choice and self-determination are recognized and respected throughout California.
- Evaluate (a) the effectiveness of this project; (b) the ease of use and recognition of PADs; (c) the impact of PADs on the quality of mental health supports and services; and (d) most importantly, the impact of PADs on the quality of life of consumers.

The PADs Innovation Project proposal provides additional details on proposed project activities.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	-
FY 2021-22	-
FY 2022-23	-

Originally designed as an MHSA Innovation project, this suite of integrated services is designed to transform Orange County's system of care for youth who are at clinical high risk (CHR) for psychosis, their family members and the community providers who may be treating them. The services offered through this system of care will leverage PEI and federal grant funds and, if approved by the Mental Health Services and Oversight Committee (MHSOAC), Innovation funding.

Community Training, Screening, Clinical Care and Consultation Services for Clinical High Risk for Psychosis (PEI, potentially INN)

HCA will implement a new integrated suite of programs and services built off Orange County's recent MHSA Innovation proposal, "Improving the Early Identification of Youth at Clinical High Risk for Psychosis and Increasing Access to Care." These services will be nested within an overall coordinated system of care designed for youth who are at clinical high risk for psychosis (CHR-P). Where relevant and applicable, services will incorporate and reflect the best practice strategies and learnings identified through the on-going Innovation Project, Early Psychosis Learning Health Care Network.

Online Screening and Engagement: This potential project is pending MHSOAC approval for the use of Innovation funding. The project proposes to engage with young people online, where many youth first go for information, and identify ways to increase the likelihood that those who screen as CHR-P move from the online space to seeking available mental health services. More specifically, Orange County will leverage the Mental Health America (MHA) National online screener to:

- Offer a direct link to CHR-P-specific support in Orange County
- Create enhanced, culturally responsive psychoeducational materials on psychosis and post them on the MHA's website
- Implement online Personalized Normative Feedback interventions

Orange County anticipates that this Innovation proposal will be brought before the MHSOAC Commission in Quarter 1 of FY 2022-23.

Outreach and Training: Funded through PEI, outreach and training will be offered to two broad categories of potential responder groups: the youth social network and the healthcare provider network. These services will also be offered to campus resource and law enforcement officers. Training will aim to improve the knowledge and skills of potential responders who are present within young people's naturally existing social networks or where they typically spend time (i.e., schools) so they feel:

- Better equipped with how to recognize a young person who may be experiencing symptoms of CHR for psychosis, and
- More comfortable with knowing when and how to refer youth for screening and/or treatment services.

To ensure cultural responsivity, outreach and training materials will be co-developed with peers, family members and community members and leaders from the various potential responder groups.

CHR-P Clinical Services: Funded through PEI, Orange County will establish a program specifically for youth between the approximate ages of 12 to 25 years and who are identified as clinical high risk for psychosis, and their families. Services will include screening, comprehensive psychosocial assessment, symptom monitoring, prescribing and medication monitoring, psychoeducation, peer support, psychosocial rehabilitation, case management, referrals and linkages to community-based care, and consumer and family consultation. It will also offer a range of evidence-supported clinical interventions for youth at CHR-P such as

cognitive behavioral therapy for psychosis and harm reduction. Services will be co-located with Orange County's first episode psychosis program, Orange County Center for Resiliency and Wellness (OC CREW), thus allowing for more supportive care transitions for youth who are identified as experiencing a first episode of psychosis during screening and assessment, or who transition from CHR-P to a first episode of psychosis.

Provider Training and Consultation: Funded through PEI, Orange County will greatly expand and enhance its consultation services for mental health care providers who may work with or encounter youth at risk of developing psychosis symptoms. Trainings will use a systematic, evidence-based and trauma-informed approach to building the existing skills and expertise of the healthcare provider, which can include, but is not limited to, the Modular Approach to Care for Individuals at CHR (Thompson et al., 2015). Trainings will consist of didactic training, practice-based coaching, direct observation and follow-up support.

To support and sustain healthcare providers' on-going learning, this program will create a CHR-P Project ECHO "community of practice." This community of practice will be complemented with stepped consultation services:

- One-Time Consultations: Scheduled CHR-P case consultation for healthcare providers. Relevant clinical records are to be shared ahead of time with an authorization to disclose (ATD) completed by the youth and/or parent/guardian
- On-Going Team Consultations: Scheduled monthly case consultation with the youth, family and provider(s) with a completed ATD
- CHR-P Office Hours (anonymous): Casual, drop-in stye office hours for providers to attend as needed for support, questions, etc.
- CHR-P Post-Training Office Hours (anonymous): Casual, drop-in stye office hours for providers, family, support network, etc. following their participation in a training to reinforce learning and use of new skills.

PROPOSED BUDGETS FROM 3YP	
Fiscal Year	**Program Budget**
FY 2020-21	-
FY 2021-22	-
FY 2022-23	$3,400,000 (PEI) $2,600,000 (INN, pending MHSOAC approval)

Potential INN Projects (INN)

During FY 2020-21, HCA explored the ability to move forward with several potential Innovation project ideas submitted through the Innovation Idea Generation Website, as well as statewide project opportunities. After additional review of submissions and the MHSA Innovation Regulations and criteria, the potential ideas listed in the table below remain under consideration. Each idea considered viable after initial vetting will include a community planning process and must be approved by the MHSOAC before implementation. Project ideas that are most aligned with MHSA Community Program Planning Process results and/or most feasible, will be prioritized for exploration.

Potential Innovation Projects and Ideas, listed in alphabetical order:

POTENTIAL IDEA	BRIEF DESCRIPTION	STATUS
Allcove	Integrated youth drop-in centers for ages 12 - 25.	Pending implementation and further review of Youth Drop-in Center grant. **Prioritized based on existing MHSOAC grant, but contingent upon appropriate facility (INN funds cannot be used for building development and renovations). Currently paused due to the impact of COVID.**
Clinical High Risk for Psychosis	Improve the early identification of youth who are at clinical high-risk for, or are experiencing very early psychosis symptoms (i.e., before a first episode of psychosis has been identified/diagnosed), and to increase their access to quality care as early as possible.	Pending MHSOAC and OC Board of Supervisors approval. **Aligns with MHSA Strategic Priorities (improving access; suicide prevention).**
Community Program Planning	Dedicate INN funds to support community planning and related activities, including but not limited to staff time, translations, subject matter experts, marketing strategies, etc.	Pending MHSOAC approval. **Prioritized based on MHSA requirements and increase in INN budget over the next 5 years.**
Social Media	Participants at a high risk for mental health disorders will agree to have their smartphone social media data monitored and will take periodic surveys to assess their MH related behaviors and outcomes.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results. **Prioritized based on FY 20-21 CEM results. Will be explored in the context of other tecŠology related projects.**
Stigma Reduction	Test competing models of stigma reduction campaigns to determine which approaches, strategies and/or techniques are more effective within different target populations. Identify, develop and test a method for measuring short-term and long-term effects on mental-health-related stigma.	Pending further review of INN requirements, fit with MHSA priorities and FY 20-21 CEM results. **Prioritized based on FY 20-21 CEM results.**
Young Adult Court	Use a randomized controlled trial to understand whether an inter-agency collaborative effort, Young Adult Court, effectively reduces recidivism and promotes positive life outcomes for eligible young men.	Pending MHSOAC and OC Board of Supervisors approval. **Identified and prioritized based on opportunity to leverage existing efforts.**

EXHIBITS AND APPENDICES

EXHIBIT A: Budget Grids

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Funding Summary

County: **Orange** Date: 4/5/2022

	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 FY2022-23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	94,671,887	36,837,760	24,593,903	-	12,989,771	33,258,769
2. Estimated New FY2022-23 Funding	198,280,000	49,570,000	13,040,000	-	-	-
3. Transfer in FY2022-23	(38,101,175)	-		6,262,162	31,839,013	-
4. Access Local Prudent Reserve in FY2022-23	-	-				-
5. Estimated Available Funding for FY2022-23	254,850,712	86,407,760	37,633,903	6,262,162	44,828,784	33,258,769
Estimated FY2022-23 Expenditures	(184,861,062)	(68,879,014)	(11,701,218)	(6,262,162)	(44,828,784)	
Estimated FY2022-23 Unspent Fund Balance	**$ 69,989,650**	**$ 17,528,746**	**$ 25,932,685**	$ -	$ -	**$ 33,258,769**

Estimated Local Prudent Reserve Balance	
Estimated Local Prudent Reserve Balance on June 30, 2022	$ 33,258,769
5. Contributions to the Local Prudent Reserve in FY 2022-23	-
6. Distributions from the Local Prudent Reserve in FY 2022-23	-
Estimated Local Prudent Reserve Balance on June 30, 2023	**$ 33,258,769**

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the average amount of total MHSA funds allocated to that County for the previous five years.

b/ Estimated expenditures for CSS/PEI for FY 22/23 are anticipated to be within funding limits avaialble but are budgeted at full-program's costs. Historical trends show actual expenditures to be under the annual budget due to various factors, such as unanticipated revenue offsets, or cost savings. The Financial Team monitors and projects the revenues and expenditures throughout the fiscal year to ensure the funds are not overspent. CSS expenditures are estimated at 82% and PEI expenditures are estimated at 90% of the budgeted amounts for each fiscal year.

c/ Per MHSUDS Info Notice No. 19-017 dated March 20, 2019, each county is now required to establish a Prudent Reserve that does not exceed 33 percent of the average Community Services and Supports (CSS) revenue received for the Local Mental Health Serices Fund in the preceding five years. Maximum Prudent Reserve amount for FY 2020-21 is capped at the average of 33% of the previous 5 FY's CSS allocation. Orange County's current Prudent Reserve amount is $33,258,769 and this same amount is budgeted for FY 2020-21 through FY 2022-23. Orange County's Prudent Reserve will be re-assessed in FY 2023-24 by using the actuals from FY 2018-19 through FY 2022-23.

d/ Estimated Unspent Fund Balances in CSS and PEI are allocated to support the Strategic Priorities identified in the three-year plan.

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 4/4/2022

	Fiscal Year 2022-23					
	A	B	C	D	E	F
Program Description	**Estimated Total Mental Health Expenditures**	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
Full Service Partnership (FSP Programs)						
1. Children's Full Service Partnership	**13,974,575**	**11,554,575**	**2,300,000**	-	-	**120,000**
2. Transitional Age Youth (TAY) Full Service Partnership	**10,098,845**	**8,184,468**	**1,803,452**	-	-	**110,925**
3. Adult Full Service Partnership	**41,288,249**	**33,207,935**	**7,697,601**	-	-	**382,713**
Adults	29,783,070	23,992,093	5,464,401	-	-	326,576
Assisted Outpatient Treatment Assessment & Linkage	5,313,599	4,715,842	541,620	-	-	56,137
Supportive services for clients in permanent housing	6,191,580	4,500,000	1,691,580	-	-	-
4. Older Adult Full Service Partnership	**5,050,164**	**4,519,899**	**502,355**	-	-	**27,910**
5. Program for Assertive Community Treatment	**13,442,128**	**10,699,650**	**2,542,158**	-	-	**200,320**
Non-FSP Programs Partially Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	**155,124**	**155,124**	-	-	-	-
2. Open Access	**1,822,154**	**1,500,000**	**282,200**	-	-	**39,954**
3. CHS Jail to Community Re-Entry	-	-	-	-	-	-
Crisis & Crisis Prevention Section:						
4. Mobile Crisis Assessment Team	**5,439,973**	**3,981,094**	**1,082,535**	-	-	**376,344**
5. Crisis Stabilization Units (CSUs)	**2,786,195**	**2,100,000**	**656,195**	-	-	**30,000**
6. In-Home Crisis Stabilization	**2,087,189**	**1,579,836**	**479,501**	-	-	**27,852**
7. Crisis Residential Services	**7,113,603**	**5,520,977**	**1,453,689**	-	-	**138,937**
OUTPATIENT TREATMENT: Clinic Expansion	-					
8. Children & Youth Expansion	-	-	-	-	-	-
9. OC Children with Co-Occurring Mental Health Disorders	**1,519,220**	**750,000**	**750,000**	-	-	**19,220**
10. Outpatient Recovery	**212,118**	**163,243**	**45,008**	-	-	**3,867**
11. Older Adult Services	**167,876**	**130,088**	**36,882**	-	-	**906**
12. Services for the Short-Term Residential Therapeutic Program	-	-	-	-	-	-
13. Telehealth/Virtual Behavioral Health Care	**1,000,000**	**1,000,000**				
Supportive Services Section:	-					
14. Peer Mentor and Parent Partner Support	-	-	-	-	-	-
15. Wellness Centers	**409,991**	**409,991**	-	-	-	-
16. Supported Employment	**431,679**	**431,679**	-	-	-	-
17. Transportation	-	-	-	-	-	-
Supportive Housing/Homelessness Section:	-					
18. Housing & Year Round Emergency Shelter	**410,154**	**410,154**	-	-	-	-
19. Bridge Housing for the Homeless	**1,300,000**	**1,300,000**	-	-	-	-
20. CSS Housing	**31,823,580**	**31,823,580**	-	-	-	-
FSP Sub-Total	***$ 140,532,817***	***$ 119,422,293***	***$ 19,631,576***	***$ -***	***$ -***	***$ 1,478,948***

Non-FSP Programs Not Categorized as FSP:						
Access and Linkage to Treatment Section:						
1. Multi-Service Center for Homeless Mentally Illness Adults	2,947,365	2,947,365	-	-	-	-
2. Open Access	1,822,154	1,500,000	282,200	-	-	39,954
3. CHS Jail to Community Re-Entry	-	-	-	-	-	-
Crisis & Crisis Prevention Section:	-					
4. Warmline	12,000,000	12,000,000	-	-	-	-
5. Mobile Crisis Assessment Team	8,403,110	6,604,764	1,511,830	-	-	286,516
6. Crisis Stabilization Units (CSUs)	15,788,436	11,900,000	3,718,436	-	-	170,000
7. In-Home Crisis Stabilization	2,485,219	1,855,644	587,357	-	-	42,218
8. Crisis Residential Services	8,809,081	5,759,868	2,763,204	-	-	286,009
OUTPATIENT TREATMENT: Clinic Expansion	-					
9. Children & Youth Expansion	3,770,000	2,500,000	1,250,000	-	-	20,000
10. OC Children with Co-Occurring Mental Health Disorders	1,519,220	750,000	750,000	-	-	19,220
11. Outpatient Recovery	10,393,789	7,998,930	2,205,374	-	-	189,485
12. Older Adult Services	2,630,059	2,038,047	577,818	-	-	14,194
13. Services for the Short-Term Residential Therapeutic Program	10,500,000	7,000,000	3,500,000	-	-	-
14. Telehealth/Virtual Behavioral Health Care	1,000,000	1,000,000				
Supportive Services Section:	-					
15. Peer Mentor and Parent Partner Support	4,714,897	4,714,897	-	-	-	-
16. Wellness Centers	3,492,672	3,492,672	-	-	-	-
17. Supported Employment	1,371,262	1,371,262	-	-	-	-
18. Transportation	850,000	850,000	-	-	-	-
Supportive Housing/Homelessness Section:	-					
19. Housing & Year Round Emergency Shelter	957,025	957,025	-	-	-	-
20. Bridge Housing for the Homeless	700,000	700,000	-	-	-	-
21. CSS Housing	10,607,860	10,607,860	-	-	-	-
Sub-Total	*$ 104,762,149*	*$ 86,548,334*	*$ 17,146,219*	*$ -*	*$ -*	*$ 1,067,596*
CSS Administration	19,469,693	19,469,693	-	-	-	
Total CSS Program Estimated Expenditures	$ 264,764,659	$ 225,440,320	$ 36,777,795	$ -	$ -	$ 2,546,544
FSP Programs as Percent of Total	53%					

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: **Orange** Date: 4/4/2022

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention: Child, Youth and Parent Programs						
1. School Readiness	1,010,000	1,000,000				10,000
2. Parent Education Services	1,512,303	1,494,303				18,000
3. Children's Support & Parenting	-	-				-
4. School-Based Behavioral Health Intervention & Support	1,968,024	1,953,024				15,000
5. Violence Prevention Education	1,380,651	1,352,651				28,000
6. Gang Prevention Services	403,600	403,100				500
7. Family Support Services	304,996	304,996				-
MENTAL HEALTH AWARENESS & STIGMA REDUCTION CAMPAIGNS & EDUCATION						
8. Mental Health Community Educ. Events for Reducing Stigma & Discrimination	1,881,000	1,881,000				-
9. Outreach for Increasing Recognition of Early Signs of Mental Illness	16,845,873	16,832,773				13,100
Behavioral Health Training Services	2,200,000	2,200,000				-
School-Based Stress Management Services	-	-				-
Early Childhood Mental Health Providers Training	1,000,000	1,000,000				-
Mental Health & Well-Being Promotion for Diverse Communities	3,393,711	3,385,711				8,000
K-12 School-Based Mental Health Services Expansion	6,278,023	6,277,923				100
Services for TAY and Young Adults	614,938	609,938				5,000
Statewide Projects	3,359,201	3,359,201				-
CRISIS PREVENTION & SUPPORT						
10. Warmline	-	-				-
11. Suicide Prevention Services	4,702,000	4,700,000				2,000
SUPPORTIVE SERVICES						
12. Transportation Assistance	200,000	200,000				-
ACCESS & LINKAGE TO TREATMENT (TX)						
13. OCLinks	5,380,000	5,380,000				-
14. BHS Outreach & Engagement (O&E)	8,999,668	8,999,668				-
15. Integrated Justice Involved Services		7,200,000				
OUTPATIENT TREATMENT - Early Intervention						
16. School-Based Mental Health Services	2,575,536	2,525,236	50,000			300
17. Clinical High Risk for Psychosis	3,000,000	3,000,000				
18. 1st Onset of Psychiatric Illness	1,525,000	1,450,000	50,000			25,000
19. OC Parent Wellness Program	3,741,072	3,738,072			3,000	-
20. Community Counseling & Supportive Services	2,536,136	2,536,136				-
21. Early Intervention Services for Older Adults	3,000,000	3,000,000				-
21. OC4VETS	2,522,316	2,520,000				2,316
PEI Administration	6,061,279	6,061,279				
Total PEI Program Estimated Expenditures	$ 69,549,454	$ 76,532,238	$ 100,000	$ -	$ 3,000	$ 114,216

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: **Orange** Date: 4/4/2022

Program Description	Fiscal Year 2022-23					
	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
Contiuum of Care for Veterans and Military Families	94,339	94,339	-	-	-	-
Help @ Hand *(formally known as Mental Health Technology Suite)*	4,709,767	4,709,767	-	-	-	-
Statewide Early Psychosis Learning Health Care Collaborative Network	310,000	310,000	-	-	-	-
Behavioral Health System Transformation	1,920,000	1,920,000	-	-	-	-
Psychiatric Advance Directives (PADS)	3,186,275	3,186,275	-	-	-	-
Subtotal Of All INN Programs	***10,220,381***	***10,220,381***	-	-	-	-
INN Administration	1,480,837	1,480,837	-	-	-	-
Total INN Program Estimated Expenditures	**$ 11,701,218**	**$ 11,701,218**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: **Orange** Date: 4/22/2021

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Workforce Staffing Support	1,814,758	1,814,758	-	-	-	-
Training and Technical Assistance	1,465,794	1,465,794	-	-	-	-
Mental Health Career Pathways	1,066,663	1,066,663	-	-	-	-
Residencies and Internships	700,000	700,000	-	-	-	-
Financial Incentives Programs	718,468	718,468	-	-	-	-
	-	-	-	-	-	-
Subtotal Of All WET Programs	***5,765,683***	***5,765,683***	-	-	-	-
WET Administration	496,479	496,479	-	-	-	-
Total WET Program Estimated Expenditures	**$ 6,262,162**	**$ 6,262,162**	**$ -**	**$ -**	**$ -**	**$ -**

FY 2022-23 Annual Update - Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: **Orange** Date: 4/22/2021

Program Description	Fiscal Year 2022-23					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Capital Facilities Projects						
Wellness Campus	20,000,000	20,000,000				
Behavioral Health Training Facility	25,000	25,000	-	-	-	-
Technological Needs Projects						
Electronic Health Record (E.H.R)	25,028,892	25,028,892	-	-	-	-
CFTN Administration	200,000	200,000	-	-	-	-
Total CFTN Program Estimated Expenditures	$ 45,253,892	$ 45,253,892	$ -	$ -	$ -	$ -

EXHIBIT B: Maximum Prudent Reserve Calculation and Prudent Reserve Assessment

The Prudent Reserve Calculation and Assessment are to be completed every five years. The next calculation and assessment will occur in FY 2023-24.

FY 2019-20 33% Maximum Prudent Reserve Calculations

Funding Year	Total MHSA Allocations July 1, 2013 - June 30, 2018
FY 13/14	$99,072,771.39
FY 14/15	$138,031,688.98
FY 15/16	$115,045,914.79
FY 16/17	$149,134,711.87
FY 17/18	$161,768,522.68
5-yr Total	663,053,609.71
CSS portion of total allocation (76%)	503,920,743.38
5-yr Avg of CSS funds	100,784,148.68
Prudent Reserve Limit for FY 18/19 (33%)	**33,258,769 .06**

State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: County of Orange
Fiscal Year: 2018/19

Local Mental Health Director

Name: Jeffrey A. Nagel
Telephone: 714-834-7024
Email: JNagel@OCHCA.com

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Jeffrey A. Nagel — Local Mental Health Director (PRINT NAME)
Signature
4/23/19 — Date

EXHIBIT C: County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange

Local Mental Health Director	Program Lead
Name: Dr. Veronica Kelley	Name: Jenny Hudson
Telephone Number: (714) 834-7024	Telephone Number: (714) 834-3105
E-mail: vkelley@ochca.com	E-mail: jhudson@ochca.com
County Mental Health Mailing Address: OC Health Care Agency, 405 W. 5th St., Ste. 477, 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.

Dr. Veronica Kelley
Local Mental Health Director/Designee (PRINT)

Signature

4-4-22
Date

County: Orange

Date: _____

EXHIBIT D: County Fiscal Certification

Enclosure 1

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Orange

- ☐ Three-Year Program and Expenditure Plan
- ☒ Annual Update
- ☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Dr. Veronica Kelley	Name: Frank Davies
Telephone Number: (714) 834-7024	Telephone Number: (714) 834-2450
E-mail: vkelley@ochca.com	E-mail: frank.davies@ac.ocgov.com
Local Mental Health Mailing Address: OC Health Care Agency, 405 W. 5th St., Ste. 477, Santa Ana, CA 92701	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Dr. Veronica Kelley
Local Mental Health Director (PRINT)

Signature

4.4.22
Date

I hereby certify that for the fiscal year ended June 30, 2020, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 2020 for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

CINDY WONG
County Auditor Controller / City Financial Officer (PRINT)

Signature

4/4/22
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5898(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

CSS

Updated March 23, 2022

		FY 2020-21			FY 2021-22			FY 2022-23			
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	FY22/23 Plan Update Notes
ACCESS & LINKAGE TO TREATMENT (TX)	**BHS Outreach & Engagement (O&E)** (all ages) (pg 81, FY 2021-22 MHSA Annual Plan Update)	2,569,933	1,195,053	47%	-	-	-	2,569,933	(2,569,933)	-	Consolidating O&E program over to PEI Component
	Multi-Service Center for Homeless Mentally Illness Adults (pg 84, FY 2021-22 MHSA Annual Plan Update)	900,000	721,278	80%	900,000		900,000	900,000	2,202,489	3,102,489	Removal of MHSA funding with end of the Courtyard Program. Increasing Salaries of counselors for this program. Expand to add a 2nd location to meet high demand
	Open Access (pg 90, FY 2021-22 MHSA Annual Plan Update)	2,300,000	3,077,168	134%	2,600,000	-	2,600,000	2,300,000	700,000	3,000,000	Added $700K to keep budget level for current service levels.
	Correctional Health Services: Jail to Community Re-Entry Program (JCRP) (pg 87, FY 2021-22 MHSA Annual Plan Update)	2,200,000	1,253,470	57%	2,700,000		2,700,000	2,800,000	(2,800,000)	-	Program will move from CSS to PEI to better align with population served
	SUBTOTAL Access & Linkage to Tx	7,969,933	6,246,968	78%	6,200,000	0	6,200,000	8,569,933	(2,467,444)	6,102,489	
CRISIS PREVENTION & SUPPORT	**Warmline** (pg 96, FY 2021-22 MHSA Annual Plan Update)							-	12,000,000	12,000,000	Moved from PEI. Increased budget from $2M to $12M. Increased call volume as well as expanding to 24/7. Adding a Spanish and Vietnamese Warmline.
	Mobile Crisis Assessment (pg 106, FY 2021-22 MHSA Annual Plan Update)	9,135,858	9,001,437	99%	9,135,858	-	9,135,858	9,135,858	1,450,000	10,585,858	
	portion of "Mobile Crisis Assessment" budget operated by CYBH for individuals ages 0-17 years	3,164,032	3,598,381	114%	3,164,032	-	3,164,032	3,164,032	450,000	3,614,032	Added $450K to budget, in order to right size to actual spending and maintain same level of service as well as funds for satellite location.
	portion of "Mobile Crisis Assessment" budget operated by AOABH for individuals ages 18 and older	5,971,826	5,403,056	90%	5,971,826		5,971,826	5,971,826	1,000,000	6,971,826	Adding $1M in budget to for the OCSD Behavioral Health Bureau to provide case management for indiviuals and their families following law enforcement response.
	Crisis Stabilization Units (CSUs) (pg 109, FY 2021-22 MHSA Annual Plan Update)	6,700,000	4,203,715	63%	10,000,000		10,000,000	10,000,000	4,000,000	14,000,000	Adding County operated CSU to MHSA funding
	In-Home Crisis Stabilization (pg 111, FY 2021-22 MHSA Annual Plan Update)	2,935,480	2,311,971	79%	2,935,480	-	2,935,480	2,935,480	500,000	3,435,480	
	portion of "In-Home Crisis Stabilzation" budget operated by CYBH for individuals ages 0-17 years	1,435,480	1,422,535	99%	1,435,480	-	1,435,480	1,435,480	500,000	1,935,480	Increase budget by $500K in order to have staffing salaries competive to hire and retain staff. Add additional clinician staff as well.
	portion of "In-Home Crisis Stabilzation" budget operated by AOABH for individuals ages 18 and older	1,500,000	889,436	59%	1,500,000		1,500,000	1,500,000		1,500,000	
	Crisis Residential Services (CRS) (pg 114, FY 2021-22 MHSA Annual Plan Update)	9,030,845	8,890,194	98%	11,280,845	-	11,280,845	11,280,845	-	11,280,845	
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 0-17 years	3,488,248	3,169,559	91%	5,253,248	-	5,253,248	4,988,248		4,988,248	
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 18-25 years	1,541,368	1,556,016	101%	1,041,368	-	1,041,368	1,541,368		1,541,368	
	portion of "Crisis Residential Services" budget operated by AOABH for individuals ages 18 and older	4,001,229	4,164,620	104%	4,986,229	-	4,986,229	4,751,229		4,751,229	
	SUBTOTAL Crisis Prevention & Support	27,802,183	24,407,318	88%	33,352,183	-	33,352,183	33,352,183	17,950,000	51,302,183	
MENT: Programs	**Children's FSP Program** (pg 162, 2021-22 MHSA Annual Plan Update)	11,054,575	10,123,324	92%	11,554,575	-	11,554,575	11,054,575	500,000	11,554,575	Increase budget by $500K in order to maintain level funding with current services as well as to increase salaries to competitive levels.
	Transitional Age Youth (TAY) FSP Program (pg 162)	8,184,468	7,037,043	86%	8,184,468	-	8,184,468	8,184,468	-	8,184,468	Increasing salaries of contract staff to stay competitive as well as adding additional positions. Increase is absorbed within existing budget.
	Adult FSP Program (pg 162)	31,307,934	23,341,286	75%	30,307,934	-	30,307,934	31,307,934	1,900,000	33,207,934	Adding $1.5M in MHSA funds to expand FSPs to address services in Vietnamese, Spanish,monolinguist, as well as veteren clients. Increase of budget is to also request for additional 60 slots. Adding $400K for limited term Step down program.
	portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older being assesed for Assisted Outpatient Treatment FSP eligibility (pg 88)	4,715,841	4,078,471	86%	4,715,841	-	4,715,841	4,715,841		4,715,841	

Printed on 4/1/202

CSS

Updated March 23, 2022

		FY 2020-21			FY 2021-22			FY 2022-23			
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	FY22/23 Plan Update Notes
OUTPATIENT TREATMENT: Full Service Partnership	*portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older residing in Permanent Supportive Housing (pg 168)*	*5,000,000*	*1,507,191*	*30%*	*3,500,000*	*-*	*3,500,000*	*5,000,000*	*(500,000)*	*4,500,000*	Riight sizing budget to be in line with expenditures. Costs will increase as more Permanent Supportive housing Services are provided with increasing housing
	Older Adult FSP Program (pg 162)	**3,219,899**	**2,941,977**	**91%**	**3,719,899**	**-**	**3,719,899**	**3,219,899**	**1,300,000**	**4,519,899**	Increasing budget $1.3M to increase caseload from 180 to 215. Adding Personal Service Coordinators and Clinical Supervisor,Increasing housing services, as well as provider salaries to stay competitve.
	Program for Assertive Community Treatment (PACT; *county-operated FSP; pg 175,FY 2021-22 MHSA Annual Plan Update*)	**10,599,650**	**8,090,661**	**76%**	**10,699,650**	**-**	**10,699,650**	**10,599,650**	**100,000**	**10,699,650**	
	portion of "PACT" budget operated by CYBH for individuals ages 0-21	*1,100,000*	*706,798*	*64%*	*1,200,000*	*-*	*1,200,000*	*1,100,000*	*100,000*	*1,200,000*	Increase of $100,000 to fund after-hours on-call coverage and expanded flexible spending used to support people on their recovery journeys (i.e., housing assistance, tuition payment, tutoring, childcare, etc.) in line with FSP program requirements. Program has been operating with a part-time psychiatrist and other staffing vacancies which resulted in savings. However when program is fully staffed, additional funds will be needed to cover 24/7 on-call, new southern satellite location, and flexible funding for clients.
	portion of "PACT" budget operated by AOABH for individuals ages 18 and older	*8,528,018*	*6,853,461*	*80%*	*8,528,018*		*8,528,018*	*8,528,018*		*8,528,018*	
	portion of "PACT" budget operated by AOABH for individuals ages 60 and older	*971,632*	*530,401*	*55%*	*971,632*		*971,632*	*971,632*		*971,632*	
	Subtotal Full Service Partnership Programs	64,366,526	51,534,290	80%	64,466,526	-	64,466,526	64,366,526	3,800,000	68,166,526	
OUTPATIENT TREATMENT: Clinic Expansion	**Children & Youth Clinic Services** (pg 147, FY FY 2021-22 MHSA Annual Plan Update)	**2,500,000**	**-**	**0%**	**2,500,000**	**-**	**2,500,000**	**3,000,000**	**(500,000)**	**2,500,000**	Reduced Budget to Current years budget to right size. Removed $500K for LCAT that won't be spent
	OC Children with Co-Occurring Mental Health Disorders (pg 149,FY 2021-22 MHSA Annual Plan Update)	**1,000,000**	**1,063,102**	**106%**	**1,000,000**		**1,000,000**	**1,000,000**	**500,000**	**1,500,000**	Increasing budget $500K to maintain same level of service with increase staffing costs
	Outpatient Recovery *(formerly known as Recovery Clinics / Centers)* (pg 154, FY 2021-22 MHSA Annual Plan Update)	**6,158,531**	**5,748,174**	**93%**	**5,858,531**	**-**	**5,858,531**	**6,158,531**	**2,003,642**	**8,162,173**	Added $2M in total budget.To add additional staffing to contract providers including additional clinicians, Data Analyst and Billing Specialist, etc. Additional increases to allow for Salary increases to stay competitive with workforce market.
	Older Adult Services (pg 157, FY 2021-22 MHSA Annual Plan Update)	**2,168,135**	**1,628,365**	**75%**	**2,168,135**		**2,168,135**	**2,168,135**		**2,168,135**	
	Services for the Short-Term Therapeutic Residential Program (STRTP) (pg 152, FY 2021-22 MHSA Annual Plan Update)	**6,500,000**	**4,060,277**	**62%**	**7,000,000**	**-**	**7,000,000**	**8,000,000**	**(1,000,000)**	**7,000,000**	Right sized budgget based off of MHSA spending actuals and anticipated spending
	RETIRED: Integrated Community Services (pg 165, FY 2019-20 Plan)	**1,197,000**	**4,193**	**0%**	-	-	-	**1,197,000**	**(1,197,000)**	**-**	
	Telehealth/Virtual Behavioral Health Care (pg 172)	**2,500,000**	**-**	**0%**	**2,500,000**	**-**	**2,500,000**	**3,000,000**	**(1,000,000)**	**2,000,000**	Right sized based off of service needs

Printed on 4/1/202

CSS

Updated March 23, 2022

		FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	
	RETIRED: Adolescent Co-Occurring MH & SUD Residential Treatment			0%							
	RETIRED: Adult Co-Occurring MH & SUD Residential Treatment	-		N/A							
	SUBTOTAL ALL Outpatient Treatment	86,390,192	64,038,400	74%	85,493,192	0	85,493,192	88,890,192	2,606,642	91,496,834	
SUPPORTIVE SERVICES	**RETIRING**: Mentoring for Children and Youth (pg 210, FY 2019-20 MHSA Plan)	500,000	466,498	93%	-	-	-	500,000	(500,000)		Program sunsetted in FY 21/22
SUPPORTIVE SERVICES	**Peer Mentor and Parent Partner Support** (all ages; pg 186, FY 2021-22 MHSA Annual Plan	4,249,888	3,909,428	92%	4,249,888		4,249,888	4,249,888	875,000	5,124,888	Increase of $875K for salary increases of Peer mentor as well as increasing staffing to provide Peer Support Services for CSU at Be-Well Campus and Hospitals.
SUPPORTIVE SERVICES	**Wellness Centers** (pg 189, FY 2021-22 MHSA Annual Plan Update)	3,354,351	2,957,660	88%	3,354,351		3,354,351	3,354,351	570,000	3,924,351	Increase $570K for increase of Peer Mentor wages as well as a 24/7 Security Guard at Wellness Center West to respond to City of Garden Grove.
SUPPORTIVE SERVICES	**Supported Employment** (pg 198, FY 2021-22 MHSA Annual Plan Update)	1,371,262	1,218,122	89%	1,371,262		1,371,262	1,371,262		1,371,262	
SUPPORTIVE SERVICES	**Transportation Program** (pg 196, FY 2021-22 MHSA Annual Plan Update)	1,150,000	558,304	49%	1,100,000	-	1,100,000	1,300,000	(450,000)	850,000	Reduced budget by $450K. Move $200K budget for PEI clients as well as $250K reduction due to using SUD funds to pay.
SUPPORTIVE SERVICES	**SUBTOTAL Supportive Services**	10,625,501	9,110,011	86%	10,075,501	0	10,075,501	10,775,501	495,000	11,270,501	
SUPPORTIVE HOUSING / HOMELESSNESS	**Housing & Year Round Emergency Shelter** (pg 201, FY 2021-22 MHSA Annual Plan Update; *formerly known as Short-Term Housing Services*)	1,367,180	539,734	39%	1,367,180	-	1,367,180	1,367,180		1,367,180	
SUPPORTIVE HOUSING / HOMELESSNESS	**Bridge Housing for Homeless** (pg 203)	2,000,000	1,472,979	74%	2,000,000	-	2,000,000	2,000,000		2,000,000	
SUPPORTIVE HOUSING / HOMELESSNESS	**CSS Housing** includes MOU with OCCR and funds for development of permanent supportive housing; (pg 205)	293,678	288,348	98%	356,046	-	356,046	311,563	42,119,877	42,431,440	Added $42M to budget for Permanent Supportive Housing through OCCR NOFA and OC Housing Trust. Added $69K to Budget to match current OCCR MOU as well as an additional $50K for Corporation for Supportive Housing (CSH) technical support of PSH..
	OCCR Housing MOU (formerly known as Housing)	*293,678*	*288,348*	*98%*	*356,046*	-	*356,046*	*311,563*	*119,877*	*431,440*	
	Permanent Supportive Housing	-	-	*0%*	-	-	-	-	*42,000,000*	*42,000,000*	
	SUBTOTAL Supportive Housing/Homelessness	3,660,858	2,301,061	63%	3,723,226	-	3,723,226	3,678,743	42,119,877	45,798,620	
	Subtotal Of All CSS Programs	136,448,667	106,103,758	78%	138,844,102	0	138,844,102	145,266,552	60,704,075	205,970,627	
	Administrative Costs	18,639,508	16,817,234	90%	19,941,008	-	19,941,008	20,053,784	(584,091)	19,469,693	Right sized budget based off of Projections. Budget includes additions such as Qualtrics, Chorus, enhancements to website, Union approved COLA Increases, Community Surveys, BHAB Community Planning/training, and additional staff.
	Total MHSA/CSS Funds Requested	155,088,175	122,920,993	79%	158,785,110	-	158,785,110	165,320,336	60,119,984	225,440,320	
	CSS TRANSFERS TO OTHER COMPONENTS SECTION										
	to WET	6,216,634	5,253,882	85%	5,219,984	-	5,219,984	5,296,662	965,500	6,262,162	
	to CFTN	12,519,749	7,280,298	58%	16,307,384	12,175,595	28,482,979	8,966,158	22,872,855	31,839,013	Increase transfer from CSS to CFTN in order to set aside funds for CFTN projects being proposed.
	to Prudent Reserve	-			-			-			
	Subtotal CSS Transfers Section	18,736,383	12,534,180	67%	21,527,368	12,175,595	33,702,963	14,262,820	23,838,355	38,101,175	
	20% CAP of 5 yr Avg of total MHSA allocation						33,702,963			38,101,175	

Printed on 4/1/202

MHSA Fund-Fiscal Update

PRESENTED BY CEO BUDGET – JULIA RINALDI

JANUARY 2022

Role of HCA vs. CEO Budget

HCA

- Focus on the MHSA Plan and Program Budgets by Fiscal Year required by State Law
- Tracking Program spending and updating projections
- Receives revenue projections provided by State Consultant and utilizes amounts in budget planning process
- HCA Accounting staff (Auditor-Controller) prepare and submits claims for reimbursement to CEO Budget
- HCA Accounting staff submit required Revenue Expenditure Report (RER) to the State

CEO BUDGET

- Focus is on tracking the cash and fund balance by component in the MHSA Fund 13Y
- Process claims for reimbursement submitted by HCA Accounting (Auditor-Controller staff)
- Track and monitor actual expenses and revenue
- Prepare informational reports utilizing information above and received by HCA

County of Orange
Summary of Mental Health Services Act Funds
Projected with Actuals through November FY 2021-22

DRAFT

MENTAL HEALTH SERVICES ACT (MHSA) FUNDS	Budget	Projections	Variance
Unspent MHSA Funds as of June 30, 2021 (Actual)	168,267,661	168,267,661	-
Projected Revenue for FY 2021-22	209,170,039	235,636,818	26,466,779
Prior Period Adjustments (Actual)	(44,743,880)	(44,743,880)	-
Total Funds Available for FY 2021-22	**332,693,820**	**359,160,599**	**26,466,779**
Estimated Costs in FY 2021-22	(247,455,770)	(227,516,676)	19,939,094
Projected Ending Balance at June 30, 2022 (SEE BELOW)	**85,238,050**	**131,643,923**	**46,405,873**
Revenue for FY 2022-23	175,439,568	175,439,568	-
Estimated Costs in FY 2022-23	(222,613,328)	(188,756,858)	33,856,470
Projected Ending Balance at June 30, 2023 (SEE BELOW)	**38,064,290**	**118,326,633**	**80,262,343**
Revenue for FY 2023-24	175,439,568	175,439,568	-
Estimated Costs in FY 2023-24	(222,613,328)	(188,756,858)	33,856,470
Projected Ending Balance at June 30, 2024 (SEE BELOW)	**(9,109,470)**	**105,009,343**	**114,118,813**
Detail of Projected Ending Balance at June 30, 2022			
Community Services and Supports (CSS)		86,125,957	
Prevention and Early Intervention (PEI)		24,886,915	
Innovation (INN)		20,631,051	
Total Projected Ending Balance at June 30, 2022		**$131,643,923**	
Detail of Projected Ending Balance at June 30, 2023			
Community Services and Supports (CSS)		69,386,564	
Prevention and Early Intervention (PEI)		21,430,329	
Innovation (INN)		27,509,740	
Total Projected Ending Balance at June 30, 2023		**118,326,633**	
Detail of Projected Ending Balance at June 30, 2024			
Community Services and Supports (CSS)		52,647,171	
Prevention and Early Intervention (PEI)		17,973,743	
Innovation (INN)		34,388,429	
Total Projected Ending Balance at June 30, 2024		**105,009,343**	

FY 2021-22 Projections

FY 2021-22 Projections by Component

County of Orange
Summary of Mental Health Services Act Funding, Fund 13Y
Fiscal Year 2021-22 as of 11/30/2021

DRAFT

Purpose: The table below summarizes the revenue, expenditures, and obligations for each MHSA component and provides estimated component balances to assist with program strategic planning and budgeting. Details for each component are also available and accompany this summary.

				Transfers from CSS			
MENTAL HEALTH SERVICES ACT FY 2021-22	**CSS**	**PEI**	**INN**	**WET**	**CFTN**	**Total**	**Prudent Reserve (3)**
Carryover of Funds from FY 2020-21	97,682,042	41,654,854	28,930,765	-	-	168,267,661	33,258,769
Prior Period Adjustments	(34,893,301)	(8,077,090)	(1,773,490)	-	-	(44,743,880)	
RESTATED Carryover funds from FY 2020-21	**62,788,741**	**33,577,764**	**27,157,275**	-	-	**123,523,781**	**33,258,769**
Projected MHSA Revenue for FY 2021-22	177,857,637	44,464,409	11,701,160	-	-	234,023,206	
Transfers from Community Services and Supports to Other MHSA Subaccounts to Cover Approved Project Expenses	(21,109,755)	-	-	5,106,512	16,003,243	-	
Projected Interest Revenue for FY 2021-22	1,226,345	306,586	80,681	-	-	1,613,612	
Total Funding Available for FY 2021-22	**220,762,968**	**78,348,759**	**38,939,116**	**5,106,512**	**16,003,243**	**359,160,599**	**33,258,769**
Projected Expenditures	(117,037,175)	(45,350,998)	(16,953,333)	(4,611,818)	(15,841,913)	(199,795,237)	
Projected Admin Expenditures	(17,599,836)	(8,110,847)	(1,354,732)	(494,694)	(161,330)	(27,721,439)	
Total Program and Administrative Costs	**(134,637,011)**	**(53,461,845)**	**(18,308,065)**	**(5,106,512)**	**(16,003,243)**	**(227,516,676)**	
Projected Carryover of Funds for FY 2022-23	**86,125,957**	**24,886,915**	**20,631,051**	-	-	**131,643,923**	**33,258,769**
Estimated MHSA Revenue for FY 2022-23	133,086,103	33,432,705	8,920,760	-	-	175,439,568	
Anticipated Costs for FY 2022-23	(135,562,676)	(36,889,291)	(2,042,071)	(5,296,662)	(8,966,158)	(188,756,858)	
Anticipated Transfers for FY 2022-23	(14,262,820)			5,296,662	8,966,158	-	
Projected Carryover of Funds for FY 2023-24	**69,386,564**	**21,430,329**	**27,509,740**	-	-	**118,326,633**	**33,258,769**
Estimated MHSA Revenue for FY 2023-24	133,086,103	33,432,705	8,920,760	-	-	175,439,568	
Anticipated Costs for FY 2023-24	(135,562,676)	(36,889,291)	(2,042,071)	(5,296,662)	(8,966,158)	(188,756,858)	
Anticipated Transfers for FY 2023-24	(14,262,820)			5,296,662	8,966,158	-	
Projected Carryover of Funds for FY 2024-25	**52,647,171**	**17,973,743**	**34,388,429**	-	-	**105,009,343**	**33,258,769**

Factors Affecting Carryover Balances

- Actual FY 2020-21 MHSA revenue was $84.9M higher than originally projected at the start of the COVID-19 Pandemic.
- Current State MHSA revenue projections are $26.5M higher than budgeted.

Actions in Process

- HCA is working closely with the Board of Supervisors' Behavioral Health ad hoc Committee to develop recommendations on the use of CSS and PEI funds for incorporation into an MHSA Plan Amendment.
- HCA is finalizing updates to the 3rd year of the current MHSA 3-year plan to increase programming.

Summary

- Expense amounts projected for FY 2021-22 reflect HCA's projections as of January 4, 2022.
- Expense Projections for FYs 2022-23 and 2023-24 represent 82% of CSS, 90% of PEI and 100% of INN, WET and CFTN updated budgeted plan amounts.
- Revenue projected for FY 2021-22 represents the state's current projections. Budget amounts for 2022-23 reflect our most recent State Consultant's projections.
- As currently projected, the carry over balance from FY 2021-22 is $131.6M, from FY 2022-23 is $118.3M and FY 2023-24 is $105M.

