ORANGE COUNTY
HEALTH CARE AGENCY

WELLNESS • RECOVERY • RESILIENCE

Orange County
MHSA
Plan Update
FY 13/14




"You are never too old to set another goal or to dream a new dream." - C.S. Lewis

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Overview and Executive Summary

The FY 13/14 Mental Health Services (MHSA) Plan Update has a different format than in previous years. This year's Update provides information on each component as a whole and then specific program information on programs/projects within the component. Component Information provides context for the programs within that component. It gives a general overview of the component in terms of its purpose and demographic information about the clients that it serves.

Program/project specific information provides data on numbers served and dollars budgeted; a description of the program/project, program evaluation results, and anticipated changes in FY 13/14. This year, there is a major focus on outcomes. For the first time, bar graphs and pie charts have been provided to show results for some specific programs. Also included are client success stories to highlight the personal impacts of a variety of programs. Review of the outcomes data provides a meaningful snapshot of how MHSA programs have created positive changes in employment, hospitalizations, education, client's quality of life, and other measures.

Other successes in the past year include the opening of a three-building campus to house the Wellness Center, the Adult Crisis Residential Unit and an Education and Training Center. The buildings are beautiful and utilize "state of the art technology." Another important success has been the increase in affordable housing units tied to mental health and supportive services for people living with a mental health diagnosis.

The MHSA Innovation Projects have started to provide preliminary data on their impact for participants and for the peers employed in the programs. The implementation of the Innovation Projects was delayed, and resulted in a delay in data collection and analysis, but additional data will be forthcoming in FY 13/14. The Integrated Care Project, which has been conducted in collaboration with local community clinics, is providing a model that is expected to give Orange County a head start on implementation of the Affordable Care Act.

The FY 13/14 Plan Update builds on the previous MHSA planning processes conducted in Orange County. The current array of services was created based on the extensive planning efforts of thousands of stakeholders from 2005 to the current day. These processes included hundreds of focus groups, community planning meetings, approval by the Orange County MHSA Steering Committee and public hearings held by the Orange County Mental Health Board. As in prior years, the MHSA planning process included a diverse group of stakeholders including clients, family members and representatives of unserved and underserved populations.

Last year, the Steering Committee adopted a new structure to enhance the planning process and provide additional opportunities for MHSA Steering Committee members and the public to provide input. The Steering Committee developed Subcommittees that are organized by MHSA component and by each of the age groups within Community Services and Supports (CSS). The role of each Subcommittee is to make recommendations on services and level of funding for MHSA programs.

Overview and Executive Summary

The four Subcommittees are:

- CSS Children and Transitional Aged Youth (TAY)
- CSS Adults and Older Adults
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET) and Innovation (INN)

As part of the MHSA FY 13/14 planning process, data on budgets, program expenditures, people served and other relevant topics was presented to each Subcommittee for the components/age groups within their area of interest. There were several different actions that were built into the planning process this year, including but not limited to, an effort to bring budgeted amounts for CSS more in line with recent spending patterns, a restructuring of the PEI component to streamline and increase efficiency in the delivery of services, implementation of a Workforce Needs Assessment and a specific planning process for new Innovations projects.

The Plan was posted by the Clerk of the Board of Supervisors for Public Comment for 30 days, April 12, 2013 through May 12, 2013. The Orange County Mental Health Board held and voted to accept the Plan at a Public Hearing on May 23, 2013. On June 18, 2013 the Orange County Board of Supervisors unanimously approved the FY 13/14 MHSA Plan Update. See Appendix II for the Minute Order from the Board.

Exhibit A:

MHSA County Compliance Certification

County: Orange

Local Mental Health Director	Program Lead
Name: Mary Hale	Name: Bonnie Birnbaum
Telephone Number: 714-834-6032	Telephone Number: 714-667-5600
E-mail: mhale@ochca.com	E-mail: bbirnbaum@ochca.com
County Mental Health Mailing Address:	Health Care Agency Behavioral Health Services 405 W. 5th St. 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 6/18/13.

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.