Housing Development and Supportive Services Update

Lisa Row, Administrative Manager I

Agenda

- **Development and Funding of MHSA housing**
- **Inventory and Pipeline**
- **Permanent Supportive Housing and Supportive Services**

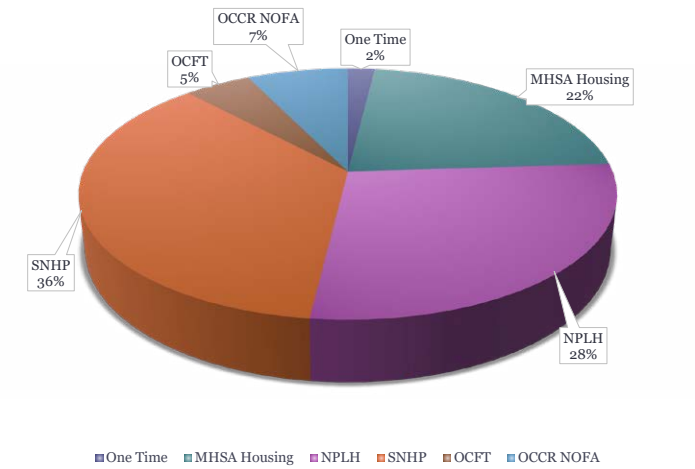
Overview of Housing Programs for MHSA Population

- One Time Funding
- MHSA Housing Program
- SNHP
- NPLH
- Orange County Housing Finance Trust
- 2020 Supportive Housing Notice of Funding Availability

MHSA Housing Development Programs

- MHSA funding provides for the development (capital/bricks and mortar), as well as the operations (capitalized operating subsidy reserve, COSR) of permanent supportive housing.
- Target Population: Individuals living with SMI and are experiencing homelessness.
- Each MHSA housing program has similar but unique guidelines and requirements.
  - One Time Funding: 2006
  - MHSA Housing Program: 2008 – 2016
  - Special Needs Housing Program (SNHP): 2016 – 2020
  - No Place Like Home (NPLH): 2018 – Present
  - OC Housing Finance Trust: 2019-Present
  - 2020 Supportive Housing NOFA (2020 NOFA): 2019-Present

Funding for MHSA Housing in Orange County



One Time Funding

- Orange County received a One-Time Funding allocation of $8 million of MHSA funds
- Two projects built

Project Name	City	MHSA Units	Total Units
Diamond Apartments	Anaheim	24	25
Doria I Apartment Homes	Irvine	10	134
	Total	**34**	**159**

MHSA Housing Program

- Orange County received $33.1 million for MHSA housing program
- Ten projects were built

Project Name	City	MHSA Unit	Total Units
Doria II Apartment Homes	Irvine	10	134
Avenida Villa	Anaheim	28	29
Cotton's Point	San Clemente	15	76
Capestone Family Apartments	Anaheim	19	60
Alegre	Irvine	11	104
Henderson House	San Clemente	14	14
Rockwood Apartments	Anaheim	15	70
Depot at Santiago	Santa Ana	10	70
Fullerton Heights	Fullerton	24	36
Oakcrest Heights	Yorba Linda	14	54
	Total	**160**	**647**

Special Needs Housing Program (SNHP)

- SNHP allowed counties to continue to fund PSH
- Administered by California Housing Finance Agency (CalHFA)
- 2020: SNHP discontinued
- SNHP funds must be expended by June 2022
- $95.5 million dedicated to SNHP funding
- Five (5) projects built
- Twelve (12) projects in process

SNHP Built

Project Name	City	SNHP Unit	Total Units
Santa Ana Arts Collective	Santa Ana	15	58
Hero's Landing	Santa Ana	20	76
Casa Querencia	Santa Ana	28	57
Buena Esperanza	Anaheim	35	70
Westminster Crossing	Westminster	20	65
	Total	**118**	**326**

SNHP In Process

Project Name	City	SNHP Units	Total Units
Altrudy Seniors	Yorba Linda	10	48
Asent	Buena Park	28	58
The Groves Senior Apartments	San Juan Capistrano	10	75
Francis Xavier	Santa Ana	13	17
Casa Paloma	Midway City	24	71
Lincoln Avenue Apartments	Buena Park	10	55
Legacy Square	Santa Ana	10	93
Villa St. Joseph	Orange	18	50
Mountain View	Lake Forest	8	66
Carwright Family Apartments	Irvine	10	60
Orchard View Gardens	Buena Park	8	66
Santa Angelina Senior Community	Placentia	16	65
	Total	**165**	**729**

SNPH/MHSA: Money at CalHFA

Now that SNHP is over, what happen to the remaining money at CalHFA?

- The remaining MHSA funds are being spent in accordance with the amended Spending Plan approved by the Board on December 17, 2019
- Remaining SNHP funds were transferred back to the County:
  - 2020 Supportive Housing NOFA (2020 NOFA): allocated up to $15.5 million
  - Orange County Housing Finance Trust (OCHFT): allocated up to $20.5 million

2020 Supportive Housing NOFA

- OC Housing & Community Development released the 2020 Supportive Housing Notice of Funding Availability in January 2020.
- The purpose of the NOFA: Make funding and vouchers available to promote the acquisition, new construction and acquisition of Supportive Housing.
- Funding Sources:
  - Orange County Housing Successor Agency funds
  - Federal HOME Investment Partnership Program funds
  - **Mental Health Services Act funds**
  - Project-Based Vouchers

2020 Supportive Housing NOFA

Project Name	City	MHSA Units	Total Units
Center of Hope	Anaheim	4	72
Huntington Beach Senior Housing	Huntington Beach	21	43
Westview	Santa Ana	26	85
Paseo Adelanto (Pending)	San Juan Capistrano	24	50
	TOTAL	**75**	**250**

Orange County Housing Finance Trust

- On September 11, 2018, Governor Jerry Brown signed Assembly Bill 448 into law which authorized the creation of the Orange County Housing Finance Trust.
- AB 448 allowed the County of Orange and any of the cities within Orange County to mutually create a joint powers authority.
- The collaborative effort allows the Orange County region to be more competitive and access additional funding sources available to address the homelessness and affordability crisis.
- On March 12, 2019, the Orange County Board of Supervisors approved the OCHFT Joint Powers Authority Agreement.

OCFT: Developments: 2020

Project Name	City	MHSA Units	Total Units
Center of Hope	Anaheim	16	72
Orchard View Senior Gardens	Buena Park	5	66
Santa Angelina Senior Community	Placentia	5	65
North Harbor Village	Santa Ana	14	90
	Total	**40**	**293**

OCFT: Developments 2021

Project Name	City	MHSA Units	Total Units
Paseo Adelanto	San Juan Capistrano	24	50
Anaheim Midway	Anaheim	8	86
Crossroads at Washington	Santa Ana	15	86
Meadows Senior Apartments	Lake Forest	7	65
	Total	**54**	**287**

No Place Like Home

- NPLH consist of two streams of funding:
  - **Non Competitive**- Orange County controlled
  - **Competitive** – Large County Pool- Statewide NOFA
- All NPLH funded units are required to only accept referrals through the local Coordinated Entry System (CES)
- Developments with more than 20 units must have less than 49% NPLH units

NPLH: Round 1

- Four (4) projects from Orange County applied
- Three (3) projects from Orange County were awarded

Project Name	City	NPLH Units	Total Units
Altrudy	Yorba Linda	10	48
Francis Xavier	Santa Ana	9	17
Legacy Square	Santa Ana	16	93
	Total	**35**	**158**

NPLH: Round 2

- Round 2 was extremely competitive and over subscribed
- Nine (9) projects from Orange County applied
- One (1) project was initially recommended for funding, however they did not move forward due to re-structuring their financing approach

NPLH: Round 3

- Seven (7) projects from Orange County applied
- Five (5) projects from Orange County were awarded

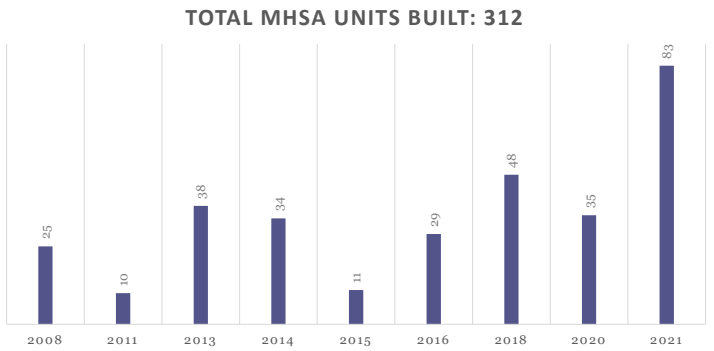
Project Name	City	NPLH Units	Total Units
Huntington Beach Seniors	Huntington Beach	21	43
Santa Angelina Senior	Placentia	21	65
Villa St. Joseph	Orange	18	50
Center of Hope	Anaheim	34	72
Westview House	Santa Ana	26	85
	Total	**120**	**315**

NPLH: Non Competitive

- County of Orange received $6,651,830 in Non Competitive Funding
- OC awarded Non Competitive Funding to three projects

Project Name	City	NPLH Non Competitive Units	Total Units
Huntington Beach Seniors	Huntington Beach	15	43
Villa St. Joseph	Orange	18	50
Center of Hope	Anaheim	16	72
	Total	**49**	**165**

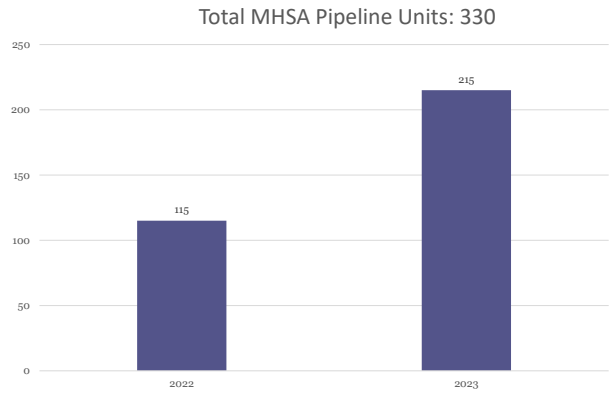
MHSA Housing Units: Completed



MHSA Housing Units: Completed

Name	City	One Time $ Units	MHSA Housing Program Units	SNHP	MHSA Units	Total Units	Completed Date
Diamond Apartment Homes	Anaheim	24			24	25	2009
Doria I & 2	Irvine	10	10		20	134	2011 & 2013
Avenida Villas	Anaheim		28		28	29	2014
Cotton's Point	San Clemente		15		15	76	2014
Capestone	Anaheim		19		19	60	2014
Alegre	Irvine		11		11	104	2015
Henderson House	San Clemente		14		14	14	2016
Rockwood	Anaheim		15		15	70	2016
Depot at Santiago	Santa Ana		10		10	70	2018
Fullerton Heights	Fullerton		24		24	36	2018
Oakcrest Heights	Yorba Linda		14		14	54	2018
Santa Ana Arts Collective	Santa Ana			15	15	58	2020
Hero's Landing	Santa Ana			20	20	57	2020
Casa Querencia	Santa Ana			28	28	57	2021
Buena Esperanza	Anaheim			35	35	70	2021
Westminster Crossing	Westminster			20	20	65	2021
Total		**34**	**160**	**118**	**312**	**979**	

MHSA Housing Units: PIPELINE



MHSA Housing Units: Pipeline

Name	City	SNHP Units	NPLH Round 1 Units	NPLH Non Competitive Units	NPLH Round 3 Units	OCCR NOFA	Trust Units	Total MHSA Units	Total Units	Estimate Completion
Altrudy Seniors	Yorba Linda	10	10					10	48	2022
Airport Inn Apartments	Buena Park	28						28	58	2022
Casa Paloma	Midway City	24						24	71	2022
Francis Xavier	Santa Ana	13	9					13	17	2022
Legacy Square	Santa Ana	10	16					16	93	2022
The Groves Senior Apartments	San Juan Capistrano	10						10	75	2022
North Harbor Village	Santa Ana						14	14	90	2022
Villa St. Joseph	Orange	18		18	18			18	50	2023
Lincoln Avenue Apartments	Buena Park	10						10	55	2023
Huntington Beach Senior Housing	Huntington Beach			15	21	21		21	43	2023
Center for Hope	Anaheim			16	34	4	16	34	72	2022
Westview	Santa Ana				26	26		26	85	2023
Orchard View Gardens	Buena Park	8					5	13	66	2023
Cartwright Family Apartments	Irvine	10						10	60	2023
Santa Angelina Senior Community	Placentia	16			21		5	21	65	2023
Meadows Senior Apartments	Lake Forest						7	7	65	2023
Paseo Adelanto	San Juan Capistrano					24	24	24	50	2023
Crossroads at Washington	Santa Ana						15	15	86	2023
Anaheim Midway	Anaheim						8	8	86	2023
Mountain View	Lake Forest	8						8	71	2023
	Total	165	35	49	120	75	94	330	1306	

What is Permanent Supportive Housing?

Permanent Supportive Housing: Supportive Services

- Supportive Housing is a combination of affordable housing with indefinite leasing and supportive services
- Designed to help vulnerable individuals and families use stable housing as a platform for health, recovery and personal growth
- Each MHSA funded housing development provides on-site support services to all residents
- Services are voluntary
- Services are unique to meet the needs of the individual
- Services are focused on housing sustainability and helping the tenants meet life goals

Examples of On-site Support Services

- Open office hours
- Advocacy
- On-site social events
- Monthly events calendar
- Engagement services
- Assist residents to access treatment
- Link to community resources
- Group activities that promote wellness
- Therapeutic interventions and/or assessments

MHSA Housing Development: A Collaborative Process

- Orange County Community Resources (OCCR)
- California Department of Housing and Community Development (HCD)
- California Housing Finance Agency(CalHFA)
- Corporation for Supportive Housing (CSH)
- OC Housing Finance Trust
- Housing Authorities
- OCHCA (Behavioral Health)
- Housing Developers
- Property Management
- Service Providers

How does a development move forward for approval?

- Housing developer submits an EOI (Expression of Interest) to HCA and/or OCCR or applies under the OCCR NOFA or OCHFT NOFA (depending on the funding i.e. NPLH vs. SNHP/MHSA)
- HCA and OCCR conduct a review of the project's appropriateness and financial viability (lasagna funding) and if submitted under a NOFA reviewed per NOFA policy.
- HCA, OCCR and CSH meet with developer to discuss the project
- If recommended to proceed, financial terms negotiated and service plans reviewed and finalized.
- The development and supporting documentation is submitted to the appropriate Board for approval (BOS and/or OCHFT Board).

Considerations before a development becomes an MHSA project

- How far along is the project in securing multiple funding sources? (Discussions vs letter of commitment)
- Are the timelines for funding compatible/realistic?
- How far along is the project in development? (Projects come to us ranging from initial concepts to gap funding)
- How far along is the developer in obtaining site control? (Do they own the property? Is it zoned accordingly? Any conflicts with city ordinances?)
- Has the developer received city and community input?

Considerations before a development becomes an MHSA project

- How many MHSA units is the developer requesting?
- Is this integrated housing? (Integrated is preferred)
- What SPA/location is the development in? Is it in an area that we have very little PSH?
- Is the development in an area where our participants have access to transportation/services/employment?
- What size are the units?
- What are the amenities/community space being offered?
- Does it meet the needs of the target population

Housing Development and Supportive Services Update

THANK YOU!

Lisa Row, LCSW
Administrative Manager I
Erow@Ochca.com
714-796-0200

OC health CARE AGENCY

County of Orange Supportive Housing Pipeline

Since June 2018 (current applications)

ATTACHMENT C

	Service Planning Area / Board District	Project Name (Developer/City)	OCCR NOFA Funding	SNHP/MHSA Funding	NPLH Funding	Total County Funding	OCCR Voucher Request	Affordable Units*	PSH Units	Total Units	Estimated Construction Start	Estimated Construction Completion	Funding/Status
1	Central /2nd	Heroes' Landing (formerly Santa Ana Veterans Village, Jamboree/Santa Ana)	$0	$2,912,000	$0	$2,912,000	0	1	75	76	Completed	Completed	Completed
2	Central /2nd	Casa Querencia (formerly Aqua, Community Dev Partners/Santa Ana)	$0	$7,035,800	$0	$7,035,800	0	1	56	57	Completed	Completed	Completed
3	North / 4th	Placentia Veterans Village (Mercy Housing/Placentia)	$2,754,000	$0	$0	$2,754,000	49	1	49	50	Completed	Completed	Completed
4	South / 3rd	Salerno at Cypress Village (formerly Cypress Village) (Chelsea/Irvine)	$1,462,860	$0	$0	$1,462,860	25	45	35	80	Completed	Completed	Completed
5	North / 4th	Buena Esperanza (formerly Jamboree PSH, Jamboree/Anaheim)	$0	$9,096,000	$0	$9,096,000	20	1	69	70	Completed	Completed	Completed
6	Central / 1st	Della Rosa (Affirmed Housing/Westminster)	$1,166,400	$0	$0	$1,166,400	25	25	25	50	Completed	Completed	Completed
7	Central /2nd	Santa Ana Arts Collective (Meta Housing/Santa Ana)	$0	$4,724,430	$0	$4,724,430	0	43	15	58	Completed	Completed	Completed
8	Central / 1st	Westminster Crossing (formerly Westminster & Locust, Meta Housing/Westminster)	$850,500	$2,912,000	$0	$3,762,500	20	45	20	65	Completed	Completed	Completed
9	North / 3rd	Altrudy Senior Apartments (Orange Housing Development Corporation/C&C Development Co., LLC/Yorba Linda)	$0	$1,514,240	$2,402,528	$3,916,768	8	38	10	48	Under Construction	Mar-22	Under Construction
10	Central /2nd	FX Residences (formerly Francis Xavier, HomeAid Orange County/Mercy House/ Santa Ana)	$0	$2,834,658	$3,382,389	$6,217,047	0	1	16	17	Jun-22	Jul-23	In Progress of Funding
11	Central /2nd	Legacy Square (National Community Renaissance of California/Santa Ana)	$0	$1,514,240	$6,013,136	$7,527,376	0	60	33	93	Under Construction	Feb-23	Under Construction
12	Central / 1st	The Prado (formerly Fountain Valley Housing, The Related Companies of California, LLC/Fountain Valley)	$453,600	$0	$0	$453,600	0	42	8	50	Under Construction	Mar-22	Under Construction
13	Central / 1st	Casa Paloma (formerly 15162 Jackson Street) (American Family Housing/Midway City)	$950,000	$6,688,000	$0	$7,638,000	48	23	48	71	Under Construction	Jun-22	Under Construction
14	South / 5th	The Groves (C&C Development/San Juan Capistrano)	$0	$1,889,772	$0	$1,889,772	8	65	10	75	Under Construction	May-22	Under Construction

County of Orange Supportive Housing Pipeline

Since June 2018 (current applications)

ATTACHMENT C

	Service Planning Area / Board District	Project Name (Developer/City)	OCCR NOFA Funding	SNHP/MHSA Funding	NPLH Funding	Total County Funding	OCCR Voucher Request	Affordable Units*	PSH Units	Total Units	Estimated Construction Start	Estimated Construction Completion	Funding/Status
15	Central /2nd	The Crossroads at Washington (The Related Companies of California, LLC/Santa Ana)	$2,280,701	$0	$0	$2,280,701	43	43	43	86	Jun-22	Sep-23	In Progress of Funding
16	North /2nd	Villa St. Joseph (Mercy Housing/Orange)	$1,020,600	$3,696,893	$5,641,722	$10,359,215	18	32	18	50	Jun-22	Jul-23	In Progress of Funding
17	North / 4th	Ascent (formerly Airport Inn /Jamboree Housing/Buena Park)	$0	$4,409,468	$0	$4,409,468	57	1	57	58	Under Construction	Apr-22	Under Construction
18	South / 3rd	Mountain View (National CORE/Lake Forest)	$453,600	$1,889,772	$0	$2,343,372	8	63	8	71	Mar-22	Jul-23	In Progress of Funding
19	South / 3rd	Cartwright Family Apartments (C&C Dev/Irvine)	$567,000	$1,574,810	$2,840,440	$4,982,250	8	50	10	60	Jun-22	Mar-24	In Progress of Funding
20	North / 4th	Lincoln Avenue Apartments (C&C Dev/Buena Park)	$567,000	$2,917,680	$0	$3,484,680	0	45	10	55	Dec-22	Mar-24	In Progress of Funding
21	North / 4th	Santa Angelina Senior Community (National CORE/Placentia)	$500,000	$2,519,696	$4,806,018	$7,825,714	21	44	21	65	Aug-22	Dec-23	In Progress of Funding
22	North / 4th	Orchard View Gardens (National CORE/Buena Park)	$453,600	$1,259,848	$4,012,527	$5,725,975	8	58	8	66	Mar-23	Sep-24	In Progress of Funding
23	North / 2nd	Center of Hope (The Salvation Army/Anaheim)	$655,120	$0	$9,504,224	$10,159,344	16	2	70	72	Under Construction	Jan-23	Under Construction
24	Central /2nd	Westview House (Community Dev Partners/Santa Ana)	$4,258,280	$0	$7,312,537	$11,570,817	0	59	26	85	Jun-22	Nov-23	In Progress of Funding
25	Central /1st	Huntington Beach Senior Housing (Jamboree Housing/Huntington Beach)	$3,603,160	$0	$2,204,188	$5,807,348	33	10	33	43	Under Construction	Sep-23	Under Construction
26	South/ 5th	Paseo Adelanto (Jamboree Housing/San Juan Capistrano)	$2,384,630	$3,303,314.50	$0	$5,687,944.50	40	10	9	50	Dec-23	Apr-24	In Progress of Funding
27	North / 2nd	Valencia Gardens (formerly Orange Corporate Yard, Orange Housing Development Corp/Orange)	$479,520	$0	$0	$479,520	8	54	8	62	Mar-22	Mar-24	In Progress of Funding
28	South / 3rd	The Meadows Senior Apartments (C&C Development/Lake Forest)	$396,900	$1,192,329	$0	$1,589,220	5	60	5	65	Dec-22	Sep-24	In Progress of Funding

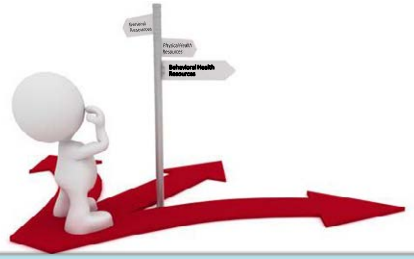
County of Orange Supportive Housing Pipeline

Since June 2018 (current applications)

ATTACHMENT C

	Service Planning Area / Board District	Project Name (Developer/City)	OCCR NOFA Funding	SNHP/MHSA Funding	NPLH Funding	Total County Funding	OCCR Voucher Request	Affordable Units*	PSH Units	Total Units	Estimated Construction Start	Estimated Construction Completion	Funding/Status
29	Central /2nd	North Harbor Village (Jamboree/Santa Ana)	$0	$2,250,000	$0	$2,250,000	0	2	89	91	Under Construction	Oct-22	Under Construction
30	Central / 4th	Homekey Property #1: Stanton Inn and Suites (Jamboree Housing/Stanton)	$0	$1,085,000	$0	$1,085,000	71	1	71	72	Apr-22	Dec-23	In Progress of Funding
31	Central / 4th	Homekey Property #2: Tahiti Motel (Jamboree Housing/Stanton)	$2,400,000	$0	$0	$2,400,000	59	1	59	60	Apr-22	Dec-23	In Progress of Funding
32	Central / 4th	Homekey Property #3: Riviera Motel (Jamboree Housing / Stanton)	$1,532,983	$0	$0	$1,532,983	10	1	20	21	TBD	TBD	In Progress of Funding
33	Central / 1st	Homekey Property #4: HB Oasis (American Family Housing & National CORE / Huntington Beach)	$0	$0	$0	$0	0	2	62	64	Jun-22	Oct-22	In Progress of Funding
34	Central / 5th	Homekey Property #5: Motel 6 (Community Development Partners / Costa Mesa)	$2,000,000	$0	$0	$2,000,000	0	48	40	88	Jul-22	Dec-22	In Progress of Funding
		Totals:	**$32,275,454**	**$66,134,942**	**$48,119,709**	**$146,530,105**	**588**	**977**	**1167**	**2144**			

*Includes property manager's unit
**Funding/voucher request still subject to Board approval



Behavioral Health Services (BHS) System Navigation

OC Links & OC Navigator Updates

Agenda

OC Links 24/7

Christina Weckerly, CYPBH Program Manager

OC Links 24/7
855-OC LINKS
(855-625-4657)
Behavioral Health Services Line

- Available 24/7, 365 days a year
- Provides information and linkage to any of the OC Health Care Agency's Behavioral Health Services (BHS), including crisis services, via telephone and chat
- Callers may be:
  - Potential participants
  - Family Members and Friends
  - Law Enforcement and other First Responders
  - Providers
  - Anyone seeking Behavioral Health resources and support

What is OC Links Behavioral Health Service Line?

- Single entry point to all BHS
- Telephone & online chat
- 24 Hours a day/ 7 Days a week
- Trained clinical staff
- All languages
- Dispatch mobile field response teams for crisis and outreach
- Information, referrals, warm-linkage, follow-up calls

OC Links 24/7

Program Updates

Services

Expanded to 24/7 in January 2021

Dispatch for Crisis Assessment Team and BHS Outreach and Engagement

Outcomes

- Prior to becoming the 24/7 behavioral health services line, OC Links averaged 1,108 calls/chats per month
- Since transitioning to 24/7, OC Links averages 758 calls/chats a *week*
  - 25% were identified as crisis-related

OC Links 24/7

OC Navigator

Flor Yousefian Tehrani, INN Program Manager

OC Navigator

- Self-navigation tool that will be available to all OC residents
- Co-created with OC community stakeholders
- Includes an optional social determinants of health survey to identify needed resources
- Offers a list of curated public and private behavioral health resources and support services
- Allows providers to update resources in real-time
- Connects to OC Links chat or phone if additional navigation support of county resources is needed

Dr. Armen Arevian, Project Director, Chorus

Upcoming Activities

Facilitate feedback groups	Translate OC Navigator	Add NAMI Warmline Resources	Add CARs Resources
In progress Ongoing meetings with stakeholders to gather feedback and improve features and functionality	In progress Site will be translated into OC threshold languages, as well as Khmer and Tagalog **Completion goal:** November 2021	In progress Ongoing discussions to move resources and workflow onto the Chorus platform **Completion goal:** March 2022	Upcoming Discussions will begin December 2021 **Completion goal:** March 2022

Navigator

Questions

Office of Suicide Prevention

Behavioral Health Services

Creation of the Office of Suicide Prevention

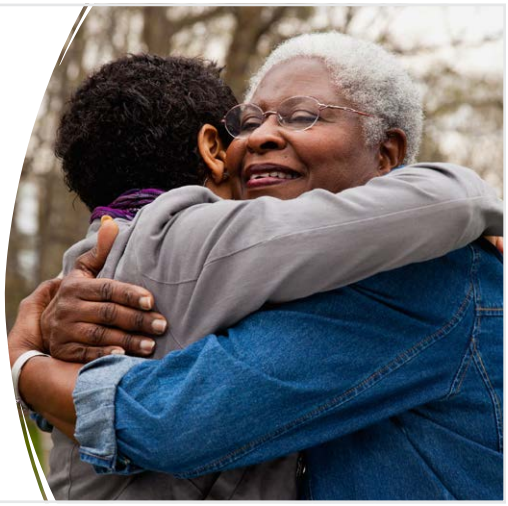
- On March 12, 2019, the Board directed the HCA to allocate $600,000 to create a countywide suicide prevention initiative with the goal of increasing awareness and accessibility to available resources.
- On October 6, 2020, the Board directed the County Executive Officer and HCA Director to create an Office of Suicide Prevention to further support these countywide efforts.

Office of Suicide Prevention (OSP)

- The Office of Suicide Prevention will coordinate suicide prevention efforts at the HCA and interface with local and statewide initiatives to identify and facilitate the implementation of evidence-based and promising suicide prevention activities in OC.

Comprehensive Approach to Suicide Prevention

- The OC Health Care Agency has a comprehensive array of suicide prevention services that are designed to support individuals of all ages who are experiencing, or at risk of experiencing, a behavioral health condition, including a crisis.
- Services at the OSP will focus on the upstream programs to :
  - Educate and raise awareness
  - Increase connectedness
  - Build life skills
  - Provide emotional support
  - Increase resilience and help seeking
  - Postvention support



OSP Activities

- **Implement State funding for programs**:
  - Mental health community education and awareness
  - Stigma reduction programs
  - Outreach/networking
  - Local Suicide Prevention hotline and postvention services
  - Liaison with Prevention and Intervention Division's programming
- **Collaborate with Stakeholders:**
  - County
  - Community
  - CalMHSA/Each Mind Matters for Mental Health and Suicide Prevention awareness month campaign activities
- **Community Suicide Prevention Initiative**
  - Align with State's Zero Suicide Plan
  - Implement projects for identified higher risk groups
- **Data Dashboard**

Staff at the OSP

- Bhuvana Rao, Division Manager
- Administrative Manager Vacant
- Olga Gore, Health Program Specialist
- Rebeka Sanchez, Health Program Specialist

Thank You

MHSA Innovation
Help@Hand Project

August 16, 2021

Flor Yousefian Tehrani
Jackie Salagubang
Maria Gonzalez

Agenda

- Project Overview
- Lessons Learned
- Technology Pilot & Implementation
- Project Activities
- Peer Activities

MHSA INN Component

- 5% of MHSA funds
- Designed to evaluate new or changed practices
- Must be approved by MHSOAC
- Time-limited, up to a maximum of five years
- Focus on learning
- Intended to transform the behavioral health system

"Innovation is about transforming the system. You are trying to climb and move that mountain at the same time."
~ Brian Sala, MHSOAC Deputy Director

Help@Hand INN Project

Innovative Component
Integrate technology-based mental health applications ("apps") into the public behavioral health system

Primary Purpose
Increase access to mental health services

Innovative Category
Introduce a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention

Collaborative Learning Goals

- Detect and acknowledge mental health symptoms
- Reduce stigma associated with mental illness by promoting mental wellness
- Increase access to the appropriate level of support and care
- Increase purpose, belonging and social connectedness of individuals served
- Analyze and collect data to improve mental health needs assessment and service delivery

Help@Hand Core Components

Technology

- 24/7 Peer Chat
- Therapy Avatar
- Customized Wellness Coach

Marketing

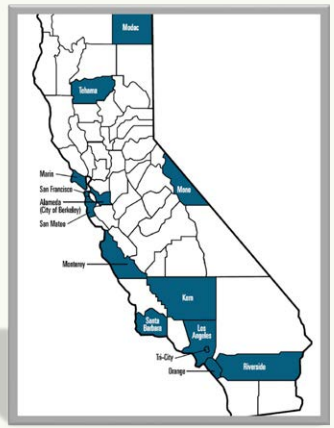
- Promotional activities
- Engagement strategies

Evaluation

- Data collection
- Analysis

Participating Counties

- This project includes 12 Counties and 2 Cities:
  - City of Berkeley
  - Kern County
  - Los Angeles County
  - Marin County
  - Modoc County
  - Mono County
  - Monterey County
  - Orange County
  - Riverside County
  - San Francisco County
  - San Mateo County
  - Santa Barbara County
  - Tehama County
  - Tri-City County
- Collectively these counties represent nearly one-half of the population in CA
- California Mental Health Services Authority (CalMHSA) serves as fiscal intermediary and contracting agent

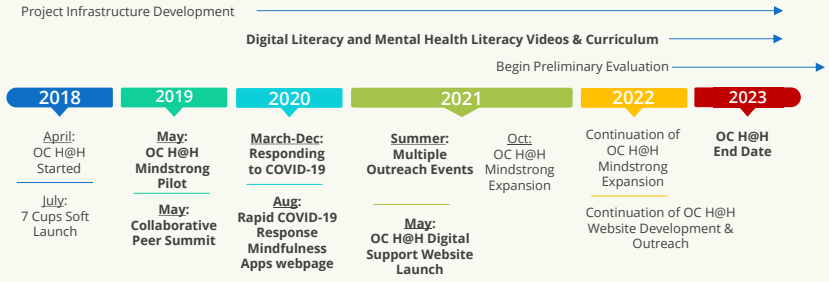


Defining Success

The success of this project is measured beyond just implementing technology, but rather by the effectiveness of collaboration.

Help@Hand OAC Project Update: December 2019

Overview of Help@Hand Project Activities



Help@Hand Lessons Learned

Cross-County Collaboration

ISSUE:

Project infrastructure, governance and planning take time to establish between multiple counties

There was no playbook for how counties should and could come together with a uniform set of processes and steps for all to follow.

FUTURE STRATEGIES:

- Include at least one year of infrastructure and collaborative planning activities in future INN proposals to align processes (i.e., contracting, governance, project roadmap, etc.)
- Start projects with only a few counties to establish the foundation before additional counties are onboarded
- Work with the OAC to establish a general guideline for County collaborative projects, including necessary steps, procedures and governance structure

Technology Integration

ISSUE: Integrating technology involves more than making an app available to consumers

- Integration requires an understanding of the app and its intended use
- Taking an existing product and attempting to tailor or customize it to meet counties specific needs can be costly, ineffective and inefficient
- Clinical apps require a planned and methodical approach to planning and launch

ISSUE: Technology is agile and ever changing. Changes in technology can happen within hours, days or weeks and can impact the entire process and workflow

- Working with technology requires flexibility and ability to adapt and respond to changes rapidly
- Any changes involve a re-evaluation of all documentation, trainings and workflows to remain consistent with the current state of the app

ISSUE: Ongoing internal and external communication is critical

- Schedule multiple weekly calls with each workstream to maintain communication between project partners to ensure alignment
- Schedule quarterly project updates, even if there are no changes, to ensure community is involved

Risk Management

Issue: Appropriate contingency planning for critical issues must be in place prior to launch

- When introducing new technology to the system, plan for the extended security vetting so that the project and vendor can still be productive in other areas of the project while vetting is going on

Issue: Substantive changes may have to go through security and or compliance review, which may delay launch or pause implementation

- Socialize project partners to County process and timeline

Definition of Terms

Issue: The same term may have different meanings

- Key terms must be discussed early on to make sure all parties are operating from the same definition and understanding
- Re-evaluate terms regularly to make sure the group remains aligned

Planning & Coordination

Issue: There were multiple tasks that needed to be done simultaneously, which required a lot of staff, resources, capacity and planning

Project Support

To the extent possible, maintain a consistent team so that historical knowledge is maintained for greater efficiency and implementation

Building a digital system of care requires a team of subject matter experts

Involve all relevant HCA departments and experts early on

OCHCA	Leadership	H@H Peers	IT	County Counsel	Compliance
OCHCA	PIO	PEACe	Purchasing	AQIS	
Partners	Cambria Solutions	Charitable Ventures	Pilot Site	Mindstrong	

Peer Involvement

OC's implementation expanded the traditional role of peers from service delivery to program development

- Continue to engage Peers in material development, feedback and problem-solving
- Continue to expand Peer roles as drivers of program planning, development and implementation

COVID-19 Impact

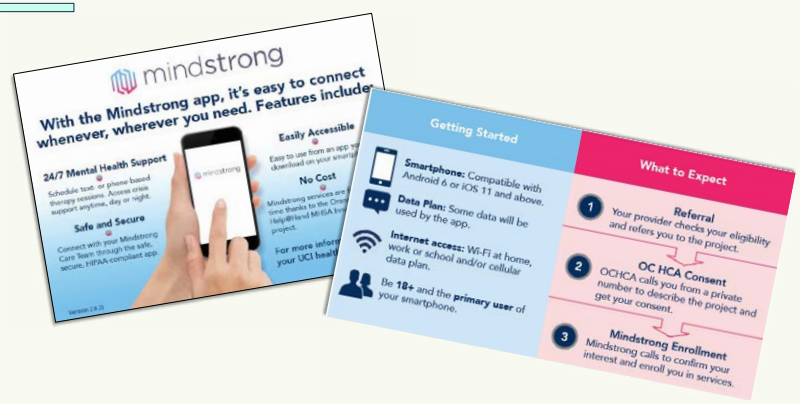
COVID-19 stay-at-home order derailed intended launch plans

Required flexibility and problem-solving to revise launch plans for rapid COVID response

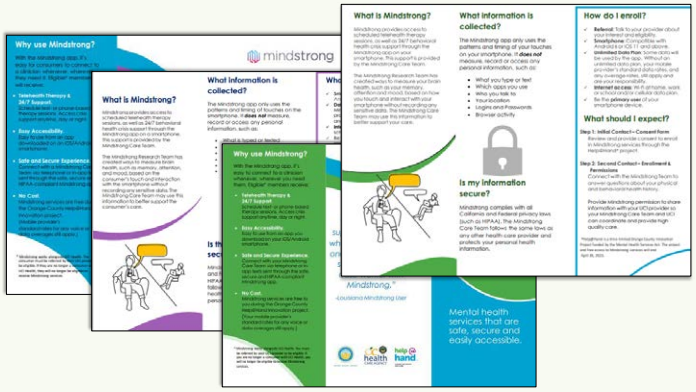
Technology: Pilot & Implementation

mindstrong

Referral & Eligibility



Outreach Materials



HCA Informed Consent

- HCA's Informed consent is a necessary and required step before a referral is sent to Mindstrong
- OC Help@Hand Peers call referred consumers and review each section of the document:
  - Mindstrong Telehealth Services
  - Care Coordination
  - Mindstrong App: Biomarkers
  - Behavioral Health Crisis
  - Data Collection
  - Privacy
  - Security
  - Participation
  - Cost to Participate
- This process takes about 15-30 minutes, and the consumer's decision to consent or decline is documented
- The consent document was converted into videos and HCA is currently working to automate the process

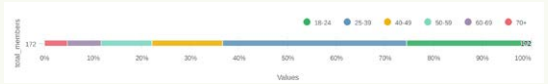
Informed Consent Example – Privacy

Written Document

"The Mindstrong Care Team follows the same privacy laws as other clinicians and protects my personal information and protected health information, My information will not be shared unless I give my permission, or it is required or permitted by law. In an emergency, Mindstrong may share my information with my local provider(s), crisis services and/or emergency contacts to help keep me and others safe. I can refer to the *Privacy Practices* contained in the "Account" tab of the Mindstrong app for more detailed information. I can find Mindstrong's HIPAA Notice of Privacy Practices at *https://mindstronghealth.com/hipaa-notice-of-privacy-practice/* "

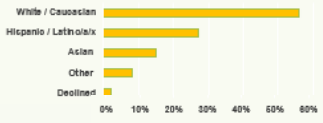
Video

Referral & Enrollment Demographics

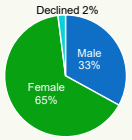


Age

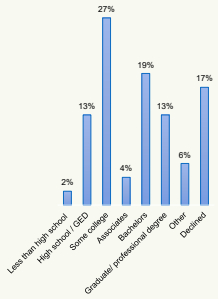
Ethnic Background



Gender



Education Level



Project Activities

Help@Hand Rapid COVID-19 Response

Smartphone apps focused on emotional well-being can provide valuable support for people looking for ways to manage stress and anxiety during these challenging times.

Take a look at the roundup of support apps and click on a logo for a brief summary of an app's features. While the products included here represent a small fraction of what is available in the marketplace, they were identified because they offer free content that does not expire and have been independently reviewed on One Mind's PsyberGuide.[1]

Please be advised that many of these apps offer subscriptions for paid content. HCA is not responsible for any fees or expenses incurred by usage of these apps or any paid content. The apps are not intended to replace services provided by a mental health practitioner.

[1] With the exception of COVID Coach, which was developed by the National Center for PTSD in response to COVID-19.

MINDFULNESS & MEDITATION APPS

INSIGHT
Peace in our Timer

SESAME STREET
Breathe, Think, Do with Sesame

STOP, BREATHE & THINK KIDS

my life

COVID Coach

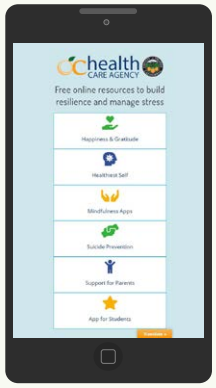
Click on the icons to learn more.

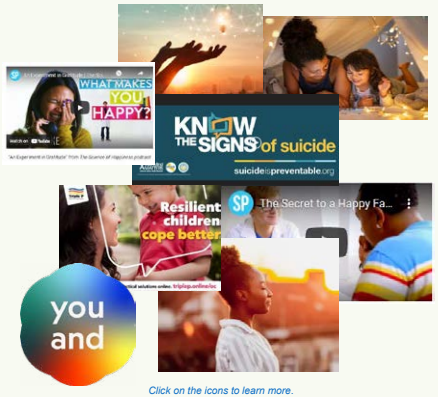
Community Outreach Events

- HCA collaborated with Angels Baseball for a campaign in support of Mental Health Awareness month
- HCA Staff attended two games in May and June reaching more than 30,000 attendees, and promoted the website to approximately 1,700 participants at the Angels 5k in August
- The Help@Hand website was shared with the community through a QR code on the Rally Monkey tag and other promotional materials

HelpatHandCA.org/OC

OC Help@Hand Digital Support Website





Click on the icons to learn more.

Peer Activities

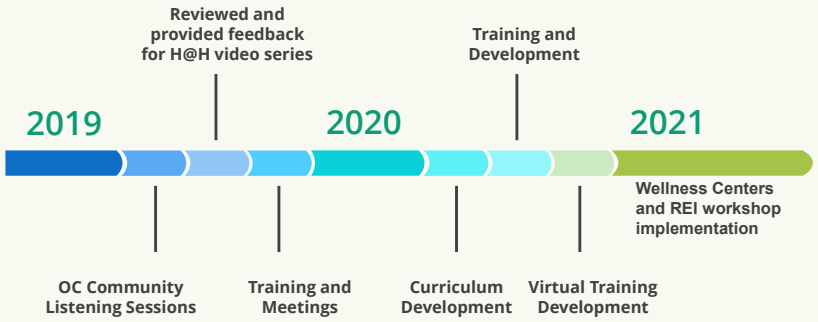
Collaborative Peer Summit

Early H@H efforts revealed differing understandings among collaborative members regarding the experience and requirements for those who served in the "Peer" role versus those who were community/constituent peers ("P vs. p")

Peer

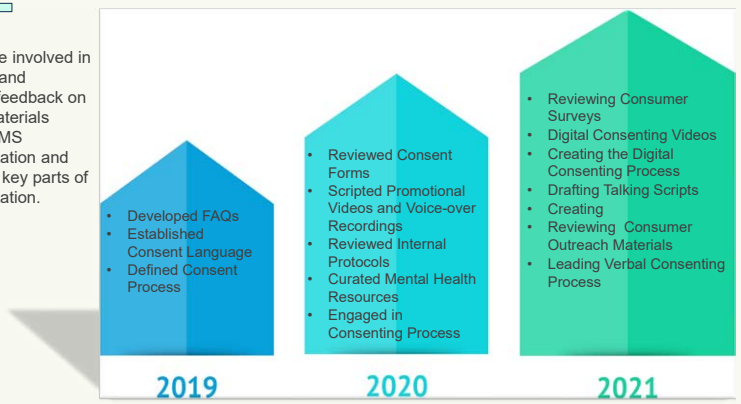
A person who publicly self-identifies with having a personal lived experience of a mental health/co-occurring issue accompanied by the experience of recovery and is trained to use that experience to support the people we serve.

Digital Mental Health Literacy (DMHL)



OC Technology Implementation Support

Peers were involved in reviewing and providing feedback on various materials related to MS implementation and supported key parts of implementation.



Summary

Help@Hand has taught us some valuable lessons that we can apply in future cross-county collaborations and/or OC technology-based projects

As we wrapped up the first year of Mindstrong implementation we created a foundation for expanding to larger sites, like community colleges, where we can engage and support thousands of students

In addition to integration technology into our public behavioral health system, Help@Hand gave us the opportunity to integrate into our community through local events and activities that drive interest in the project website and resources

Peer Specialists continue to expand their roles, responsibilities and contributions to our behavioral health system of care and its programs

Thank You

MHSA Fund-Fiscal Update

PRESENTED BY CEO BUDGET – JULIA RINALDI

JULY 2021

Role of HCA vs. CEO Budget

HCA

- Focus on the MHSA Plan and Program Budgets by Fiscal year required by State Law
- Tracks Program spending and updates projections regularly
- Receives revenue projections provided by State Consultant and utilizes amounts in budget planning process
- Accounting staff (Auditor-Controller) prepare and submits claims for reimbursement to CEO Budget
- Accounting staff submit required Revenue Expenditure Report (RER) to the State

CEO BUDGET

- Focus is on the cash and fund balance by component in the MHSA Fund 13Y
- Process claims for reimbursement submitted by HCA Accounting (Auditor-Controller staff)
- Track and monitor actual expenses and revenue receipts
- Prepare informational reports utilizing information above and received by HCA that show expected fund balances

DRAFT

County of Orange
Summary of Mental Health Services Act Funds
Projected with Actuals through June FY 2020-21

MENTAL HEALTH SERVICES ACT (MHSA) FUNDS		Budget	Projections	Variance
Unspent MHSA Funds as of June 30, 2020 (Actual)		142,843,831	142,843,831	-
Projected Revenue for FY 2020-21		173,601,083	230,910,774	57,309,691
Prior Period Adjustments (Actual)	(1)	(60,477,823)	(60,477,823)	-
Total Funds Available for FY 2020-21		**255,967,092**	**313,276,783**	**57,309,691**
Estimated Costs in FY 2020-21		(239,232,402)	(189,753,001)	49,479,401
Projected Ending Balance at June 30, 2021 (SEE BELOW)		**16,734,690**	**123,523,782**	**106,789,092**
Revenue for FY 2021-22		209,281,233	209,281,233	-
Estimated Costs in FY 2021-22		(247,455,771)	(213,260,041)	34,195,730
Projected Ending Balance at June 30, 2022 (SEE BELOW)		**(21,439,848)**	**119,544,974**	**140,984,822**
Revenue for FY 2022-23		175,439,568	175,439,568	-
Estimated Costs in FY 2022-23		(222,613,328)	(188,756,857)	33,856,471
Projected Ending Balance at June 30, 2022 (SEE BELOW)		**(68,613,608)**	**106,227,684**	**174,841,292**
Detail of Projected Ending Balance at June 30, 2021				
Community Services and Supports (CSS)			62,788,742	
Prevention and Early Intervention (PEI)			33,577,765	
Innovation (INN)			27,157,275	
Total Projected Ending Balance at June 30, 2021			**$123,523,782**	
Detail of Projected Ending Balance at June 30, 2022				
Community Services and Supports (CSS)			70,111,322	
Prevention and Early Intervention (PEI)			22,811,506	
Innovation (INN)			26,622,146	
Total Projected Ending Balance at June 30, 2022			**119,544,974**	
Detail of Projected Ending Balance at June 30, 2023				
Community Services and Supports (CSS)			53,371,930	
Prevention and Early Intervention (PEI)			19,354,920	
Innovation (INN)			33,500,834	
Total Projected Ending Balance at June 30, 2023			**106,227,684**	

FY 2020-21 Projections

FY 2020-21 Projections by Component

DRAFT

MENTAL HEALTH SERVICES ACT FY 2020-21		CSS	PEI	INN	Transfers from CSS: WET	Transfers from CSS: CFTN	Total	Prudent Reserve (3)
Carryover of Funds from FY 2019-20		75,575,827	40,408,161	26,859,844	-	-	142,843,831	33,258,769
Prior Period Adjustments	(1)	(53,739,867)	(6,213,732)	(524,224)	-	-	(60,477,823)	
RESTATED Carryover funds from FY 2019-20		**21,835,960**	**34,194,429**	**26,335,620**	-	-	**82,366,009**	**33,258,769**
Projected MHSA Revenue for FY 2020-21	(6)	175,497,735	42,668,857	11,297,144	1,083	-	229,464,820	
Transfers from Community Services and Supports to Other MHSA Subaccounts to Cover Approved Project Expenses	(2)	(12,534,179)	-	-	5,253,881	7,280,298	-	
Projected Interest Revenue for FY 2020-21		840,470	378,549	226,937	-	-	1,445,955	
Total Funding Available for FY 2020-21		**185,639,986**	**77,241,835**	**37,859,700**	**5,254,964**	**7,280,298**	**313,276,783**	**33,258,769**
Projected Expenditures		(106,034,010)	(37,677,423)	(9,641,732)	(4,765,487)	(7,095,839)	(165,214,491)	
Projected Admin Expenditures		(16,817,234)	(5,986,647)	(1,060,693)	(489,477)	(184,459)	(24,538,510)	
Total Program and Administrative Costs	(4)	**(122,851,244)**	**(43,664,070)**	**(10,702,425)**	**(5,254,964)**	**(7,280,298)**	**(189,753,001)**	-
Projected Carryover of Funds for FY 2021-22		**62,788,742**	**33,577,765**	**27,157,275**	-	-	**123,523,782**	**33,258,769**
Estimated MHSA Revenue for FY 2021-22	(5)	159,053,740	39,763,432	10,464,061	-	-	209,281,233	
Anticipated Costs for FY 2021-22		(130,203,791)	(50,529,691)	(10,999,190)	(5,219,985)	(16,307,384)	(213,260,041)	
Anticipated Transfers for FY 2021-22		(21,527,369)			5,219,985	16,307,384	-	
Projected Carryover of Funds for FY 2022-23		**70,111,322**	**22,811,506**	**26,622,146**	-	-	**119,544,974**	**33,258,769**
Estimated MHSA Revenue for FY 2022-23	(5)	133,086,103	33,432,705	8,920,760	-	-	175,439,568	
Anticipated Costs for FY 2022-23		(135,562,676)	(36,889,291)	(2,042,071)	(5,296,662)	(8,966,158)	(188,756,857)	
Anticipated Transfers for FY 2022-23		(14,262,820)			5,296,662	8,966,158	-	
Projected Carryover of Funds for FY 2023-24		**53,371,930**	**19,354,920**	**33,500,834**	-	-	**106,227,684**	**33,258,769**

Variance Explanation

- As a result of the State Consultant's update in February 2021, revenue projections for FY 2020-21 increased by $27.7M and FY 2021-22 increased by $43.5M for a total of **$71.2M**.
- May and June Revenues came in $26.6M higher than the previous year's May and June revenue and the YE total is **$32.2M** greater than the state consultant's most recent projection.
- Year End Actual Expenses for FY 2020-21 have decreased by $8.5M and the FY 2021-22 Expense projections have increased by $10.9M for a net increase of **$2.4M** since the February projections

Feb. 2021 Revenue Projection Increase	$71.2 M
Year-End Revenue Amt. Over Projection	$32.2 M
Net Increase in Expense	($2.4) M
Variance Since Feb Presentation	$101.0 M

Summary

- Expense amounts projected for FY 2020-21 reflect actuals through Period 13.2 (almost final actuals for FY 2020-21)
- Projections for FYs 2021-22 and 2022-23 represent 82% of CSS, 90% of PEI and 100% of INN, WET and CFTN updated budgeted plan amounts.
- Revenue budget amounts for FYs 2021-22 and 2022-23 reflect our State Consultant's projections.
- As currently projected, the carry over balance from FY 2020-21 is $123.6M, from FY 2021-22 is $119.6M and FY 2022-23 is $106.2M.

OC health CARE AGENCY What's Up

OCTOBER 2021 NEWSLETTER **HAPPY HALLOWEEN!**

Director's Message

Dear OC Health Care Agency (HCA) Team,

October is Breast Cancer Awareness Month. According to the American Cancer Society, breast cancer is the most common cancer diagnosed among U.S. women and the second leading cause of death among women after lung cancer. One in 8 women will be diagnosed with breast cancer in her lifetime. The risk for breast cancer increases with age, with most breast cancers diagnosed after age 50.

When breast cancer is detected early, and is in the localized stage, the 5-year relative survival rate is

. . . continued on page 3

FEATURED ARTICLES

Peer-to-Peer *Lorena Fischer*

"I work with others, using conventional things in an unconventional manner. People rarely understand what I do. I just say I am additional support to the clinic and those who visit and work here." As a Mental Health Worker I, Peer-to-Peer recipient, **Lorena Fischer** aims at providing comfort for patients at the OC Health Care Agency (HCA) Behavioral Health Services (BHS) outpatient clinic in Aliso Viejo. "I am proud of the people that I work with. Having a supportive team with same goals, helping others. I would like to continue to connect with people and decrease the mental health stigma and increase the awareness on mental health wellness."

At the clinic, Lorena spends her time at the Clubhouse, a "Safe Place" for incoming patients waiting to see their doctors. The space includes arts and crafts, movies, music, and mental health workers such as Lorena, to talk to. With her charm and positivity, her job is to create comfort in a seemingly tense environment. As Lorena puts it, simply "being there," is her job. "My role includes many things such as advocating for participants, greeting clinic visitors, providing resources, creating a calm atmosphere, facilitating peer led groups and activities, creating a monthly calendar, creating a monthly newsletter, and assisting front office staff with translating. I also help front office staff when needed, providing additional support when a first time visitor has anxieties and fears, providing information on coping skills, and providing information on illness symptoms to

. . . continued on page 7

SUICIDE PREVENTION WEEK AND MONTH

The Orange County Board of Supervisors (Board) proclaimed September 5-11 as Suicide Prevention Week and September as Suicide Prevention Month. In its proclamation, the Board said it, "prioritized suicide prevention by establishing the Office of Suicide Prevention (OSP) to support and expand countywide suicide prevention efforts," and urged all Orange County (OC) residents, "to play a role in suicide prevention and promote mental health and wellness as we strive towards zero suicides."

During the Board presentation, **Dr. Clayton Chau**, OC Health Care Agency (HCA) Director and County Health Officer thanked families and those who speak out for youngsters. "Let us celebrate life. I know it's difficult to see hope, but services are available and treatments are effective. I urge everyone to know what's available and to encourage their use. For all the youngsters living with mental illness or suicidal thoughts, I want to give you hope. I've been there, I got treatment and I recovered. Get treatment, don't let anyone shame you or stigmatize you. Reach out to someone, to family or a friend. And please call (800) 273-TALK (Suicide Prevention Hotline)."

Suicide is something that has touched many as noted by **Dr. Jeffrey Nagel**, OC Behavioral Health Director. "I want to thank the Board for their support on this resolution, for creating the Office of Suicide Prevention, and for their support throughout the years. I want to break the myth that talking to someone who is suicidal will make them become more suicidal. The opposite is true. If you know someone who is struggling, don't hesitate to reach out and to talk to them. And know where to access resources."

And there are several suicide prevention action items underway said **Bhuvana Rao**, Division Manager, OSP. "We really want to raise awareness about suicide prevention in Orange County. It's never too early to have those conversations with someone who might be struggling. While this is such a serious topic, we never want to lose hope and the most important message, for anyone who

is struggling or if you know of someone who is struggling, is that it is never too early to have those conversations." Dr. Rao encouraged everyone to get familiar with the signs by going to www.suicideispreventable.org. "The signs are subtle, but they are there. When people are struggling, they really are trying to reach out. We can all play a part in suicide prevention by understanding those signs and reaching out to someone who might be struggling."

Director's Message

continued from page 1

99%. Early detection includes doing monthly breast self-exams, and scheduling regular clinical breast exams and mammograms. Many breast cancer symptoms are invisible and not noticeable without a professional screening, but some symptoms can be caught early just by being proactive about your breast health.

I encourage you to visit nationalbreastcancer.org to learn more about the causes of breast cancer, and how to be proactive with early detection and healthy habits to reduce your risk of getting breast cancer.

As the fall season begins, I also want to encourage you and your loved ones over the age of six months to get vaccinated against influenza, also known as the seasonal flu. According to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics, **influenza vaccines can be safely co-administered with COVID-19 vaccines for both eligible children and adults**.

Last year, we saw very low numbers of flu cases, most likely due to the mitigation measures that were in place to avoid the spread of COVID-19 including mask wearing, social distancing, and remote working and learning. Now that people are returning to normal activities, and due to reduced population immunity from low virus activity since the COVID-19 pandemic started, we may see an early and higher prevalence of influenza this year.

Many of us have already experienced a great deal of stress with COVID-19 alone, so let us not also worry about the flu, too. If you are not yet vaccinated for either COVID-19 or the flu, please know that you can receive both the COVID-19 and flu vaccines at the same time.

The flu season typically lasts from October through May. The virus constantly changes, which means people can get infected with the flu every year. Like COVID-19, the best way to prevent the flu is through vaccination. You can get the flu vaccine by asking your doctor, visiting your health care provider, or going to a local pharmacy or clinic. For more information on flu shots in Orange County, visit ochealthinfo.com/flu.

Stay Well,

Dr. Clayton Chau, MD, PHD
HCA Director and County Health Officer

2021 ANNUAL OC COMMUNITY BEHAVI

The OC Health Care Agency (HCA), in partnership with the Long Beach Veterans Administration (VA) Health Care System (HCS), held another successful Annual Orange County Community Behavioral Summit on September 24, 2021. The theme of this year's conference was "Resilience" with all of the sessions focused on improving the resilience of Veterans through innovative practices. Several community partners joined the HCA and the VA in support of the annual summit, including:

- Strength in Support
- Orange County Veterans and Military Families Collaborative (OCVMFC)
- California National Guard, Mental Health Division
- Strong Families Strong Children
- Human Options
- Veterans Legal Institute
- Jamboree Housing

The Annual OC Community Behavioral Health (BH) Summit provides an opportunity to engage in active dialogue on how we can address the needs of our Veterans and their families and also seek collaborative support for those needs. Due to the COVID-19 pandemic and public health safety, we shifted our in-person event to a virtual event using WebEx as our virtual host. The 2021 Community BH Summit focused on building resilience through connection with others, highlighting resources and intervention strategies the following available to support Orange County Veterans and their families.

The 2021 Community BH summit included two keynote speakers and four 75-minute breakout sessions. Each breakout session offered two training options for the attendees. **Dr. Clayton Chau**, the Director of the HCA, was our morning keynote speaker, speaking to the impact of COVID-19 on Veteran mental health. Dustin Thompson, the Chief Experience Officer for the Long Beach VA HCS, was our afternoon keynote speaker, speaking to the importance of communication in advocating for personal needs. The keynotes and presentations were as follows:

Morning Keynote Address

COVID-19 and Mental Health, Clayton Chau, M.D., Ph.D. (HCA)

Breakout Session One

- Implementing Best Practices in Suicide Prevention, Jarod Rouch Ph.D. (LB VA HCS)
- VA Whole Health Approach to Care, Lia Kramer, Ph.D (LB VA HCS), Sonika Ung, Ph.D. (LB VA HCS)

Breakout Session Two

- Supporting Veteran Families in a Time of Crisis: Strengthening Partnerships to Improve Family Outcomes, Mitzi Huff, Larisa Owens Ph.D., Jacob Lampe ACSW, Rubi Lara, (Strong Families Strong Children), Sara Behmerwohld, Esq., (Human Options), Antionette Balta Esq., LLM, (Veterans Legal Institute)
- Identifying and Lifting Barriers to Integrating Medication-Assisted Therapies, Ricardo Restrepo-Guzman, M.D., MPH (LB VA HCS)

ORAL HEALTH SUMMIT

Contributors: **Kevin Alexander**, Service Chief II
Dr. Michael Mullard, Behavioral Health Clinician II

Afternoon Keynote Address

- No, Really, How are you?, Dustin Thompson, MA (LB VA HCS)

Breakout Session Three

- The Transition from Active Duty to VA for Service Members with Serious Mental Illness, Laura Marrone, M.D., Sterling Atkins M.D., Robyn Coughlin, LCSW, BCD, Anne Vermillion, RN, BSN, RNC (LB VA HCS)
- Veteran Homelessness: A Pathway to Functional Zero in Orange County, Richard Owens (Jamboree Housing)

Breakout Session Four

- Coming Out of COVID-19 and Learning to Virtually Address the "New Isolation," Robert Stohr, MS, LMFT, (U.S. Veterans Initiative)
- Finding Comfort in our Vices, Connie Thomas, MA, LMFT (Strength in Support)

We wish to thank everyone who presented, participated and planned the event. Special thanks to HCA staff: **Dr. K.C. Pickering**, Service Chief I; **Stella Dang**, Information Processing Specialist; **Christy Ortega**, Office Specialist; **Shelby St. Clair** and **Brittany Whetsell**, Office Technicians; and **Allyson Palas**, Research Analyst IV.

We look forward to next year's conference which will be in September 2022.

At the direction of the Orange County Board of Supervisors, the Community Suicide Prevention Initiative will bring together the Orange County community for a two-day conference on suicide prevention. See below for information. To register click here.

BE WELL TOGETHER:

Community Action for Suicide Prevention

A virtual 2-day conference will bring together the Orange County community to raise awareness and share resources on suicide prevention.

October 14-15, 2021
9:00 a.m. to 12:00 p.m.
No Cost Event

Keynote Speakers:
Day 1: Keris Myrick, MS, MBA, Director at the Jed Foundation; Co-Director of The Mental Health Strategic Impact Initiative

Day 2: Dr. Christine Moutier, American Foundation for Suicide Prevention

Join Us at the "Out of the Darkness Walk"

October 16 from 9 a.m. - 12 p.m.

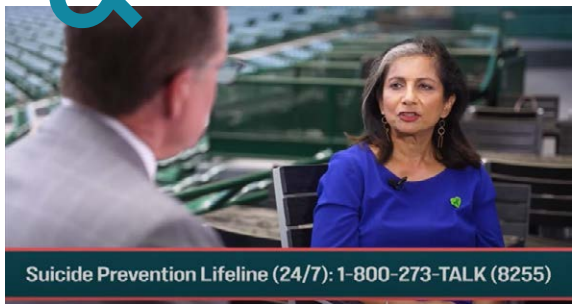
Community Suicide Prevention Initiative funded by: The OC Health Care Agency (OCHCA), Behavioral Health Services, Prevention & Intervention, Mental Health Services ACT/Prop 63

For a time of healing and awareness, we invite all conference attendees to join us at the AFSP Out of the Darkness Orange County California Walk at Saddleback Church, virtually, or in your own neighborhood.

Register at: afsp.org/orangecountywalk

SUICIDE PREVENTION & ANGELS BASEBALL

Contributor: **Julia Mayuga**, Communications Intern



The OC Health Care Agency (HCA) and Angels Baseball teamed up to promote suicide prevention in September. Before a game at The Big A, Office of Suicide Prevention Director, **Dr. Bhuvana Rao** sat down with Angels host Kent French to recognize September as Suicide Prevention Month. You can watch the 90-second interview by clicking here. The full 3-minute interview is also available here.

"Stigma continues to surround the topic of suicide," Dr. Rao says. She hopes "the collaboration with the Angels will normalize conversations surrounding suicide that may seem taboo." Suicide prevention, as Dr. Rao states, "is a balance between pain and hope. It's important to provide reasons for living and emotional support to those afflicted from suicide."

Fans can go to suicideispreventable.org to learn more about recognizing warning signs, starting a conversation, and the steps you can take to create a safe environment for

5 Things You Need to Know Abo

1 According to the Centers for Disease Control and Prevention (CDC) viruses constantly change through mutation, and new variants of a virus are expected to occur. Numerous variants of the virus that causes COVID-19 are being tracked in the United States and globally during this pandemic. Read more on variants here.

2 There are three classes of variants according to the US government SARS-CoV-2 Interagency Group (SIG). Variants of Interest; Variants of Concern; and Variants of High Consequence. You can read more about the classifications here.

3 The OC Health Care Agency (HCA) tracks COVID-19 variants in Orange County (OC). You can find the data by clicking on the blue and yellow Desktop Version and Mobile Version dashboard links here. The data is updated on Thursdays.

Reference:
1. Monitoring Incidence of COVID-19 Cases, Hospitalizations, and Deaths, by Vaccination Status — 13 U.S. Jurisdictions, April 4–July 17, 2021 Early Release / September 10, 2021 / 70; https://www.cdc.gov/mmwr/volumes/70/wr/mm7037e1.htm?s_cid=mm7037e1_w

your loved ones.

The HCA continues working with community partners on suicide prevention. A two-day conference is scheduled for anyone who wants to learn more about suicide prevention. The virtual conference will be on October 14 and 15. The event will end with an "Out of Darkness" Walk, sponsored by the American Foundation to Suicide Prevention on October 16. See page 5 for more information.

If you or anyone you know is in need of assistance, please call the Suicide Prevention Lifeline at (800) 273-TALK (8255).

Peer-to-Peer
continued from page 1

raise awareness."

Lorena has also been active during the COVID-19 pandemic. Before the COVID-19 vaccine was released, Lorena spent time at the Joplin Youth Camp where homeless individuals were voluntarily protected from the virus. She assisted with providing stimulus checks, food stamp benefits and connecting clients to mental health services, education and job-skill training. During a six-month deployment, Lorena joined the County of Orange's mass vaccine initiative at several point of dispensing (POD) sites. She served most of the time at Santa Ana College where she accommodated individuals who were anxious and hesitant about receiving the vaccine. Lorena called these, "opportunities to be of service to the greater public. I am honored at being able to be part of such an incredible experience."

When asked what's the best part of her job, Lorena said it was being inspired by those she works with and those she serves. "I admire my colleagues and how genuine services are being provided at this site and the regard for the well-being of those who come in through these doors. Those characteristics are what makes me proud to work for the HCA."

Contributor: **Julia Mayuga**, Communications Intern

ut: COVID-19 VARIANTS

As of mid-September the Delta variant was the most widespread in OC. The CDC says the Delta variant spreads faster and is more than two times as contagious as previous variants. The HCA provided information on the Delta variant which you can read here. You can also sign up to receive information from the CDC on variants by entering your email here. (Note the CDC offers 282 publications for subscription.)

"When it comes to reducing the risk of contracting COVID-19 and variants such as Delta, the best action one can take is to get vaccinated and continue following public health precautions," said **Dr. Regina Chinsio-Kwong** (Dr. CK), County Deputy Health Officer. "Studies continue to show that all authorized COVID-19 vaccines in the US are highly effective in preventing hospitalization and death," said Dr. CK. A recent study showed that after Delta became the most common variant, fully vaccinated people had reduced risk of infection five-fold, and had reduced risk of hospitalization and death over ten-fold compared to unvaccinated[1]. For the Delta variant, the risk of breakthrough infections in vaccinated people is low, and when it does occur, the infectious period appears to be shorter and symptoms are milder compared to unvaccinated people.

Tips for a Safe Halloween

During COVID-19

Halloween is a holiday enjoyed by adults and children alike. It's a great time to encourage nutritious snacking, physical activity and focus on safety. However, with COVID-19, additional safety measures should be put in place to have a happy and safe Halloween. Here are a few reminders for COVID-19 safety:

- **Keep your Distance**: Trick-or-Treating can sometimes lead to crowds when walking or waiting for candy to be handed out. Keep your distance from others who are not part of your household.
- **Wear a Mask**: There are so many creative costumes for Halloween. Substitute your regular mask with a festive Halloween themed cloth mask that matches your costume. Your Halloween cloth mask should be constructed of two or more breathable fabric layers, cover your nose and mouth, fit snugly against your face with no gaps, and have a nose wire to prevent air from leaking out of the top of the mask.
- **Play it Safe**: Instead of Trick-or-Treating in the neighborhood, create a daytime-outdoor scavenger hunt, haunted play area, or Halloween-themed early outdoor dinner for your family.
- Giving Candy: Distribute candy outside by setting up a station with individually wrapped candies or goodie bags for Trick or Treaters to grab and take to go while adhering to social distancing.

In addition to taking steps to be COVID-safe, the following are a few additional tips to keep in mind as you celebrate:

- **Walk Safely**: Encourage children to walk and not run to avoid slips and falls. When crossing neighborhood streets or intersections, obey traffic signals and look both ways before crossing. Put electronic devices down and keep your head up while walking to prevent trips and be aware of cars that are turning or backing up.
- **Drive Safely**: Prime trick-or-treating hours are between 5:30 to 9:30 p.m. Be especially alert for pedestrians who may be walking, riding their bikes or skateboarding during these times. Plan your drive accordingly to anticipate heavy pedestrian traffic and be cautious when entering and exiting neighborhoods or residences.
- **Additional Tips**: Wear reflective gear, walk with a group of your family members and carry a flashlight to see and so others can see you. Plan ahead to review the route you anticipate taking. Have kids carry glow sticks to help them be seen by drivers.
- **Vaccinations**: Vaccines are widely available, and more groups are now eligible for vaccination. You can find a vaccine location here.

For a few extra trick-or-treating safety tips, visit the Centers for Disease Control and Prevention's Halloween Health and Safety tips website here.

Diversity, Equity & Inclusion:

Cultural Spotlight

Contributor: **Dr. Bhuvana Rao**, Director, Office of Suicide Prevention

Diwali, meaning "rows of lighted lamps," is a Hindu-originated "festival of lights" celebrated in India and by the Indian diaspora across the world. During the five-day celebration, clay lamps known as diyas are lit to symbolize the inner light that protects from spiritual darkness. This festival is one of the most important celebrations for people of the Hindu, Sikh and Jain faiths, along with the Indian immigrant communities in the United States (US) as well.

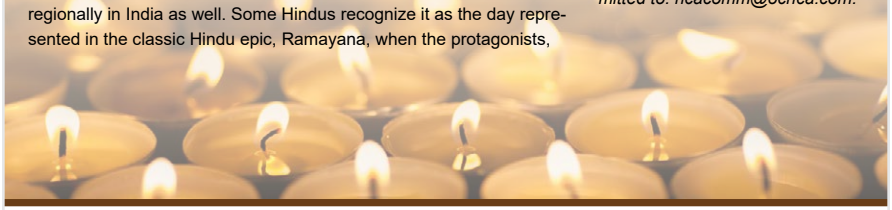
Diwali typically coincides with harvest and new year celebrations. It's a festival of new beginnings, and the triumph of good over evil and light over darkness. People celebrate the festival by decorating their homes with oil lamps, candles, lights, flowers, and rangoli, which are colorful and elaborate floor designs. There's an exchanging of gifts and sweets, and Lakshmi, the Hindu goddess of wealth, is worshipped as the bringer of blessings for the new year. This year Diwali begins on Tuesday, November 2 and lasts for five days, with the main day of celebrations taking place on Saturday, November 6. For this year's Diwali celebration, various temples and places of worship will conduct online puja, a ceremonial prayer that offers fruits and flowers to Hindu deities.

Diwali celebrations have become much more mainstream in the US. Prior to COVID-19, Diwali celebrations in Orange County have occurred in the City of Irvine and at the Disney California Adventure Park in Anaheim as part of a festival of holidays at the theme park and included performances of traditional Indian dances and a Bollywood dance party. Many other US cities have hosted celebrations including San Francisco, New York City, San Antonio and Seattle.

Diwali has mythological origins and carries different meanings for the different religious communities and has many local interpretations regionally in India as well. Some Hindus recognize it as the day represented in the classic Hindu epic, Ramayana, when the protagonists, Rama and Sita, arrive back home in Ayodhya after 14 years of exile; Diwali is often celebrated as the day of their return. In South India, many Hindus mark Diwali as the day lord Krishna defeated the demon Narakasura and thereby freed the 16,000 girls in his captivity. In Western India, many Hindu and Jain communities consider Diwali the first day of the new year.

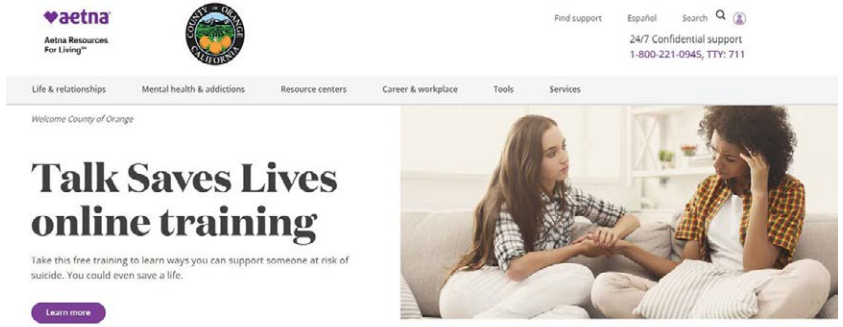
Regardless, Diwali celebrates the triumph of righteousness, represented by light. Happy Diwali to our OC Health Care Agency colleagues who celebrate.

*The **Diversity, Equity and Inclusion** column reflects the OC Health Care Agency's commitment to celebrate the diversity of our workforce. It will also include information on our continuing efforts to develop diversity, equity, and inclusion as core components of the work we do in service to the community. Employees are welcome to contribute ideas and stories that help create a more inclusive and equitable workplace, which recognizes and values all backgrounds, voices, roles and contributions. Ideas can be submitted to: hcacomm@ochca.com.*



Leveraging Your Benefits

Mental Illness Awareness Week



Mental Illness Awareness Week (MIAW) runs from October 3-9, 2021. The MIAW theme is, "Together for Mental Health." For more click here.

There are resources and services available to OC Health Care Agency employees, dependents and the Orange County community. The National Alliance on Mental Illness-OC has resources here. County of Orange employees can access resources through Aetna's www.resourcesforliving.com.

The Resources for Living website includes support, training, assessments, setting up a personal account to match your interests and more.

Information in "Leveraging Your Benefits" is to make you aware of benefits available to you as a County of Orange employee. This is not an endorsement of any program.

Connect with Us

The **What's Up** newsletter is created and distributed monthly by HCA Communications. We welcome your ideas, input and/or insight into HCA people and programs. To contribute, comment or connect please email us at hcacomm@ochca.com or call (714) 834-2178. Thank you!

APPENDIX II: Review of Proposed MHSA Budget Adjustments – April 6, 2022

MHSA Community Meeting

FY 2022-23 MHSA Annual Plan Update

1

Agenda

Welcome, Introductions	9:00
Community and Agency Changes	9:10
How does the plan get developed?	9:20
What Changes are proposed in the plan?	9:30
Discussion and Questions	10:10
Follow Up	10:30

2

How to Zoom

The meeting in the Main Room is recorded. Breakout Room discussions are not recorded.

In Zoom

You can hear and see who is speaking

Mute — UNMUTED Mic is ON

Unmute — MUTED Mic is OFF

find by your name

or tap MORE to find the hand

Chat

*with **EVERYONE** vs Direct Message that is only seen by **Co-Host***

Stop Video — Video is ON

Start Video — Video is OFF

If you are in a place with background noise, please keep your device/phone MUTED when you're not speaking *

To ask questions / make comments, use:

"RAISE HAND"

and the Co-Host will call on you when it's your turn to speak

or **CHAT**

Chat to EVERYONE is seen by everyone. Attendees can also direct message the OCHCA Co-Host, who will read your message anonymously

If the Zoom connection is breaking up, turning your video OFF may help

On Phone

You can only hear who is speaking

press *6 to **MUTE** and **UNMUTE**

press *9 to **RAISE HAND** and let the Co-Host know you would like to speak

* *Participants who are On Zoom with a computer or tablet and calling in over a telephone may need to mute/unmute both, and watch out for feedback*

We appreciate and value your time! To help create a comfortable and safe virtual environment, please be respectful of others when sharing your comments and opinions.

3

MHSA Plan and Annual Updates

Mental Health Services Act

- MHSA is a funding source for Mental Health and Recovery Services in California.
- Similar to a grant in that there are guidelines, regulations, documentation requirements and outcome expectations.
- It requires community input and collaboration, emphasizes transformation of the mental health system. Emphasizes equity and accessibility in provision of services.
- The MHSA budget is divided between five components:
  - Community Support and Services (CSS)
  - Prevention and Early Intervention (PEI)
  - Innovations (INN)
  - Workforce Education and Training* (WET)
  - Capitol Facilities and Technological Needs (CFTN)

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MHSA Plan and Annual Updates

Mental Health Services Act

- Requires a three-year plan and an annual plan update for subsequent years.
- Plan components:
  - Community planning process
  - Outcomes
  - Program summaries
  - Budget
  - Progress reports
  - Executive Summary

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MHSA Plan and Annual Updates

Mental Health Services Act

Orange County is currently in the 3rd year of our three-year plan.

- The three-year plan identified "Strategic Priorities" that help to guide us during the three years.
- The Strategic Priorities are important because they are like a golden thread that weaves through each annual plan update.
- The information being presented today is for the Fiscal Year 2022 – 2023 MHSA Annual Plan Update.

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1 Mental Health Awareness & Stigma Reduction

GOAL: Further expand on campaigns, trainings and community education focused on increasing awareness of mental health signs and available resources, as well as reducing stigma

2 Suicide Prevention

GOAL: Expand support for suicide prevention efforts

3 Access to Behavioral Health Services

GOAL: Improve access to behavioral health services and address transportation challenges

FY 2020-23 MHSA **Strategic Priorities**

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Community and Agency Changes

New Leadership for Mental Health and Recovery Services

Newly formed Community Group: Community Voices

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A New Landscape

- New leadership in Mental Health and Recovery Services
  - Dr. Veronica Kelley, Behavioral Health Director (Chief of MHRS)
  - Jenny Hudson, LCSW, Division Manager, MHSA Coordinator
  - Sharon Ishikawa, PhD, Research Manager
  - Office of Health Population and Health Equity was created in December 2020
  - MHSA Office in collaboration with the Office of Project Management and Quality Management, working to re-structure the Agency approach to Community Engagement and Planning (presentation at the November 2021 BHAB meeting)

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A New Landscape

- Community Changes:
  - A new integrated Behavioral Health Advisory Board was created March 2021.
  - MHSA Steering Committee dissolved in June 2021
  - A new Community Advocacy Group is starting; Community Voices
  - Community Voices leadership: Johnice Williams
  - We anticipate that we will be coordinating with this advocacy group regarding MHSA planning and

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Other Considerations

- Entering a post pandemic
- Changing financial projections
- Many people transitioned to telecommuting or a hybrid.
- Many people remained in our programs providing direct services throughout the pandemic.
- Integrated virtual services
- Universal trauma; many people managing multiple losses, life changes, isolation

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Other Considerations

- In mid-January 2022, HCA became aware of a significant increase in MHSA projections. This update was shared in the BHAB meeting on February 23, 2022
- This had a significant impact on the MHSA planning process as we are vigorously working with our stakeholders to allocate funding accordingly
- The funding amounts listed in the worksheet are **proposed** changes
- HCA has very clear contracting guidelines that require request for proposals (RFP) and a competitive process

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How do we develop the plan?

- Collaboration
- Subject matter experts
- Data
- Best Practices
- New Legislation
- CEO Office
- Cal Optima
- Community Meetings
- Orange County Board of Supervisors
- Recommendations from the BHAB
- Collaboration with other counties
- Provider Feedback
- Lessons learned
- Community surveys
- Workgroups

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We appreciate your time and dedication!

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County of Orange
MENTAL HEALTH SERVICES ACT (MHSA) FUNDS
Point in time : Projected Carry Over Balances FY 21/22 - FY 22/23

	CEO Presented Jan 12, 2022	CEO Reported Updated allocations Feb 23, 2022	Proposed Plan update Mar 23, 2022
Beginning Balance FY 2021-22	**123,523,781**	**123,523,781**	**123,523,781**
Estimated Revenue for FY 2021-22	235,636,818	260,019,440	260,019,440
Estimated Costs in FY 2021-22	(227,516,676)	(227,516,676)	(214,449,900)
Projected Ending Balance FY 21/22	**131,643,923**	**156,026,545**	**169,093,321**
Projected Beginning Balance FY 22/23 (SEE BELOW)	**131,643,923**	**156,026,545**	**169,093,321**
Estimated Revenue for FY 2022-23	175,439,568	260,890,000	260,890,000
Estimated Costs in FY 2022-23	(188,756,858)	(188,756,858)	(316,532,241)
Projected Ending Balance FY 22/23 (SEE BELOW)	**118,326,633**	**228,159,687**	**113,451,080**
Detail of Projected Ending Balance FY 21/22			
Community Services and Supports (CSS)	86,125,957	104,559,060	94,671,887
Prevention and Early Intervention (PEI)	24,886,915	29,544,152	36,837,760
Innovation (INN)	20,631,051	21,923,333	24,593,903
Workforce Education and Training (WET)	-	-	-
Capital Facilities and Technological Needs	-	-	12,989,771
Total Projected Ending Balance FY 21/22	**131,643,923**	**156,026,545**	**169,093,321**
Detail of Projected Ending Balance FY 22/23			
Community Services and Supports (CSS)	69,386,564	153,013,564	69,989,649
Prevention and Early Intervention (PEI)	21,430,329	42,224,861	17,528,746
Innovation (INN)	27,509,740	32,921,262	25,932,685
Workforce Education and Training (WET)	-	-	-
Capital Facilities and Technological Needs	-	-	-
Total Projected Ending Balance FY 22/23	**118,326,633**	**228,159,687**	**113,451,080**

Orange County MHSA CSS Budget Analysis for Three-Year Plan

Fiscal Years: 2020-21 through 2022-23

Purpose: To provide projected CSS balances for 3-year planning

Updated as of 3/23/2022

Current Balances for Planning

CSS FY 2019-20	
Beginning Balance	$55,747,255
Actual Revenue (inc. interest)	$114,583,988
Actual Expenditures	-$152,779,182
Actual WET Transfer	-$3,823,525
Actual CFTN Transfer	-$14,799,492
Shift from Prudent Reserve	$22,906,915
Ending Balance	$21,835,959

CSS FY 2020-21	Budgeted	Actuals
Beginning Balance	$21,835,959	$21,835,959
Revenue (inc. Interest)	$128,900,000	$176,338,205
Carryover CFTN Remaining Balance	$0	$0
Approved Budget from Three-Year Plan	-$155,088,175	
Actual Expenditures		-$122,851,246
WET Transfer	$6,216,634	-$5,253,881
CFTN Transfer	$12,519,749	-$7,280,298
Preliminary Ending Balance	$14,384,167	$62,788,739

CSS FY 2021-22	Budgeted	Current Projections 3/23/22
Beginning Balance	$62,788,739	$62,788,739
Projected Revenue (inc. Interest)	-$158,969,230	$197,517,085
Approved Plan Update Budget	-$158,785,111	
Projected Expenditures		-$131,930,976
Projected WET Transfer	-$5,219,584	-$4,711,279
Proposed CFTN Transfer based on Plan update presented 3/23/22	-$28,482,979	-$28,991,684
Projected Ending Balance	-$288,668,165	$94,671,885

CSS FY 2022-23	Budgeted	Projected CSS Est. 82% spending
Projected Beginning Balance	$94,671,885	$94,671,885
Projected Revenue (inc. Interest)	$198,280,000	$198,280,000
Proposed Plan update Budget presented 3/23/22	-$225,440,320	
Projected Expenditures based off of proposed budget		-$184,861,062
Proposed WET Transfer based off of proposed budget	-$6,262,162	-$6,262,162
Proposed CFTN Transfer based off of Plan update presented 3/23/22	-$31,839,013	-$31,839,013
Projected Ending Balance	$29,410,390	$69,989,648

Projected Unspent CSS funds at the end of three-year plan ending FY 22/23	$69,989,648

Orange County MHSA PEI Budget Analysis for Three-Year Plan

Fiscal Years: 2020-21 through 2022-23

Purpose: To provide projected PEI balances for 3-year planning

Updated as of 3/23/2022

Current Balances for Planning

PEI FY 2019-20	
Beginning Balance	$41,309,501
Actual Revenue (inc. Interest)	$29,262,641
Actual Expenditures	-$39,790,578
Shift from Prudent Reserve to meet 33% Max. Req.	$3,412,864
Ending Balance	$34,194,428

FY 2020-21	Planning with Budgeted Amounts	Actuals. 7/23/21
Projected Beginning Balance	$34,194,428	$34,194,428
Actual Revenue (inc. Interest)	$43,047,406	$43,047,406
Approved Budget from Three-Year Plan	-$47,061,483	
Preliminary Actual Expenditures		-$43,664,070
Preliminary Ending Balance	$30,180,351	$33,577,764

FY 2021-22	March 2022 Projections Used for Planning	PEI Est. 90% spending
Preliminary Beginning Balance	$33,577,764	$33,577,764
Projected Revenue (inc. Interest)	$39,742,307	$49,428,232
Approved Plan Update Budget	-$56,144,101	
Projected Expenditures		-$46,168,237
Projected Ending Balance	$17,175,970	$36,837,759

FY 2022-23	March 2022 Projections Used for Planning	Est. 90% spending
Projected Beginning Balance	$36,837,759	$36,837,759
Projected Revenue	$49,570,000	$49,570,000
Proposed Plan update Budget presented 3/23/22	-$76,532,238	
Projected Expenditures based off of proposed budget		-$68,879,014
Projected Ending Balance	$86,407,759	$17,528,745

Projected Unspent PEI funds at the end of three-year plan ending FY 22/23	$17,528,745

CSS Updated March 23, 2022		FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget		
ACCESS & LINKAGE TO TREATMENT (TX)	**BHS Outreach & Engagement (O&E)** (all ages) (pg 81, FY 2021-22 MHSA Annual Plan Update)	2,569,933	1,195,053	47%	-	-	-	2,569,933	(2,569,933)	-	Consolidating O&E program over to PEI Component	Keep the budget same level for the lease cost as program will need to relocate in FY20/21.
	Multi-Service Center for Homeless Mentally Illness Adults (pg 84, FY 2021-22 MHSA Annual Plan Update)	900,000	721,278	80%	900,000		900,000	900,000	2,202,489	3,102,489	Removal of MHSA funding with end of the Courtyard Program. Increasing Salaries of counselors for this program. Expand to add a 2nd location to meet high demand	
	Open Access (pg 90, FY 2021-22 MHSA Annual Plan Update)	2,300,000	3,077,168	134%	2,600,000	-	2,600,000	2,300,000	700,000	3,000,000	Added $700K to keep budget level for current service levels.	Open Access previously part of Recovery Center program. Programs separated beginning FY 20/21, with level funding.
	Correctional Health Services: Jail to Community Re-Entry Program (JCRP) (pg 87, FY 2021-22 MHSA Annual Plan Update)	2,200,000	1,253,470	57%	2,700,000		2,700,000	2,800,000	(2,800,000)	-	Program will move from CSS to PEI to better align with population served	Program approved for 28 FTEs and has been diligently trying to hire despite on-going hiring challenges. As of mid-January 2020, program has filled 17 FTEs, and antipcates being being fully staffed by FY 22-23. Budget request for the Three-Year Plan are based on estimated increases in costs due to continual filling of remaining 11 vacancies over each Fiscal Year.
	SUBTOTAL Access & Linkage to Tx	7,969,933	6,246,968	78%	6,200,000	0	6,200,000	8,569,933	(2,467,444)	6,102,489		
CRISIS PREVENTION & SUPPORT	**Warmline** (pg 96, FY 2021-22 MHSA Annual Plan Update)							-	12,000,000	12,000,000	Moved from PEI. Increased budget from $1.1M to $12M. Increased call volume as well as expanding to 24/7. Adding a Spanish and Vietnamese Warmline.	
	Mobile Crisis Assessment (pg 106, FY 2021-22 MHSA Annual Plan Update)	9,135,858	9,001,437	99%	9,135,858	-	9,135,858	9,135,858	1,450,000	10,585,858		
	portion of "Mobile Crisis Assessment" budget operated by CYBH for individuals ages 0-17 years	*3,164,032*	*3,598,381*	*114%*	*3,164,032*	-	*3,164,032*	*3,164,032*	*450,000*	*3,614,032*	Added $450K to budget, in order to right size to actual spending and maintain same level of service as well as funds for satellite location.	Beginning FY 2020-21, increase budget back up to approved FY 2018-19 budget to support efforts to improve response time.
	portion of "Mobile Crisis Assessment" budget operated by AOABH for individuals ages 18 and older	*5,971,826*	*5,403,056*	*90%*	*5,971,826*		*5,971,826*	*5,971,826*	*1,000,000*	*6,971,826*	Adding $1M in budget to for the OCSD Behavioral Health Bureau to provide case management for indiviuals and their families following law enforcement response.	Budget for new lease cost at 4000 Metropolitan.
	Crisis Stabilization Units (CSUs) (pg 109, FY 2021-22 MHSA Annual Plan Update)	6,700,000	4,203,715	63%	10,000,000		10,000,000	10,000,000	4,000,000	14,000,000	Adding County operated CSU to MHSA funding	Requesting to add one new CSU in FY20/21 at Anita Wellness Campus. The total amount will support 2 CSUs (1 at College Hospital in Costa Mesa serving 18+ and 1 at Anita Wellness Campus serving 13+). Budget reflects partial funding for Anita CSU in FY 2020-21.
	In-Home Crisis Stabilization (pg 111, FY 2021-22 MHSA Annual Plan Update)	2,935,480	2,311,971	79%	2,935,480	-	2,935,480	2,935,480	500,000	3,435,480		
	portion of "In-Home Crisis Stabilization" budget operated by CYBH for individuals ages 0-17 years	*1,435,480*	*1,422,535*	*99%*	*1,435,480*	-	*1,435,480*	*1,435,480*	*500,000*	*1,935,480*	Increase budget by $500K in order to have staffing salaries competive to hire and retain staff. Add additional clinician staff as well.	Requesting an annual increase of $350,000 beginning FY 2020-21. Children's provider is currently serving 700 clients, which is 300 over the contracted number of 400 clients.
	portion of "In-Home Crisis Stabilization" budget operated by AOABH for individuals ages 18 and older	*1,500,000*	*889,436*	*59%*	*1,500,000*		*1,500,000*	*1,500,000*		*1,500,000*		Program launched in FY 2018-19. Propose to keep funding at approved budget level as program is still fully ramping up.
	Crisis Residential Services (CRS) (pg 114, FY 2021-22 MHSA Annual Plan Update)	9,030,845	8,890,194	98%	11,280,845	-	11,280,845	11,280,845	-	11,280,845		
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 0-17 years	*3,488,248*	*3,169,559*	*91%*	*5,253,248*	-	*5,253,248*	*4,988,248*		*4,988,248*		**Track 1**: Existing Crisis Residential Services - current budget for this program is $2,988,248 and will remain level for the next 3 fiscal years. **Track 2**: Crisis Children's Residential (New State Mandated Service as part of Continuum of Care reform) - Program is requesting to add $500,000 for FY 2020-21 which will be carried forward to FY 2021-23; in FY 2021-22, Program is requesting an additional increase of $1.5 million to fully implement the program, which will be carried forward to FY 2022-23. Timelines are estimated as HCA still waiting for final guidelines to be released by DHCS. Waymakers:
	portion of "Crisis Residential Services" budget operated by CYBH for individuals ages 18-25 years	*1,541,368*	*1,556,016*	*101%*	*1,041,368*	-	*1,041,368*	*1,541,368*		*1,541,368*		$50k increase beginning FY 2020-21 to cover increased lease costs.
	portion of "Crisis Residential Services" budget operated by AOABH for individuals ages 18 and older	*4,001,229*	*4,164,620*	*104%*	*4,986,229*	-	*4,986,229*	*4,751,229*		*4,751,229*		$1.5M increase due to adding new 15-bed facility at Anita Wellness Campus beginning FY 20/21. Budget reflects partial funding for Anita CSU in FY 2020-21. Program is creating beds for Older Adults; due to high MediCal reimbursement by provider, no additional CSS funding was needed to increase capacity to serve for Older Adults.
	SUBTOTAL Crisis Prevention & Support	27,802,183	24,407,318	88%	33,352,183	-	33,352,183	33,352,183	17,950,000	51,302,183		***As part of the MHSA Strategic Priority of "Suicide Prevention," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs.***
MENT: Programs	**Children's FSP Program** (pg 162, 2021-22 MHSA Annual Plan Update)	11,054,575	10,123,324	92%	11,554,575	-	11,554,575	11,054,575	500,000	11,554,575	Increase budget by $500K in order to maintain level funding with current services as well as to increase salaries to competitive levels.	Approved/requested budgets are to cover the contracted maximum obligations for services. Annual CSS expenditures vary based on MediCal billing. HCA is working with providers to increase MediCal billing, and as less CSS funds are needed, CSS budgets will be adjusted accordingly. Adult budget is also less lease costs due to one program being housed temporarily at another FSP clinic.
	Transitional Age Youth (TAY) FSP Program (pg 162)	8,184,468	7,037,043	86%	8,184,468	-	8,184,468	8,184,468	-	8,184,468	Increasing salaries of contract staff to stay competitive as well as adding additional positions. Increase is absorbed within existing budget.	
	Adult FSP Program (pg 162)	31,307,934	23,341,286	75%	30,307,934	-	30,307,934	31,307,934	1,900,000	33,207,934	Adding $1.5M in MHSA funds to expand FSPs to address services in Vietnamese, Spanish,monolinguist, as well as veteren clients. Increase of budget is to also request for additional 60 slots. Adding $400K for limited term Step down program.	
	portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older being assessed for Assisted Outpatient Treatment FSP eligibility (pg 88)	*4,715,841*	*4,078,471*	*86%*	*4,715,841*	-	*4,715,841*	*4,715,841*		*4,715,841*		FY 20-21 reduction of $300K based on the current year FY 19-20 projection and prior year's actuals.