Mary R. Hale
Local Mental Health Director/Designee (PRINT)

Mary R Hale 6/18/13
Signature Date

County: Orange

Date: 6/18/13

Exhibit B:

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: Mary Hale	Name: Jan E. Grimes, CPA Chief Deputy Auditor-Controller
Telephone Number: 714-834-6032	Telephone Number: 714-834-2450
E-mail: mhale@ochca.com	E-mail: jan.grimes@ac.ocgov.com
Local Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th St. Santa Ana, CA 92701	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/report is true and correct to the best of my knowledge.

Mary R. Hale
Local Mental Health Director (PRINT)

Mary R Hale 6/18/13
Signature Date

I hereby certify that for the fiscal year ended June 30, 2012, 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 12/18/12 for the fiscal year ended June 30, 2012. I further certify that for the fiscal year ended June 30, 2012, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Jan E. Grimes
County Auditor Controller / City Financial Officer (PRINT)

Jan E 4/15/13
Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Workforce Needs ASSESSMENT




"You need to overcome the tug of people against you as you reach for high goals."
- George S. Patton

Exhibit C:
Workforce Needs Assessment

Methodology:

An electronic survey was conducted within each of the five divisions of Behavioral Health Services (BHS). These are Adult Mental Health Services (AMHS), Alcohol and Drug Abuse Services (ADAS), Children and Youth Services (CYS), Prevention and Intervention (P&I), Center of Excellence (COE).

The survey included County employees, employees in the county contract agencies, and individual county contractors. Results from each division were compiled together to obtain results for all BHS. The survey asked for budgeted and currently filled positions by job titles, number of estimated personnel needed to meet current client caseload, number of positions designated for consumers and family members and occupied by consumers or family members (self-reported), and the capability of staff (based on bilingual pay status) in providing services in Spanish, Vietnamese, Farsi and Korean.

A. Needs by occupational category

Across BHS, direct service staff and non-direct service staff categories have the most need for additional staff to meet the needs of current clientele **(Tables 2 & 3)**. Among the direct service staff, the greatest need is in the areas of licensed clinical social workers, licensed substance abuse specialists, mental health workers, life coaches and employment specialists/job coaches (data available but not shown here.) The current workforce in the program for the directors or service chief category appears to be in line with the number needed to meet the current needs **(Table 1)**. Across BHS, 86% of the needed positions are currently filled. ADAS, AMHS and COE all have over 90% of their total needed positions currently filled while only 65% in P&I and 85% in CYS are filled. Among the divisions, P&I and CYS have the greatest need for additional staff especially in the direct service and non-direct service categories **(Table 2)**. For both, P&I and CYS, the number of full time equivalents (FTEs) budgeted, however, is less than the number of FTEs actually needed to meet current client needs **(Table 4)**.

B. Positions designated for consumers or family members

Across all BHS, 29% of the budgeted positions are designated for consumers/family members, and 17% of the currently filled positions are occupied by self-disclosed consumers/family members **(Table 4)**. Since individuals may self-disclose or not, depending on their preference, the number is highly likely to be under-reported. The majority (79%) of consumers/family members occupies positions in the direct service staff category, and this trend is true across all divisions of BHS **(Tables 3 & 4)**. These figures highlight the number of positions (i.e. peer mentors) that have recently been created and occupied by the graduates of our consumer training program. Among the divisions, COE and ADAS have nearly 50% of their current workforce self-identified as consumers/family members. Between 39 to 50% of budgeted positions in ADAS, AMHS and COE are designated for consumers and family members **(Table 4)**.

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Exhibit C:
Workforce Needs Assessment

C. Language proficiency

Language proficiency was assessed for four languages: Spanish, Vietnamese, Farsi and Korean. Across all BHS, 30% of the current workforce is able to provide services in Spanish, 8% in Vietnamese, 2% in Farsi and 2% in Korean **(Table 4)**. Among the program directors/service chiefs, a similar ranking (13% in Spanish, 2% in Vietnamese, 1% in Farsi and 2% in Korean) of language proficiency was observed **(Table 1)**. Among the non-direct and direct service staff categories, the threshold languages are similarly represented with about 30% in Spanish, 6% in Vietnamese, and less than 3% in Farsi and Korean languages **(Tables 2 & 3)**.