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	CSS Updated March 23, 2022	FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget		
OUTPATIENT TREAT Full Service Partnership	*portion of "Adult FSP" budget operated by AOABH for individuals ages 18 and older residing in Permanent Supportive Housing (pg 168)*	*5,000,000*	*1,507,191*	*30%*	*3,500,000*	*-*	*3,500,000*	*5,000,000*	*(500,000)*	*4,500,000*	Right sizing budget to be in line with expenditures. Costs will increase as more Permanent Supportive housing Services are provided with increasing housing	Program will specifically support clients who are living with SPMI and in permanent supportive housing.
	Older Adult FSP Program (pg 162)	**3,219,899**	**2,941,977**	**91%**	**3,719,899**	**-**	**3,719,899**	**3,219,899**	**1,300,000**	**4,519,899**	Increasing budget $1.3M to increase caseload from 180 to 215. Adding Personal Service Coordinators and Clinical Supervisor,Increasing housing services, as well as provider salaries to stay competitive.	Increase to serve 30 additional clients for a total of 180 clients.
	Program for Assertive Community Treatment (PACT; *county-operated FSP; pg 175,FY 2021-22 MHSA Annual Plan Update)*	**10,599,650**	**8,090,661**	**76%**	**10,699,650**	**-**	**10,699,650**	**10,599,650**	**100,000**	**10,699,650**		
	portion of "PACT" budget operated by CYBH for individuals ages 0-21	*1,100,000*	*706,798*	*64%*	*1,200,000*	*-*	*1,200,000*	*1,100,000*	*100,000*	*1,200,000*	Increase of $100,000 to fund after-hours on-call coverage and expanded flexible spending used to support people on their recovery journeys (i.e., housing assistance, tuition payment, tutoring, childcare, etc.) in line with FSP program requirements. Program has been operating with a part-time psychiatrist and other staffing vacancies which resulted in savings. However when program is fully staffed, additional funds will be needed to cover 24/7 on-call, new southern satellite location, and flexible funding for clients.	Program launched in FY 2018-19. Propose to keep funding at approved budget level as program is still fully ramping up and looking for additional ways to increase crisis responsiveness, which will result in additional costs.
	portion of "PACT" budget operated by AOABH for individuals ages 18 and older	*8,528,018*	*6,853,461*	*80%*	*8,528,018*		*8,528,018*	*8,528,018*		*8,528,018*		Right-sized budget while retaining funds for 6 FTEs that will be transferred (4 from ICS program) beginning in FY 20-21, and looking for additional ways to increase crisis responsiveness, which will result in additional costs.
	portion of "PACT" budget operated by AOABH for individuals ages 60 and older	*971,632*	*530,401*	*55%*	*971,632*		*971,632*	*971,632*		*971,632*		Right-sizing budget, incorporating increased lease costs at 4000 Metropolitan and looking for additional ways to increase crisis responsiveness, which will result in additional costs.
	Subtotal Full Service Partnership Programs	**64,366,526**	**51,534,290**	**80%**	**64,466,526**	**-**	**64,466,526**	**64,366,526**	**3,800,000**	**68,166,526**		
OUTPATIENT TREATMENT: Clinic Expansion	**Children & Youth Clinic Services** (pg 147, FY FY 2021-22 MHSA Annual Plan Update)	**2,500,000**	**-**	**0%**	**2,500,000**	**-**	**2,500,000**	**3,000,000**	**(500,000)**	**2,500,000**	Reduced Budget to Current years budget to right size. Removed $500K for LCAT that won't be spent	**Existing Outpatient Services** (formerly Youth Core Services): Current budget is $500,000 which will remain level for the next 3 FYs. Proposing to expand services to all eligible youth living with SED/SMI (and not just youth eligible for State Pathways to Well-Being program, as described in the last Three-Year Plan). // **Beginning FY 2020-21:** $1.5 million annually is requested to implement mental health services to support the State-mandated program Therapeutic Foster Care (TFC). Funds would also provide mental health services for youth referred by Social Services Agency who are in foster care and/or at-risk of foster care involvement, as well as for youth screened in primary care settings through the ACES Aware Initiative. At full implementation, the numbers of youth referred by these sources is estimated to be up to an additional 2,500 youth. // In support of the Access and Suicide Prevention Priorities, also proposing adding $500k for planning with school-districts/OCDE on expanding outpatient treatment for school-aged youth experiencing SED and their families. Planning will include identifying schools that will match MHSA dollars with LCAP or other funds. Proposed services will also draw down Medi-Cal FFP, thus promoting sustainability and increased service capacity. Planning will also include establishing data-sharing metrics and methods, MOUs, etc with participating schools. // **Beginning FY 2021-22:** Add another $500k (for a total of $1million annually) for LCAP match to support student outpatient treatment, with continued drawing down of MediCal. TFC/ACES/SSA-referred services will continue at $1.5 million and Existing Outpatient Services will continue at $500k annually. Services provided may be clinic- or field-based depending on the needs of the child/youth/family. // STRTP costs have been moved to the Residential Treatment category.
	OC Children with Co-Occurring Mental Health Disorders (pg 149,FY 2021-22 MHSA Annual Plan Update)	**1,000,000**	**1,063,102**	**106%**	**1,000,000**		**1,000,000**	**1,000,000**	**500,000**	**1,500,000**	Increasing budget $500K to maintain same level of service with increase staffing costs	$400,000 increase was moved from the corresponding Children's FSP contract to adjust for the budget increase of this contract.
	Outpatient Recovery *(formerly known as Recovery Clinics / Centers)* (pg 154, FY 2021-22 MHSA Annual Plan Update)	**6,158,531**	**5,748,174**	**93%**	**5,858,531**	**-**	**5,858,531**	**6,158,531**	**2,003,642**	**8,162,173**	Added $2M in total budget.To add additional staffing to contract providers including additional clinicians, Data Analyst and Billing Specialist, etc. Additional increases to allow for Salary increases to stay competitive with workforce market.	Separated Open Access' $2.3M budget from Recovery Center's budget and moved to Access & Linkage to Treatment Section; level funding for program.
	Older Adult Services (pg 157, FY 2021-22 MHSA Annual Plan Update)	**2,168,135**	**1,628,365**	**75%**	**2,168,135**		**2,168,135**	**2,168,135**		**2,168,135**		Increasing to right-size budget, incorporating increased lease costs at 4000 Metropolitan.
	Services for the Short-Term Therapeutic Residential Program (STRTP) (pg 152, FY 2021-22 MHSA Annual Plan Update)	**6,500,000**	**4,060,277**	**62%**	**7,000,000**	**-**	**7,000,000**	**8,000,000**	**(1,000,000)**	**7,000,000**	Right sized budgget based off of MHSA spending actuals and anticipated spending	**Beginning FY 2020-21**: Transfer annual budget of $4,870,000 from Continuum of Care (formerly Youth Core Services) to separate STRTP program (which was previously embedded within the former Youth Core Services program), and increase the annual budget by $130,000 to right-size the annual budget since those funds had been previously transferred to CFTN for capital renovations to bring an office serving MHSA clients up to code, thus bringing current annual STRTP budget to $5 million. Also requesting an increase of $1.5 million in FY 2020-21 to cover the increasing number of providers signing onto this State-mandated program, as well as the increasing costs of these intensive services, bringing total requested FY 2020-21 budget to $6.5 million. **Beginning FY 2021-22:** Add another increase of $1.5 million to cover additional providers and high cost of these intensive services, bringing total on-going annual budget to $8 million.
	RETIRED: Integrated Community Services (pg 165, FY 2019-20 Plan)	**1,197,000**	**4,193**	**0%**	**-**	**-**	**-**	**1,197,000**	**(1,197,000)**	**-**		4 County FTEs will move to PACT in FY 20-21 because program will no longer provide county-operated services within the Community Health Clinic.
	Telehealth/Virtual Behavioral Health Care (pg 172)	**2,500,000**	**-**	**0%**	**2,500,000**	**-**	**2,500,000**	**3,000,000**	**(1,000,000)**	**2,000,000**	Right sized based off of service needs	Proposed expansion using tele- & virtual behavioral health options to promote access to services, alleviate high caseloads in outpatient clinics, and provide the option for increased telepsychiatry services. HCA will monitor service demand/capacity and program expenditures, and transfer CSS carryover funds should service demand/expenditures exceed the current proposed budget. HCA will update the Steering Committee should the need for additional CSS carryover funds be identified.

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CSS

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		FY 2020-21			FY 2021-22			FY 2022-23				
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
	RETIRED: Adolescent Co-Occurring MH & SUD Residential Treatment			0%								Program continuing through non-MHSA funds.
	RETIRED: Adult Co-Occurring MH & SUD Residential Treatment	-		N/A								Program will be at Anita Campus and funded through non-MHSA funds.
	SUBTOTAL ALL Outpatient Treatment	86,390,192	64,038,400	74%	85,493,192	0	85,493,192	88,890,192	2,606,642	91,496,834		
SUPPORTIVE SERVICES	**RETIRING**: Mentoring for Children and Youth (pg 210, FY 2019-20 MHSA Plan)	500,000	466,498	93%	-	-	-	500,000	(500,000)		Program sunsetted in FY 21/22	
SUPPORTIVE SERVICES	**Peer Mentor and Parent Partner Support** (all ages; pg 186, FY 2021-22 MHSA Annual Plan	4,249,888	3,909,428	92%	4,249,888		4,249,888	4,249,888	875,000	5,124,888	Increase of $875K for salary increases of Peer mentor as well as increasing staffing to provide Peer Support Services for CSU at Be-Well Campus and Hospitals.	FY 2019-20 are partial expenditures due to vacancies for positions added when program expanded in FY 2018-19 mid-year. Hiring for FTEs is nearing completion, thus requesting to keep budget level
SUPPORTIVE SERVICES	**Wellness Centers** (pg 189, FY 2021-22 MHSA Annual Plan Update)	3,354,351	2,957,660	88%	3,354,351		3,354,351	3,354,351	570,000	3,924,351	Increase $570K for increase of Peer Mentor wages as well as a 24/7 Security Guard at Wellness Center West to respond to City of Garden Grove.	Adjusted per contract agreements and facility maintenance/ improvements at Wellness Center Central.
SUPPORTIVE SERVICES	**Supported Employment** (pg 198, FY 2021-22 MHSA Annual Plan Update)	1,371,262	1,218,122	89%	1,371,262		1,371,262	1,371,262		1,371,262		
SUPPORTIVE SERVICES	**Transportation Program** (pg 196, FY 2021-22 MHSA Annual Plan Update)	1,150,000	558,304	49%	1,100,000	-	1,100,000	1,300,000	(450,000)	850,000	Reduced budget by $450K. Move $200K budget for PEI clients as well as $250K reduction due to using SUD funds to pay.	Requesting to add $250K starting FY 20/21 to increase transportation assistance, which includes right-sizing rides for adults 18+ and beginning transportation assistance to families with young minors. Increase budget by another $150k beginning FY 21/22 as expansion for families is fully implemented. HCA will monitor service demand/capacity and program expenditures, and transfer CSS carryover funds should service demand/expenditures exceed the current proposed budget. HCA will update the Steering Committee should the need for additional CSS carryover funds be identified.
	SUBTOTAL Supportive Services	10,625,501	9,110,011	86%	10,075,501	0	10,075,501	10,775,501	495,000	11,270,501		
SUPPORTIVE HOUSING / HOMELESSNESS	**Housing & Year Round Emergency Shelter** (pg 201, FY 2021-22 MHSA Annual Plan Update; *formerly known as Short-Term Housing Services*)	1,367,180	539,734	39%	1,367,180	-	1,367,180	1,367,180		1,367,180		
SUPPORTIVE HOUSING / HOMELESSNESS	**Bridge Housing for Homeless** (pg 203)	2,000,000	1,472,979	74%	2,000,000	-	2,000,000	2,000,000		2,000,000		
SUPPORTIVE HOUSING / HOMELESSNESS	**Housing** includes MOU with OCCR and funds for development of permanent supportive housing; (pg 205)	293,678	288,348	98%	356,046	-	356,046	311,563	42,119,877	42,431,440	Added $42M to budget for Permanent Supportive Housing through OCCR NOFA and OC Housing Trust. Added $69K to Budget to match current OCCR MOU as well as an additional $50K for Corporation for Supportive Housing (CSH) technical support of PSH..	Combines OCCR Housing MOU & PSH Funds into single budget line
	OCCR Housing MOU (formerly known as Housing)	*293,678*	*288,348*	*98%*	*356,046*	-	*356,046*	*311,563*	*119,877*	*431,440*		3% annual increase due to labor union negotiations
	Permanent Supportive Housing	-	-	*0%*	-	-	-	-	*42,000,000*	*42,000,000*		
	SUBTOTAL Supportive Housing/Homelessness	3,660,858	2,301,061	63%	3,723,226	-	3,723,226	3,678,743	42,119,877	45,798,620		
	Subtotal Of All CSS Programs	136,448,667	106,103,758	78%	138,844,102	0	138,844,102	145,266,552	60,704,075	205,970,627		
	Administrative Costs	18,639,508	16,817,234	90%	19,941,008	-	19,941,008	20,053,784	(584,091)	19,469,693	Right sized budget based off of Projections. Budget includes additions such as Qualtrics, Chorus, enhancements to website, Union approved COLA Increases, Community Surveys, BHAB Community Planning/training, and additional staff.	Added 3% increases per FY due to the recently approved COLAs for OCEA's and OCMA's members. Propose to add $542,000 annually to 100% oversample CHIS in Orange County. Data would be used to support community planning through a systematic, existing effort to identify mental health disparities in Orange County.
	Total MHSA/CSS Funds Requested	155,088,175	122,920,993	79%	158,785,110	-	158,785,110	165,320,336	60,119,984	225,440,320		
	CSS TRANSFERS TO OTHER COMPONENTS SECTION											
	to WET	6,216,634	5,253,882	85%	5,219,984	-	5,219,984	5,296,662	965,500	6,262,162		
	to CFTN	12,519,749	7,280,298	58%	16,307,384	12,175,595	28,482,979	8,966,158	22,872,855	31,839,013	Increase transfer from CSS to CFTN in order to set aside funds for CFTN projects being proposed.	
	to Prudent Reserve	-			-			-				
	Subtotal CSS Transfers Section	18,736,383	12,534,180	67%	21,527,368	12,175,595	33,702,963	14,262,820	23,838,355	38,101,175		
	20% CAP of 5 yr Avg of total MHSA allocation						33,702,963			38,101,175		

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		FY 2020-21			FY 2021-22			FY 2022-23				
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
Prevention	*Child, Youth and Parent Programs*											
	School Readiness (pg 53, FY 2021-22 MHSA Annual Plan Update)	1,600,000	1,389,938	87%	1,000,000	-	1,000,000	1,600,000	(600,000)	1,000,000	Reduction of $600K to right size and align with current Contract Max Ob.	FY 18/19 and FY 19/20 budgets included carryover funds for 5-year School Readiness expansion. Expansion started FY18/19 and ends FY 22/23. Annual Carryover Amount=$600,000 and full 5-Yr Carryover Obligation=$2,700,000 (FY 18/19 is partial year funding)
	Parent Education Services (pg 56, FY 2021-22 MHSA Annual Plan Update)	1,064,770	1,010,427	95%	1,450,000	-	1,450,000	1,064,770	429,533	1,494,303	Increase Budget by $430K to maintain current level of services	
	Children's Support & Parenting Program (pg 59, FY 2021-22 MHSA Annual Plan Update)	1,700,000	641,549	38%	1,000,000	-	1,000,000	1,700,000	(1,700,000)		Sunsetting Program	
	School-Based Behavioral Health Intervention & Support (pg 62, FY 2021-22 MHSA Annual Plan Update)	3,408,589	3,245,012	95%	2,128,589	-	2,128,589	1,808,589	144,435	1,953,024	Increased budget by $145K for "You And" app update for translation to Spanish, Vietnamese, and subtitles for deaf and hard of hearing.	FY 18/19 and FY 19/20 budgets included carryover funds for 3-year expansion. Expansion started FY18/19 and ends FY 20/21. Annual Carryover Amount=$1,600,000 and full 3-yr Obligation=$4,000,000 (FY 18/19 is partial year funding)
	Violence Prevention Education (pg 66, FY 2021-22 MHSA Annual Plan Update)	1,352,651	1,250,676	92%	1,352,651	-	1,352,651	1,352,651		1,352,651		FY 18/19 and FY 19/20 budgets included carryover funds for adding a 5- yr Active Shooter Contract. Contracts started FY18/19 and ends FY 22/23. Annual Carryover Amount=$247,000 and full 5-yr Carryover Obligation=$1,235,000
	Gang Prevention Services (pg 69, FY 2021-22 MHSA Annual Plan Update)	403,100	369,805	92%	403,100	-	403,100	253,100	150,000	403,100	Increase Budget by $150K to maintain current level of contract funding.	**FY 19/20: PEI CPP: Priority #7** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20, and ends FY 21/22. Annual Carryover Amount=$150,000 and full 3-yr Carryover Obligation=$450,000
	Subtotal: Child, Youth and Parent	$ 9,529,110	$ 7,907,407	83%	$ 7,334,340	$ -	$ 7,334,340	$ 7,779,110	$ (1,576,032)	$ 6,203,078		
	Family Support Services (pg 72, FY 2021-22 MHSA Annual Plan Update)	282,000	282,174	100%	282,000	-	282,000	282,000	22,996	304,996	Increased budget by $23K to pay Peer staff fair market rate	
	SUBTOTAL Prevention	$ 9,811,110	$ 8,189,581	83%	$ 7,616,340	$ -	$ 7,616,340	$ 8,061,110	$ (1,553,036)	$ 6,508,074		
TION CAMPAIGNS & EDUCATION	**Mental Health Community Education Events for Reducing Stigma and Discrimination** (pg 38, FY 2021-22 MHSA Annual Plan Update)	881,000	187,385	21%	1,200,000	-	1,200,000	214,333	1,666,667	1,881,000	Increased budget based on community feedback to decrease stigma and discrimination.	**FY 19/20: PEI CPP: Priority #8** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$666,667 and full 3-yr Carryover Obligation=$2,000,000.
	Outreach for Increasing Recognition of Early Signs of Mental Illness (pg 44)	9,491,945	8,682,538	91%	13,118,412	-	13,118,412	6,433,245	10,399,528	16,832,773		
	portion of "Outreach for Increasing Recognition" budget operated by Behavioral Health Training Services (BHTS) Office through former Behavioral Health Community Training & Technical Assistance	*700,000*	*1,174,420*	*168%*	*1,180,000*	*0*	*1,180,000*	*700,000*	*1,500,000*	*2,200,000*	Increase budget by $500K to maintain current level of contract funding. Add $1M for to address health equity with service needs for specific ethnic, gender, or age groups. Targeting the elderly population.	**FY 19/20: PEI CPP: Priority #9** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$500,000 and full 3-yr Carryover Obligation=$1,500,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former School-Based Stress Management Services	*155,000*	*36,929*	*24%*	*-*	*0*	*-*	*155,000*	*(155,000)*		Program Sunsetted in FY 21/22	

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		FY 2020-21			FY 2021-22			FY 2022-23				
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget	FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
MENTAL HEALTH AWARENESS & STIGMA REDUC	*portion of "Outreach for Increasing Recognition" budget operated by PEI through former Early Childhood Mental Health Providers Training*	*829,533*	*806,324*	*97%*	*1,000,000*	-	*1,000,000*	-	*1,000,000*	*1,000,000*	Increase budget by $1M to maintain current level of contract funding.	**FY 19/20: PEI CPP: Priority #3** Budget includes carryover funds for 3 yrs of these services. Program starts FY19/20 and ends FY 21/22. Full 3-yr Carryover Obligation=$2,000,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Outreach & Engagement Collaborative / Mental Health and Wellbeing for Diverse Communities	*3,385,711*	*3,115,808*	*92%*	*3,385,711*	-	*3,385,711*	*2,719,044*	*666,667*	*3,385,711*	Increase budget by $666K to maintain current level of contract funding.	**FY 19/20: PEI CPP: Priority #6** Budget includes carryover Funds for 3- yr O&E Collaborative expansion. Expansion starts FY19/20 and ends FY 21/22. Full Annual Amount=$666,667 3-yr Obligation=$2,000,000
	portion of "Outreach for Increasing Recognition" budget from former K-12 School-Based Mental Health Services Expansion	*2,312,500*	*1,693,345*	*73%*	*2,312,500*	-	*2,312,500*	-	*6,277,923*	*6,277,923*	Increase budget by $1.3M to maintain current level of contract funding. One less provider than FY 21/22 Add additional $5M to develop a service to provide the support and funding for school-based programs for the youth, their families, and teachers.	**FY 19/20: PEI CPP: Priority #2** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount= $2,312,500 and full 3-yr Carryover Obligation=$5,550,000
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Services for TAY and Young Adults	*1,250,000*	*474,100*	*38%*	*580,000*	-	*580,000*	-	*609,938*	*609,938*	Increase budget by $610K to maintain current level of contract funding.	**FY 19/20: PEI CPP: Priority #1** Budget includes carryover funds for 3 yrs of these services. Program starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$1,250,000 and full 3-yr Carryover Obligation= $3,000,000.
	portion of "Outreach for Increasing Recognition" budget operated by PEI through former Statewide Projects (includes local mental health campaigns)	*859,201*	*1,381,611*	*161%*	*4,660,201*	-	*4,660,201*	*2,859,201*	*500,000*	*3,359,201*	Increased budget by $500K to expand stigma reduction campaign	**Statewide Projects** (CalMHSA) include Each Mind Matters (green ribbon), Know the Signs, Cognito, Directing Change, Walk in Our Shoes, technical assistance, etc managed/operated by CalMHSA. **Local mental health campaigns:** Proposed expansion is for local funds to be used for large-scale, local mental health awareness campaigns and community educational activities. These efforts will partner with and leverage the community reach and existing efforts of local professional sports teams, universities/colleges, County Agency partners, etc. If additional potential projects/ campaigns are identified that exceed the proposed amount ($2 million annually), HCA will update the Steering Committee.
SUBTOTAL MH Awareness & Stigma Reduction		**$ 10,372,945**	**$ 8,869,923**	**86%**	**$ 14,318,412**	-	**$ 14,318,412**	**$ 6,647,578**	**$ 12,066,195**	**$ 18,713,773**		**As part of the MHSA Strategic Priority of "Increase MH Awareness," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs, drawing upon feedback received during community engagement meetings.**
CRISIS PREVENTION & SUPPORT	**Warmline** (pg 96, FY 2021-22 MHSA Annual Plan Update)	**1,116,667**	**1,282,665**	**115%**	**2,000,000**	-	**2,000,000**	**1,116,667**	**(1,116,667)**	-	Warmline moved over to CSS component.	Budget right-sized to meet increasing call volume. The Crisis Prevention Hotline and Survivior Support Services will be combined into a single, expanded Suicide Prevention Program in the Three-Year Plan. Per identified need, HCA will monitor service demand/capacity and program expenditures, and transfer PEI carryover funds should service demand/expenditures exceed the current right-sized budget. HCA will update the Steering Committe should the need for additional PEI carryover funds be identified.
	Suicide Prevention Services (includes Crisis Prevention Hotline and Survivor Support Services (pg 99)	**1,200,000**	**1,070,035**	**89%**	**1,700,000**	-	**1,700,000**	**1,200,000**	**2,000,000**	**3,200,000**	Increase of $2M to Survivor Support hotline to add additional services such as step down services and follow up care	
	Formally Survivor Support Services (pg 78)	600,000	-	0%	-	-	-					
	Office of Suicide Prevention (pg103, FY 2021-22 MHSA Annual Plan Update)				**1,500,000**	-	**1,500,000**	-	**1,500,000**	**1,500,000**	Increase budget by $1.5M to maintain current level of existing budget.	
	SUBTOTAL Crisis Prevention & Support	**$ 2,316,667**	**$ 2,352,700**	**102%**	**$ 5,200,000**	**$ -**	**$ 5,200,000**	**$ 2,316,667**	**$ 2,383,333**	**$ 4,700,000**		**As part of the MHSA Strategic Priority of "Suicide Prevention," available funding may be added to one or more of the programs in this section to meet program and/or Strategic Priority Needs.**

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		FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget		
SUPPORTIVE SERVICES	Transportation Assistance	150,000	-	0%	200,000	-	200,000	500,000	(300,000)	200,000	Reduced budget by $300K based on current transportation needs in PEI.	To address one of the identified needs (i.e., challenges with accessing behavioral health services), carryover PEI funds will be used to provide transportation assistance for enrolled PEI clients. Planning, particularly with regard to meeting the specialized transportation needs of families with young children and older adults, procurement and program ramp-up will occur in FY 2020-21, with full implementation anticipated beginning in FY 2021/22. HCA will monitor service demand/ capacity and program expenditures, and transfer PEI carryover funds should service demand/expenditures exceed the proposed budgets. HCA will update the Steering Committe should the need for additional PEI carryover funds be identified.
	SUBTOTAL Supportive Services	$ 150,000	$ -	0%	$ 200,000	$ -	$ 200,000	$ 500,000	$ (300,000)	$ 200,000		
ACCESS & LINKAGE TO TREATMENT (TX)	OCLinks (pg 78)	1,000,000	1,125,673	113%	4,000,000	-	4,000,000	1,000,000	4,380,000	5,380,000	Increased budget by $4.4M to provide additional staff necessary to operate 24/7 program.	
	BHS Outreach & Engagement (O&E) (pg 81)	2,232,523	2,552,554	114%	3,129,668	-	3,129,668	2,232,523	6,767,145	8,999,668	Increase budget by $4.8M. Add 5 teams to increase case management service capacity for homeless individuals w/ MH and/or SUD conditions. This includes 10 MHS as field-based teams, 6 MHW IIs/Peers, 4 Housing Navigators (MHS), 1 SC I. Adding addtl $2M for MHSA portion of O&E Street Medicine program with Cal Optima.	**FY 19/20:** Additional funds are per 11/23/18 Board directive to add new positions (n=12 FTEs); 5 FTEs filled as of Dec 2019
	Integrated Justice Involved Services *(formerly called Correctional Health Services: Jail to Community Re-Entry Program (JCRP)) (pg 87, FY 2021-22 MHSA Annual Plan Update)*							-	7,200,000	7,200,000	Program will move from CSS to PEI to better align with population served. Increasing original budget by $1M for assessment and diversion services for jails, $1M for Family Support Services, as well as $2.3M to open a pilot family resource center.	
	SUBTOTAL Access & Linkage to Tx	$ 3,232,523	$ 3,678,227	114%	$ 7,129,668	$ -	$ 7,129,668	$ 3,232,523	$ 18,347,145	$ 21,579,668		
y Intervention	*Child, Youth and Parent Programs*											
	School-Based Mental Health Services (pg 122, FY 2021-22 MHSA Annual Plan Update)	2,525,236	2,322,794	92%	2,525,236		2,525,236	2,525,236		2,525,236		
	Clinical High Risk for Psychosis (Thrive Together OC, TTOC)							-	3,000,000	3,000,000	PEI funding being leveraged to implement community outreach and education, clinical and consultation services for youth at clinical high risk for psychosis. This program compliments the proposed Innovation project "Improving the early identification of youth at clincal high risk for psychosis and increasing access to care"	
	1st Onset of Psychiatric Illness (OC CREW) (pg 124)	1,500,000	1,155,841	77%	1,450,000		1,450,000	1,500,000	(50,000)	1,450,000	Reduction in budget of $50K to rightsize MHSA spending. Program is generating FFP to offset MHSA costs.	

PEI

Updated March 23, 2022

		FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested Plan Update FY 2022-23 Budget		
OUTPATIENT TREATMENT - Ear	**OC Parent Wellness Program** (pg 128)	3,738,072	3,565,573	95%	3,738,072	-	3,738,072	3,738,072	-	3,738,072		New legislation effective Jan 2018 requires perinatal screening for all new mothers. BHS will continue to monitor program referrals and may return with amendment for increased funds if needed. Connect the Tots and Stress Free Families will be combined with OC Parent Wellness Program. The merge will allow for greater administrative efficiences and no decrease in services.
	RETIRED PROGRAM:School Based Behav. Health Intervention & Support - Early Intervention (pg 99)	-										Contract Expires at the end of FY 19/20. Not Renewing
	Subtotal Child, Youth and Parent	$ 7,763,308	$ 7,044,208	91%	$ 7,713,308	0	$ 7,713,308	$ 7,763,308	$ 2,950,000	$ 10,713,308		
	Community Counseling & Supportive Services includes LGBTIQ+ services (pg 132)	2,536,136	2,163,673	85%	2,536,136	-	2,536,136	2,536,136		2,536,136		Community Counseling & Supportive Services and OC ACCEPT will be merged into a single, expanded counseling program in the Three-Year Plan. The merge will allow for greater administrative efficiencies and no loss of services or specialization in providing culturally responsive and appropriate services for the LGBTQ
	Early Intervention Services for Older Adults includes older adults from diverse cultural/ racial/ethnic backgrounds (pg 135)	2,469,500	2,474,061	100%	2,469,500	-	2,469,500	1,469,500	1,530,500	3,000,000	Increase budget by $1.5M to expand services with staff at Leisure World Seal Beach and Laguna Woods	**FY 19/20: PEI CPP: Priority #5** Budget includes carryover funds for 3-yr expansion. Expansion starts FY19/20 and ends FY 21/22. Annual Carryover Amount=$1,000,000 and full 3-yr Carryover Obligation=$3,000,000
	OC4VETS includes, college students, court-involved, peer support and military-connected families (*formerly called Early Intervention Servies for Veterans;* pg 138, FY 2021-22 MHSA Annual Plan Update)	2,695,957	2,337,461	87%	2,400,000	-	2,400,000	2,400,000	120,000	2,520,000	Adding 1 BH Clinician to help with OC4Vets waitlist and to increase referrals.	**FY 19/20:** Budget includes carryover funds to keep OC4Vets at level funding for 2 yrs. Carryover funds applied in FY 19/20 and FY 20/21. Annual Carryover Amount=$295,957 and full 2-yr Carryover Obligation=$591,914.
	Subtotal - All Ages/ Specialized Services	$ 7,701,593	$ 6,975,195	91%	$ 7,405,636	$ -	$ 7,405,636	$ 6,405,636	$ 1,650,500	$ 8,056,136		
	SUBTOTAL ALL Outpatient Treatment	$ 15,464,901	$ 14,019,403	91%	$ 15,118,944	$ -	$ 15,118,944	$ 14,168,944	$ 4,600,500	$ 18,769,444		
	Subtotal All PEI Programs	$ 41,348,146	$ 37,109,834	90%	$ 49,583,364	0	$ 49,583,364	$ 34,926,822	35,544,137	$ 70,470,959		
	Administrative Costs	5,713,337	5,986,647	105%	6,560,737	-	6,560,737	6,061,279		6,061,279		*Component budgets are approximations based on program estimates. Within the PEI component, funds can be shifted to meet actual expenditures. These shifts will be reflected each year during the Annual Plan Update.*
	GRAND TOTAL PEI	$ 47,061,483	$ 43,096,481	92%	$ 56,144,101	0	$ 56,144,101	$ 40,988,101	35,544,137	$ 76,532,238		

ORANGE COUNTY HEALTH CARE AGENCY

FY 2022-2023 MHSA Plan Update Budget --- Innovations (INN)

	INN Updated March 23, 2022	FY 2020-21			FY 2021-22			FY 2022-23			FY 22/23 Plan Update Notes	Original 3 Yr Plan Notes
		FY 2020-21 Approved Budget	Actual Expenditures from RER	% Spent	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requested Updated FY 2021-22 Budget	Approved FY 2022-23 Budget	Proposed Changes	Requested FY 2022-23 Plan Update Budget		
	Behavioral Health Services for Independent Living	-	5,182									
1	**Contiuum of Care for Veterans and Military Families**	962,445	803,941	84%	745,000	-	745,000	-	94,339	94,339	Innovation Funding ends March 2023.	
2	**Help @ Hand** *(formally known as Mental Health Technology Suite)*	6,000,000	4,635,838	77%	3,100,000	-	3,100,000	-	4,709,767	4,709,767		Ends at the end of FY 21/22. Requesting OAC to extend program through FY 22/23. Approved through April 2023. No Addtl funding. Funding will be rollover from prior years.
3	**Statewide Early Psychosis Learning Health Care Collaborative Network**	510,584	344,946	68%	561,234	-	561,234	561,234	(251,234)	310,000	Reduced FY 22/23 Budget due to increase spending in FY 21/22	Ends FY 23/24
4	**Behavioral Health System Transformation**	9,477,500	6,249,576	66%	5,355,250	-	5,355,250	-	1,920,000	1,920,000		Ends at the end of FY21/22. OAC approved through FY 23/24.
5	**Psychiatric Advance Directives (PADS)**								3,186,275	3,186,275	Project approved by BOS March 2022.	
	Subtotal Of All Programs	**$ 16,950,529**	**$ 12,039,482**	**71%**	**$ 9,761,484**	**$ -**	**$ 9,761,484**	**$ 561,234**	**$ 9,659,147**	**$ 10,220,381**		
	Administrative Costs	1,395,831	1,060,693	76%	1,237,706	-	1,237,706	1,480,837		1,480,837	Administrative costs are not included as part of approved Innovation project budgets.	Methodology for budgeting Admin Costs calculated by using actuals from Previous year and adding a 3% inflation rate.
Total MHSA Funds Requested for INN		**$ 18,346,360**	**$ 13,100,175**	**71%**	**$ 10,999,190**	**$ -**	**$ 10,999,190**	**$ 2,042,071**	**$ 9,659,147**	**$ 11,701,218**		

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WET

Updated March 23, 2022

	FY 2020-21			FY 2021-22			FY 2022-23			FY22/23 Plan Update Notes	Original 3 Yr Plan Notes
	FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan Update Budget	Proposed Changes	Requeted Updated FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested FY 2022-23 Plan Update Budget		
Workforce Staffing Support (pg 213, FY 2021-22 MHSA Annual Plan Update)	1,710,584	1,474,320	86%	1,761,901	-	1,761,901	1,814,758	-	1,814,758	Increased budget $120K for expanded Workforce Support. This will allow for various additional trainings.	Right Sized budget based off of historic data
Training and Technical Assistance (pg 215, FY 2021-22 MHSA Annual Plan Update)	1,223,390	1,138,423	93%	1,282,434	-	1,282,434	1,241,794	224,000	1,465,794	Increased budget $74K to support the Workplace Welness Advocate program by providing resources.$30k for additional training.	Increased budget due to increase in training as well as additonal costs for BH Training Facility.
Mental Health Career Pathways (pg 217, FY 2021-22 MHSA Annual Plan Update)	1,046,663	913,827	87%	1,046,663	-	1,046,663	1,046,663	20,000	1,066,663	Increased Budget $20K Collaborate with an OCDE's Deaf program to market the behavioral health field for deaf students due to severe shortage of deaf and ASL fluent behavioral health workers	Expansion of REI contract. Adding new curriculum courses for Peer Specialists
Residencies and Internships (pg 219, FY 2021-22 MHSA Annual Plan Update)	170,000	29,487	17%	5,000		5,000	170,000	530,000	700,000	Increased budget $530K to hire clinical supervisors to support placement of student interns and hiring of pre-licensed clinicians. Funds would also be used to recruit paid interns who are deaf and/or ASL Fluent	Right Sized budget based off of historic data
Financial Incentives Programs (pg 220, FY 2021-22 MHSA Annual Plan Update)	526,968	304,717	58%	646,968	-	646,968	526,968	191,500	718,468	Increased budget for additional tuition repayment for staff to pursue further education	Right Sized budget based off of historic data
WET Statewide Five-Year Plan with CalMHSA	1,071,050	-	0%	-	-	-	-	-	-		OC Contributed $904,713 to Program in FY 20/21. Expenditures will reported as expense is incurred by JPA
Subtotal Of WET Programs	5,748,655	3,860,775	67%	4,742,966	-	4,742,966	4,800,183	965,500	5,765,683		
Administrative Costs	467,979	489,477	105%	477,018		477,018	496,479	-	496,479		Methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
Total MHSA/WET Funds Requested	$ 6,216,634	$ 4,350,252	70%	$ 5,219,984	$ -	$ 5,219,984	$ 5,296,662	$ 965,500	$ 6,262,162		

1) All WET programs are now funded by CSS funds

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CF-TN

Updated March 23, 2022

	FY 2020-21			FY 2021-22			FY 2022-23			FY 22/23 Plan Update Notes	Original 3 Yr Plan Notes
	FY 2020-21 Approved Budget	Actual Expenditures from RER	% Change	Approved FY 2021-22 Plan update Budget	Proposed Changes	Requested FY 2021-22 Budget	Approved FY 2022-23 3-yr Plan Budget	Proposed Changes	Requested FY 2022-23 Plan Update Budget		
Capital Facilities Projects											
Wellness Campus	-	-	-	-	-	-	-	20,000,000	20,000,000	Adding $20M for additional Wellness Campus to be built	
Behavioral Health Training Facility	65,000	21,504	33%	65,000	-	65,000	65,000	(40,000)	25,000	Riight sizing budget to be in line with expenditures.	Capital Facility Costs for BH Training facility will be for 10 years. Started FY 18/19 ends FY 27/28
SUBTOTAL Capital Facilities	65,000	21,504	33%	65,000	-	65,000	65,000	19,960,000	20,025,000		
Technological Needs Projects											
Electronic Health Record (E.H.R.)	12,154,749	7,074,335	58%	16,042,384	-	16,042,384	8,582,888	16,446,004	25,028,892	Increase budget $6.3M to contract vendors to get systems in compliance with state regulations. Added $7M for Population Health, addtl $1.2M for Business Intelligence, $2M Cerner upgrade.	Funds are to continue the work of consolidating data from multiple sources into the EHR, as well as integrating with Contract Providers' health information exchange. EHR project costs will include, but not be limited to: software licenses, network infrastructure such as servers, storage and network monitoring appliances, and internal human resources and external consultants. Adding $1M budget for Data Integration System. These funds will support the development and ongoing support for a System of Care Data Integration System designed to coordinate appropriate data sharing across county departments and external stakeholders. Data integration will aid in providing essential and critical services that include mental health care to county residents in a more efficient and timely manner.
Administrative Costs	300,000	184,459	61%	200,000	-	200,000	318,270	(118,270)	200,000	Riight sizing budget to be in line with expenditures.	Beginning FY 18/19, methodology for budgeting Admin Costs changed from using a flat 18% rate to using actuals from Previous year and adding a 3% inflation rate.
SUBTOTAL Technological Needs	12,454,749	7,258,794	58%	16,242,384	-	16,242,384	8,901,158	16,327,734	25,228,892		
Total MHSA/CFTN Funds Requested	$ 12,519,749	$ 7,280,298	58%	$ 16,307,384	$ -	$ 16,307,384	$ 8,966,158	$ 36,287,734	$ 45,253,892		

1) In the event costs of approved CF or TN projects are lower than originally anticipated, remaining funds may be used to fund future CF or TN projects.
HCA and CEO Budget will monitor any carryover balances to ensure that all funds transferred to CFTN are spent within the 10-year reversion timeframe.
2) Project funds approved for a specific project within one FY of a Three-Year Plan may be used to cover that project's costs during a different FY within the Three-Year plan depending on the project's implementation timeline.

APPENDIX III: PEI Regulations and Legislation

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

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

PEI Regulations

In addition, the MHSOAC and, most recently, Senate Bill (SB) 1004, implemented several regulations specific to PEI programs:

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

MHSOAC-Required PEI Programs

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

- **Stigma and Discrimination Reduction**: Activities to reduce negative feelings, attitudes, beliefs, stereotypes and/or discrimination related to having a mental illness or seeking services, and to increase acceptance, dignity and inclusion.
- **Outreach for Increasing Recognition of Early Signs of Mental Illness**: Process of engaging, encouraging, educating and/or training and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.
- **Prevention**: Activities that reduce risk factors for developing a potentially serious mental illness and to build protective factors with the goal or promoting mental health.
- **Early Intervention**: Treatment/services that promote recovery and functioning for a mental illness early in its emergence.
- **Access and Linkage to Treatment**: Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable.
- **Suicide Prevention** (optional): Activities that aim to prevent suicide as a consequence of mental illness.

MHSOAC-Required PEI Service Strategies

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

- **Improve Timely Access to Mental Health Services for Underserved Populations**: Strategies designed to overcome barriers and improve timely access to services for underserved populations.
- **Access and Linkage to Treatment**: Activities to connect individuals with SED/SMI to medically necessary care and treatment as early in the onset of these conditions as practicable.
- **Non-stigmatizing and non-discriminatory**: Strategies to reduce and circumvent stigma, including self-stigma, and discrimination related to being diagnosed with a mental illness, having a mental illness or seeking mental health services, and making services accessible, welcoming and positive.

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

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

To address the above issues, the County continues to work on modifying its own Electronic Health Record and on developing and coordinating standardized data collection procedures across County-operated and County-contracted programs, and will report on its progress in these and other areas in future Annual Plan Updates. Other required PEI Report elements are contained within this Plan Update (i.e., demographic information is on the following pages, service strategies are described in each service area section).

Senate Bill 1004 and PEI Priorities

Senate Bill (SB) 1004, passed in 2018, establishes priorities for the use of PEI funds that are in addition to the MHSOAC PEI regulations. These priorities are as follows:

- Childhood trauma prevention and early intervention as defined in Section 5840.6(d) to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programing as defined in Section 5840.6(d).
- Youth outreach and engagement strategies as defined in Section 5840.6(d) that target secondary school and TAY, with a priority on developing partnerships with colleges/universities.
- Culturally competent and linguistically appropriate prevention and intervention as defined in Section 5840.6(d).
- Strategies targeting mental health needs of older adults.
- Other programs the commission identifies, with stakeholder participation, that are proven effective in achieving, and are reflective of, the goals stated in Section 5840 (as of March 2020, the Commission has not identified additional priorities).

A series of tables below summarizes the information a County is required to report in its PEI Component of the Three-Year Plan, per SB 1004:

- The specific PEI Priorities addressed in the Plan,
- An estimate of the share of PEI funding allocated to each priority, and
- If the County has determined to pursue alternative or an additional priority to those listed above, a description of how it made this determination through its stakeholder process and identify the metric(s) used to assess the program's effectiveness.

An explanation of how stakeholder input contributed to the priorities and allocations is provided in the section describing the 2019 Community Planning Process for the Three-Year Plan, as well as in Appendix IV describing the 2018 Community Planning Process.

A required by SB 1004, the table below provides an estimated share of the annual projected PEI **component** budget allocated to each of the PEI Priorities by FY. In addition, subsequent tables show the estimated share of **individual program** budgets allocated to each of the PEI Priorities, which were used to calculate the estimated shares for the annual projected component budget. Please note, these estimates may change if there are changes in the projected annual allocations, program expenditures and/or budgets, or PEI priorities.

Projected (Proj.) Annual PEI Component Budget by FY	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
FY 2020-21 Proj. PEI Budget = $47,061,483 (Est. % of annual PEI Budget)	$17,631,930 (37%)	$8,026,047 (17%)	$7,411,580 (16%)	$6,988,942 (15%)	$6,698,569 (14%)	$304,415 (<1%)
FY 2021-22 Proj. PEI Allocation = $49,286,926 (Est. % of annual PEI Budget)	**$18,091,164 (37%)**	**$8,453,942 (17%)**	**$7,838,421 (16%)**	**$7,243,166 (15%)**	**$7,001,185 (14%)**	**$659,047 (<1%)**
FY 2022-23 Proj. PEI Allocation = $40,988,101 (Est. % of annual PEI Budget)	$14,083,058 (34%)	$8,420,174 (21%)	$6,079,610 (15%)	$6,051,959 (15%)	$5,689,481 (14%)	$663,818 (<2%)

Estimated Share of Annual PEI Program Budget Assigned to SB 1004 Priority, by MHSOAC PEI Program Categories

** This is a new program to the PEI Component and metrics will be developed once the scope of work and services is determined.*

MHSOAC-Required PEI Program	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
ACCESS AND LINKAGE TO TREATMENT						
OCLinks	20%	20%	20%	20%	20%	
BHS Outreach & Engagement			70%		30%	

MHSOAC-Optional PEI Program Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
SUICIDE PREVENTION						
Warmline	20%	20%	20%	20%	20%	
Suicide Prevention Services	20%	20%	20%	20%	20%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
EARLY INTERVENTION PROGRAMS						
Community Counseling & Supportive Services		85%		15%		
School-Based Mental Health Services	75%		25%			
Early Intervention Services for Older Adults					100%	
OC Parent Wellness Program	35%	65%				
First Onset of Psychiatric Illness (OC CREW)		50%	50%			
OC4Vets	20%	5%	5%	50%	20%	

MHSOAC-Required PEI Programs Names in *italics* reflect separate programs that are being consolidated into the **BOLD** program name in the Three-Year Plan. Future Plan Updates will report on the **BOLD** program name only.	Estimated Share by SB 1004 Priority					
	Childhood Trauma	Early Psychosis/ Mood	Secondary School/TAY	Culturally/ Linguistically Competent	Older Adults	Other
STIGMA AND DISCRIMINATION REDUCTION PROGRAM						
MH Community Educ. Events for Reducing Stigma & Discrimination	25%		25%	25%	25%	
OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS PROGRAM						
Beh. Health Community Training & Technical Assistance	20%	20%	20%	20%	20%	
Early Childhood Mental Health Providers Training	100%					
MH & Well-Being Promotion for Diverse Communities	25%		25%	25%	25%	
Services for TAY and Young Adults		5%	70%	25%		
K-12 School-Based MH Services Expansion	50%		25%	25%		
Statewide Projects	20%	20%	20%	20%	20%	
PREVENTION PROGRAM						
School Readiness	100%					
School-Based Behavioral Health Intervention & Support	100%					
Violence Prevention Education	100%					
Gang Prevention Services	100%					
Parent Education Services	100%					
Family Support Services	25%		25%	25%	25%	
Children's Support & Parenting	100%					
Transportation Assistance*						100%*

Other Recent California Legislation Affecting PEI Programming

In addition to the MHSOAC Regulations and SB 1004, California has recently passed a number of bills that either directly affect PEI or align with PEI's general goals and purpose. These include:

- **Assembly Bill (AB) 2246 (Pupil Suicide Prevention Policies)**, effective the beginning of the 2017-18 school year, requires schools serving students in grades 7-12 to adopt policy on pupil suicide including prevention, intervention and postvention.
- **SB 972 (Pupil and Student Health: Identification cards: Suicide Prevention Hotline),** effective July 1,2019, requires schools serving students in grades 7-12 to issue student identification cards that have the National Suicide Prevention Lifeline on the card.
- **AB 293 (Maternal Mental Health Screening and Supports),** effective July 1, 2019**,** requires obstetricians to confirm that screenings for maternal depression has occurred or to screen women directly, at least once during the pregnancy or the postpartum period. It also requires private and public health plans and health insurers to create maternal health programs.
- **AB 3032 (Hospital Maternal Mental Health)**, effective Jan 1, 2020, requires hospitals to provide maternal mental health training to clinical staff who work with pregnant and postpartum women, and to educate woman and families about the signs and symptoms of maternal mental health disorders as well as local treatment options.