At least 25% of the ADAS, AMHS, P&I and CYS workforce is able to provide services in Spanish. Proficiency in Vietnamese is highest in COE (18%) followed by AMHS (13%), P&I (6%), CYS (4%) and ADAS (1%). Up to 3% of the current workforce in each of the divisions (except COE with 7% in Korean) is able to provide services in Farsi or Korean. By division, ADAS has only 1% of the current workforce that is able to provide services in Vietnamese and none is able to provide services in Korean. AMHS has the highest percentage of the workforce being able to provide services in Spanish (26%) and second highest in Vietnamese (13%) **(Table 4)**.

In addition, data was analyzed on the number of clients in our Integrated Records Information System (IRIS) during FY 11/12 that had requested services in one of the threshold languages. These data show that across BHS, 16% requested services in Spanish, 3% in Vietnamese, 0.5% in Farsi and 0.5% in Korean. Among the divisions, P&I had the highest percentage of its clients requesting services in Spanish (63%), followed by CYS (24%), COE (11%), AMHS (10%) and ADAS (9%). The clients requesting Vietnamese language was highest in AMHS (6%). The number of clients requesting Farsi or Korean languages remained consistent (less than 1% except for Korean, 3%, in COE) across all divisions **(Table 5)**. Comparison of these numbers to the current language proficiency of our workforce might suggest that our current workforce is over-represented in Spanish and is well-represented in other threshold languages.

Exhibit C:
Workforce Needs Assessment

Table 1. Workforce needs assessment among Program Directors/Service Chiefs by division in BHS

Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	41	34	29	13	12	7 21.4%	1 3.0%	0 0.0%	0 0.0%
AMHS	90	86	81	17	7	13 15.6%	1 1.2%	1 1.2%	5 5.8%
COE	16	15	17	0	1	1 6.7%	0 0.0%	0 0.0%	0 0.0%
P&I	38	37	38	0	0	2 4.1%	1 2.7%	1 2.2%	0 0.0%
CYS	101	95	103	4	4	13 13.2%	3 3.3%	1 1.1%	1 1.1%
BHS	285	266	268	34	24	36 13.4%	6 2.3%	3 1.1%	6 2.3%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

Exhibit C:
Workforce Needs Assessment

Table 2. Workforce needs assessment among non-direct service staff by division in BHS

Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	58	48	24	15	20	20 40.4%	0 0.0%	2 4.1%	0 0.0%
AMHS	142	127	119	23	12	47 37.4%	14 11.1%	2 1.6%	0 0.0%
COE	22	22	25	5	5	1 4.5%	1 2.2%	0 0.0%	1 2.2%
P&I	29	26	129	0	0	8 29.5%	1 3.9%	0 0.0%	0 0.0%
CYS	148	141	162	4	6	51 35.9%	5 3.5%	0 0.0%	1 0.7%
BHS	400	365	459	47	43	126 34.7%	21 5.6%	4 1.1%	2 0.4%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

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Exhibit C:
Workforce Needs Assessment

Table 3. Workforce needs assessment among direct service staff by division in BHS

Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	194	178	210	85	92	40 22.6%	2 1.1%	1 0.6%	0 0.0%
AMHS	462	411	478	284	67	100 24.4%	65 15.7%	17 4.1%	10 2.4%
COE	77	69	75	50	48	16 23.4%	18 26.3%	2 2.9%	7 9.5%
P&I	142	136	142	0	0	55 40.4%	11 7.7%	5 3.8%	4 3.2%
CYS	530	456	554	115	41	200 44.0%	22 4.8%	5 1.2%	8 1.8%
BHS	1404	1249	1458	534	248	412 33.0%	117 9.4%	31 2.5%	29 2.3%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table.