First Onset of Psychiatric Illness (OC CREW)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	16	20	13
	Age 16-25 (TAY)	56	35	35
	Age 26-59 (Adult)	1	0	1
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	54	43	39
	Farsi	0	0	0
	Korean	3	2	0
	Spanish	13	7	7
	Vietnamese	1	1	0
	Decline/Unknown	0	0	1
	Other	2	2	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	0	0
	Asian	13	14	10
	Black/African American	2	1	3
	Native Hawaiian/PI	1	1	1
	White	16	6	3
	Multi-Race	0	0	0
	Decline/Unknown	1	0	1
	Other	49	6	2
ETHNICITY	Hispanic/Latino	33	27	29
	Non-Hispanic/Non-Latino	16	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown		0	0
GENDER	Male	41	30	0
	Female	32	25	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	8	7	0
	Veteran "No"	54	43	0
	Decline/Unknown	11	5	0

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BHS Outreach & Engagement Services

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	116	127	25
	Age 16-25 (TAY)	1,234	952	720
	Age 26-59 (Adult)	24,388	29,108	25,107
	Age 60+ (Older Adult)	6,164	8,873	7,632
	Decline/Unknown	216	501	506
PRIMARY LANGUGE	Arabic	0	5	2
	English	24,719	32,187	26,731
	Farsi	63	37	7
	Korean	9	7	3
	Spanish	4,196	2,433	1,848
	Vietnamese	1,906	4,466	4,973
	Decline/Unknown	27	15	44
	Other	100	31	11
SEXUAL ORIENTATION	Gay or Lesbian	0	6	4
	Heterosexual	0	219	172
	Bisexual	0	8	4
	Questionning	0	1	0
	Queer	0	0	0
	Decline/Unknown	0	10	4
	Other	0	109	91

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	50	20
	Asian	2,602	5,000	5,758
	Black/African American	2,772	2,741	2,101
	Native Hawaiian/PI	0	0	0
	White	15,473	19,968	15,430
	Multi-Race	8	17	13
	Decline/Unknown	1,882	493	3
	Other	10,937	5,377	9,969
ETHNICITY	Hispanic/Latino	10,814	2,895	99
	Non-Hispanic/Non-Latino	0	1,171	153
	More than one ethnicity	0	17	0
	Decline/Unknown	0	0	0
GENDER	Male	19,442	25,112	23,164
	Female	12,503	14,153	10,478
	Decline/Unknown	0	86	51
	Other	93	12	73
DISABILITY	Disability "Yes"	0	1,555	720
	Disability "No"	0	54	34
	Decline/Unknown	0	7	1
VETERAN STATUS	Veteran "Yes"	0	369	309
	Veteran "No"	0	206	148
	Decline/Unknown	0	26	9

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Children's Support & Parenting Program - Track 1

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	295	281	0
	Age 16-25 (TAY)	60	56	2
	Age 26-59 (Adult)	499	463	80
	Age 60+ (Older Adult)	21	13	1
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	2	0	0
	English	364	299	24
	Farsi	1	0	0
	Korean	0	0	0
	Spanish	475	487	56
	Vietnamese	10	15	0
	Decline/Unknown	12	0	0
	Other	13	8	1
SEXUAL ORIENTATION	Gay or Lesbian	6	0	0
	Heterosexual	726	0	80
	Bisexual	7	0	0
	Questionning	1	0	0
	Queer	4	0	0
	Decline/Unknown	128	0	0
	Other	3	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	15	0	1
	Asian	32	25	1
	Black/African American	12	3	0
	Native Hawaiian/PI	2	0	0
	White	0	19	10
	Multi-Race	0	0	0
	Decline/Unknown	6	0	0
	Other	747	16	1
ETHNICITY	Hispanic/Latino	743	736	103
	Non-Hispanic/Non-Latino	4	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	260	12
	Female	0	539	69
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	6
	Disability "No"	0	0	74
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	5	5	0
	Veteran "No"	639	606	81
	Decline/Unknown	62	6	0

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Community Counseling and Supportive Services – General Unit (originally CCSS)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	14	27	43
	Age 16-25 (TAY)	73	92	92
	Age 26-59 (Adult)	312	276	374
	Age 60+ (Older Adult)	18	19	27
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	24	24	8
	English	163	180	224
	Farsi	1	1	1
	Korean	0	0	0
	Spanish	202	189	283
	Vietnamese	5	2	1
	Decline/Unknown	0	0	0
	Other	7	18	3
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	4	0	0
	Asian	23	37	36
	Black/African American	5	6	9
	Native Hawaiian/PI	3	3	2
	White	48	64	63
	Multi-Race	0	0	0
	Decline/Unknown	7	4	7
	Other	283	14	18
ETHNICITY	Hispanic/Latino	283	286	401
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	120	120	126
	Female	297	292	409
	Decline/Unknown	0	0	0
	Other	0	2	1
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	8	39	30
	Veteran "No"	343	340	312
	Decline/Unknown	35	35	11

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Early Intervention Services for Older Adults

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	3	6	3
	Age 60+ (Older Adult)	506	938	1,044
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	27	51	54
	English	152	268	267
	Farsi	30	56	65
	Korean	25	104	150
	Spanish	100	204	234
	Vietnamese	98	136	138
	Decline/Unknown	0	2	0
	Other	73	134	6
SEXUAL ORIENTATION	Gay or Lesbian	3	0	0
	Heterosexual	298	0	0
	Bisexual	0	0	0
	Questionning	1	0	0
	Queer	0	0	0
	Decline/Unknown	58	0	0
	Other	1	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	5	6
	Asian	126	391	448
	Black/African American	12	14	24
	Native Hawaiian/PI	0	1	3
	White	179	303	305
	Multi-Race	0	0	0
	Decline/Unknown	0	4	6
	Other	114	2	2
ETHNICITY	Hispanic/Latino	114		266
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	284	282	343
	Female	93	671	712
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	1,193	1,927	1,835
	Disability "No"	34	135	173
	Decline/Unknown	5	22	13
VETERAN STATUS	Veteran "Yes"	14	49	0
	Veteran "No"	470	875	0
	Decline/Unknown	7	21	0

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Family Support Services

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	1	0	0
	Age 16-25 (TAY)	36	24	35
	Age 26-59 (Adult)	320	257	292
	Age 60+ (Older Adult)	143	105	96
	Decline/Unknown	106	0	4
PRIMARY LANGUGE	Arabic	0	1	0
	English	483	345	412
	Farsi	5	2	0
	Korean	0	2	0
	Spanish	51	24	16
	Vietnamese	1	1	0
	Decline/Unknown	56	0	1
	Other	13	14	1
SEXUAL ORIENTATION	Gay or Lesbian	5	0	6
	Heterosexual	231	0	395
	Bisexual	4	0	4
	Questionning	1	0	0
	Queer	3	0	1
	Decline/Unknown	367	0	0
	Other	1	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	15	6	0
	Asian	51	46	660
	Black/African American	24	3	22
	Native Hawaiian/PI	4	9	0
	White	331	214	197
	Multi-Race	0	0	0
	Decline/Unknown	85	0	25
	Other	135	0	5
ETHNICITY	Hispanic/Latino	124	112	153
	Non-Hispanic/Non-Latino	11	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	182	114	113
	Female	341	277	314
	Decline/Unknown	89	0	3
	Other	0	0	0
DISABILITY	Disability "Yes"	260	0	284
	Disability "No"	156	0	256
	Decline/Unknown	276	0	0
VETERAN STATUS	Veteran "Yes"	13	0	1
	Veteran "No"	265	0	0
	Decline/Unknown	332	0	0

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Community Counseling and Supportive Services – LGBTIQ Unit (originally OC ACCEPT)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	15	13	10
	Age 16-25 (TAY)	27	26	22
	Age 26-59 (Adult)	35	37	39
	Age 60+ (Older Adult)	2	3	1
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	66	67	61
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	12	12	9
	Vietnamese	0	0	1
	Decline/Unknown	0	0	0
	Other	1	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	0	0
	Asian	7	7	12
	Black/African American	3	1	3
	Native Hawaiian/PI	0	0	0
	White	27	36	25
	Multi-Race	0	0	0
	Decline/Unknown	7	6	2
	Other	0	1	1
ETHNICITY	Hispanic/Latino	33	28	29
	Non-Hispanic/Non-Latino	1	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0		0
	Female	0		0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	2	13	11
	Veteran "No"	56	60	60
	Decline/Unknown	9	6	1

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Information and Referral / OC Links

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	25	19	110
	Age 16-25 (TAY)	1,658	1,282	971
	Age 26-59 (Adult)	10,570	7,046	5,606
	Age 60+ (Older Adult)	1,856	1,345	1,236
	Decline/Unknown	4,019	3,600	15,181
PRIMARY LANGUGE	Arabic	9	3	8
	English	15,820	11,684	16,156
	Farsi	152	114	43
	Korean	82	38	28
	Spanish	1,774	1,297	1,451
	Vietnamese	225	116	182
	Decline/Unknown	1	1	5,202
	Other	65	39	34
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	19	12	20

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	91	62	19
	Asian	1,165	728	707
	Black/African American	511	297	241
	Native Hawaiian/PI	42	25	38
	White	6,497	4,584	4,089
	Multi-Race	0	0	0
	Decline/Unknown	4,222	3,429	14,448
	Other	5,600	4,167	3,562
ETHNICITY	Hispanic/Latino	5,600	4,167	3,556
	Non-Hispanic/Non-Latino	1,273	715	737
	More than one ethnicity	0	0	7
	Decline/Unknown	0	0	0
GENDER	Male	6,354	8,540	6,488
	Female	11,700	4,672	11,922
	Decline/Unknown	40	62	4,690
	Other	34	18	4
DISABILITY	Disability "Yes"	12	9	8
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	25	57	51
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

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OC Parent Wellness Program (Track 1: new/expecting parents, Track 2: parents of young, at-risk children)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	7	4	5
	Age 16-25 (TAY)	155	156	295
	Age 26-59 (Adult)	377	432	848
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	6	3	0
	English	285	363	810
	Farsi	3	1	0
	Korean	2	1	4
	Spanish	223	214	328
	Vietnamese	6	2	3
	Decline/Unknown	0	0	0
	Other	14	8	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	0	4
	Asian	27	33	71
	Black/African American	11	15	35
	Native Hawaiian/PI	5	8	7
	White	71	100	205
	Multi-Race	0	0	0
	Decline/Unknown	0	3	7
	Other	419	11	45
ETHNICITY	Hispanic/Latino	402	422	774
	Non-Hispanic/Non-Latino	17	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	21	0
	Female	0	571	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	2	43	59
	Veteran "No"	477	528	864
	Decline/Unknown	25	21	28

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Parent Education Services

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	98	99	0
	Age 16-25 (TAY)	1,524	1,424	163
	Age 26-59 (Adult)	46	44	1,440
	Age 60+ (Older Adult)	154	0	18
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	59	48	0
	English	483	536	769
	Farsi	11	15	5
	Korean	68	0	93
	Spanish	921	731	619
	Vietnamese	131	98	88
	Decline/Unknown	0	0	58
	Other	44	152	0
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	1,170	0	0
	Bisexual	12	0	0
	Questionning	0	0	0
	Queer	2	0	0
	Decline/Unknown	586	0	0
	Other	5	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	21	36	66
	Asian	323	329	294
	Black/African American	43	44	70
	Native Hawaiian/PI	12	5	24
	White	259	264	392
	Multi-Race	0	0	0
	Decline/Unknown	106	0	0
	Other	1,759	0	1
ETHNICITY	Hispanic/Latino	1,748	1,024	1,024
	Non-Hispanic/Non-Latino	11	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	364	289	384
	Female	1,375	1,299	1,240
	Decline/Unknown	88	0	36
	Other	1	0	0
DISABILITY	Disability "Yes"	263	0	0
	Disability "No"	1,412	0	0
	Decline/Unknown	203	0	0
VETERAN STATUS	Veteran "Yes"	21	0	0
	Veteran "No"	1,499	0	0
	Decline/Unknown	304	0	0

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Prevention Mental Health & Well-Being Promotion: School Readiness

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	961	644	389
	Age 16-25 (TAY)	73	63	39
	Age 26-59 (Adult)	841	767	478
	Age 60+ (Older Adult)	5	23	3
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	20	9	6
	English	834	699	441
	Farsi	22	8	11
	Korean	0	0	1
	Spanish	885	691	362
	Vietnamese	43	27	12
	Decline/Unknown	27	18	5
	Other	62	42	13
SEXUAL ORIENTATION	Gay or Lesbian	6	5	0
	Heterosexual	1,487	1,369	0
	Bisexual	3	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	173	113	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	8	14	3
	Asian	176	142	82
	Black/African American	40	29	23
	Native Hawaiian/PI	4	2	5
	White	333	261	128
	Multi-Race	0	0	0
	Decline/Unknown	24	30	4
	Other	1,426	0	0
ETHNICITY	Hispanic/Latino	1,408	1,107	666
	Non-Hispanic/Non-Latino	18	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	754	690	363
	Female	916	791	502
	Decline/Unknown	15	17	4
	Other	0	0	0
DISABILITY	Disability "Yes"	78	41	38
	Disability "No"	1,576	1,443	830
	Decline/Unknown	38	20	0
VETERAN STATUS	Veteran "Yes"	5	7	4
	Veteran "No"	1,295	1,468	489
	Decline/Unknown	69	22	0

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Prevention Violence & Bullying Prevention: Gang Prevention Services

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	441	431	615
	Age 16-25 (TAY)	3	426	0
	Age 26-59 (Adult)	431	1	611
	Age 60+ (Older Adult)	7	4	4
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	535	560	765
	Farsi	0	2	2
	Korean	0	0	0
	Spanish	344	293	461
	Vietnamese	1	1	0
	Decline/Unknown	0	0	0
	Other	2	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	3	8	11
	Asian	12	6	8
	Black/African American	16	19	26
	Native Hawaiian/PI	7	8	9
	White	31	43	78
	Multi-Race	0	0	0
	Decline/Unknown	0	0	7
	Other	1,203	0	1
ETHNICITY	Hispanic/Latino	1,203	793	1,110
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	358	340	470
	Female	524	522	760
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	2	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

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Prevention Violence & Bullying Prevention: Violence Prevention Education

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	9,375	6,413	7,674
	Age 16-25 (TAY)	1,060	468	150
	Age 26-59 (Adult)	1,896	1,325	676
	Age 60+ (Older Adult)	137	62	14
	Decline/Unknown	393	0	778
PRIMARY LANGUGE	Arabic	52	46	34
	English	7,707	5,103	5,503
	Farsi	52	45	0
	Korean	212	78	0
	Spanish	3,121	2,122	0
	Vietnamese	640	382	0
	Decline/Unknown	0	0	0
	Other	0	312	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	526	321	555
	Asian	2,879	1,831	2,459
	Black/African American	454	20	358
	Native Hawaiian/PI	242	162	213
	White	2,295	1,597	1,264
	Multi-Race	0	0	0
	Decline/Unknown	1,202	0	1,582
	Other	7,335	0	389
ETHNICITY	Hispanic/Latino	6,918	4,563	3,973
	Non-Hispanic/Non-Latino	417	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	0	0
	Female	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

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School-Based Mental Health Services - Early Intervention - Track 1

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	672	588	435
	Age 16-25 (TAY)	0	0	0
	Age 26-59 (Adult)	0	0	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	467	429	299
	Farsi	0	0	1
	Korean	0	0	0
	Spanish	203	158	134
	Vietnamese	0	0	0
	Decline/Unknown	0	0	0
	Other	2	1	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	1	3	2
	Asian	11	5	7
	Black/African American	7	6	7
	Native Hawaiian/PI	2	2	3
	White	18	20	19
	Multi-Race	0	0	0
	Decline/Unknown	22	0	18
	Other	0	18	0
ETHNICITY	Hispanic/Latino	594	534	379
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	230	0
	Female	0	357	0
	Decline/Unknown	0	1	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	1	23	10
	Veteran "No"	565	531	404
	Decline/Unknown	82	34	20

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School-Based Mental Health Services – Prevention (formerly Track 2, now part of Early Intervention)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	2,003	1,793	0
	Age 16-25 (TAY)	287	197	0
	Age 26-59 (Adult)	0	0	0
	Age 60+ (Older Adult)	0	0	0
	Decline/Unknown	1	4	0
PRIMARY LANGUGE	Arabic	8	3	0
	English	2,076	1,805	0
	Farsi	1	2	0
	Korean	3	1	0
	Spanish	143	132	0
	Vietnamese	5	2	0
	Decline/Unknown	10	24	0
	Other	45	22	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	37	33	0
	Asian	180	162	0
	Black/African American	29	28	0
	Native Hawaiian/PI	10	9	0
	White	445	306	0
	Multi-Race	0	94	0
	Decline/Unknown	44	79	0
	Other	1,452	0	0
ETHNICITY	Hispanic/Latino	1,452	1,280	0
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	1,106	0
	Female	0	868	0
	Decline/Unknown	0	1	0
	Other	0	16	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	2	190	0
	Veteran "No"	1,870	1,614	0
	Decline/Unknown	192	187	0

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OC Parent Wellness Program (Track 3: parents referred by SSA)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	10	0	0
	Age 16-25 (TAY)	132	8	8
	Age 26-59 (Adult)	0	140	114
	Age 60+ (Older Adult)	5	6	5
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	59	85	91
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	81	60	58
	Vietnamese	5	7	3
	Decline/Unknown	0	0	0
	Other	2	2	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	1	0
	Asian	11	19	16
	Black/African American	4	3	5
	Native Hawaiian/PI	0	0	0
	White	0	31	29
	Multi-Race	1	0	0
	Decline/Unknown	3	2	2
	Other	0	1	4
ETHNICITY	Hispanic/Latino	105	97	101
	Non-Hispanic/Non-Latino	1	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	24	0
	Female	0	130	0
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	1	11	13
	Veteran "No"	133	142	141
	Decline/Unknown	1	1	3

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Suicide Prevention (Crisis Prevention Hotline)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	663	712	908
	Age 16-25 (TAY)	2,923	2,932	3,577
	Age 26-59 (Adult)	3,108	3,181	3,460
	Age 60+ (Older Adult)	483	517	520
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	0	13,613	0
	Farsi	0	0	0
	Korean	11	5	17
	Spanish	370	197	260
	Vietnamese	2	2	2
	Decline/Unknown	0	0	0
	Other	2	1	2
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	0	0
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	21	21	43
	Asian	1,219	987	886
	Black/African American	241	233	297
	Native Hawaiian/PI	60	38	26
	White	2,654	2,649	2,895
	Multi-Race	0	0	0
	Decline/Unknown	0	0	404
	Other	2,082	0	549
ETHNICITY	Hispanic/Latino	1,796	1,507	1,960
	Non-Hispanic/Non-Latino	286	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	4,749	0
	Female	0	4,660	0
	Decline/Unknown	0	0	0
	Other	0	70	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	0	0
	Veteran "No"	0	0	0
	Decline/Unknown	0	0	0

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Suicide Prevention (Survivor Support Services)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	7	12	1
	Age 16-25 (TAY)	8	11	5
	Age 26-59 (Adult)	76	83	46
	Age 60+ (Older Adult)	25	21	20
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	116	119	61
	Farsi	1	2	3
	Korean	2	0	0
	Spanish	13	25	7
	Vietnamese	0	1	0
	Decline/Unknown	0	0	0
	Other	0	5	2
SEXUAL ORIENTATION	Gay or Lesbian	2	0	0
	Heterosexual	87	0	0
	Bisexual	2	0	0
	Questionning	1	0	0
	Queer	0	0	0
	Decline/Unknown	30	0	0
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	5	4	0
	Asian	14	25	7
	Black/African American	2	6	2
	Native Hawaiian/PI	4	0	2
	White	77	70	38
	Multi-Race	0	0	0
	Decline/Unknown	11	0	5
	Other	39	0	1
ETHNICITY	Hispanic/Latino	37	58	16
	Non-Hispanic/Non-Latino	2	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	31	33	16
	Female	98	102	43
	Decline/Unknown	6	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	46
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	1	0	0
	Veteran "No"	95	0	30
	Decline/Unknown	33	0	0

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Early Intervention Veteran Services - Community Locations (formerly OC4 Vets-Veterans Court)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	6	11	7
	Age 26-59 (Adult)	38	31	28
	Age 60+ (Older Adult)	2	0	0
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	44	40	34
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	1	0	0
	Vietnamese	0	0	0
	Decline/Unknown	1	2	1
	Other	0	0	0
SEXUAL ORIENTATION	Gay or Lesbian	0	0	0
	Heterosexual	0	1	3
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	41	32
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	0	0
	Asian	1	3	1
	Black/African American	0	1	3
	Native Hawaiian/PI	1	0	0
	White	23	19	15
	Multi-Race	0	5	0
	Decline/Unknown	10	7	5
	Other	11	7	11
ETHNICITY	Hispanic/Latino	7	9	4
	Non-Hispanic/Non-Latino	2	3	3
	More than one ethnicity	7	5	0
	Decline/Unknown	0	0	0
GENDER	Male	41	32	25
	Female	4	10	10
	Decline/Unknown	1	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	35	35	30
	Veteran "No"	5	3	3
	Decline/Unknown	6	4	2

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Early Intervention Veteran Services - Community Locations (formerly OC4Vets)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	0	0	0
	Age 16-25 (TAY)	4	5	7
	Age 26-59 (Adult)	56	65	74
	Age 60+ (Older Adult)	12	16	18
	Decline/Unknown	0	0	0
PRIMARY LANGUGE	Arabic	0	0	94
	English	64	78	0
	Farsi	0	0	0
	Korean	0	0	1
	Spanish	2	3	0
	Vietnamese	0	0	0
	Decline/Unknown	6	5	2
	Other	0	0	2
SEXUAL ORIENTATION	Gay or Lesbian	0	0	1
	Heterosexual	0	13	28
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	0	73	70
	Other	0	0	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	0	0
	Asian	3	3	5
	Black/African American	5	4	9
	Native Hawaiian/PI	0	0	0
	White	12	23	30
	Multi-Race	0	8	0
	Decline/Unknown	41	33	42
	Other	11	15	13
ETHNICITY	Hispanic/Latino	10	19	12
	Non-Hispanic/Non-Latino	3	5	5
	More than one ethnicity	7	8	0
	Decline/Unknown	0	0	0
GENDER	Male	52	60	73
	Female	16	23	20
	Decline/Unknown	4	3	5
	Other	0	0	1
DISABILITY	Disability "Yes"	0	0	0
	Disability "No"	0	0	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	54	60	76
	Veteran "No"	1	20	16
	Decline/Unknown	17	6	7

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Early Intervention Veteran Services - College Locations (formerly College Veterans Program)

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	0	0	1
	Age 16-25 (TAY)	25	25	25
	Age 26-59 (Adult)	52	71	62
	Age 60+ (Older Adult)	4	5	5
	Decline/Unknown	1	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	77	88	85
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	1	4	3
	Vietnamese	2	1	0
	Decline/Unknown	1	7	4
	Other	1	1	1
SEXUAL ORIENTATION	Gay or Lesbian	1	1	2
	Heterosexual	75	84	75
	Bisexual	4	4	7
	Questionning	0	0	1
	Queer	0	3	3
	Decline/Unknown	2	8	5
	Other	0	1	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	1	1	0
	Asian	22	9	7
	Black/African American	6	13	15
	Native Hawaiian/PI	0	0	0
	White	29	30	22
	Multi-Race	0	13	17
	Decline/Unknown	0	5	4
	Other	31	30	28
ETHNICITY	Hispanic/Latino	31	37	36
	Non-Hispanic/Non-Latino	25	44	73
	More than one ethnicity	8	13	17
	Decline/Unknown	0	5	5
GENDER	Male	61	75	58
	Female	20	26	35
	Decline/Unknown	1	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	87	133	93
	Disability "No"	29	24	28
	Decline/Unknown	10	10	10
VETERAN STATUS	Veteran "Yes"	74	85	77
	Veteran "No"	3	11	15
	Decline/Unknown	5	5	1

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Warmline

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	28,270	73	284
	Age 16-25 (TAY)	57	2,427	5,002
	Age 26-59 (Adult)	1,808	38,832	60,745
	Age 60+ (Older Adult)	9,721	16,213	24,645
	Decline/Unknown	2,491	0	0
PRIMARY LANGUGE	Arabic	6	127	0
	English	23,049	49,960	886
	Farsi	6	244	1
	Korean	1	117	0
	Spanish	133	1,664	4
	Vietnamese	0	775	0
	Decline/Unknown	0	0	0
	Other	23	3,234	15
SEXUAL ORIENTATION	Gay or Lesbian	0	1,519	0
	Heterosexual	0	46,257	0
	Bisexual	0	3,732	0
	Questionning	0	820	0
	Queer	0	22	0
	Decline/Unknown	0	3,599	0
	Other	560	322	0

MHSOAC PEI Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	0	305	0
	Asian	0	6,009	0
	Black/African American	0	13,209	0
	Native Hawaiian/PI	0	0	0
	White	0	0	0
	Multi-Race	0	0	0
	Decline/Unknown	0	8,684	0
	Other	0	0	0
ETHNICITY	Hispanic/Latino	0	4,664	0
	Non-Hispanic/Non-Latino	0	0	0
	More than one ethnicity	0	0	0
	Decline/Unknown	0	0	0
GENDER	Male	0	21,063	0
	Female	0	36,283	0
	Decline/Unknown	0	0	0
	Other	0	16	0
DISABILITY	Disability "Yes"	1,302	6,045	6
	Disability "No"	6,363	13,501	0
	Decline/Unknown	0	0	0
VETERAN STATUS	Veteran "Yes"	0	2,578	0
	Veteran "No"	0	47,688	0
	Decline/Unknown	0	7,039	0

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APPENDIX IV: INN Regulations

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

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

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

MHSOAC Demographic information for active INN projects that enroll participants are on the following pages.

Continuum of Care for Veterans and Military Families

MHSOAC Innovation Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15 (Child)	68	131	125
	Age 16-25 (TAY)	20	38	33
	Age 26-59 (Adult)	47	98	80
	Age 60+ (Older Adult)	4	4	6
	Decline/Unknown	2	0	0
PRIMARY LANGUGE	Arabic	0	0	0
	English	132	262	235
	Farsi	0	0	0
	Korean	0	0	0
	Spanish	8	6	7
	Vietnamese	1	1	1
	Decline/Unknown	0	1	0
	Other	0	1	1
SEXUAL ORIENTATION	Gay or Lesbian	0	2	2
	Heterosexual	138	269	241
	Bisexual	0	0	0
	Questionning	0	0	0
	Queer	0	0	0
	Decline/Unknown	3	0	1
	Other	0	0	0

MHSOAC Innovation Demographic Categories		FY 18-19	FY 19-20	FY 20-21
RACE	American Indian/Alaska Native	1	4	3
	Asian	7	21	15
	Black/African American	17	34	20
	Native Hawaiian/PI	0	0	0
	White	60	92	106
	Multi-Race	13	41	31
	Decline/Unknown	6	1	2
	Other	1	1	0
ETHNICITY	Hispanic/Latino	50	122	138
	Non-Hispanic/Non-Latino	42	115	84
	More than one ethnicity	4	24	16
	Decline/Unknown	45	18	26
GENDER	Male	65	135	118
	Female	76	136	126
	Decline/Unknown	0	0	0
	Other	0	0	0
DISABILITY	Disability "Yes"	22	63	55
	Disability "No"	104	203	189
	Decline/Unknown	15	5	0
VETERAN STATUS	Veteran "Yes"	21	48	30
	Veteran "No"	120	223	214
	Decline/Unknown	0	0	0

4/13/2022 1:26:12 PM

Enrolled in Mindstrong

Date Range: May 26, 2020 - October 20, 2021

MHSOAC INN Demographic Categories		FY 18-19	FY 19-20	FY 20-21
AGE GROUP	Age 0-15	0	0	0
	Age16-25 (TAY)	0	1	45
	Age 26-59 (Adult)	0	5	133
	Age 60+ (Older Adult)	0	1	31
	Mean Age	0	29	34
Gender	Male	0	2	68
	Female	0	5	141
	Decline/Unknown	0	0	0
	Other	0	0	0

*The demographic data in this table are not reflective of numbers served reported on page 299 due to a discrepancy in numbers, as reported by a contractor. Corrected data will be reflective in future three year plan

MHSA Innovation (INN) Public Hearing

- Young Adult Court INN Proposal
- Clinical High Risk for Psychosis INN Proposal
- Community Program Planning INN Proposal

April 13, 2022

Young Adult Court (YAC) INN Proposal

Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice-Involved Young Adult Men:

A Randomized Controlled Trial

PRIMARY NEED

- Within the justice system, young adults are traditionally processed and sanctioned with the same rules and regulations that apply to mature adults
- Young adulthood is a sensitive period of development with critical transitions in several domains (e.g., education, employment, housing, parenthood, etc.)
- Many justice-system-involved young adults have serious pre-existing risk factors for a variety of psychosocial and health-related problems

Orange County Young Adult Court

Click on the link above to watch a brief video

- Specialized Court
- Developmental Focus
- 2-year diversion program
- Reduce/Dismiss Felony

INNOVATION

What currently exists……	What we will do……..
Interagency collaboration to divert youth through YAC	Behavioral health services integrated within YAC
Probation officer & case managers	Expand the research from pilot phase to power analysis
Empirically robust Randomized Controlled Trial with pilot data	Extend the research to measure long-term outcomes, including whether racial, ethnic, and socioeconomic disparities are reduced

YAC INN PROJECT DESCRIPTION

Behavioral Health & Supportive Services:

- Trauma-informed, culturally-sensitive early intervention mental health and co-occurring services (new)
- Peer mentoring by YAC program graduates (new)
- Apprenticeship programs (new)
- Financial literacy courses (new)
- Scholarships to pursue degrees and certifications (expanded from pilot)
- Childcare resources (new)
- Housing and transportation vouchers (expanded from pilot)
- Other services tailored to the young adult's needs (new)

RCT Study Design:

- Eligible young men are 1) notified about whether they have been randomized into the YAC or to traditional court; 2) asked whether they would like to participate in the RCT pilot; 3) and, if yes, complete the informed consent process.
  - *No participant assigned to a traditional court is denied or intentionally delayed from being referred to needed services.*
  - *Young men also have the option to participate in the Young Adult Court without having to participate in the YAC RCT pilot.*
  - *Study eligibility criteria were determined by the Court and District Attorney's Office and cannot be adjusted for this project.*
- Study participants complete structured interviews at baseline and then 8 more times over 4 years.

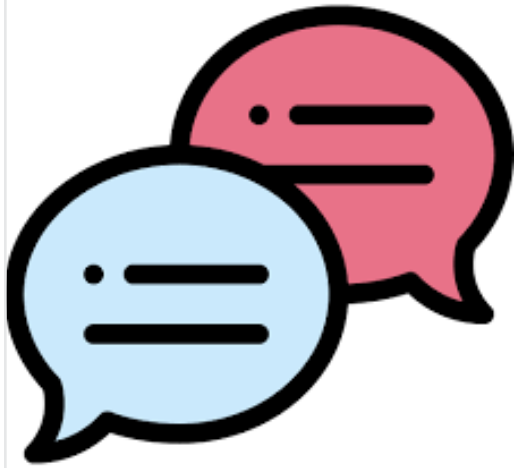
YAC INN PROJECT OVERVIEW

- **Primary Purpose:**
  - Promote interagency and community collaboration related to Mental Health Services or supports or outcomes
  - Increase access to mental health services to underserved groups
- **MHSA INN Project Requirement:**
  - Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- **Learning Objectives:**
  - Understand whether the OC Young Adult Court "works"
    - Reduces the impact of mental health and/or substance use conditions?
    - Promotes prosocial & positive socio-economic outcomes?
    - Reduces recidivism?
  - If the Young Adult Court works, we want to know:
    - Why it works
    - Whether it reduces racial, ethnic, and socio-economic disparities
- **Project Duration:**
  - 5 years
- **Total Budget:**
  - Not to exceed $12 million over 5 years

YAC TOTAL ESTIMATED INN COSTS

YAC MENTAL HEALTH AND SUPPORTIVE SERVICES			
Category of Expense	Est. Annual Cost*	Est. 5-Year Cost	Notes
Clinical Staffing	$755,546	$3,420,864	Principal Investigator, Clinical Director, Multiple Clinicians and Clinical Trainees. Includes salaries and benefits (N=8)
Clinic Office Space & Operational Costs	$110,026	$547,214	Includes start up, supplies, on-going lease, insurance and other operating expenses including parking validation if space has paid parking (to reimburse participants for parking)
Flexible Funding For Participants	$245,600	$1,231,000	N=300 estimated participants; Housing support, education, childcare, transportation, etc.
DIRECT CLINICAL	$1,111,172	$5,199,078	
YAC RCT RESEARCH STUDY			
Research Staffing	$689,292	$3,329,006	Principal Investigator, Research Manager, Administrative Manager, multiple Research Staff; Includes salaries and benefits (N=7)
Research Staff Training, Supplies, Study Travel, etc.	$17,631	$94,719	Includes training, computers, interview tablets, travel reimbursement for participant interviews, etc.
Stipends for Participants	$53,710	$234,188	N=300 incentives/stipends, etc.
DIRECT RESEARCH	$760,633	$3,657,912	
UCI INDIRECT	$261,437	$1,243,366	15% rate
HCA ADMIN/ INDIRECT	$383,984	$1,818,064	18% rate
PROJECT TOTAL	**$2,517,225**	**$11,918,420**	

** Year 3 as example, other years vary*



YAC INN Proposal 30-Day Public Comments

PUBLIC COMMENT #1

- Public comment #1 provides a general summary of the Young Adult Court initial pilot as a randomized controlled trial and potential for results to support the positive impact of more developmentally appropriate consequences for young adults.
- Comment highlights the goal of the project to improve quality of care and better outcomes and offers support for the Innovation project proposal.

Response:

- Thank you for your feedback.

PUBLIC COMMENT #2

- Public comment #2 identified several projects that appear similar to the YAC INN Proposal:
  - California Judicial Council
  - California Association of Youth Courts
  - Baltimore City Teen Court Evaluation
  - San Diego Teen Court

Response:

- The programs cited above are all Teen Courts. The YAC program serves adults ages 18-25. Please refer to page 7 of the INN proposal for the developmental rationale of the project.
- Although other young adult courts and transitional-aged youth programs exist, none have been evaluated through an RCT study design. Pre-post evaluations cannot robustly assess demonstrated effectiveness in the same way as an RCT. The YAC INN proposal will extend and expand the rigorous RCT design, which is consistent with the INN Primary Purpose of "Promote interagency and community collaboration related to Mental Health Services or supports or outcomes."

PUBLIC COMMENT #3

- Public comment #3 expressed support for the YAC INN proposal and noted that based on personal experience it is a step in the right direction.

Response:

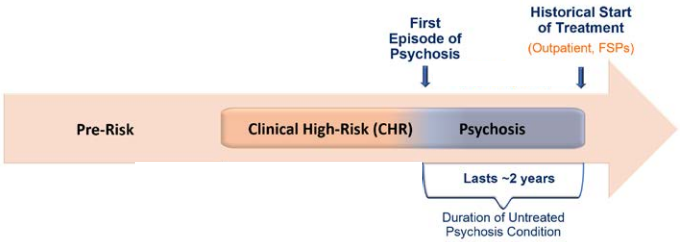
- Thank you for your feedback.

Clinical High Risk for Psychosis INN Proposal

Improving the Early Identification of Youth at Clinical High Risk for Psychosis (CHR-P) and Increasing Access to Care

PRIMARY NEED

- **12,000 adolescents and young adults develop a first episode of psychosis each year**
- **Delays in needed, effective treatment can result in heavy impacts on:**
  - Life expectancy by 20 years
  - Risk of suicide
  - Independent functioning
  - Family functioning
  - Quality of life
  - $155 billion per year in the United States



Adapted from Marshall et al, 2005

CO-DEVELOP AN INTEGRATED COMMUNITY OF CARE & SUPPORT

1 Tapping Social Networks

Provide on-going, culturally responsive outreach and education to people in contact with youth at high risk of developing psychosis

2 Leveraging the Online Space

Utilize the MHA National website to increase youth's interest in linking to clinical services (i.e., weblink to CHR assessment/services or Personalized Normative Feedback Tool), and/or to enhanced psychoeducation

3 Upskilling MH Providers

Provide culturally responsive training, support and consultation within a Project ECHO "community of practice" that helps providers build upon their existing skills and adapt them for CHR-P-appropriate care

4 Strengthening Safety Planning

Adapt Youth Nominated Support Teams so that individuals closest to youth at CHR-P can serve as a source of support

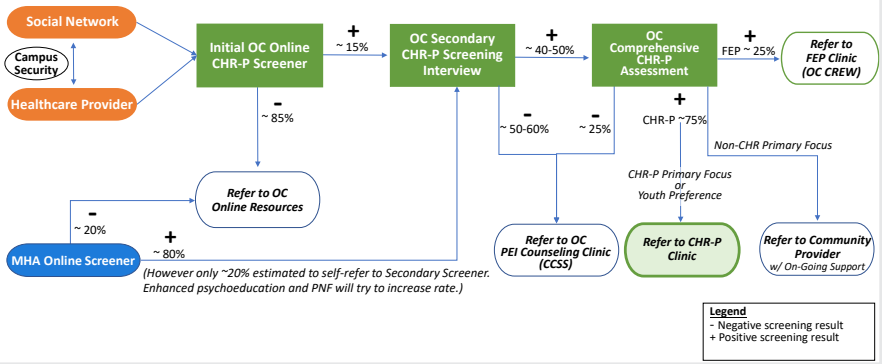
Improving Early Identification — *Increasing Access to Appropriate Care*

CHR-P: Clinical High Risk for Psychosis

CHR-P SCREENING-TO-SUPPORT PROCESS FLOW

Training in early identification of Clinical High-Risk-P (CHR-P) indicators…

… can result in a referral to start a multi-step CHR-P screening process that connects youth to the appropriate level of care based on their clinical needs



CHR-P PROJECT OVERVIEW

- **Primary Purpose:**
  - Increase access to mental health services to underserved groups
- **MHSA INN Project Requirement:**
  - Makes a change to an existing practice in the field of mental health, including but not limited to, application to a different population
- **Learning Objectives: To what extent can we…**
  1. … improve the knowledge and skills of potential responders within young people's naturally existing social networks so they feel a) better equipped with how to recognize a young person who may be experiencing symptoms of CHR for psychosis, and b) more comfortable with knowing when and how to refer youth for screening and/or treatment services?
  2. **… engage with young people online, where many youth first go for information, and identify ways to increase the likelihood that youth who are clinical high risk for psychosis move from the online space to seeking available mental health services through a stepped screening process?**
  3. … expand the number of mental health providers qualified to work with youth at CHR-P by training them on a modularized approach to care that builds upon providers' existing skills and adapts them for youth at CHR for psychosis and supporting their learning through the University of New Mexico's Project Echo model?
  4. … improve one of the core elements of CHR-P intervention – safety planning – by implementing and evaluating the Youth-Nominated Support Teams (YST) approach adapted to CHR-P population?
- **INN Project Duration:**
  - 5 years
- **Total Budget:**
  - Not to exceed $38 million over 5 years
    - ***New opportunities to leverage additional sources of revenue are available so not all costs are from Innovation***

CHR-P INNOVATION PROJECT BUDGET SUMMARY

Budget Category	5-Year Staffing	5-Year Services & Supplies	5-Year Indirects
CHR-P Outreach, Training, Clinical and Consultation Services: $24.73 million total over 5 years			
Project Management	$3.41 million		
Potential Responder & Provider Training	$2.38 million		
CHR-P Screening & Assessment Services	$2.32 million		
CHR-P Clinic & Consultation Services	$7.65 million		
Community Co-Development	$595 thousand	$1.04 million	
Evaluation	$1.68 million	$50 thousand	
CHR-P Services, Supplies, Indirects		$2.38 million	$3.23 million
MHA National Online Services: $9.8 million total over 5 years			
Platform Enhancements & Evaluation	5.17 million	$3.34 million	$1.28 million
HCA: $3.47 million total over 5 years			
HCA Administrative & Indirects		$3.47 million	
Total Project budget not to exceed $38 million over 5 years			

CHR PROJECT BUDGET SUMMARY

Revised 5-year CHR-P System of Care Total MHSA = ~$29.7 M
- New CHR-P Outreach, Training, Clinical, Consultation: ~$18.4 M PEI
- New MHA National Online Screening/HCA Admin: ~$11.3 M INN

Budget Category	5-Year Staffing	5-Year Services & Supplies	5-Year Indirects
CHR-P Outreach, Training, Clinical and Consultation Services: $24.73 million total over 5 years			
Project Management	**$3.41 million**		
Potential Responder & Provider Training	**$2.38 million**		
CHR-P Screening & Assessment Services	**$2.32 million**		
CHR-P Clinic & Consultation Services	**$7.65 million**		
Community Co-Development	**$595 thousand**	**$1.04 million**	
Evaluation	**$1.68 million**	**$50 thousand**	**$170 thousand**
CHR-P Services, Supplies, Indirects		**$2.38 million**	**$3.23 million**
MHA National Online Services: $9.8 million total over 5 years			
Platform Enhancements & Evaluation	**5.17 million**	**$3.34 million**	**$1.28 million**
HCA: $3.47 million total over 5 years			
HCA Administrative & Indirects	$3.47 million total over 5 years		
Total INN Project budget not to exceed $38 million over 5 years (original)			

Change to Original INN Budget by Leveraging Additional Funding Sources:

Reduction of ~$6.3 M (over 5 years) by:
- Pausing implementation of Youth-Nominated Support Team (YST) during NIMH study (~ $2 M)
- Moving some CHR-P services to SAMHSA grant ($1.6 M potential)
- Applying resulting savings in reduced CHR-P services, supplies & indirects
- Truing up est. Y1 PEI expenditures

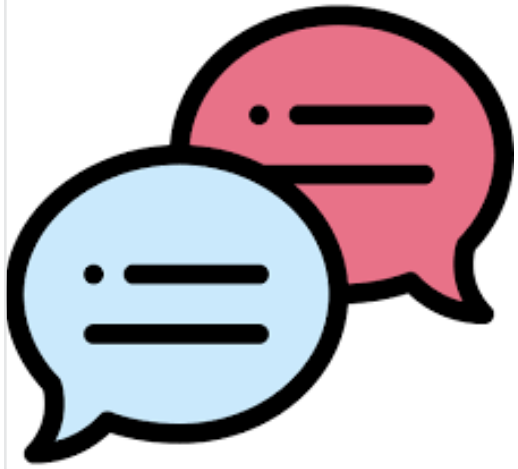
Reduction of ~$1.9 million (over 5 years) by moving CHR-P/YST evaluation costs to SAMHSA and NIMH grants

No changes

Reduction of ~$2 million (over 5 years) in HCA INN Admin/Indirects

Revised 5-year INN total = ~11.3 million

Graduate of OC CREW
expressing their gratitude and appreciation for program services



CHR-P INN Proposal
30-Day Public Comments

PRIMARY NEED

- Additional community planning efforts are needed to reach the broader community and gather meaningful input
- Orange County anticipates an increase to $11M annually and $73.7M in available INN funding through FY 2027-28. Without the ability to utilize INN dollars toward staff time and resources needed to develop new proposals, Orange County will revert these dollars.
- INN concept development, research activities, community engagement and proposal development can take up to nine months or longer
- Factors such as staff capacity and community feedback may result in further delays or inability to continue pursuing potential ideas.

PUBLIC COMMENT #2

- Public comment #2 notes the existing programs and screening tools focused on early identification of mental health conditions, including psychosis.
- The comment highlights the need to address early screening in the proposal and improve the coordination and collaboration to current screenings and services.

Response:

- We agree that this would be an excellent opportunity for collaboration and coordination so that we do not unnecessarily duplicate efforts and collectively reach as many youth and families in need of services.

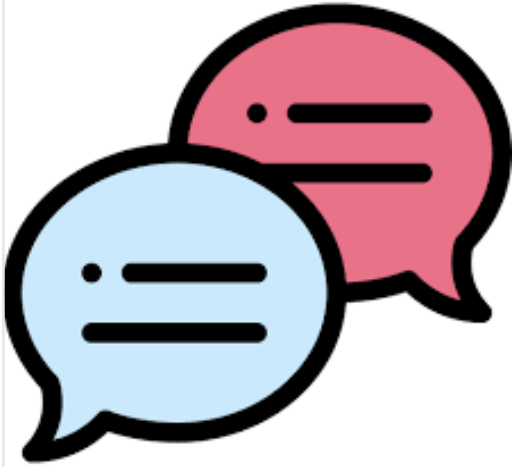
Community Program Planning INN Proposal

PRIMARY NEED

- Additional community planning efforts are needed to reach the broader community and gather meaningful input
- Orange County anticipates an increase to $11M annually and $73.7M in available INN funding through FY 2027-28. Without the ability to utilize INN dollars toward staff time and resources needed to develop new proposals, Orange County will revert these dollars.
- INN concept development, research activities, community engagement and proposal development can take up to nine months or longer
- Factors such as staff capacity and community feedback may result in further delays or inability to continue pursuing potential ideas.

PROPOSAL DESCRIPTION

- Utilize $950,000 INN funds toward community planning and related activities for new and/or ongoing INN Plans over the next 5 years
- Planning and related activities include:
  - INN staff time and support
  - Translation and interpretation services
  - Consultants/Subject Matter Experts to support and/or facilitate meetings
  - Marketing strategies and materials to reach the broader community
  - Program supplies (e.g., stipends; transportation costs; printing, etc.).
- INN staff will provide ongoing reports about its community planning efforts



Community Program Planning INN Proposal 30-Day Public Comments

PUBLIC COMMENT #1

- Public comment #1 noted the challenge in developing INN projects, including time and effort and expressed support for the INN Community Program Planning Proposal.

Response:

- Thank you for your feedback.

County of Orange
Health Care Agency, Behavioral Health Services
MHSA Office
405 W. 5th St. Suite 354
Santa Ana, CA 92701

Phone: (714) 834-3104 E-mail: mhsa@ochca.com

Mental Health Services Act (MHSA)

30-Day Public Comment Form – Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice-Involved Young Men: A Randomized Controlled Trial

PERSONAL INFORMATION			
Name			
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☒	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

This is the second of two MHSA Innovations projects under current 30-day public commnt that could not be more different. This project is the more admirable of the two. This Young Adult Court project originates from the rigor of a National Institute of Justice (NIJ) grant that required a strong experimental design. This project comes to MHSA with the prerequisites for publishable results: a Randomized Controlled Design, strong human subject research outcomes tracking, and an Institutional Review Board . Publishable results can convince other jurisdictions, Health Insurance Companies, the Justice Community and healthcare professionals that developmentally appropriate consequences result in better outcomes for young men with still-developing brains.

Although the MHSA General Requirement and Primary Purpose for this project do not include the goal of improved quality or better outcomes, this project is designed to show possible improved quality or possible better outcomes. The grantwriters acknowledge that this project is experimental. All participants, both Justice Professionals and Justice Involved Youth are provided informed consent that describe the risks and benefits for participation in this research.

It is my hope that both the Orange County Supervisors and the Mental Health Services Oversight and Accountability Commission approve this project. It is my hope that in about 5 years the Justice Professionals involved in this project will publish their outcomes, building a coalition to change how judicial consequences are delivered to those with still-developing brains.

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Mental Health Services Act

30-Day Public Comment Form

PERSONAL INFORMATION			
Name			
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

Examining Whether Integrating Early Intervention Services into a Specialized Court Improves the Well-Being of Justice-Involved Young Adult Men: A Randomized Controlled Trial

"Mental health practices or approaches that have already demonstrated effectiveness are only eligible with an adaptation and rationale for the adaptation."

There has already been the exact same project with evaluation that has been completed by:

- California Judical Council
- California Association of Youth Courts
- Baltimore City Teen Court Evaluation
- San Diego Teen Court
- And several others

From:
To:
Cc:
Subject:
Date:

From:
Sent: Tuesday, March 22, 2022 11:30 AM
To: MHSA <mhsa@ochca.com>
Subject: Regarding Orange County Young Adult Court

I am a retired police officer who has engaged in this very topic for some years. Very excited to see this evidence come forward in this fashion. Based on my experience, training, and studies I think this is a big step in the right direction.

I am excited to follow this project and the published results.

As far as I can see, you have studied the topic and researched it in all the ways I thought possible. I commend you and support you. I have nothing more to add. I wish you the best of luck.

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Mental Health Services Act (MHSA)

30-Day Public Comment Form – Improving the Early Identification of Youth at Clinical High Risk for Psychosis and Increasing Access to Care

PERSONAL INFORMATION			
Name			
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip		**CA**	

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☒	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please**

COMMENTS

This is one of two MHSA Innovation projects under currrent 30-day public comment that could not be more different. This Early Psychosis project is the disappointing of the two projects. Originating within the Orange County MHSA community, this project is not structured to produce actionable nor publishable outcomes. An existing intervention, Youth Nominated Support Teams (YNST) is being applied in a novel way to patients expereincing a different mental health diagnosis. Right now we don't know that YNST will prevent Early Psychosis or reduce sequelae experienced by those with Clinical High Risk. Because this project lacks an experimental design it will be impossible to show that interventions in this project result in better outcomes. Thus an opportunity to show other jurisdictions, Health Insurance Companies, Healthcare Professionals, Police Officers and the general public that YNST could possibly work is missed. Note that the stated goals of 1) Makes a Change to an Existing Practice in the field of Mental Health; and 2) Increases access to mental health services to underserved groups; do not include showing better outcomes. This is a weakness in the MHSA law.

Of great concern is the lack of informed consent and Institutional Review Board support. The grantwriters for this project exude extreme confidence that YNST already works on the Clinical High Risk population. This has yet to be shown. This project lacks the experimental design and strong Human Subject outcomes tracking to validate efficacy. Yet, this project will train clinicians and the general public as if YNST do work for better outcomes. This is greatly concerning because the most basic and longstanding standards for Human Subject Research are not met. People experiencing mental illness and their families deserve the same Human Subject Research protections as any other human.

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Mental Health Services Act

30-Day Public Comment Form

PERSONAL INFORMATION			
Name			
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

In reviewing the propoal for early identification of youth at high risk of psychosis it shoulkd be noted that there a re a number of methodologies, resources, and upstream programs focused on the issue of early identification of mental distress, including psychosis.

In the past 2 years, a number of behavioral health programs and screening tools have been implemented or expanded by stakeholders in Orange County including Western Youth Services (ACES screening), UCI, in school mental health resource centers, provider & family education programs offered through NAMI and other organizations.
.
Early screening is critical and yet this is barelyaddressed in this proposal. This is a critical requirement in any effort to identify at risk indiviuals. Numerous early screening modalities are avalable and shold br front and center of any effort to improve early identification of psychosis.

There are 400,000 students in our public schools and another 20,000 in Diocesan and other schools in Orange County. In order to have an impact screening is critical to success. Then, where to the resources come from?

We need better coordination and collaboration and resources should be directed towards increasing the availability of current screening and services.

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Mental Health Services Act (MHSA)

30-Day Public Comment Form – Orange County Innovation Community Program Planning Proposal

PERSONAL INFORMATION			
Name			
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☒	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

Developing Innovative mental health projects is difficult. It takes much thought to design a project that shows evidence of better outcomes believable by healthcare providers, Health Insurance Companies, Police, First Responders, Government Officials and the General Public. Conducting literature reviews of the published knowledge takes time, but is required to understand any MHSA Innovation project. Some people are willing to invest the time, others take an attitude of "less is more." Funding an Innovation project is not enough. We must understand what we are funding to determine if it would change the thinking of healthcare providers, Health Insurance Companies, Police, First Responders, Government Officials and the General Public.

It is our hope that this funding would be inclusive of peers with interest in MHSA Innovation projects. It is our hope that the Orange County Board of Supervisors and Mental Health Services Oversight and Accountability Commission (MHSOAC) approve this project.

APPENDIX VI: MHSA Community Survey 2021-22

English

Intro

Thank you for sharing your input on potential approaches to implement the MHSA Strategic Priorities from the Three-Year Plan, proposed extensions to time-limited funding for specific Prevention and Early Intervention (PEI) programs, and some new program initiatives. This survey will take about 15 - 30 minutes to complete.

- Click HERE to review the current MHSA 3 - Year Plan or Plan Update.
- Click HERE to review information on the MHSA Strategic Priorities identified through previous community planning (i.e., Mental Health Awareness and Stigma Reduction; Suicide Prevention; Increasing Access to Services).

If you have additional questions, please contact the MHSA office: mhsa@ochca.com or 714-834-3104.

Mental Health Awareness Campaigns

Strategies for *Mental Health Awareness and Stigma Reduction* identified in the MHSA Three-Year Plan include:

- Incorporate findings and recommendations from RAND reports on social marketing.
- Partner with media / marketing organizations.
- Continuing to partner with local groups engaged with the priority populations.
- Continuing to partner with CalMHSA's Statewide Projects and other organizations.

A 2019 Rand Report on Social Marketing shows mental health campaigns have a positive effect on reducing stigma and on encouraging people to reach out for needed services (Click here to learn more about the report). Although each area of focus listed below is of great importance, which would you prioritize in developing a campaign to raise mental health and recovery awareness? (Please rank **at least** your top 3 areas of focus):

Acceptance

Recovery / hope

Symptoms of Mental Health

Substance Use

Trauma

Suicidal thoughts / feelings

Other (please specify)

Language is important in developing campaigns. Of the three areas of focus you ranked above, can you please identify and list up to 3 non-stigmatizing words or phrases that would attract your attention if used in a campaign.

Words / Phrases 1

Words / Phrases 2

Words / Phrases 3

Strategic Priority: Suicide Prevention

Strategies for *Suicide Prevention* identified in the MHSA Three-Year Plan include:

- Use strategies from the Mental Health Accountability Commission's (MHSOAC) Striving for Zero Report (Click HERE)
- Increase capacity of Warmline and Suicide Prevention Services
- Increase crisis services for youth under age 18
- Increase Crisis Residential Services for adults/older adults
- Continue partnering with OC Community Suicide Prevention Initiative (CSPI)

Orange County is making progress in establishing its local suicide prevention strategies using the MHSOAC's Striving for Zero Suicide Prevention Plan (Click HERE). One future area of focus will be how we can encourage and support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis. To help with planning, please share up to 3 recommendations:

Recommendation 1

Recommendation 2

Recommendation 3

Recent review of call volume to the OC WarmLine has shown an increase in calls over the past several months. Many are missed because more staff can't be hired on the current budget.

Would you support increasing the OC WarmLine budget to meet demand, including an emphasis on supporting Spanish- and Vietnamese-speaking callers?

- ◯ Yes
- ◯ No
- ◯ Don't Know / Unsure

During this current Three-Year Plan, the County initiated two Suicide Prevention Campaigns HelpIsHereOC.com and BeAFriendForLife.com. Are you familiar with either of these two campaigns?

- ◯ Yes
- ◯ No

Do you feel these two suicide prevention campaigns increase connectedness between individuals, family members, and community?

- ◯ Yes
- ◯ No
- ◯ Don't Know / Unsure

What do you like about these campaigns? Please describe below:

What do you dislike about these campaigns? Please describe below:

Increasing Access to Behavioral Health Services

Strategies for *Increasing Access to Mental Health and Recovery Services* identified in the MHSA Three-Year Plan include:

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

In your experience accessing mental health and recovery services, has any of the following kept you from getting help from a healthcare professional? Please check all that apply.

- ☐ No childcare
- ☐ Do not have insurance
- ☐ Not covered by my insurance plan
- ☐ Inconvenient/delayed appointment times
- ☐ Don't know who to call
- ☐ People thinking something is wrong with me/us
- ☐ No transportation
- ☐ Provider doesn't speak same language
- ☐ Technical difficulties using telehealth
- ☐ Trouble with privacy / finding a quiet place to talk during telehealth
- ☐ Only want face-to-face services instead of telehealth
- ☐ Other (please explain)
- ☐ Prefer not to answer

Would having adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan help you with using telehealth services?

- ○ [ ] Yes, why? Please indicate below.
- ○ [ ] No, why not? Please indicate below.
- ○ Don't know / unsure

Programming planning expansions related to existing MHSA programs

Based on feedback from diverse stakeholders in a series of Prevention and Early Intervention (PEI) community engagement meetings, the PEI Division increased funding for specific programs on a time-limited basis. The expansions expire at the end of this fiscal year, and the PEI Division is proposing to continue these expanded programs for one additional year due to the impact of the coronavirus pandemic.

Please let us know to what extent you agree with the proposal to expand these services for one additional year.

Parent Educational Services (Click to view brief program description)

Aims to prevent the occurrence or worsening of negative mental health outcomes in children by promoting protective factors in parents and

caregivers. [See pg. 56 of the FI 2021-2022 Annual Plan Update for additional information]

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

School-Based Behavioral Health Intervention Services (Click to view brief program description)

Provides three-tiers of services aimed at preventing and/or intervening early with students at risk of developing a mental health condition and their families. [See Page 62 of the FY 2021-22 Annual Plan Update for additional information]

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

Gang Prevention Services Services (Click to view brief program description)

At participating schools, staff provide education to students, parents and teachers on gang prevention and offers workshops, structured group interventions, and weekly case management. Staff also work 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.

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

Outreach for Increasing Recognition of Early Signs of Mental Illness (Click to view brief program description)

Aims to prepare and inform a wide range of potential responders on how to:

- Identify behavioral health conditions as early as practicable in all age groups
- Assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively
- Increase knowledge regarding accessing behavioral health services
- Promote mental health and wellness throughout the community
- Provide free behavioral health trainings in schools and communities throughout the County

[See Page 44 of the FY 2021-22 Annual Plan Update for additional information]

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

Early Intervention Services for Older Adults (Click to view brief program description)

Provides comprehensive in-home evaluations and services tailored to meet the needs of older adults. A new addition to this program would include an expansion of services into Leisure World in Laguna Woods and Seal Beach. [See Page 135 of the FY 2021-22 Annual Plan Update for additional information]

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

OC4Vets (Click to view brief program description)

Provides behavioral health screening and assessment, referrals to behavioral health treatment and other services as needed, brief individual counseling, case management, employment and housing support services, outreach and engagement, and community trainings. Services are provided to military-connected individuals and their families by trained clinicians and peer navigators with experience and knowledge of the military culture. [See Page 138 of the FY 2021-22 Annual Plan Update for additional information]

Please provide a response below:

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

MHRS Program Initiatives

HCA is also interested in your input on three MHSA program initiatives.

As part of the current MHSA Three-Year Plan, Orange County planned to launch school-based services leveraging different funding sources.

Given the recent increase in funding available to schools for mental health support, to what extent do you agree supporting the expanded use of MHSA funding to include youth-focused mental health services that are provided outside of a school setting?

Strongly disagree	Somewhat disagree	Neither disagree nor agree	Somewhat agree	Strongly agree
○	○	○	○	○

How supportive would you be of the County funding a Mental Health Rehabilitation Center/Therapeutic Residential Center (MHRC/TRC)?

This 24/7 program would serve adults 18 years and old who are living with a mental health condition and would otherwise be placed in a state hospital or other mental health facility. The overarching goal of MHRC/TRC

would be for adults to develop skills to become self-sufficient and capable of increasing levels of independence and functioning, with the goal of re-integrating into the community.

Not at all supportive	Somewhat unsupportive	Neither unsupportive nor supportive	Somewhat supportive	Very supportive
○	○	○	○	○

If the State/County were to experience a financial downturn and had to use the MHSA Prudent Reserve to sustain existing MHSA-funded programs, the law would prohibit the County from transferring funds to Workforce, Education and Training (WET) or Capital Facilities and Technological Needs (CFTN) in the same year.

Would you support maintaining an on-going balance in WET and CFTN that would allow for one-year of continued funding to pay for the following items in the year the Prudent Reserve is accessed:

- WET and IT staff
- Provider trainings, prioritizing those that help clinicians maintain licensure
- Existing software licenses
- Replacement of outdated/broken technology hardware

Please note that these funds would not be used to expand training capacity or technology in years where Prudent Reserve funds are used.

Not at all supportive	Somewhat unsupportive	Neither unsupportive nor supportive	Somewhat supportive	Very supportive
○	○	○	○	○

Block 6

Thank you for taking time to provide feedback in this community planning survey!

The following questions are not required. However, providing this additional information will help MHSA planning.

What is your age?

- ○ 15 years or younger
- ○ 16-17 years
- ○ 18-25 years
- ○ 26-59 years
- ○ 60 years and older
- ○ Prefer not to answer

What is your race? (Select all that apply)

- ☐ American Indian or Alaska Native
- ☐ African / African American / Black
- ☐ Asian
- ☐ Hispanic / Latino
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White / Caucasian
- ☐ Another (please specify)
- ☐ Prefer not to answer

Race Continued

American Indian / Alaska Native (Select all that apply)

- ☐ Alaskan Native
- ☐ Aleut
- ☐ American Indian
- ☐ Inuit
- ☐ Another (please specify)
- ☐ Prefer not to answer

African / African American / Black (Select all that apply)

- ☐ African
- ☐ African-American / Black
- ☐ Afro-Caribbean
- ☐ Algerian
- ☐ Another (please specify)
- ☐ Prefer not to answer

Asian (Select all that apply)

- ☐ Asian Indian / South Asian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese
- ☐ Filipino
- ☐ Hmong

- [ ] Japanese
- [ ] Korean
- [ ] Laotian
- [ ] Mien
- [ ] Pakistani
- [ ] Sri Lankan
- [ ] Thai
- [ ] Vietnamese
- [ ] Another (please specify)
- [ ] Prefer not to answer

Native Hawaiian / Pacific Islander (Select all that apply)

- [ ] Guamanian
- [ ] Native Hawaiian
- [ ] Samoan
- [ ] Another (please specify)
- [ ] Prefer not to answer

Hispanic / Latino (Select all that apply)

- [ ] Caribbean
- [ ] Central American
- [ ] Cuban
- [ ] Mexican / Mexican-American / Chicano
- [ ] Puerto Rican
- [ ] South American
- [ ] Spanish

- [ ] Another (please specify)
- [ ] Prefer not to answer

White / Caucasian (Select all that apply)

- [ ] Middle Eastern / North African
- [ ] Western European
- [ ] Eastern European
- [ ] Another (please specify)
- [ ] Prefer not to answer

Stakeholder Groups

Current gender identity (Select one)

- ◯ Male
- ◯ Female
- ◯ Transgender
- ◯ Genderqueer / Gender non-Conforming / Non-Binary
- ◯ Questioning or unsure of gender identity
- ◯ Another gender identity (please specify)
- ◯ Prefer not to answer

Sex assigned at birth (Select one)

- ○ Male
- ○ Female
- ○ Intersex
- ○ Prefer not to answer

Sexual Orientation (Select one)

- ○ Gay
- ○ Lesbian
- ○ Heterosexual or Straight
- ○ Bisexual
- ○ Queer
- ○ Questioning or unsure of sexual orientation
- ○ _____ Another sexual orientation (please specify)
- ○ Prefer not to answer

Stakeholder groups that I identify with (Select all that apply)

- ☐ Current / Previous Recipient of Mental Health and/or Substance Use Services
- ☐ Family Member of Current / Previous Recipient of Mental Health and/or Substance Use Services
- ☐ Advocate / Advocacy Organization
- ☐ Community-based Organization
- ☐ Educational Agency / Institution
- ☐ Religious / Spiritual Organization
- ☐ Law Enforcement / Court
- ☐ Medical / Health Care Organization
- ☐ Provider of Mental Health Services
- ☐ Provider of Alcohol or Other Drug Services
- ☐ Social Services Agencies
- ☐ Veterans or Veterans Organizations

- ☐ Local or State Government Agency
- ☐ Interested Community Member
- ☐ _____ Another (please specify)
- ☐ Prefer not to answer

To receive information about MHSA meetings, surveys, community engagement, etc., please provide your contact information below. Otherwise, please leave this section blank and continue to the next page to complete your survey.

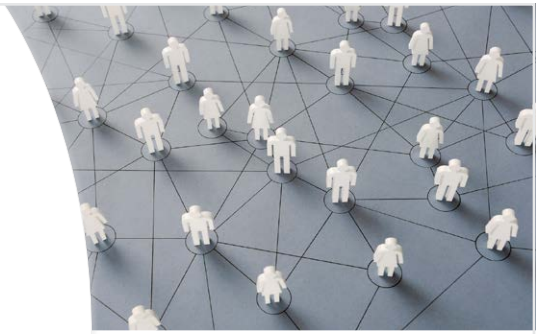
What is your first name?

What is your last name?

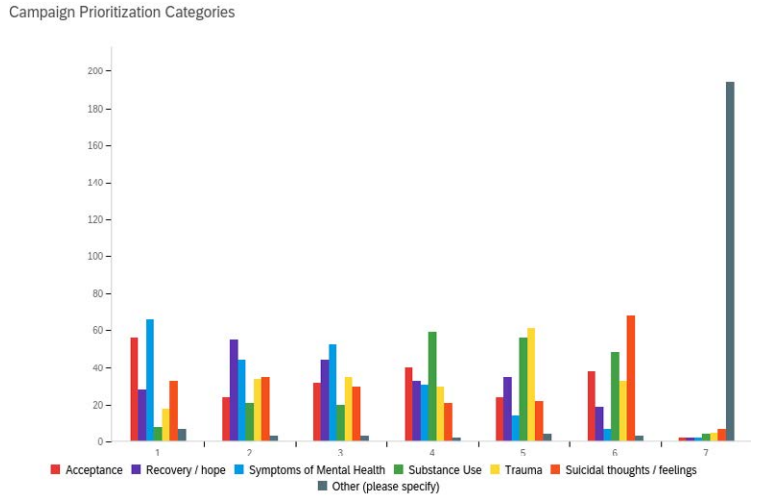
What is your email address?

Powered by Qualtrics

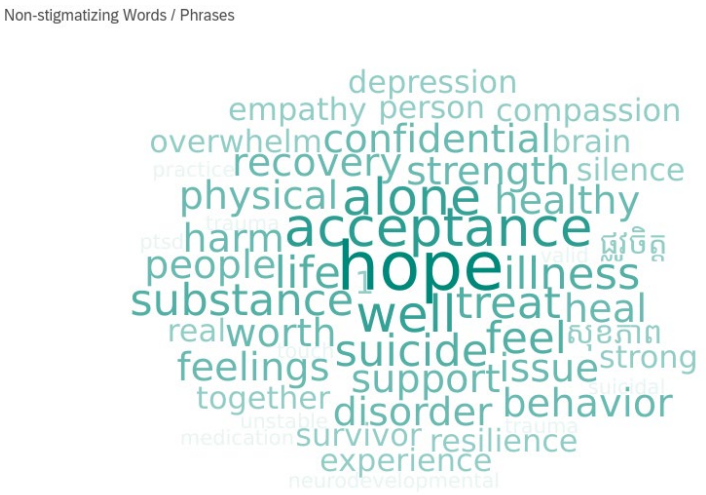
CEM Survey Summary Draft



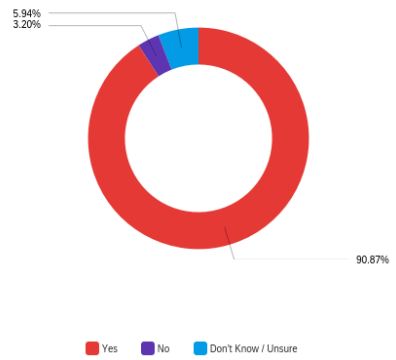
Q2 - A 2019 Rand Report on Social Marketing shows mental health campaigns have a positive effect on reducing stigma and on encouraging people to reach out for needed services. Although each area of focus listed below is of great importance, which would you prioritize in developing a campaign to raise mental health and recovery awareness? (Please rank at least your top 3 areas of focus):



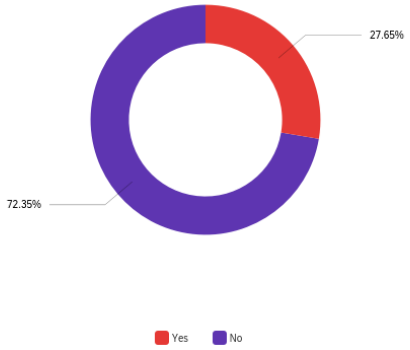
Q3 - Language is important in developing campaigns. Of the three areas of focus you ranked above, can you please identify and list up to 3 non-stigmatizing words or phrases that would attract your attention if used in a campaign.



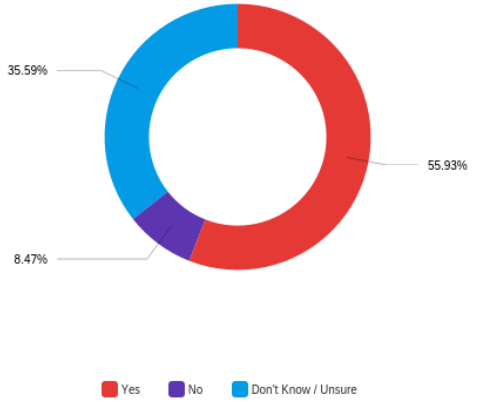
Q6 - Recent review of call volume to the OC WarmLine has shown an increase in calls over the past several months. Many are missed because more staff can't be hired on the current budget. Would you support increasing the OC WarmLine budget to meet demand, including an emphasis on supporting Spanish- and Vietnamese-speaking callers?



Q7 - During this current Three-Year Plan, the County initiated two Suicide Prevention Campaigns HelpIsHereOC.com and BeAFriendForLife.com. Are you familiar with either of these two campaigns?



Q8 - Do you feel these two suicide prevention campaigns increase connectedness between individuals, family members, and community?



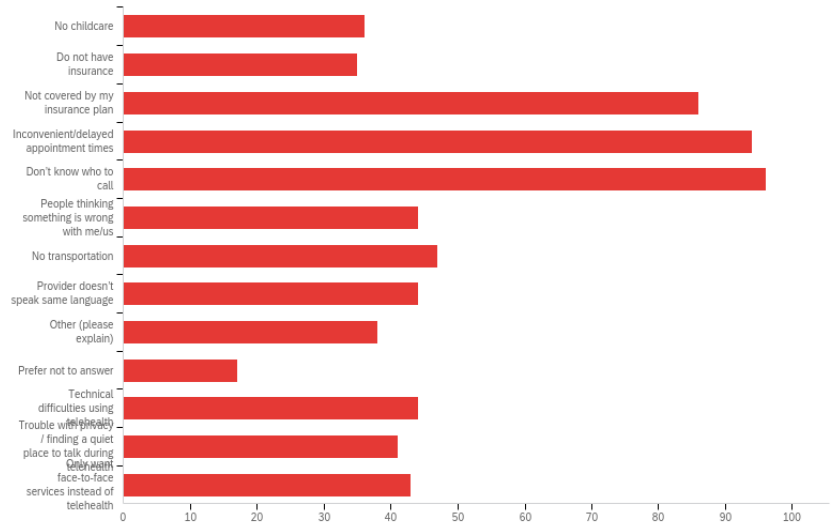
Q9 - What do you like about these campaigns? Please describe below:

What do you like about these campaigns? Please describe below:
They offer hope to individuals and the community.

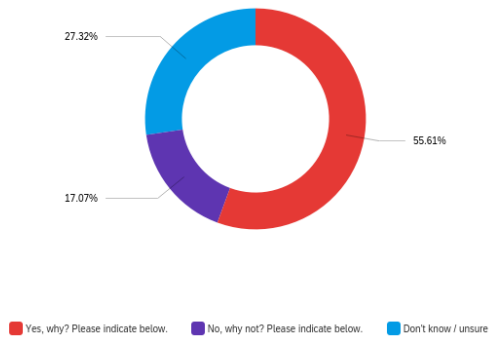
Q10 - What do you dislike about these campaigns? Please describe below:

What do you dislike about these campaigns? Please describe below:
They don't go far enough to reach out and educate. They should do more. They should provide better resources to help those in crisis.
Disconnected and siloed
Sometimes just verbally support don’t help they need physical stability of homes and courts to take over to make choices for them
doesn't connect with low income families

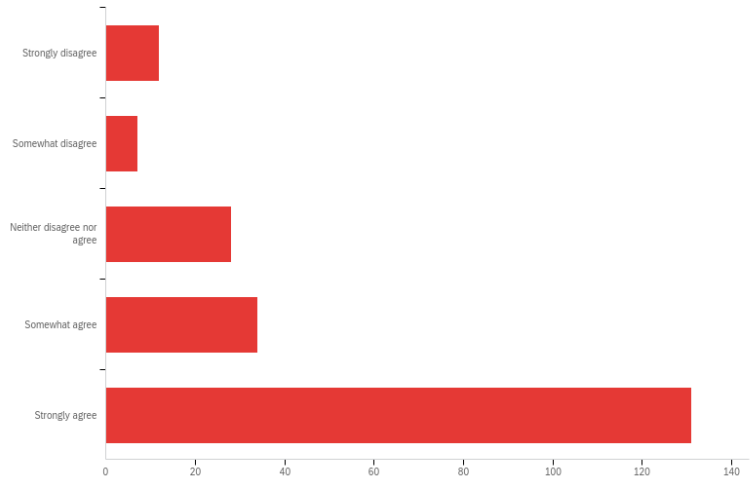
Q12 - In your experience accessing mental health and recovery services, has any of the following kept you from getting help from a healthcare professional? Please check all that apply.



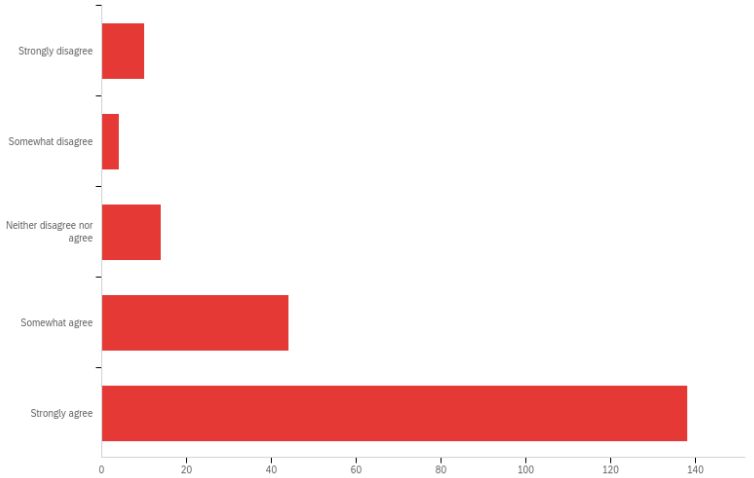
Q13 - Would having adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan help you with using telehealth services?



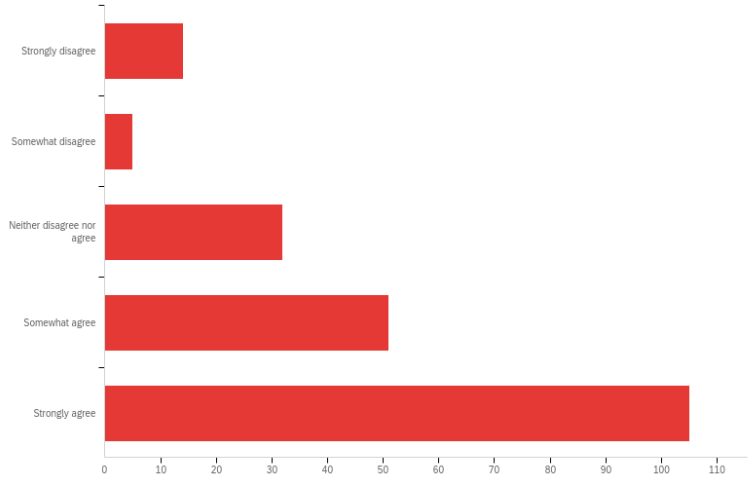
Q16 -Parent Educational Services aims to prevent the occurrence or worsening of negative mental health outcomes in children by promoting protective factors in parents and caregivers.



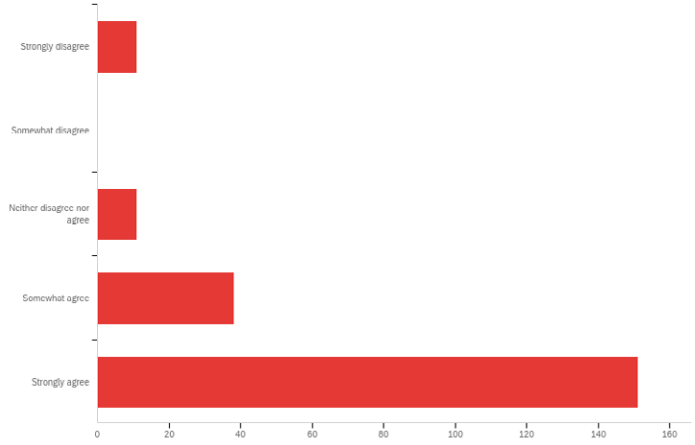
Q18 - School-Based Behavioral Health Intervention Services provides three-tiers of services aimed at preventing and/or intervening early with students at risk of developing a mental health condition and their families.



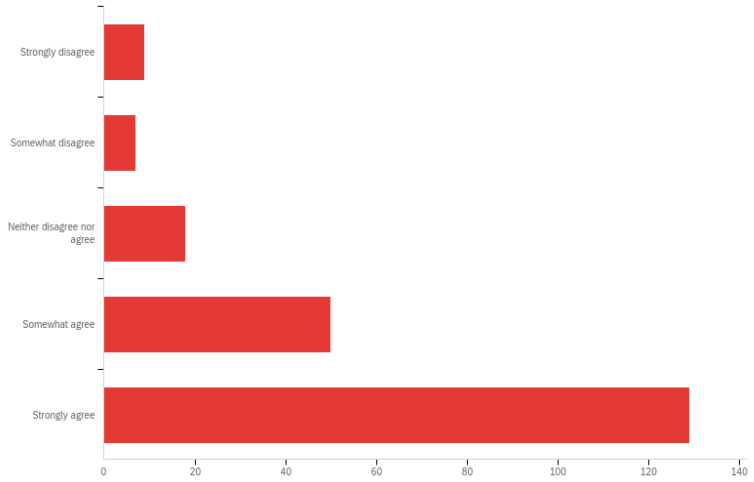
Q20 - Gang Prevention Services
At participating schools, staff provide education to students, parents and teachers on gang prevention and offers workshops, structured group interventions, and weekly case management. Staff also work with students and their families to create an individualized action plan that addresses attendance, academic behavior, disciplinary improvement, parenting contracts and an anti-gang dress code plan.



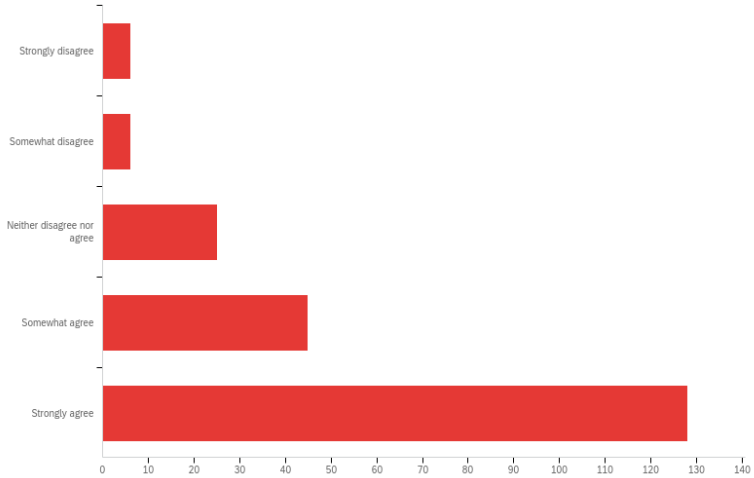
Q22 -Outreach for Increasing Recognition of Early Signs of Mental Illness **a**ims to prepare and inform a wide range of potential responders on how to:
- Identify behavioral health conditions as early as practicable in all age groups
- Assist individuals exposed to trauma and/or living with behavioral health conditions and their families effectively
- Increase knowledge regarding accessing behavioral health services
- Promote mental health and wellness throughout the community
- Provide free behavioral health trainings in schools and communities throughout the County



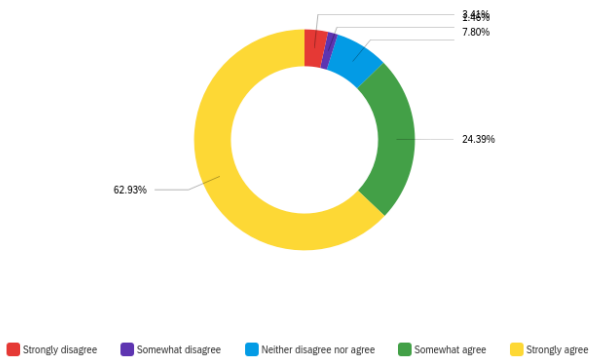
Q24 - Early Intervention Services for Older Adults Provides comprehensive in-home evaluations and services tailored to meet the needs of older adults. A new addition to this program would include an expansion of services into Leisure World in Laguna Woods and Seal Beach.



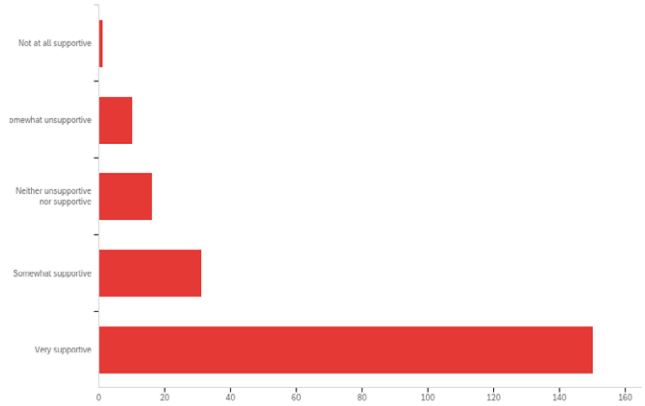
Q26 - OC4Vets provides behavioral health screening and assessment, referrals to behavioral health treatment and other services as needed, brief individual counseling, case management, employment and housing support services, outreach and engagement, and community trainings. Services are provided to military-connected individuals and their families by trained clinicians and peer navigators with experience and knowledge of the military culture.



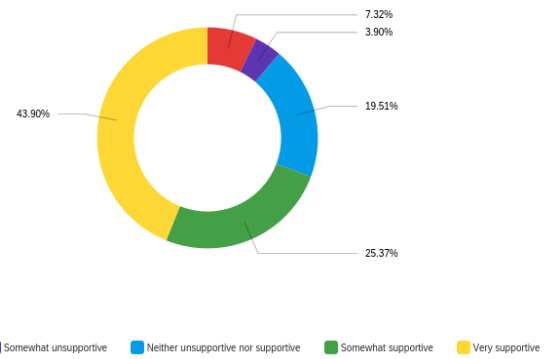
Q28 - As part of the current MHSA Three-Year Plan, Orange County planned to launch school-based services leveraging different funding sources. Given the recent increase in funding available to schools for mental health support, to what extent do you agree supporting the expanded use of MHSA funding to include youth-focused mental health services that are provided outside of a school setting?



Q29 - How supportive would you be of the County funding a Mental Health Rehabilitation Center/Therapeutic Residential Center (MHRC/TRC)? This 24/7 program would serve adults 18 years and old who are living with a mental health condition and would otherwise be placed in a state hospital or other mental health facility. The overarching goal of MHRC/TRC would be for adults to develop skills to become self-sufficient and capable of increasing levels of independence and functioning, with the goal of re-integrating into the community.



Q30 - If the State/County were to experience a financial downturn and had to use the MHSA Prudent Reserve to sustain existing MHSA-funded programs, the law would prohibit the County from transferring funds to Workforce, Education and Training (WET) or Capital Facilities and Technological Needs (CFTN) in the same year. Would you support maintaining an on-going balance in WET and CFTN that would allow for one-year of continued funding to pay for the following items in the year the Prudent Reserve is accessed: • WET and IT staff • Provider trainings, prioritizing those that help clinicians maintain licensure • Existing software licenses• Replacement of outdated/broken technology hardware Please note that these funds would not be used to expand training capacity or technology in years where Prudent Reserve funds are used.



APPENDIX VII: Community Engagement Meeting PowerPoint Presentation

Community Engagement Meeting

FY 2022-23 MHSA Annual Plan Update

1

Agenda

- Welcome, Introductions
- Overview of MHSA
- Breakout Session 1: Survey Results: Accessing Mental Health Recovery Services
- Report Out 1
  Return to main room and present key discussion points from each group
- Breakout Session 2: Survey Results: Suicide Prevention Strategies
- Report Out 2
  Return to main room and present key discussion points from each group
- Wrap Up *(includes link to register for gift card pick up)*

2

How to Zoom

The meeting in the Main Room is recorded.
Breakout Room discussions are not recorded.

In Zoom

You can hear and see who is speaking

Mute — UNMUTED Mic is ON
Unmute — MUTED Mic is OFF

find by your name
or tap MORE to find the hand

Chat
*with **EVERYONE** vs Direct Message that is only seen by **Co-Host***

Stop Video — Video is ON
Start Video — Video is OFF

If you are in a place with background noise, please keep your device/phone MUTED when you're not speaking *

To ask questions / make comments, use:
"RAISE HAND"
and the Co-Host will call on you when it's your turn to speak

or **CHAT**
Chat to EVERYONE is seen by everyone. Attendees can also direct message the OCHCA Co-Host, who will read your message anonymously

If the Zoom connection is breaking up, turning your video OFF may help

On Phone

You can only hear who is speaking

press *6
to **MUTE** and **UNMUTE**

press *9
to **RAISE HAND** and let the Co-Host know you would like to speak

* *Participants who are On Zoom with a computer or tablet and calling in over a telephone may need to mute/unmute both, and watch out for feedback*

We appreciate and value your time! To help create a comfortable and safe virtual environment, please be respectful of others when sharing your comments and opinions.

3

What is MHSA Community Planning?

And why have I been invited to participate?

4

What is the MHSA?

Mental Health Services Act

- Passed by California voters in November 2004
- Implemented a 1% tax on income over $1 million
- Emphasizes transformation of the mental health system
- Strives to improve the quality of life for Californians living with a mental illness, particularly those living with serious mental illness (SMI) or serious emotional disturbance (SED), and their families

5

What are MHSA's Core Values?

- Community **Collaboration**
- **Cultural** Competence
- **Client** and **Family** Driven
- **Wellness**, **Recovery** and **Resilience** Focused
- **Integrated Services Experience** for Clients and their Families

❖ *Focus of the Feb-March 2021 CEMs*

CA Code of Regulations § 3320
CA Welfare & Institutions Code 5848

6

What is the MHSA CPPP?

Community Program Planning Process

- Refers to the **process used by the County** to **develop** the MHSA Three-Year Plan or Plan Updates, in partnership with stakeholders
- Involves clients with SED/SMI and their family members **in all aspects**
- Includes participation of **stakeholders**
- **Provides training**, as needed, to stakeholders, clients and family members participating in the CPPP

CA Code of Regulations 3200.070
CA Code of Regulations 3300

7

Who are MHSA's Stakeholders?

❖ **Adults and seniors living with severe mental illness**
❖ **Families of children, adults and seniors living with severe mental illness**
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans, Representatives from Veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests

CA Welfare & Institutions Code 5848

❖ Stakeholders must include representatives of **un-/ under-served populations** & their **family** members
❖ Stakeholders should reflect the **diversity** of the county (i.e., geographic location, age, gender, race/ethnicity)

CA Code of Regulations 3300

❖ *Target audience for the Feb-March 2021 CEMs*

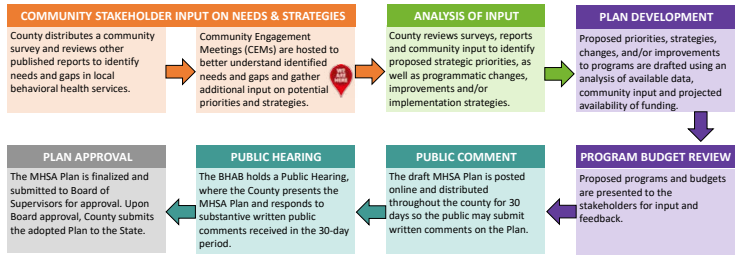
8

What is the **Goal** of the CPPP?

- Through the CPPP, local MHSA stakeholders help:
  - Identify **community issues** related to mental illness resulting from lack of community services and supports, including any issues identified during the implementation of the MHSA
  - Analyze the **mental health needs** in the community
  - Identify and re-evaluate **priorities** and **strategies** to meet those mental health needs*

CA Code of Regulations 3200.070

9



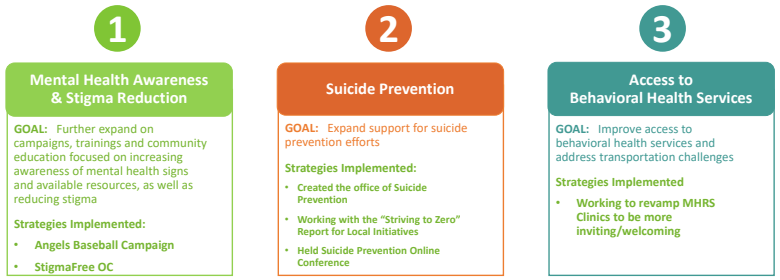
What are the **Steps** in OC's CPPP?

10

2021 Community Engagement Meetings

- **In 2021, the MHSA Office held 24 Community Engagement Meetings targeting specific populations, asking questions on how to address the three strategic priorities**
  - Providers of services
  - Law enforcement agencies
  - Education
  - Social services agencies
  - Veterans, Representatives from Veterans organizations
  - Providers of alcohol and drug services
  - Health care organizations
  - Other important interests (Housing, Older Adults, Monolingual populations)

11



FY 2020-23 MHSA **Strategic Priorities**

12

MHSA Community Engagement Planning

MHSA Plan Update for FY 2022-23

13

- The MHSA Office sent out a Community Survey on December 30, 2021, and it remained open until January 31, 2022.
- Translated into threshold languages
- Distributed via email to more than 1500 individuals
- Individuals from each of the identified MHSA Stakeholder groups from the WIC were represented in the distribution and responses 290 Survey Responses were Recorded
- White/Caucasian – Hispanic/Latino – Asian/Pacific Islander were the top three identified race participants in the survey
- Survey age Participants ranged in age groups of 18-25/26-59/60 and older. (The largest group was the 26-59 group which is referred to as Adults for MHSA programs)
- Females took the survey at more than double the rate of male participants

FY 2022-23 MHSA Plan Update Community Survey

14

- Survey focused in three areas:
- MHSA Strategic Priorities from the Three-Year Plan
- Extensions to time-limited Prevention and Early Intervention Programs
- New Program Initiatives (Youth Focused Mental Health Support 87% Strongly agree or somewhat agree; MHRC – 87% very supportive or somewhat supportive; One year of continued WET & CFTN funding - 69% very supportive or somewhat supportive)

FY 2022-23 MHSA Plan Update Community Survey

15

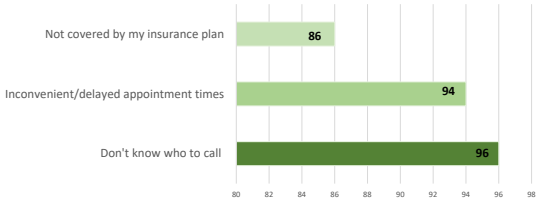
Strategic Priority: Accessing Mental Health and Recovery Services

MHSA Plan Update for FY 2022-23

16

Accessing Mental Health and Recovery Services

In your experience accessing mental health and recovery services, has any of the following kept you from getting help from a healthcare professional?



No childcare **36**
Do not have insurance **35**
People thinking something is wrong with me/us **44**

No Transportation **47**
Provider doesn't speak same language **44**
Technical difficulties **44**

Trouble with Privacy/finding a quiet place to talk during telehealth **41**
Only want face-to-face services **43**
Prefer not to answer **17**
Other **38**

2021-22 Community Survey Results

17

Have you tried to access mental health and recovery services for yourself, a family member, or a friend within the past year?

Were you trying to access services to address a crisis, obtain information, schedule an appointment, or new request for services?

What age group were you trying to access information/services for? Older Adults, Transitional Age Youth (TAY), Children, Adult

In your experience, did you feel like you knew who to call based on the circumstances of the situation?

2022 CEM Breakout Room 1: Access to Mental Health and Recovery Services

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In your experience, was it a challenge to know who to call or where to call?

In your experience, did you feel any hesitancy calling for assistance?

Feedback on the survey indicated that appointments might be inconvenient/delayed. What would help to make appointments more convenient?

2022 CEM Breakout Room 1: Access to Mental Health and Recovery Services

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Breakout Discussion 1: Report Out

Our goal is to ensure everyone's input is included

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Suicide Prevention and Stigma Reduction

MHSA Plan Update for FY 2022-23

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Suicide Prevention and Stigma Reduction

In the 2021-22 MHSA Community Survey, there were three questions associated with MHSA Suicide Prevention and Stigma Reduction Campaign efforts that have taken place.

Question 1:

Orange County is making progress in establishing its local suicide prevention strategies using the MHSOAC's Striving for Zero Suicide Prevention Plan. One future area of focus will be how we can encourage and support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis. To help with planning, *please share up to 3 recommendations*

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Suicide Prevention and Stigma Reduction

Themes identified:

Education (training, awareness, youth, family)

Resources for the Community (hotline, warmline, programs, groups)

Outreach Ideas (media, schools, community advertisements)

Support Services (support for parents, more crisis residential services, crisis care packages, support services in schools)

Increase Recovery Based Language (honesty, recovery, help, compassionate)

Targeting Populations (appropriate cultural linguistic matching, campaigns, youth)

Address Systemic Issues with Stigma (promoting health, normalize mental health, recovery stories)

Services for the Community (increase: crisis, therapy, access, intervention)

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Suicide Prevention and Stigma Reduction

Could we identify the top three themes that would support people, families and communities to reach out for help when experiencing a mental health and/or substance use crisis

2022 CEM Breakout Room 2: Suicide Prevention and Stigma Reduction

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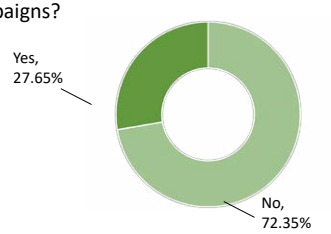
Suicide Prevention and Stigma Reduction

Question 2:

During this current Three-Year Plan, the County initiated two Suicide Prevention Campaigns: HelpIsHereOC.com and BeAFriendForLife.com. Are you familiar with either of these two campaigns?



25

Suicide Prevention and Stigma Reduction

Question 3:

What do you like about these campaigns?

What do you dislike about these campaigns?

Likes:
- Normalizing MH and hope/recovery
- It's important
- It's inviting
- Not stigmatizing
- It is needed
- Messaging
- Raises Awareness

Dislikes:
- Needs to go further to educate – better resources
- **Disconnected and siloed**
- Verbal support isn't enough – needs physical stability of homes and courts to make choices
- **Doesn't connect with low-income families**

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Suicide Prevention and Stigma Reduction

How could we make these campaigns more noticeable/reach a larger audience?

If we were to relaunch these campaigns, how and where would you recommend, they be distributed to reach a broader audience, including underserved populations?

Would you be interested in continuing conversations on any new campaign being developed by HCA as a part of a focus group?

2022 CEM Breakout Room 2: Suicide Prevention and Stigma Reduction

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Breakout Discussion 2: Report Out

Our goal is to ensure everyone's input is included

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How to Claim the Gift Card

Please be respectful of others when sharing your comments and opinions. Participants who use inappropriate or offensive language will be removed from the meeting and no longer eligible for a gift card.

We appreciate your ideas and suggestions! Participants who attend the entire meeting are eligible for a $20 gift card to a grocery store.
All gift cards are physical gift cards and must be received in person.

TO RECEIVE YOUR GIFT CARD:

1. **You attended the entire meeting**
   a. *We will take attendance throughout the meeting (even if you get disconnected and rejoin)*
2. **Decide how you would like to pick up the card:**
   a. Come to HCA in Santa Ana:
      - M - W - F between 8am-11am (except holidays)
      - T - Th between 2-4pm (except holidays)
      - *Please call before coming to confirm someone will be available to help you*

      OR

   b. Come to a **community location on March 3rd (Orange, Garden Grove, Lake Forest, Anaheim)**
3. **Tell us what your preference for pick up is:**
   a. At the end of today's meeting:
      - Click on the URL link that will be sent through Zoom chat
      - Complete a brief, anonymous feedback survey
      - Click to go register in a separate gift card registration link

      OR

   b. After today's meeting, contact us at:
      - mhsa@ochca.com or
      - 714-834-3104

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We appreciate your time and input!

For any questions please call: 714-834-3104 or email: mhsa@ochca.com

Please wait for gift card registration link…

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APPENDIX VIII: Analytic Strategy for CEM Feedback

Analysis of Qualitative Open-ended Responses

Next, qualitative responses were analyzed by MHRS Research Staff using phenomenological thematic analysis (See example of coding process):

Roses are red, violets are blue → Flowers = 2, Color = 2

This iterative analytic approach contrasts thematic analysis that uses a pre-determined, or a priori established set of coding parameters, which does not allow for emergent themes to develop. This approach also provides an impartial framework to compile responses about individual experiences, feelings, and ideas. Analysis was conducted through multiple phases and loops of initial coding, and repeated focused coding. The pertinent, recurring categories and themes were analyzed from constant comparison and inferences gathered from each feedback survey. Themes were reviewed throughout this process by RA Staff (MM and LC). This led to the development of higher-level categories and new themes to emerge. This procedure was repeated throughout the duration of the qualitative data analysis phase.

Resultingly, a count was tallied each time an emergent theme was mentioned. This led to an average of 3 - 4 themes per open-ended question (Sample Item: What would make an ad something you would remember or want to learn more about?), with an average tally of 15 - 30 per theme (See appendix). This process also led to several key findings, including the importance of representation and culturally appropriate messaging, positive messaging, good visuals and color, and simple wording and language accessibility as methods to make advertisements more engaging and memorable. Another key finding was that the modality of which advertisements were marketed using (i.e., Social media for youth, newspapers for seniors and older adults) varied more as a function of age, and less when considering gender or cultural background.

Ancillary Sentiment Analysis

Using the same open-ended qualitative responses, sentiment was also analyzed using the Quantitative Discourse Analysis Package (also known as QDAP) in R Statistical Software using a general additive (GAM) smoothing model. The sentiment analysis chart illustrates that sentiment scores fell primarily between 0 to +1, indicating a high degree of positive sentiment across the results. Examples of positively valanced words, also known as sentiment, include words such as “joy”, “pleasure”, or “happiness”. Examples of negatively valanced words include words such as “anger”, “frustration”, or “disgust”. Overall, there was a positive response across the CEM surveys. This is important because monitoring community sentiment provides valuable insight for understanding stakeholder support and feedback, particularly over a longitudinal period of time. Constellation Charts (known as word association visualizations) were also created using Qualtrics to visualize word frequency and the density with which words appeared. This allowed for consideration of more nuanced themes that could be discerned from paragraphs and long sentences.

APPENDIX IX: Description of Assisted Outpatient Treatment (AOT) Screening Criteria and Procedures

AOT Purpose

Assisted Outpatient Treatment (AOT) is intended to interrupt the cycle of hospitalization, incarceration and homelessness for adults ages 18 and older who are living with serious mental illness and have been unable and/or unwilling to participate in mental health services on a voluntary basis.

AOT Criteria

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

1. Adult is 18 years or older and suffering from a serious mental health illness;
2. A clinical determination is made that the person is unlikely to survive safely in the community without supervision;
3. A history of lack of compliance with treatment for mental illness, in that at least one of the following is true:
    a. The person must have two or more psychiatric hospitalizations in the past 36 months (or been placed on the acute mental health unit in jail); or
    b. The person has had one or more serious acts or threats of violence in the past 48 months;
4. The person has been offered an opportunity to participate in a treatment plan and continues to fail to engage in treatment;
5. The person's condition is substantially deteriorating;
6. It is likely the person will benefit from assisted outpatient treatment;
7. Assisted outpatient treatment is necessary to prevent relapse or deterioration that would be likely to result in grave disability or serious harm to self or others; and
8. Participation in the AOT program would be the least restrictive placement necessary to ensure the person's recovery and stability.

AOT Screening & Eligibility Determination

Per California Assembly Bill 1976, which became effective 7/1/21, 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; (5) a peace officer, parole or probation officer supervising the individual; or (6) a judge in a superior court before whom the client appears. Orange County has established a toll free number (1 (855) 422-1421) for the general community to call for more information about the AOT program and for qualified requestors to make AOT referrals.

Due to the complexity of qualifying for AOT, Orange County has dedicated a trained, County-operated team to screen and assess all individuals referred for an AOT evaluation. The team determines whether referred individuals qualify for AOT, engages those who meet AOT criteria and attempts to link them directly to voluntary services prior to going through the court system as follows:

- Upon receiving a referral from a qualified requestor, the team connects with the requestor to gather additional information about the referral, including identifying information about the requestor and the referred individual; information about their circumstances; and the reason(s) for the AOT referral. The team will then outreach to the client to screen for program eligibility and offer voluntary mental health services.
- When an AOT candidate appears to meet criteria for AOT but refuses voluntary services, a licensed clinical psychologist from the team meets with the candidate, reviews their records, and conducts a psychological assessment to determine if they meet AOT criteria.
- If the AOT candidate continues to meet criteria and refuses voluntary services, they may be ordered by the court to participate in the AOT FSP. Despite a court order to participate, however, the judge cannot impose involuntary treatment should a participant fail to comply because AOT in Orange County has been implemented with MHSA funds, which can only be used for voluntary services.

Strategies to Improve Timely Access to Services for Underserved Populations

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

Of those linked to services, an overwhelming majority continue to accept services voluntarily (81% - 90% over the past three years), thus demonstrating the team's success in working with this marginalized and unserved population.

AOT Assessment & Linkage Team Activity					
	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20	FY 2020-21
# Referrals	637	488	611	441	192
# Eligible for AOT	193	194	222	158	105
# Linked to Service	193	194	222	158	105
% Voluntarily Linked to Services	76% (n=147)	80% (n=156)	81% (n=179)	82% (n=130)	90% (n = 95)

Community Impact

Through FY 2018-19, the AOT ALT has provided services to 2,216 individuals since its inception in October 2014. In addition to providing assessment and linkages services to eligible individuals, the team also provides the community with information about AOT in Orange County. This includes spreading awareness and

providing education about AOT services to community partners such as police departments, hospitals, NAMI, other treatment providers, etc. The program responded to 261 informational calls in FY 2019-20 and 299 informational calls in FY 2020-21. Due to the team's efforts, the majority of referrals accept voluntary services and do not proceed with the court order process. As clients engage in treatment voluntarily, they work to reduce hospitalizations and incarcerations and promote positive recovery outcomes.

APPENDIX X: Glossary of Outcome Measures

Generalized Anxiety Disorder (GAD-7)

- ***Description:*** The GAD-7 is a widely used, 7-item measure of anxiety. It assesses the severity of symptoms related to social phobia, post-traumatic stress disorder and panic disorder. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, severe, etc.).
- ***Rater:*** Clinician, staff, self-report; for individuals ages 18 and older

Grief Experiences Questionnaire (GEQ)

- ***Description:*** The GEQ is a 55-item measure of grief that captures the unique experience associated with losing someone to suicide. It assesses various components of grief and generates on overall score, as well as the following subscale scores:
  - Somatic Reactions
  - General Grief Reactions
  - Search for Explanation
  - Loss of Social Support
  - Stigmatization
  - Self-destructive Behavior or Orientation
  - Feelings of Guilt
  - Responsibility
  - Shame or Embarrassment
  - Abandonment or Rejection
  - Unique Reactions (i.e., reactions specific to this unique form of death).
- ***Rater:*** Self-report for adults ages 18 and older

North Carolina Family Assessment Scale (NCFAS)

- ***Description:*** The NCFAS is an assessment tool designed to examine family functioning at the individual and aggregate level. Family functioning is measured on five domains. It is used to inform the development of a service plan, as well as assess changes in family functioning between pre-and post-service delivery.
  The family functioning domains assessed include:

- Environment (i.e., housing stability/habitability, neighborhood safety, etc.).
- Parental Capabilities (i.e., supervision/ disciplinary practices, enrichment opportunities, etc.).
- Family Interactions (i.e., emotional support, family bonding, etc.).
- Family Safety (i.e., abuse and/or neglect of children).
- Child Well-Being (i.e., mental health, behavior, school performance, etc.).

The NCFAS-General Services also assesses the following general functioning domains:

- Social/Community Life (i.e., social relationships, connection to neighborhood/cultural/ ethnic community, relationships with child care, schools, extracurricular services, etc.).
- Self-Sufficiency (i.e., stability of caregiver employment, family income).
- Family Health. (i.e., physical and mental health of the caregiver).

- ***Rater:*** Clinician, Staff

Outcome Questionnaire (OQ) 30 .2

- ***Description:*** The OQ measures the treatment progress for adults receiving any form of behavioral health treatment. This 30-item scale is sensitive to short-term change and assesses the frequency with which adults are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoffs that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful rather than the result of random fluctuations.
- ***Rater:*** Self-Report for adults ages 18 and older

Parenting Children and Adolescents (PARCA-SE)

- ***Description:*** The PARCA-SE is a brief self-report measure designed to assess the frequency in which parents engaged in three important types of parenting behaviors. This measure consists of 19 questions that generate an Overall Score, as well as the following three subscale scores:
  - Supporting Positive Behavior (e.g., “Notice and praise your child’s good behavior?”).
  - Setting Limits (e.g., “Make sure your child followed the rules you set all or most of the time?”)
  - Proactive Parenting (e.g., “Prepare your child for a challenging situation.”).

  Each question rates how often they were able to engage in each parenting strategy on a scale from 1 (not at all) to 7 (most of the time) during the last month.

- ***Rater:*** Self-report for parents/caregivers

Patient Health Questionnaire (PHQ-9)

- ***Description:*** The PHQ-9 is a widely used, 9-item screening instrument for diagnosing, monitoring and measuring the severity of depression. Scores can be classified according to their severity level (i.e., minimal, mild, moderate, moderately severe, severe).

- ***Rater:*** Clinician, staff, self-report; for individuals ages 18 and older

Profile of Mood States (POMS)

- ***Description:*** The POMS is a scale that assesses the extent to which an individual is experiencing affective mood states: calm, agitated, annoyed, anxious, confused, depressed, helpless, overwhelmed, uncertain and worried.
- ***Rater:*** Self-rated (verbal rating) by individuals of any age calling the WarmLine

PROMIS Global Health

- ***Description:*** The PROMIS Global Health is a 10-item self-assessment of a participant's perceived overall health and functioning. This measure is from the National Institutes of Health (NIH) Patient Reported Outcome Measurement Information System (PROMIS) and includes subscales for Global Mental Health and Global Physical Health with a measure-defined cutoff score for each of the subscales.
- ***Rater*:** Self-report for adults ages 18 and older

PROMIS Pediatric Global Health

- ***Description:*** The PROMIS Pediatric and PROMIS Parent Proxy Global Health are 7-item measures that assess a child's overall evaluations of their physical, mental and social health. These scales are conceptually equivalent to its PROMIS adult counterpart, except these measures yield a single global health score that do not have a cutoff.
- ***Rater:*** Self-report for youth ages 8-17; parent-report for youth ages 5-17

Youth Outcome Questionnaire (YOQ)

- ***YOQ 30.2 Description:*** The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful.
- ***YOQ 2.0 Description:*** The YOQ is the youth analog of the OQ 30.2. It is sensitive to short-term change and assesses the frequency with which youth are experiencing general psychopathology symptoms and functioning related to intrapersonal distress, somatic concerns, interpersonal relations, social problems, behavioral dysfunction, and more. The measure contains a clinical cutoff that identifies scores that fall in the clinical range of severity, as well as a reliable change index that quantifies whether the difference between baseline and follow-up scores is clinically meaningful.
- ***Rater (Both instruments)**:* Self-report for youth ages 12-18; parent-report for youth ages 4-17.

APPENDIX XI: MHSA Program Providers and Contracts by Service Area

Mental Health Awareness & Stigma Reduction Campaigns & Education Programs	
Outreach for Increasing Recognition of Early Signs of Mental Illness	
Portion operated by Behavioral Health Training Services (BHTS) Office through former Behavioral Health Community Training & Technical Assistance	**Provider:** County **Provider:** Western Youth Services **Contract Name:** Behavioral Health Training Services
Portion operated by PEI through former Early Childhood Mental Health Consultation Services	**Provider:** Charitable Ventures of Orange County **Contract Name:** Early Childhood Mental Health Consultation Services
Portion operated by PEI through former K-12 School-Based Mental Health Services Expansion	**Provider:** Latino Center for Prevention and Action in Health & Welfare dba Latino Health Access **Contract Name:** K-12 School-Based Mental Health Training Services **Provider:** Orange County Department of Education for provision **Contract Name:** K-12 School-Based Mental Health Education Services **Provider:** Center for Applied Research Solutions **Contract Names:** K-12 School-Based Mental Health Resource Development Services, K-12 School-Based Mental Health Community Networking Services
Portion operated by PEI through former Services for TAY and Young Adults	**Provider:** Laguna Play House **Contract Name:** Transitional Age Youth and Young Adult Mental Health Outreach Services **Provider:** NAMI OC **Contract Name:** Transitional Age Youth and Young Adult Mental Health Educational Activities **Provider:** National Council on Alcoholism and Drug Dependency **Contract Names:** Transitional Age Youth and Young Adult Mental Health Community Networking Services
Portion operated by PEI through former Outreach and Engagement Collaborative/Mental Health & Well-Being Promotion for Diverse Communities	**Provider:** County **Provider:** Other(s) TBD; solicitation to be released to add contracted provider(s) **Contract Name(s)**: TBD

Portion operated by PEI through former Statewide Projects (includes local mental health campaigns)	**Provider:** County **Contract Name:** Participation Agreement with CalMHSA **Contract Name:** Mental Health Awareness Campaign with Angels Baseball LP
Operated by PEI formerly operated through Behavioral Health Training Services	**Provider: Western Youth Services** **Contract Name: Crisis Intervention Training for Public Safety Personnel**

Mental Health Awareness & Stigma Reduction Campaigns & Education Programs con't	
Mental Health Community Education Events for Reducing Stigma and Discrimination	**Provider:** Council on Aging Southern California **Contract Name:** Mental Health Community Educational Event Services **Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Mental Health Community Educational Event Services **Provider:** Gay and Lesbian Community Services Center of Orange County **Contract Name:** Mental Health Community Educational Event Services **Provider:** Access California Services **Contract Name:** Mental Health Community Educational Event Services **Provider:** Casa De La Familia **Contract Name:** Mental Health Community Educational Event Services **Provider:** Latino Center for Prevention and Action in Health and Welfare dba Latino Health Access and dba LACPRACH **Contract Name:** Mental Health Community Educational Event Services **Provider:** Multi-Ethnic Collaborative of Community Agencies (MECCA) **Contract Name:** Mental Health Community Educational Event Services **Provider:** Wellness and Prevention Foundation dba Wellness Prevention Center **Contract Name:** Mental Health Community Educational Event Services

Prevention Programs	
School Readiness	**Provider:** The Priority Center Ending the Generational Cycle of Trauma, Inc. **Contract Name:** School Readiness Services **Provider:**
School-Based Behavioral Health Interventions and Support	**Provider:** Phoenix House Orange County, Inc. **Contract Name:** School Based Behavioral Health Intervention and Support Services **P**
Violence Prevention Education	**Provider:** Orange County Superintendent of Schools dba Orange County Department of Education **Contract Name:** School Based Violence Prevention Education Services
Gang Prevention Services	**Provider:** Waymakers **Contract Name:** School-Based Gang Prevention Services
Parent Education Services	**Provider:** Olive Crest **Contract Name:** Parent Education Services
Family Support Services	**Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Family Support Services
Children's Support and Parenting	**Provider:** County

Access and Linkage to Treatment/Services	
OC Links (PEI)	**Provider:** County
BHS Outreach and Engagement (PEI)	**Provider:** County
Multi-Service Center for Homeless Mentally Ill Adults	**Provider:** Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Multi-Service Center Services for Homeless Mentally Ill Adults
Open Access	**Provider:** County
Correctional Health Services: Jail to Community Re-entry Program (JCRP)	**Provider:** County

Crisis Prevention and Support Services

Warmline	**Provider:** National Alliance on Mental Illness (NAMI) Orange County **Contract Name:** Warmline Network Services
Suicide Prevention Services	**Provider:** Didi Hirsch Psychiatric Service dba Didi Hirsch Mental Health Services **Contract Name:** Suicide Prevention and Support Services **Provider:** MInd OC **Contract Name:** Suicide Prevention and Support Services
Mobile Crisis Assessment Team/PERT	**Provider:** County
Crisis Stabilization Units	**Provider:** Exodus Recovery, Inc.**Contract Name:** Crisis Stabilization Services**Provider:** College Hospital Costa Mesa **Contract Name:** CSU, LLC, dba College Hospital Crisis Stabilization Unit **Provider:** CEP America-Psychiatry, PC dba Vituity **Contract Name:** Crisis Stabilization Unit
In Home Crisis Stabilization	**Provider:** The Priority Center Ending the Generational Cycle of Trauma, Inc. **Contract Name:** Children's In-Home Crisis Stabilization Services **Provider:** The Priority Center Ending the Generational Cycle of Trauma, Inc. **Contract Name:** Adults In-Home Crisis Stabilization Services
Crisis Residential Services	**Provider:** Waymakers (children) **Contract Name:** Children's Crisis Residential Services **Provider:** Waymakers (TAY) **Contract Name:** Transitional Age Youth Crisis Residential Services **Provider:** Telecare Corporation (Adult/OA) **Contract Name:** Adult Crisis Residential Services North Region **Provider:** STARS Behavioral Health Group **Contract Name:** Adult Crisis Residential Services Central Region **Provider:** Telecare Corporation (Adult/OA) **Contract Name**: Adult Crisis Residential Services South Region **Provider:** Exodus Recovery, Inc. **Contract Name:** Adult Crisis Residential Services North Campus
MHRS Disaster Response	**Provider: County**

Outpatient Treatment: Early Intervention Programs	
Community Counseling and Supportive Services CCSS	**Provider(s):** County
School-Based Mental Health Services	**Provider:** County
Early Intervention Services for Older Adults	**Provider:** Multi-Ethnic Collaborative of Community Agencies (MECCA) **Contract Name:** Early Intervention Services for Older Adults **Provider:** Council on Aging Southern California **Contract Name:** Early Intervention Services for Older Adults
OC Parent Wellness Program	**Provider:** County
First Onset of Psychiatric Illness (OC CREW)	**Provider:** County
Early Psychosis Learning Healthcare Network	**Administrative Oversight:** California Mental Health Services Authority (CalMHSA) **Participation Agreement Name:** Early Psychosis Learning Healthcare Network (EPLHCN)
OC4 Vets	**Provider:** County **Provider:** Working Wardrobes **Contract Name:** Veteran Peer Support Services **Provider:** United States Veterans Initiative **Contract Name:** Early Intervention Services for Veteran College Students **Provider:** Child Guidance Center, Inc. **Contract Name:** Behavioral Health Services for Military Families

Outpatient Treatment: Clinic Expansion Programs	
Child and Youth Clinic Expansion *(Formerly, in part, Youth Core Services)*	**Provider:** Western Youth Services **Contract Name:** Behavioral Health Outpatient Services for Children and Youth **Provider:** Child Guidance Center, Inc **Contract Name:** Behavioral Health Outpatient Services for Children and Youth **Provider:** Pathways Community Services LLC **Contract Name:** Behavioral Health Outpatient Services for Children and Youth **Provider:** Seneca Family of Agencies **Contract Name:** Behavioral Health Outpatient Services for Children and Youth

	Provider: Waymakers **Contract Name:** Behavioral Health Outpatient Services for Children and Youth **Provider:** Olive Crest **Contract Name:** Behavioral Health Outpatient Services for Children and Youth **Provider:** South Coast Children's Society, Inc **Contract Name:** Behavioral Health Outpatient Services for Children and Youth
Services for the Short-Term Residential Therapeutic Program (STRTP)	**Provider:** New Alternatives, Inc. **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Olive Crest **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Rite of Passage Adolescent Treatment Centers and Schools, Inc. **Contract Name:** Short-Term Residential Therapeutic Programs **C** **Provider:** Child Help, Inc **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** Hart Community Homes **Contract Name:** Short-Term Residential Therapeutic Programs **Provider**: Mary's Shelter DBA Mary's Path **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** South Coast Children's Society, Inc **Contract Name:** Short-Term Residential Therapeutic Programs **Provider:** The Teen Project, Inc **Contract Name:** Short-Term Residential Therapeutic Programs
Children and Youth with Co-Occurring Medical and Mental Health Disorders	**Provider:** Children's Hospital Orange County (CHOC) **Contract Name:** Integrated Medical and Behavioral Health Services Outpatient Services
Outpatient Recovery formerly Recovery Center/ Clinic	**Provider:** College Community Services **Contract Name:** Adult Behavioral Health Outpatient Recovery Center Service

	Provider: Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Adult Behavioral Health Outpatient Recovery Center Service **Provider:** County
Older Adult Services	**Provider:** County

Outpatient Treatment: Full Service Partnership Programs	
Children's/TAY FSPs	**Provider:** Pathways Community Services, LLC. **Contract Name:** Transitional Age Youth Full Service Partnership/Wraparound Services **Provider:** Pathways Community Services, LLC. **Contract Name:** Children's Full Service Partnership/Wraparound Services **Provider:** Orange County Asian and Pacific Islander Community Alliance, Inc. **Contract Name:** Children and Transitional Age Youth Full Service Partnership/Wraparound Services **Provider:** Children's Hospital of Orange County, DBA CHOC Children's **Contract Name:** Children and Transitional Age youth Full Service Partnership/Wraparound Services for Co-Occurring Disorders **Provider:** Waymakers **Contract Name:** Collaborative Courts Full Service Partnership/Wraparound Services **P** **Provider:** Waymakers **Contract Name:** Full Service Partnership/Wraparound Services for Youthful Offenders
Adult FSPs	**Provider:** College Community Services **Contract Name:** Older Adult Full Service Partnership Services **Provider:** College Community Services **Contract Name:** Criminal Justice Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** General Population Region A Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** General Population Region B Full Service Partnership Services

	Provider: Telecare Corporation **Contract Name:** General Population Region C Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** Assisted Outpatient Treatment Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** Collaborative Court Full Service Partnership Services **Provider:** Telecare Corporation **Contract Name:** Enhanced Recovery Full Service Partnership Services
Older Adult FSP	Provider: College Community Services Contract: Older Adult Full Service Partnership Services
Home First FSP	**Provider:** Telecare Contract Name: Supportive Services at Permanent Housing

Outpatient Treatment: Program for Assertive Community Treatment	
PACT	**Provider:** County

Supportive Services	
Peer Mentor/Parent Partner Support	**Provider:** College Community Services **Contract Name:** Peer Mentoring Services for Adults and Older Adults
Wellness Centers	**Provider:** College Community Services **Contract Name:** Mental Health Peer Support and Wellness Center Services Central Region **Provider:** College Community Services **Contract Name:** Mental Health Peer Support and Wellness Center Services South Region **Provider:** Orange County Association for Mental Health dba Mental Health Association of Orange County **Contract Name:** Mental Health Peer Support and Wellness Center Services West Region
Transportation	**Provider:** CABCO Yellow, Inc. dba California Yellow Cab **Contract Name:** Non-Emergency Transportation Services

Supported Employment	**Provider:** Goodwill Industries of Orange County **Contract Name:** Adult Supported Employment Services
Continuum of Care for Veterans and Military Families	**Provider:** Child Guidance Center **Contract Name:** Continuum of Care for Veterans and Military Families
Year Round Emergency Shelter *(formerly known as Short-Term Housing Services*	**Provider:** Grandma's House of Hope **Contract Name:** Short Term Housing Services **Provider:** Friendship Shelter **Contract Name:** Short Term Housing Services **Provider:** Colette's Children's Home **Contract Name:** Short Term Housing Services **Provider:** Mercy House **Contract Name:** Bridges at Kraemer Place **Provider:** PATH **Contract Name:** Yale Navigation Center
Bridge Housing for the Homeless	**Provider:** Grandma's House of Hope **Contract Name:** Homeless Bridge Housing Services**Provider:** Friendship Shelter **Contract Name:** Homeless Bridge Housing Services **Provider:** Colette's Children's Home **Contract Name:** Homeless Bridge Housing Services
MHSA/ CSS Housing Program	**Provider:** County

Special Projects	
Help@Hand *(formerly Mental Health Technology Suite) (INN)*	**Administrative Oversight:** California Mental Health Services Authority (CalMHSA) (through 12/31/2021) **Participation Agreement Name:** Mental Health Services Act Innovation Program (ended 12/31/2021) **Provider:** Cambria Solutions, Inc. **Contract Name:** Technology-based Innovation Project Management Services **Provider:** Mindstrong, Inc **Contract Name:** Telehealth and Digital Mental Health Support Services **Provider:** Charitable Ventures of Orange County

	Contract Name: Outreach and Marketing Services **Provider:** Regents of the University of California at Irvine **Contract Name:** Evalution of Behavioral Health Innovation Projects
Behavioral Health System Transformation Innovation Project (INN)	**Provider:** Mind OC **Contract Name:** Behavioral Health System Transformation Innovation Project **Administrative Oversight:** CalMHSA (through 5/31/2021) **Participation Agreement Name:** Orange County Behavioral Health System Transformation Innovation Project Part II (ended 5/31/2021) **Provider:** Chorus Innovations, Inc. **Contract Name:** Behavioral Health System Transformation OC Navigator **Provider:** Regents of the University of Californa at Irvine **Contract Name:** Evaluation of Innovation Projects (formerly Evaluation of Behavioral Health System Transformation Innovation Project)
Psychiatric Advance Directives	**Administrative Oversight:** Syracuse University (pending Board of Supervisors approval) **Contract Name:** Personal Services Agreement Between Syracuse University and the County of Orange **Provider:** Syracuse University on behalf of its Burton Blatt Institute (Pending Board of Supervisors approval for evaluation services) **Contract Name:** Personal Services Agreement Between Syracuse University and the County of Orange
Recovery Education Institute	**Provider:** Pacific Clinics **Contract Name:** Recovery Education Institute Services

Public Comment #1

Veterans Programs

PERSONAL INFORMATION			
Name	Cory Vigil		
Agency/Organization	Child Guidance Center		
Phone number		E-mail	
Mailing address (street)			
City, State, Zip	Santa Ana, Ca		

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
X	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

I just wanted to communicate that SFSC needs more funding. Currently referrals for this program have tripled and there's a waiting list of 30-45 days. Some of the needs involving families consist of suicide, domestic violence, PTSD and peer navigation is needed.Please consider significant funding for this amazing program. When I served in Iraq during my first deployment my daughter was diagnosed with Acute Lymphoid Leukemia. I could have really used a program like this to support me and my family. I would like the opportunity to continue to serve miltary-connected families in Orange County.

HCA Response to Veterans Programs (Comment #1)

First and foremost, thank you for your service and advocacy for veterans and military-connected families in Orange County. The Strong Families Strong Children (SFSC) is a limited term Innovations funded project that by MHSA regulations is limited to up to five years. (Innovations Regulations code: Section 3910.010.) The HCA Mental Health and Recovery Services appreciates the services provided by SFSC during this Innovations project. MHRS will continue to reevaluate existing program needs to address the waiting list and meet the unique needs of Veterans and Military-connected families.

Public Comment #2

Veterans Programs

PERSONAL INFORMATION			
Name	**Bre Onna Mathis**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
X	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

My comment is on behalf of Strong Families, Strong Children, a program that services family members of veterans in Orange County.

The rate of veteran suicide increased dramatically over the last two years. An estimated 20 or more veterans a day dying by suicide. National and local trends in suicide, mental health and suicide COVID-19 data, and veteran suicide data across service eras show the needs of these veteran families. The SFSC model has had a significant impact on correlated risk factors related to suicide both generally and in the veteran population.

It is clear from County, Statewide and National data that substance use has increased in many communities as families cope with the economic and socially isolating effects of the COVID pandemic, which has affected minority families disproportionately. This is especially important in view of the extent to which SUDs co-occur with trauma and other mental health issues, as well as their effects on employment, income, family stability, and housing issues.

HCA Response to Veterans Programs (Comment #2)

Thank you for your advocacy for Veterans Services. We look forward to your continued participation in the next MHSA three-year Plan Community Planning Process. Mental Health and Recovery Services (MHRS) agrees that veterans and military families are managing a great deal of challenges, and the MHSA plan update continues to prioritize veteran's services and recognizes veterans as a priority population, particularly in Suicide Prevention efforts. (Please see page 19; see priority populations)

Public Comment #3

Veterans Programs

PERSONAL INFORMATION			
Name	**Robin Williams**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)** **Legal Assistance**

COMMENTS

My comment is on behalf of the Strong Families, Strong Children (SFSC) program, which you can reference on page 184 in the 22-23 MHSA Plan, under one of the five OC4Vets-PEI programs. To quote the plan: Strong Families, Strong Children provides "an array of services that are tailored to meet the needs of the individuals and/or the families and can include peer support, community outreach, housing navigation and assistance, employment support, behavioral health screening and assessment, referral and linkages to community and behavioral health resources, clinical case management, individual counseling, family counseling, group counseling, domestic violence support, workshops and educational support groups for families, and legal support and advocacy services."

My name is Robin Williams, and I am the Grants Manager at Veterans Legal Institute, a pro-bono legal non-profit providing legal representation to veterans and their families with family law, landlord-tenant, unemployment, economic impact payment, veteran benefits, estate planning, financial assistance, discharge upgrades, consumer law, and others. I am also a US Army Veteran.

As a partner of the Strong Families, Strong Children collaborative, we need to highlight the fact that children, spouses, and family members of veterans who are dealing with one or more legal matters that were served by this program have had a positive impact on the entire family.

Veterans Legal Institute's partnership with Strong Families, Strong Children has provided veterans and their families with the support needed to access legal services while also addressing their family needs around housing, mental health, education, parenting, employment, basic needs, etc. The SFSC families that are dealing with a legal matter are also dealing with other concerns such as mental health, medical, and housing. The need for legal services has increased dramatically and we need additional funding to serve these families in need.

The families and children of veterans who have served their country deserve our best efforts to provide them the services they need, and without the expansion funding these families will be on waitlists and the impact on our capacity to serve these families will suffer.

HCA Response to Veterans Programs (Comment #3)

Thank you for your military service and advocacy for veterans' services. Mental Health and Recovery Services (MHRS) agrees that veterans and military-connected families are managing a great deal of challenges, and the MHSA Plan Update continues to prioritize veteran's services and recognizes veterans as a priority population, particularly in Suicide Prevention efforts. (Please see page 19; priority populations) The plan proposes to expand services through creating a Full- Service Partnership as well as OC4VETS (Please see pages 22-23; see proposed program expansions). These programs are specifically designed to meet the unique needs of veterans, including substance use services, trauma, family support, and legal issues. (Please see page 183; see program description for OC4Vets)

Public Comment #4

Children and Youth Programs

PERSONAL INFORMATION			
Name	**Sandy Avzaradel**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☒	**Family member**	☒	**Education**
☒	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

As a passionate advocate for upstream work to solve systemic issues, I am concerned about the imbalance of the budget dedicated toward upstream efforts. Approximately 95% of brain development has occurred by the age of eight. Children entering kindergarten at age five have developed 90% of their brain. The trajectory based on both adverse and benevolent expriences of a young child before they enter school has been set. We know that if we identify what is causing the issues and work on that, we greatly decrease the interventions necessary later in life. In dollars and cents, the return on investment working upstream (early childhood years) can be anywhere from 5-16% (depending on the investments).

In looking at the Priority Populations in the plan, the term youth can and does include young children, but the way it is defined is up until age 25. The needs of a young child versus a 12 year old, 18 year old, or 25 year old is very different. The approach is different, what mental health looks like is different, services and access to services are different and the workforce MUST be different.

Suicide Prevention starts in early childhood. If we start looking at suicide prevention as building social and emotional skills – the very skills that build resilience, then we are preventing suicide. But, when you look at the priority populations and the progress updates in the MHSA plan, we are starting with TAY. Mental Health issues of the "at risk youth" started in their very early years based on their experiences, environment and epigenetics. Let's take an upstream approach to suicide prevention.

Of the $365,089,830 budget, only $2,000,000 (.5%) is *specifically dedicated* to early childhood years (not including K-12 school based mental health services or other "all age group" funds). I am concerned that the budget does not take an upstream approach that will ensure systemic change in Orange County.

Public Comment #5

Children and Youth Programs

PERSONAL INFORMATION			
Name	**Kim Goll**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
X	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

Thank you for the opportunity to provide comment on the Mental Health Services Act (MHSA) Annual Plan Update for FY2022/23. As you are aware, mental health is critical throughout the lifetime. Research is clear that young children under age 5 can – and do – suffer from mental health conditions. In fact, even the parent's mental health pre-natally has an impact on that child's outcomes from the start. Those early years are a vital opportunity to establish appropriate social-emotional development and relational health, that can ultimately lead to more positive future mental health outcomes.

It is therefore very disappointing to see that although there has been a substantial increase in MHSA revenue from the state, the prenatal to age five population has not been specifically prioritized and supported in Orange County. This despite the fact that there have been numerous and significant reports describing the critical needs at this time, and highlighting the responsibility of MHSA investment. In particular, the 2021 report, *Addressing infant & early childhood mental health needs: Opportunities for community solutions*, specifically highlights the need for MHSA to prioritize young children, which includes the most often under-served age group of prenatal through age 5. The report further details specific needs and opportunities that are a roadmap for MHSA investment for families of young children. In addition, the 2021 AAP Policy Statement, *Preventing Childhood Toxic Stress: Partnering with Families and Communities to Promote Relational Health*, calls for an immediate and urgent shift from current practices to a focus on safe, stable, and nurturing relationships that buffer adversity and build resilience for young children. Furthermore, the First 5 Orange County Early Developmental Index has (since the onset of data collection in 2015) demonstrated that nearly 10% of kindergarteners arrive vulnerable on the social-emotional index assessment. After the most recent impact of COVID-19, and based on anecdotal observations from caregivers, we are anticipating an increase in vulnerability in the 2022 data that is currently being aggregated. The need - and responsibility - of MHSA prioritization and investment in this population is clear.

There are models of investment from other programs and counties that have already demonstrated success and must be explored and implemented through MHSA leadership in the Orange County mental health system of services for Orange County. The needs are beyond clinical care and include prevention, education, and experiences that are supportive for caregivers (parents, grandparents, child care and early education providers, and all those who care for young children). Examples of these supports are detailed in the reports mentioned above, but a sampling of these include:

Public Comment #5 (Continued)

Children and Youth Programs

- Establish prevention efforts such as public awareness campaigns on the importance of mental health for young children (and how this is linked to behavior and relationships with adults)
- Increase protective factors through family activities and supports such as playgroups
- Directly support the early care and education field with increased support services and training on children's behabvioral and emotional development
- Establish broader implementation of the Infant and Early Mental Health Consultation model for early childhood education and beyond, to include coordination with programs such as Family Resource Centers, homeless and domestic violence shelters, substance use disorder treatment programs, and hospitals serving pre- and post-partum famlies
- Provide support towards workforce development including investing in county training programs, scholarship and work agreements, supporting caregiver pathways in public schools, training programs specifically for child care and preschool teachers, and ensuring representation by engaging the local community members, representing their unique community and culture in the workforce
- Expand school-based mental health services to include pre-kindergarten students and staff (such as the newly mendated Transitional Kindergarten and school-based head start programs)
- Lead an effort of intentional collaboration with other related initiatives (such as ACEs and CalAIM) to effectively streamline efforts and services for young children

It is important to recognize that the needs and strategies related to mental health for children prenatal to five years of age are very different from those relevant for teens or even elementary students. This population must be specifically prioeritized and targeted for effective prevention and education services. Orange County MHSA is uniquely positioned, during this very critical time in the field, to make a difference that will impact future generations. We must prioritize young children (particularly defined as prenatal through age 5) to effectively promote well-being, prevent mental health conditions, and ensure early identification to support the best possible outcomes for every individual in our county.

First 5 Orange County is particularly focused on this population, and works regularly in collaboration with community organizations and partners that can and do support this work. We would like to be a support in this process, and we welcome any opportunity to meet with you and discuss how the prioritization of young children can be incorporated into your plan.

We appreciate the opportunity to provide input and look forward to further collaboration and partnership to support the individuals and families of Orange County.

HCA Response to Children and Youth Programs (Comments #4-5)

Thank you for your comments and identification of the specific needs of children and youth, including addressing differential needs for underserved age groups prenatal through age 5. Priority Populations within the MHSA Plan Update were determined by the community planning process in the development of the current three-year plan. Youth was identified as a priority population for the strategic priority Access to Behavioral Health Services (Please see page 17). Youth, specifically boys ages 4-11 were identified as a priority population for the strategic priority Mental Health Awareness and Stigma Reduction (Please see page 18).

Mental Health and Recovery Services (MHRS) agrees that upstream approaches are an important component of the continuum of care, supporting families, and the social and emotional development of young children. MHSA currently funds several programs/services that focus on new or expecting parents as well as families with young children using upstream approaches. Examples of upstream programing within the plan include Orange County Parent Wellness Program (please see program description on page 170), and Safe From the Start (please see page 100).

Additional programming has been developed through PEI programs to address at-risk and stressed families with children, including pregnant females and partners affected by pregnancy or birth of a child.

On page 27 of the MHSA Plan Update, we propose to expand programs under Outreach for Increasing Recognition of Early Signs of Mental Illness Programs by $10,399,528. Specifically, expanding Behavioral Health Training, Early Childhood Mental Health Providers Training, Outreach and Engagement, and K-12 School-Based Mental Health Services Expansion.

It is important to note that all programming dedicated to children is not reflected in the MHSA budget.

MHRS values its collaborative work with Start Well and First 5, including the additional content developed for the Stigma Free OC movement and participating in the learning cohort for enhancing home visiting referral pathways for families (Please see page 73). HCA looks forward to further explore the community need through these and other efforts as we continue to come out of the pandemic and work together in finding solutions. We look forward to discussing the 2022 Early Developmental Index data to further inform community planning and applaud your effort in providing this information.

Public Comment #6

Children and Youth Programs

PERSONAL INFORMATION			
Name	**Michael Arnot**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☒	**Other (please state) Advocate**

COMMENTS

Please include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. We support its adoption by the Orange County Board of Supervisors to address significant gaps in children's mental health services by providing access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally responsive and available in Spanish, Vietnamese, Korean, Arabic, Farsi, Khmer, Chinese, Pashto, and other languages as part of the Project are needed to address ongoing disparities in access to children's mental health services. This collaborative project that brings together twelve children's mental health community-based providers is needed immediately to address the current children's mental health crisis in our county.

The Update would also benefit from having a responsive funding mechanism that could provide support for community-based initiatives that are aligned with Orange County's MHSA priorities. This mechanism would also provide flexibility in addressing ongoing surplusses.

Finally, having a "cause of change" report indicating the reasons the previous plan update did not meet its planned expenditures

Public Comment #7

Children and Youth

PERSONAL INFORMATION			
Name	Sandra Brookhart		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

Please include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. We support its adoption by the Orange County Board of Supervisors to address significant gaps in children's mental health services by providing access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally responsive and available in Spanish, Vietnamese, Korean, Arabic, Farsi, Khmer, Chinese, Pashto, and other languages as part of the Project are needed to address ongoing disparities in access to children's mental health services. This collaborative project that brings together twelve children's mental health community-based providers is needed immediately to address the current children's mental health crisis in our county

Public Comment #8

Children and Youth

PERSONAL INFORMATION			
Name	Vattana Peong		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

Thank you so much for the opportunity to provide comments on Orange County Mental Health Services Act Plan Update for FY 2022-23.

We would like to see the plan include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. We support its adoption by the Orange County Board of Supervisors to address significant gaps in children's mental health services by providing access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally responsive and available in Spanish, Vietnamese, Korean, Arabic, Farsi, Khmer, Chinese, Pashto, and other languages as part of the Project are needed to address ongoing disparities in access to children's mental health services. This collaborative project that brings together twelve children's mental health community-based providers is needed immediately to address the current children's mental health needs in our county.

We thank you in advance for your consideration.

Public Comment #9

Children and Youth

PERSONAL INFORMATION			
Name	Lorry Leigh Belhumeur, Ph.D.		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

Please include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. We support its successful efforts to address significant gaps in children's mental health services by providing much needed access to mental health resources through access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally responsive and available in Spanish, Vietnamese, Korean, Arabic, Farsi, Khmer, Chinese, Pashto, and other languages that can be provided by the CMHA Project are needed to address ongoing disparities in access to children's mental health services. This collaborative CMHA Project brings together twelve children's mental health community-based providers and is needed immediately to address the current children's mental health crisis in our county.

Public Comment #10

Children and Youth

PERSONAL INFORMATION			
Name	Meridith Cagle		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

Please include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. Beyond Blindness supports its adoption by the Orange County Board of Supervisors to address significant gaps in children's mental health services by providing access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally and linguistically appropriate and support children with low incidence health needs such as vision impairment are needed to address ongoing disparities in access to children's mental health services. This collaborative project that brings together twelve children's mental health community-based providers is needed immediately to address the current children's mental health crisis in our county.

Public Comment #11

Children and Youth

PERSONAL INFORMATION			
Name	Nahla Kayali		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☒	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state) Veteran

COMMENTS

Please include the Children's Mental Health Access (CMHA) Project in the FY 2022-23 MHSA Plan Update. We support its adoption by the Orange County Board of Supervisors to address significant gaps in children's mental health services by providing access coordination, universal mental health screenings and response in schools, PC-CARE, early childhood mental health case management, and other supportive services. Children's mental health education and outreach activities that are culturally responsive and available in Spanish, Vietnamese, Korean, Arabic, Farsi, Khmer, Chinese, Pashto, and other languages as part of the Project are needed to address ongoing disparities in access to children's mental health services. This collaborative project that brings together twelve children's mental health community-based providers is needed immediately to address the current children's mental health crisis in our county."

HCA Response to Children and Youth Programs (Comments #6-11)

Thank you for your collaboration in addressing children's mental health needs in Orange County. MHRS leadership continues to meet with Children's Cause Orange County and Community-Based Organizations regarding the Children's Mental Health Access (CMHA) project. We will continue to evaluate how this project could contribute to the development of the children and youth system of care in Orange County.

The HCA is working diligently in collaboration with Orange County Department of Education as well as CalOptima, to re-evaluate the current needs, existing programs, and gaps in services for youth and family. This partnership is critical while OCDE is the recipient of School Based Health Incentive Program (SBHIP) funding for the provision of supportive mental health services for children, youth, families, caregivers, and educators. This collaboration supports maximizing the funding to avoid duplication of services and create a thoughtful, seamless system of care for this target population.

The HCA MHRS values collaborating with community-based organizations and initiatives. The recommendation of creating a "responsive funding source mechanism" will continue to be evaluated and explored.

In previous years, various approaches have been implemented to share reasons for variances in projected expenditures and actual expenditures. This is often part of the "true up" process discussed in the Plan Update on pages 26-28. Frequently, these variances are due to changes in physical location, delays in implementation, and staffing challenges.

Public Comment #12

Children and Youth Programs

PERSONAL INFORMATION			
Name	Jazmin Suarez		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☒	**Other (please state)** Student/Youth

COMMENTS

Hello, My name is Jazmin and I am a 10th grader attending school in the city of Santa Ana. I would to see more of the following provided for youth substance use disorder prevention and mental wellness:

1. More Youth after school programs and activities- After school programs where you could go and get assistance with homework. Also where you can get help with College applications and scholarships. Something where youth can be more athletic and where they can get real equipment. a real coach, someone who can show them how to do the things right and show the best ways and can take away a lot and learn. have a place where youth can get a trainer if they are thinking of going to the gym and show them how to work their equipment.

2. More youth mental wellness activities- Having a place where you're able to go relax and just on wine being able to have someone there to talk to and give information or get information from them to be able to survive the daily life of a student there should be clubs where you wasn't able to socialize and just have fun to be able to network and get those tools that they would need in the future another example of what we could do is have tutors that are therapists so as you're doing your homework you're able to talk about what's going on in life and how you could get assistance with what you are doing both mentally and educationally.

3. More safe spaces for youth socialization- The best way to have you engage with people that are trying to help is to have them in a setting where their friends are with them for example at school. where you could have a class or a. To be able to just do this or even after school or before school would be a great time then from there have all the youth come together at least once or twice a month to where they're able to talk about breakthrough

4. More services for youth struggling with mental health, developmental, or home-life differences- Having someone there that is open-minded and is there for the students. talking to them as if they are their friends and being able to just help them with their ideas having people there that really care about how are you guys doing and not just there just to be there a great idea is go on walks with the students to get to know them in a more open area

5. More restorative justice policies—helping youth and police to reconcile and relate to each other more positively The police could do a pop-up stand where people could come up and just ask questions related to the police being able to educate the community and letting them know that they're there to help. Something a policeman should do is walk around the neighborhood and get to know the people there so you know that they're there to help and not do what television has done in the past and made things unrealistic. have a place where policemen and you are able to sit down and have questions have a fun day to where they are able to sit down and have fun and just answer all the questions that we have to be able to assist more youth to come.

HCA Response to Public Comments on Children and Youth Programs (Comment #12)

The MHSA office sincerely appreciates the thoughtful insights that you shared along with recommendations to improve the well-being of youth in Orange County. The HCA is currently in discussion with various community partners including Social Services Agency to enhance their Family Resource Centers specifically to address after school programs. The current plan update also proposes to expand preK-12th grade school based supportive services which doesn't highlight afterschool programs but does not exclude afterschool programs.

The HCA is working diligently in collaboration with Orange County Department of Education as well as CalOptima, to re-evaluate the current needs, existing programs, and gaps in services for youth and family. This partnership is critical while OCDE is the recipient of School Based Health Incentive Program (SBHIP) funding for the provision of supportive mental health services for children, youth, families, caregivers, and educators. This collaboration supports maximizing the funding to avoid duplication of services and create a thoughtful, seamless system of care for this target population.

We value your voice and encourage your participation in MHSA community engagement opportunities.

Public Comment #13

Data/Outcomes

PERSONAL INFORMATION			
Name	Barry Ross		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☒	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

I commend the County for seeking community input into the MHSA priorities and budget process. The expanded budget in 2022-2023 provides a great opportunity to move the mental health system forward. I commend the large upstream investments in PSH and in Be Well. There is recognition that the current mental health system is hard to navigate and complex. I would encourage the County to establish metrics that tell us whether residents were able to access the services that they looked for and need and that there are metrics that demonstrate that residents are being diagnosed earlier, hospitalizations are being prevented and suicides are being decreased. If there are not baselines and benchmarks for these types of metrics, I would encourage that they be established. We need to know which investments are effective and which ones are not, as well as how the system as a whole is improving.

HCA Response to Data/Outcomes (Comments #13)

Thank you for your comments. Each program description reports the process and, where appropriate, performance outcomes over the past several fiscal years to aid in the identification of trends over time. The presented outcomes and metrics align with state and other regulatory requirements. We nevertheless recognize the value and importance of outcomes and are beginning a multi-step process of modernizing our data collection systems and pipeline and updating our data analytics and visualization. The investment in the Capital Facilities and Technological Needs component in this year's Annual Plan Update reflects, in part, the acceleration of work in this area, which will progressively roll out in phases over the course of the next MHSA Three-Year Plan.

Public Comment #14

Community Planning, Plan Performance and Budget Considerations

PERSONAL INFORMATION			
Name	Stephen McNally		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☒	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

Community Planning:

I feel that community planning should focus on community's needs and awareness of available services, or missing services, their level of understanding to access services and when accessed how were customers treated and what quality of care was received. A professional marketing research firm should be hired to design questions that result in specific actions about access/navigation, expansion /retraction ofprograms, or deletion of programs based on need.

The plan does not clearly present community needs or segment sizes: for many years, I have voiced a concern about the quality of research.

Most community members will be overwhelmed by the document size and find it difficult to understand a 400 plus document. The addition of an executive summary for outcomes, program eligibility requirements, and a video explanation for the plan. Neighboring counties present the plan to the community, capture a recording, then host a recording online during the public comment period. The county advertisies the recording availability and invites the community.

Plan Performance:

Outcomes are hidden within the narrative however, it is to difficult to see perfomance by county operated or contracted providerss such as:

- Budget (Available, Spent, Spent As a percent of Available Funds,)
- Outvomes (Expected, Acjieved, Achieved as a pervent of Expected Outcomes)
- Cost Per Outcomes (Expected, Acjieved, Achieved as a pervent of Expected Outcomes)

Possibly adding this information in a similar executive summary format (pages 21-28) - CEO prepared quarterly budget review and the Annual Revenue and Expenditure Report (ARER) presented to the state document financial performance; the documents do not include outcomes.

Adding program designation as (C) county operated and contracted provider by name as part of the program name would make it easier to evaluate specific performance. would m.

Budget Considerations:

On page 311, the current budget plans to not spend $113,3M I recommend eliminating " this carryover" creating a responsive funding mechanism as part of the approved budget. This would allow the county to quickly respond to new opportunities, support smaller organizations who are not staffed to address county procurement and identify champions hidden behind filters. Additionally, we can address equity issues around sub contractor pay (bigger providers using smaller ethnic providers but at lower pay)

Clarification is requested how Cal Aim affects federal funds participation (FFP. This plan continues to significantly under achieve federal funds participation at the levels of neighboring counties. Is this program design, training, or something else.

My comments are mostly about the budget as this is most easily understood in the plan. I will submit comments added as a tect boxes and highlights within the plan as a separate comment.

Thank you for the opportunity to make a public comment

HCA Response to Data, Community Planning and Budget Considerations (Comments #14)

Community Planning

Thank you for the recommendations and sharing your insights as you look at the MHSA process and plan in surrounding counties. In Orange County, we recognize that the CPP has evolved since the implementation of MHSA as the needs of the system have changed. (Please see the summary of the strategy/approach on page 37 of the plan update)

The HCA agrees that in our current stage of development as a system, community engagement should focus on community/client needs, awareness and access to services, gaps in services, evaluating individual experience in services, and quality of care. As we start developing our CPP plan for the next three-year plan, we are also aware of our staffing limitations and plan to reach out to various partners, particularly with cultural and language capabilities to assist with the process and effectively reach the diverse ethnic communities and MHSA target populations in Orange County. In addition, the MHSA office is working closely with CalOptima, and the office of Population Health Equity to collaborate with similar county wide initiatives. This will expand our reach into the community and reduce redundancy for the community members participating in surveys and focus groups. We anticipate that as the data collection and reporting process evolves, as addressed below in "Plan Performance", this will lead to additional opportunities for the community to evaluate the efficiency and efficacy of the programs.

Thank you for your additional recommendations regarding providing various videos to share program information as well as a video explanation of the MHSA plan. We will explore the option further and consider as a tool for the next three-year plan.

Plan Performance

Thank you for your comments. Each program description reports the process and, where appropriate, performance outcomes over the past several fiscal years to aid in the identification of trends over time. The presented outcomes and metrics align with state and other regulatory requirements. We nevertheless recognize the value and importance of outcomes and are beginning a multi-step process of modernizing our data collection systems and pipeline and updating our data analytics and visualization. The investment in the Capital Facilities and Technological Needs component in this year's Annual Plan Update reflects, in part, the acceleration of work in this area, which will progressively roll out in phases over the course of the next MHSA Three-Year Plan.

Budget Considerations

As a core standard of MHSA, HCA continues to follow the Community Program Planning Process to utilize MHSA funds while aligning responsibly and strategically with the County's Strategic Priorities, which will further decrease the current projected carry over balance.

DHCS is transforming the Medi-Cal delivery system. This transition is done through CalAIM. Reform Implementation is already underway and will continue through 2027. This process is still being developed and with it, CalAIM will change what we can bill for as well as how we bill and receive Medi-Cal FFP. As the Calami system continues to be finalized the hope is additional services could be claimed that are currently not eligible to be billed for Medi-Cal reimbursement. This may result in increased FFP generation and free up additional MHSA funds.

The amount of FFP Generated by our MHSA programs is limited due to how our MHSA programs are designed. Our MHSA programs are designed to fill in gaps within our Mental Health and Recovery Services System. With this design many of the services provided by our MHSA programs are not eligible for Medi-Cal FFP. Almost all PEI programs do

not bill Medi-Cal as they are serving individuals who do not meet criteria for Specialty Mental Health Services (SMHS). It is the intent of the plan to intervene early to prevent individuals from meeting criteria for serious mental health services (SMHS) which is a higher level of care. Additionally, HCA's Mental Health and Recovery Services has a variety of programs that are not funded through MHSA which provide Medi-Cal eligible services and bill Medi-Cal therefore generating a high rate of FFP that would not be mentioned in the MHSA plan.

Public Comment #15

Crisis CAT/PERT

PERSONAL INFORMATION			
Name	Carla DiCandia		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☒	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

I am so proud of our County for all of the effort that continues to go into mental health services. As an employee of Ocean View Adult Psych Hospital in south Long Beach, I work with a variety of residents from OC, as well as with many of the SUD and mental health providers in OC. An ongoing challenge is the lack of availability of the CAT and PERT teams. It was implied in the executive summary that there will be an expansion of such teams but I feel it must be called out specifically. As well, I continue to hear from families that their loved ones are being taken to the local ER only to a) be transferred to a psych unit in another county or b)be released because they're not "sick enough". This is a true travesty as evidenced by the patient who was released from a local hospital last year as "stable" only to go down the street, break into a home and assault a neighbor. This is a chronic and recurring problem that extends beyond OC, but worthy of attention if we are to be the new standard and benchmark in this arena. Last but not least, what a BLESSING to have the addition of the two Signature psych units (Aliso Viejo and Anaheim). Now if only we could convert the San Clemente Hospital into a psych hospital with an ER!!! Please count on me if there's anything I can do to advocate for any of these issues.

HCA Response Crisis CAT/PERT (Comment #15)

Thank you for the feedback regarding availability of the CAT and PERT teams. By definition, unplanned crises eb and flow and wait times can be unfavorable during peak demand periods. Recently, the ability of the CAT and PERT teams to consistently meet the increased community requests for crisis response in the timeliest manner has been impacted by several staffing vacancies. HCA is actively working to address recruitment and retention factors.

Please refer to page 21 of the MHSA Plan Update where the proposed Mobile Crisis and Assessment increase is referenced.

Although MHRS works closely with local hospitals to support continuity of care and discharge planning, following admission to a hospital, client care lies with the treating hospital.

Public Comment #16

Prevention and Early Intervention

PERSONAL INFORMATION			
Name	Kim Versluis		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☒	**Family member**	☒	**Education**
☒	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

Please provide for more financial support towards prevention and promotion. Prevention is key to supporting individuals and families in need and essential to our county's continued success and forward thinking agenda on mental health services.

HCA Response to Prevention and Early Intervention (Comment #16)

Thank you for your comment. HCA agrees with the importance of prevention and mental health promotion and is looking forward to new mental health and wellness promotion services to begin next year in addition to the prevention services birth – all ages described in the Plan.

Public Comment #17

allcove

PERSONAL INFORMATION			
Name	**Stephen Schueller**		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☒	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☐	**Other (please state)**

COMMENTS

We appreciate the mention of allcove as part of the MHSA 2022-2023 plan and the potential of allcove for support from innovation funding in Orange County. allcove is an innovative model to welcome young people ages 12 to 25 with mild to moderate needs looking for support. A network of allcove projects have been funded by the MHSOAC, with technical assistance provided by Stanford University, including an Orange County project led by the University of California, Irvine and the Wellness & Prevention Center. The MHSOAC funding comes from legislated state funds. The funding started in October 2021 and runs through June 2024 to support the planning and launching of two allcove centers here in Orange County. We are currently in planning phases for these centers including forming our Youth Advisory Groups and Community Consortium, establishing our partners for service delivery, and opening the doors for allcove Irvine and allcove Orange County in late 2022 and early 2023. County MHSA funding is vital to the operation, expansion, and sustainability of allcove in Orange County.

We strongly support the use of MHSA innovation funds to support allcove in Orange County. We also note additional ways that MHSA funding might support allcove. With its focus on youth with mild to moderate needs, prevention and early intervention and stigma reduction funding could support allcove services for youth and prevent the need for more costly interventions later in life. Workforce education and training funding could support training mental health providers in these allcove centers, especially through UCI's involvement in this project. We also strongly support the inclusion of funding for allcove in relation to the BeWELL Irvine campus as an allcove center on the BeWELL Irvine campus could help support youth of ages 12-25 in Orange County and leverage the funding from the MHSOAC and the learnings and community engagement of planning and launching our centers.

Public Comment #18

allcove

PERSONAL INFORMATION			
Name	William H Carson		
Agency/Organization			
Phone number		E-mail	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

My name is William H Carson and I have been a board member of the Wellness and Prevention Center for the last 5 years.

I support the use of MHSA INN(innovation) funds for the operation of allcove OC. The University of California Irvine and the Wellness & Prevention Center are working with the MHSAOC and Stanford, through especially legislated state funds, to have the first Orange County allcove facilities open on the campus of UCI this year and in South Orange County in the first half of 2023. County MHSA funding is vital to the expansion and sustainability of allcove in Orange County.

Please also consider allocating prevention and early intervention and stigma reduction funding to allcove as the services provided along with the extensive youth outreach and leadership development supports youth wellness and access to supportive services that prevent the need for more costly interventions later in life.

I also support the inclusion of allcove in funding for the BeWELLL Irvine campus as the model is a source of wellness for youth ages 12-25 in Orange County.

It is important to note that there are other pending projects through the University of California Irvine supported by MHSA dollars, that allcove can complement and support, specifically Clinical High Risk for Psychosis and Young Adult Court. County MHSA funding for allcove serves to further leverage these collaborations.

In conclusion, we have seen an ever increasing need for Mental Health, Drug Education, and other social and clinical services for our underserved youth and young adult populations. Suicide, drug over doses, negativity and over politicization, Covid and economic stressors do not appear to be waning. The California and Stanford initiative allcove is a game changer in providing many of the resources, under one roof, to combat these issues. Thank you for time and consideration in this matter.

HCA Response to allcove (Comments #17-18)

Thank you for your comments, consideration, and support regarding the allcove project. allcove continues to be examined as a potential Innovation project. Further exploration has been on hold due to COVID-19.

The potential use of MHSA funding for allcove will involve several factors, one of which the identification of locations/sites that meet the allcove space and design requirements.

We look forward to learning more about the implementation of allcove at the existing locations.

It is important to note that generally, INN funding cannot be used for sustaining projects as these funds, by law, are for time-limited projects that meet MHSA Innovation criteria.

HCA will continue to gather more information regarding allcove for consideration in the next three-year plan.

Public Comment #19

MHRS Systems – Center for Asian Americans in Action

PERSONAL INFORMATION			
Name	Priscilla Huang		
Agency/Organization			
Phone number		**E-mail**	
Mailing address (street)			
City, State, Zip			

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	**Person in recovery**	☐	**Probation**
☐	**Family member**	☐	**Education**
☐	**Service provider**	☐	**Social Services**
☐	**Law enforcement/criminal justice**	☒	**Other (please state)** Advocacy

COMMENTS

The organizations listed below submit the following comments in response to the Orange County Health Care Agency (HCA), Mental Health and Recovery Services (MHRS) Mental health Services Act (MHSA) Annual Plan Update for FY 2022-23. Our organizations provide a range of health and social services to primarily low-income, Asian American and Pacific Islander communities and other communities of color, and most of our community members live in immigrant and/or refugee households. With a projected $85 million increase in FY 2022-23 MHSA funds, HCA has an unprecedented opportunity to make meaningful investments in programs and services that transform Orange County's mental health system, particularly for unserved and underserved community members.

Strategic Priorities
We continue to support HCA's three MHSA strategic priorities. We appreciate HCA's identification of Asian/Pacific Islander as a priority population and the use of culturally tailored and in-language strategies to address the strategic priority around Access to Behavioral Health Services (slide 11).1 We are particularly supportive of the proposed strategies and activities to develop a pipeline of staff members for hard to fill positions, especially bi-lingua/bi-cultural individuals (slide 17). We also thank you for making ongoing investments in in-language outreach and engagement activities for vulnerable populations, such as monolingual older adults.

We note, however, that while the strategic priority around Mental Health Awareness & Stigma Reduction (slide 10) recognizes specific age and identity groups as priority populations, numerous surveys and studies continue to show that Asian Americans face greater challenges to seeking mental health care compared to other racial groups due to stigma and the lack of culturally and linguistically competent health care professionals.2 The recommendation to implement upstream campaigns to raise awareness regarding stigma and mental health (slide 18) can be helpful for more "mainstream" populations, however many of the unserved and underserved populations in Orange County rely on other methods of communication. For example, many of these individuals primarily turn to ethnic-serving community-based organizations (CBOs) like Korean Community Services, The Cambodian Family, Orange County Asian and Pacific Islander Community Alliance (OCAPICA), Southland Integrated Services, and others. We recommend the strategies and activities proposed for this strategic priority explicitly include CBOs.

In addition, in response to the strategic priority on Suicide Prevention (slide 12), we strongly urge HCA to add Asian Americans as a priority population. OCAPICA has experienced a dramatic increase in suicide ideation among Asian American (young people and adults) in Orange County since the start of the pandemic. This trend aligns with national reports of increased rates of depression, anxiety and Post Traumatic Stress Disorder symptoms among Asian Americans over the past two years. A report from Stop AAPI Hate found that Asian Americans are experiencing unprecedented mental health challenges due to the COVID-19 pandemic and effects of anti-Asian racism.[3] Additionally, we note that even before the pandemic, young Asian American women (aged 15-24 years old) had the highest suicide rates of all racial/ethnic group.[4]

Proposed Recommendations
We are pleased to see MHRS's proposed recommendation to expand the adult Full Service Partnership Programs to increase access and services to underserved target populations including Older Adults, monolingual Spanish and Vietnamese individuals, and veterans (slide 13). We support this expansion, and recommend HCA also plan for access and service expansions to other monolingual, non-English speakers.

We also support the expansion in Prevention and Early Intervention (PEI) services, which are particularly important for our communities (slide 14). We are concerned, however, that the recommendation to add preK-12 school-based services does not include a corollary recommendation to fund after-school programs and services offered at CBOs. Many Asian American and Pacific Islander families rely on CBOs such as The Cambodian Family to provide after-school care and programming for their children, youth, and parents, which is an intergenerational approach to mental health and wellness. Schools have a critical role to play in meeting the emotional and behavioral health concerns of children and youth, however, family engagement can be limited due to language and cultural barriers, work schedules, and other challenges. CBOs continue to serve as the connective tissue between unserved and underserved communities of color because they are trusted service providers and have a proven track record of providing culturally and linguistically appropriate linkages to services.

We urge MHRS to consider expanding the funding available to CBOs to provide these important PEI services in a community-based afterschool program setting and to add CBOs as a strategic collaborator to increase awareness and reduce stigma (slide 19).
In addition, we strongly recommend MHRS continue PEI funding for CBOs that provide short-term clinical services. Similar to community-based after-school programs, CBO providers are best positioned to work with monolingual, immigrant/refugee, and other unserved and underserved populations who often shy away from large healthcare/hospital systems. CBOs are trusted providers, and there is a demand for more community-based services. OCAPICA, which is currently funded to provide full-service wrap-around services for Asian/Pacific Islander children and transitional age youth (TAY), has a waiting list of over 30 community members and its Prevention and Early Intervention Services provides short term counseling for mild to moderate needs to more than 3,000.

Lastly, we are supportive of MHRS' proposed recommendation to increase the mental health services workforce and to improve staff cultural and language competency (slide 15). We appreciate MHRS' increased investment in expanding Workforce Education and Training (WET) programs to support the hiring, training, and retention of qualified staff. We have grave concern about the loss of bilingual and bicultural staff in community-based settings to the private sector and have found it increasingly difficult to hire health care professionals to fill vacancies. Thus, there is an urgent need to prioritize WET programs for providers in unserved and underserved communities. To this end, we also support the proposed strategies and activities to improve access to behavioral health services through workforce development initiatives and quality improvement issues (slide 17).

Community Planning Process
We appreciate MHRS continued engagement with community stakeholders to strengthen and improve MHSA services and programs. As required by law, the analysis and reporting of unserved, underserved, inappropriately and fully served county residents who qualify for MHSA services by various demographic characteristics has been helpful in both assessing the scope of needed services and estimating the proportion of each population group that will be served. In developing the MHSA Three-Year Plan, HCA provided detailed estimates of the population demographics to be served for each MHSA component and service area, however, there has been very limited data reported to the public comparing the estimates to the actual number of individuals served. Slide 32 provides some of this information, however the percentages are aggregated into two main categories– 1) individuals served in CSS Clinical Services, and 2) Individuals served in PEI. These numbers are not separated into program/service areas and there is no information available about what languages community members requested services or in what language services were delivered. It is difficult to evaluate the accessibility and impact of these programs and services by demographic group without this data.

Additionally, we support the use of community surveys to collect qualitative and quantitative data about mental health services and community needs. We wondered, however, how the questions posed in the survey conducted from December 31, 2021, to January 31, 2022 (slide 38) were developed. Respondents were asked to provide "yes," "no" or "don't know" answers to questions regarding specific MHSA programs, instead of questions that provided an opportunity for more open-ended responses. It was unclear whether the purpose of the community survey was to gather feedback about their experiences with existing services or to test potential marketing strategies to promote these services.
In conclusion, we thank HCA for the opportunity to review and comment on the proposed MHSA FY 2022-23 Plan Update. We look forward to future opportunities to engage with MHRS and other MHSA stakeholders and work collaboratively to strengthen our county's mental health services network.

Sincerely,
Center for Asian Americans in Action
Korean Community Services
Orange County Asian and Pacific Islander Community Alliance
Southland Integrated Services, Inc.
The Cambodian Family

1 Slide number references correlate with the Mental Health Services Act FY 2022-2023 Annual Plan Update, Draft for Public Comment, https://www.ochealthinfo.com/sites/hca/files/2022-04/MHSA_2022-23_Plan_Public_Comment_v05.pdf.

2 *See* National Alliance on Mental Illness, Communities of Color Face Greater Challenges Finding Effective Therapy, National Survey Finds (Oct. 2021), https://www.nami.org/Press-Media/Press-Releases/2021/Communities-of-Color-Face-Greater-Challenges-Finding-Effective-Therapy-National-Survey-Finds. *See also* California Health Report, How the Mental Health System Fails Asian Americans–And How to Help (Feb. 2, 2022), https://www.calhealthreport.org/2022/02/02/heres-why-many-asian-americans-dont-get-mental-health-care-and-how-to-help/.

3 Stop AAPI Hate, Stop AAPI Hate Mental Health Report (May 2021), https://stopaapihate.org/wp-content/uploads/2021/05/Stop-AAPI-Hate-Mental-Health-Report-210527.pdf.

4 American Psychological Association, Suicide Among Asian Americans, https://www.apa.org/pi/oema/resources/ethnicity-health/asian-american/suicide.

Response to MHRS Systems – Center for Asian Americans in Action (Comment 19):

Thank you for the detailed review and feedback of the MHSA annual Plan Update for FY 2022-23. The HCA would also like to acknowledge the collaboration between five community-based organizations and the advocacy for the Asian Pacific Islander community in Orange County.

Strategic Priorities

"*We recommend the strategies and activities proposed for this strategic priority explicitly include CBO's*"

The HCA and MHRS highly value our partnerships with community-based organizations and recognize the importance of ethnic-serving community-based organizations. Many individuals and families have established trust with the community organizations. In the MHSA plan update, it is established that ethnic populations were disproportionately impacted by the Covid-19 pandemic. (page 37) Requests for proposals that are released can highlight the need and prioritization of organizations with cultural and linguistic capabilities to meet the unique needs of the priority population being served.

"*We strongly urge HCA to add Asian Americans as a priority population."*

This recommendation is in response to the strategic priority of Suicide Prevention. The priority populations for each strategic priority were identified in the community planning process for the current three-year plan which was pre-pandemic. As we start our community planning process for the next three-year plan, it will be important to re-evaluate the specific needs of the Asian Pacific Islander population. We look forward to your participation to further assess the post-pandemic priorities and needs of the community.

"We recommend HCA also plan for access and service expansions to other monolingual, non-English speakers."

A specific focus of this plan update is to reach underserved and unserved community members, noting the disproportionate impact of Covid-19 on ethnic communities. It will continue to be a priority to identify opportunities to expand services for other non-English speakers throughout the implementation of this plan.

"We are concerned, however, that the recommendation to add preK-12 school-based services does not include a corollary recommendation to fund after-school programs and services offered at CBO's"

After school programs are not highlighted in the plan update but they are not excluded from the preK-12 services referenced on page 94.

"Thus, there is an urgent need to prioritize WET programs for providers in unserved and underserved communities."

Many of the WET programs and trainings are extended to contract providers. The recent loan repayment program was extended to contract providers, to support recruitment and retention of staff. In addition, the 5-year statewide WET Grant has several components that addresses workforce retention, recruitment of hard-to-fill positions, and pipeline efforts to recruit a future workforce in public mental health. Programs like loan repayment, graduate student stipends, and pipeline marketing campaigns are a few of the efforts being done to address the workforce shortages and to recruit for highly qualified bi-lingual and bi-cultural workforce.

The community survey conducted in December 2021 through January 2022, used both open ended and closed ended questions. It was designed as a follow up to obtain more focused community feedback regarding established strategic priorities, existing initiatives, and existing programming. The results from the survey established the questions and discussion prompts for the community engagement meetings that were held in February 2022.

APPENDIX XIII: Behavioral Health Advisory Board Public Hearing Minutes

County of Orange
Behavioral Health Advisory Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:
http://ochealthinfo.com/bhs/about/mhb

Wednesday, May 25, 2022
5:30 p.m. – 7:30 p.m.

Meeting Location:
Zoom Teleconference Meeting

General Meeting and MHSA Public Hearing
MINUTES
Page 1 of 4

Members Present: Matthew Holzmann, Mara James, Stephen McNally, Kristen Pankratz, Courtney Smith, Jim Taylor, Duan Tran, Frederick Williams, Chase Wickersham

Members Absent: Karyl Dupee, Supervisor Doug Chaffee

Call to Order
- The meeting was called to order at 5:35 p.m. by Matt Holzmann who then led the group in the Pledge of Allegiance.

Welcome and Introductions
- Each member introduced themselves via roll call.

Approval of Minutes
- April 13, 2022
  - Jim Taylor made a motion to approve the minutes from the April 13, 2022, meeting and Frederick Williams seconded the motion with a no changes. The minutes were approved via roll call for the record. Yes 8 / No 0 / Abstain 1
- April 27, 2022
  - Matthew Holzmann made a motion to approve the minutes from the April 27, 2022, meeting and Duan Tran seconded the motion with a comment to include one change. The minutes were approved via roll call for the record. Yes 9 /0 No.

Public Comment
No public comments

Open of MHSA Public Hearing
Opening Remarks and Overview of the Mental Health Services Act (MHSA) Plan Update and HCA Responses to Public Comments received: Jenny Hudson

- Jenny thanked the guests in attendance and the members of the Behavioral Health Advisory Board (BHAB), MHSA Office staff, and the community members who took part in participating in the community planning process. She explained the purpose of today's Public Hearing, which included a brief overview and all public comments received during the 30-day public comment period.

County of Orange
Behavioral Health Advisory Board

Wednesday, May 25, 2022
5:30 p.m. – 7:30 p.m.

MINUTES

- Jenny provided a detailed presentation overview of the 19 MHSA public comments and HCA responses to all public comments received during the 30-day public comment period for the MHSA Plan Update. The comments for the plan were arranged into 8 separate categories for their response. The categories included Veterans Strong Family, Strong Children (SFSC) which received 3 comments, Children and Youth Services which received 8 comments, Data Outcomes which received 2 comments, Crisis (CAT/ PERT) which received 1 comment, Prevention and Early Intervention which received 1 comment, alcove which received 2 comments, MHRS Systems received 1 comment, and Community planning and Budget which received 1 comment.

Public Comments:
- Helen Cameron:
  Ms. Cameron shared she is excited to see the MHSA Plan Update, and the 19 comments which provide a template to engage the community. It also provides so many exciting opportunities available to engage the community. HCA continues to have robust services and recommends BHAB leadership advance the system of care for the community.

- Lori Pack:
  Ms. Pack shared her concern for the SFSC not being included in the plan update. She added, there is concern that there is a need for veteran services.

- Michael Arnot:
  Mr. Arnot thanked the BHAB for the Children's Mental Health Access collaborative and advocated for the increased needs of children. Mr. Arnot also thanked Dr. Kelley and the MHSA team and hopes to continue to work with this collaboration going forward. Mr. Arnot shared that we have several different levels of services, and there is a universal need for a common agenda for children's mental health, including universal definition of terms will be helpful

- Michelle Pulido: (read out loud by Karla Perez)
  Comment was from a member of the public, resident of Santa Ana, who expressed concern for homeless in Santa Ana and inquired if any funding would be allocated for to help with the homeless population.

- Matthew Menchavez:
  Mr. Menchavez inquired about Requests for Proposals and how to apply to contract with the County of Orange.

BHAB Discussion
- Matthew Holzmann, Chair of the Board called upon the board for discussion on the MHSA Plan Update FY 22/23. Some of the discussion included the following:
- Steve McNally recommended MHSA staff to speak to people that submit public comments as a form of clarification and follow-up. He also asked for clarification on whether the MHSA Plan will be submitted with any amendments.

County of Orange
Behavioral Health Advisory Board

Wednesday, May 25, 2022
5:30 p.m. – 7:30 p.m.

BHAB Discussion: *(Continued)*

- Chase Wickersham asked if there was a way to promote the MHSA Plan Updates to a larger audience. HCA agreed with Chase and will continue to market the MHSA program to a larger audience. HCA was thankful for the thoughtfulness of these comments, and will continue to seek more community feedback, more comments, and more community participation.
- Frederick Williams suggested there is a need for summer programs be added to the increased services for youth and children.
- Kristen Pankratz shared her excitement to hear a public comment from a 10th grader. She suggested spreading the word about these comments to encourage youth an opportunity to have their voices be heard.
- Steve McNally encouraged HCA to hire people to increase awareness of the MHSA Plan, including via social media outlets.
- Clarification was provided on how MHSA financial adjustments are made once an MHSA Plan is submitted and approved the Board of Supervisors.
- Jenny Hudson and Annette Mugrditchian addressed some of the concerns raised by members.

BHAB Recommendations and Vote:

- Matthew Holzmann called on members for any substantive recommendations on the MHSA Annual Plan Update. The following 4 substantive recommendations were made by the 9 members present; quorum was met.

Recommendation #1: Steve McNally called for a motion to allow funding for Strong Families, Strong Children – at the full amount of $1.1 million, to protect staffing, protect children and the distribution network where they distribute services which can be beneficial to HCA, with a 9 yes/ 0 No / 0 abstain vote.

1st Motion: Matthew Holzmann, 2nd Motion: Duan Tran

Name	Yes	No	Abstain
Supervisor Doug Chaffee			
Karyl Dupee			
Matthew Holzmann	X		
Mara James	X		
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Courtney Smith	X		
Jim Taylor	X		
Duan Tran	X		
Fred Williams	X		
Chase Wickersham	X		

County of Orange
Behavioral Health Advisory Board

Wednesday, May 25, 2022
5:30 p.m. – 7:30 p.m.

Recommendation #2: Steve McNally called for a motion to Determine Universal Mental Health Screening, particularly for kinder, 1st, 5th, 7th, 9th, and 12th grade, with a 9 yes/ 0 No / 0 abstain vote.

1st Motion: Matthew Holzmann, 2nd Motion: Jim Taylor

Name	Yes	No	Abstain
Supervisor Doug Chaffee			
Karyl Dupee			
Matthew Holzmann	X		
Mara James	X		
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Courtney Smith	X		
Jim Taylor	X		
Duan Tran	X		
Fred Williams	X		
Chase Wickersham	X		

Recommendation #3: Matthew Holzmann called for a motion to Allow funding of $2-4 million for an overdose prevention campaign – to provide education for family members to know how to access Narcan as a life saving measure, with a 9 yes/ 0 No / 0 abstain vote.

1st Motion: Frederick Williams, 2nd Motion: Steve McNally

Name	Yes	No	Abstain
Supervisor Doug Chaffee			
Karyl Dupee			
Matthew Holzmann	X		
Mara James	X		
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Courtney Smith	X		
Jim Taylor	X		
Duan Tran	X		
Fred Williams	X		
Chase Wickersham	X		

County of Orange
Behavioral Health Advisory Board

Wednesday, May 25, 2022
5:30 p.m. – 7:30 p.m.

MINUTES
Page 5 of 5

Recommendation #4: Steve McNally called for a motion to Become aware of Alcove's needs and recommendation to allow funding for Alcove and related programs, with a 9 yes/ 0 No / 0 abstain vote.

1st Motion: Matthew Holzmann, 2nd Motion: Duan Tran

Name	Yes	No	Abstain
Supervisor Doug Chaffee			
Karyl Dupee			
Matthew Holzmann	X		
Mara James	X		
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Courtney Smith	X		
Jim Taylor	X		
Duan Tran	X		
Fred Williams	X		
Chase Wickersham	X		

The BHAB voted in support to move forward with the MHSA Annual Plan Update FY 22–23, for the approval of the Board of Supervisors, with a 9 yes/ 0 No / 0 abstain vote.

1st Motion: Matthew Holzmann, 2nd Motion: Frederick Williams

Name	Yes	No	Abstain
Supervisor Doug Chaffee			
Karyl Dupee			
Matthew Holzmann	X		
Mara James	X		
Stephen McNally	X		
Kristen Pankratz, MSW	X		
Courtney Smith	X		
Jim Taylor	X		
Duan Tran	X		
Fred Williams	X		
Chase Wickersham			

Adjournment
- 7:45 p.m.

Officially submitted by: Karla Perez
***Note: Copies of all writings pertaining to items in these BHAB 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: OCMentalHealthBoard@ochca.com*

COUNTY OF ORANGE
HEALTH CARE AGENCY
MENTAL HEALTH AND RECOVERY SERVICES

MATTHEW HOLZMANN
CHAIR

STEPHEN MCNALLY
DUAN TRAN, MSW
CO-VICE CHAIRS

MAILING ADDRESS
405 W. 5TH STREET
SANTA ANA, CA 92701
TELEPHONE: (714) 834-5481

BEHAVIORAL HEALTH ADVISORY BOARD

May 27, 2022
Orange County Board of Supervisors
10 Civic Center Plaza
Santa Ana, CA 92701

Subject: Mental Health Services Act Public Hearing – FY 2022-2023 Update

Dear Honorable Board Members and Mental Health & Recovery Services Director,

On May 24, the Chair and a quorum of the Orange County Behavioral Health Advisory Board (BHAB) hosted the FY 2022-2023 Mental Health Services Act Annual Update (Annual Update) Public Hearing. The Behavioral Health Services Department, received 19 comments during the 30 Day requirement ending on May 15, 2022. The Behavioral Health Advisory Board, established under California Code Section 5604 in accordance with California Code 5848, the adopted Annual Update shall summarize and analyze the BHAB's recommended revisions.

We commend Behavioral Health Services for its continued efforts to strengthen its engagement with community stakeholders through its ongoing efforts to improve services for unserved and underserved communities and engagement in the planning process. We look forward to continued progress in serving all county residents, especially those in need of behavioral health services.

We urge you and the Board of Supervisors to review all stakeholder testimony received during the public comment period when rendering your final decisions on the Annual Update. Please consider inequities & disparities, housing & homelessness, budget transparency and accountability and veteran's needs.

The Behavioral Health Advisory Board submits the following recommendations:

1 - Now more than ever Orange County needs to improve its early childhood and school age children's services. We request that funding be continued in the amount of $1.1 million for the Strong Families – Strong Children program, which will sunset on June 30 as an Innovation Project. We must protect staffing and ensure that the good work of this program continues.

2 – Please support universal mental health screening and services, particularly at critical stages including kindergarten, 5th Grade, 7th Grade, 9th Grade and 12th Grade.

3 – Orange County is in an overdose crisis, much of it involving fentanyl, a synthetic opioid. Please allow funding of $2-4 million for an overdose prevention campaign to provide for media and for the education of family members and the community to create awareness and educate on accessing Naloxone (Narcan) as a lifesaving measure.

4 – Increase awareness & funding dramatically for the allcove and similar teen behavioral health programs in and around our schools.

Currently the MHSA budget is in excess of $365 million. It is critical to drive this funding into the community by increasing services, increasing funding for stakeholder engagement and increasing prevention and early intervention efforts.

In closing the Behavioral Health Advisory Board urges the Board of Supervisors to approve the FY 2022-2023 MHSA Update and encourage our Behavioral Health Services Department to continually improve upon stakeholder and community engagement in preparing future annual updates and MHSA 3 Year Plans.

The Board looks forward to continued progress in making Orange County a beacon for behavioral wellness in our public health system.

Respectfully,

Sincerely,

Matthew Holzmann, Chair
Behavioral Health Advisory Board

Matthew Holzmann – Chair, Family Member
Stephen McNally – Vice Chair, Family Member
Duan Tran – Vice Chair, 4th District Representative

APPENDIX XIV: Orange County Board of Supervisors Minute Order

ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
June 28, 2022

Submitting Agency/Department: HEALTH CARE AGENCY

Adopt annual updates to Orange County Mental Health Services Act Three-Year Program and Expenditure Plan, 7/1/22 - 6/30/23 ($142,576,502); and authorize Director or designee to execute updates - All Districts (Continued from 6/7/22, Item 7)

The following is action taken by the Board of Supervisors:
APPROVED AS RECOMMENDED ☒ OTHER ☐

Unanimous ☒ (1) DO: **Y** (2) FOLEY: **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. 37

Special Notes:

Copies sent to:

HCA—Annette Mugrditchian

6/28/22

I certify that the foregoing is a true and correct copy of the Minute Order adopted by the Board of Supervisors , Orange County, State of California.
Robin Stieler, Clerk of the Board

By: _____ Deputy

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Agenda Item 7

AGENDA STAFF REPORT

ASR Control 22-000361

MEETING DATE:	06/07/22
LEGAL ENTITY TAKING ACTION:	Board of Supervisors
BOARD OF SUPERVISORS DISTRICT(S):	All Districts
SUBMITTING AGENCY/DEPARTMENT:	Health Care Agency (Approved)
DEPARTMENT CONTACT PERSON(S):	Annette Mugrditchian (714) 834-5026
	Veronica Kelley (714) 834-7024

SUBJECT: Mental Health Services Act Annual Plan Update FY 2022-23

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	No Legal Objection	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** $142,576,502

Staffing Impact: No **# of Positions:** **Sole Source:** N/A
Current Fiscal Year Revenue: N/A
Funding Source: 100% (Mental Health Services Act/Prop 63) **County Audit in last 3 years:** No

Prior Board Action: 6/22/2021 #47, 6/2/2020 #52, 5/21/2019 #33, 1/29/2019 #26

RECOMMENDED ACTION(S):

1. Adopt the annual updates to the Orange County Mental Health Services Act Three-Year Program and Expenditure Plan for the period of July 1, 2022, through June 30, 2023, in an amount not to exceed $142,576,502.

2. Authorize the Health Care Agency Director, or designee, to execute the adopted annual update to the County's Mental Health Services Act Three-Year Program and Expenditure Plan as referenced in the Recommended Action above.

SUMMARY:

Approval of the fiscal year 2022-23 annual update to the Orange County Mental Health Services Act Three-Year Program and Expenditure Plan will provide funding to all Mental Health Services Act Programs for the upcoming fiscal year.

Page 1

BACKGROUND INFORMATION:

In November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA). MHSA provides counties a source of funding for expanded county mental health programs. The overall goal of the expanded county mental health programs is to reduce the long-term adverse impact of untreated mental illness and provide a comprehensive system of care for the target population through the various Mental Health Services Act (MHSA) programs, e.g., Prevention and Early Intervention (PEI), Innovation, Community Services and Support (CSS) evidence-based programs and practices.

Your Honorable Board of Supervisors (Board) took the previous Board actions related to the MHSA Three-Year Plan:

Board Date	Contract/ Amendment	Action	Term
January 29, 2019	MHSA FY 2018-19 Plan Amendments	Board Approved	July 1, 2018 - June 30, 2019
May 21, 2019	MHSA Annual Plan Update FY 2019-20	Board Approved	July 1, 2019 - June 30, 2020
June 2, 2020	MHSA Three-Year Program and Expenditure Plan FY 2020-21 to FY 2022-23	Board Approved	July 1, 2020 - June 30, 2023
June 22, 2021	MHSA Annual Plan Update FY 2021-22	Board Approved	July 1, 2021 - June 30, 2022

Welfare and Institutions Code § 5847 and § 5848 require that a three-year program and expenditure plan, and annual updates, be prepared through a meaningful stakeholder process at the local level and subsequently adopted by the county board of supervisors prior to its submission to the Mental Health Services Oversight and Accountability Commission and State Department of Health Care Services. The FY 2022-23 Plan Update was developed through robust community planning, which included a Community Survey, Community Engagement Meetings and Provider Engagement Meetings.

The FY 2022-23 annual update to the Three-Year Plan is a comprehensive plan and review of all County MHSA programs, budgets and outcomes from the previous fiscal year. The programs in the plan cover the full continuum of services including Awareness and Prevention, Access and Linkage to Treatment/Services, Crisis Prevention, Outpatient Treatment, Supportive Services, Workforce Education and Training, Capital Facilities and Technological Needs and Special Projects. Many of these programs assist individuals in need of treatment and/or experiencing homelessness and can provide resources for those who need specialized care.

The FY 2022-23 annual update to Plan is a comprehensive look at all County's MHSA programs, budgets and outcomes from the previous fiscal year. For the upcoming fiscal year, the proposed annual update to the Three-Year Plan provides expected community impacts, challenges, and estimated numbers of clients to be served. The Behavioral Health Advisory Board (BHAB) was presented with the FY 2022-23 programs and budgets included in the proposed annual update at their regularly scheduled meetings on March 23, 2022. Additionally, the MHSA Office held a community stakeholder meeting on April 6, 2022, to discuss program budgets and expansions with interested stakeholders in the community. In accordance with Welfare and Institution Code § 5848, the proposed Annual Plan Update was posted and distributed on April 15, 2022, throughout the community for a 30-day Public Comment period. At the close of the Public Comment period, BHAB held a Public Hearing on the Plan Update on May 25, 2022. As of the filing of this Agenda Staff Report, there have been 13 public comments received. In accordance with Welfare & Institutions Code § 5848, Health Care Agency (HCA) will submit to the Board prior to the

Board's meeting all substantive written recommendations that HCA receives at the end of the Public Comment period, including BHAB's recommendations.

The following are the Notable Changes/Additions to the Three-Year Plan as a Result of the Proposed Annual Updates:

Community Services and Supports (CSS)

- Expand the Multi-Service Center for Homeless Adults with a Mental Illness Program to add a second location to meet high demand
- Increase the Warmline Program to expand the service hours to meet the 24 hours a day, seven days a week program needs as well as add Spanish and Vietnamese language capacity
- Expand Full-Service Partnerships to include a Spanish, Vietnamese and Veterans Program
- Expand Crisis Stabilization Units (CSU) for a new County Operated CSU
- Add $42 million for permanent supportive housing through Orange County Community Resources Notice of Funding Availability and OC Housing Trust

Prevention and Early Intervention (PEI)

- Expand OC Links to provide 24 hours a day, seven days a week coverage
- Expand Outreach and Engagement to increase case management for homeless individuals and for MHSA portion of Street Medicine Program in collaboration with CalOptima
- Increase and Expand the Integrated Justice Involved Services (program formerly known as Jail to Community Reentry Program) for assessment and diversions from jail program; services for justice involved individuals and their family members; and a pilot program to expand linkage and supportive resources for justice involved individuals
- Expand Suicide Prevention Services for step-down and follow up care for the Survivor Support hotline program
- Expand Early Intervention Services for Older Adults for staff at the new Leisure World Seal Beach and Laguna Woods sites
- Expand Outreach for Increasing Recognition of Early Signs of Mental Illness for programs to address health equity, services for Early Childhood Providers, Stigma Reduction Programs and for outreach and education awareness programs for under represented youth and their families

Capital Facilities and Technological Needs

- Expand Capital Facilities for estimated construction costs for new South County Be Well Campus
- Increase funds for the Electronic Health Record for upgrades, business intelligence, population health, and for state compliance

Component	Requested Increase	Proposed FY 2022-23 Budget
CSS	$60,119,984	$225,440,320
PEI	$35,544,137	$76,532,238
Innovation	$9,659,147	$11,701,218
Workforce Education and Training	$965,500	$6,262,162
Capital Facilities and Technological Needs	$36,287,734	$45,253,892
TOTAL	$142,576,502	$365,189,830

The program highlights above are some of the more significant or noteworthy changes to the MHSA Plan. Due to program rightsizing, every change is not listed. The total increase for the FY 2022-23 County MHSA Plan is $142,576,502, for an overall budget of $365,189,830.

HCA requests the Board adopt the MHSA Plan Update for FY 2022-23 as referenced in the Recommended Actions.

FINANCIAL IMPACT:

All expenditures related to the FY 2022-23 annual update to the MHSA Three-Year Program and Expenditure Plan are approved by your Board through separate actions, in accordance with County budgeting and procurement processes.

Appropriations and Revenue for the MHSA Plan will be included in the Budget Control 042 FY 2022-23 Budget.

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - MHSA Annual Plan Update FY 2022-23
Attachment B - Welfare and Institutions Code § 5847 and § 5848