Exhibit C:
Workforce Needs Assessment

Table 4. Workforce needs assessment among all classifications by division and BHS

Division	Number of FTEs budgeted (FTE = Full Time Equivalents)	Number of current FTEs	Number of FTEs actually needed to meet the needs of current number of clients	Of column (2), how many individuals are specifically designated for consumers or family members	Of column (3), how many are disclosed as consumers or family members	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in	Of Column (3), how many are capable of providing services in
	Col-2	Col-3	Col-4	Col-5	Col-6	Spanish	Vietnamese	Farsi	Korean
ADAS	293	260 98.1%	263	113 38.6%	124 47.6%	67 25.7%	3 1.2%	3 1.2%	0 0.0%
AMHS	694	623 91.8%	678	323 46.6%	86 13.8%	161 25.8%	80 12.8%	20 3.2%	15 2.4%
COE	115	106 91.4%	116	55 48.1%	54 52.2%	18 17.0%	19 17.5%	2 1.9%	7 6.6%
P&I	208	199 64.4%	309	0 0%	0 0%	64 32.3%	13 6.3%	6 3.0%	4 2.2%
CYS	778	692 84.6%	818	123 15.8%	51 7.4%	264 38.1%	30 4.3%	6 0.9%	10 1.5%
ALL BHS	2089	1800 86.1%	2185	615 29.4%	315 16.8%	574 30.5%	144 7.6%	37 2.0%	36 1.9%

Percentages shown were calculated prior to rounding of the raw numbers to whole numbers. Therefore, these percentages may vary slightly from the percentages calculated using the whole numbers shown in the table. Col(3) percentages: (Col-3 / Col-4)

Exhibit C:
Workforce Needs Assessment

Table 5. Fiscal Year 2011-2012 Clients with Requested Primary Languages in IRIS by Division

Division	Farsi	Korean	Spanish	Vietnamese	Total Requested Languages By Division	Total All Other Languages In Divisions	Total Division Clients
ADAS	8	8	593	33	642	5686	6328
% ADAS to All Clients in ADAS	0.13%	0.13%	9.37%	0.52%	10.15%	89.85%	100.00%
AMHS IP/Res	3	23	88	84	198	1306	1504
% AMHS IP/Res to All Clients in AMHS IP/Res	0.20%	1.53%	5.85%	5.59%	13.16%	86.84%	100.00%
AMHS OP Oper	101	90	1214	701	2106	9622	11728
% AMHS OP Oper to All Clients in AMHS OP Oper	0.86%	0.77%	10.35%	5.98%	17.96%	82.04%	100.00%
CYS	29	20	3516	90	3772	10897	14669
% CYS to All Clients in CYS	0.20%	0.14%	23.97%	0.61%	25.71%	74.29%	100.00%
PEI	1	0	116	0	117	69	186
% PEI to All Client in PEI	0.54%	0.00%	62.37%	0.00%	62.90%	37.10%	100.00%
BOCE	0	6	23	57	86	128	214
% BOCE to All Clients in BOCE	0.00%	2.80%	10.75%	26.64%	40.19%	59.81%	100.00%
Total Languages	142	141	5527	908	6835	27580	34629
% Grand Total Languages to All Divisions	0.41%	0.41%	15.96%	2.62%	19.74%	79.64%	100.00%

Community Program PLANNING




Community Program Planning

The Planning Process for the FY 13/14 Mental Health Services Act (MHSA) Update builds on the previous MHSA planning processes conducted in Orange County. The current array of services was created based on the extensive planning efforts of thousands of stakeholders from 2005 to the current day. These processes included hundreds of focus groups, community planning meetings, approval by the Orange County MHSA Steering Committee and public hearings held by the Orange County Mental Health Board. As in prior years, the MHSA planning process included a diverse group of stakeholders including clients, family members and representatives of unserved and underserved populations.

The MHSA planning process is guided by a Steering Committee composed of approximately 65 individuals. This Steering Committee includes representatives from many stakeholder groups. These include consumers of mental health services, family members, law enforcement, schools, the criminal justice system, veterans, providers of alcohol and substance abuse services, social services, healthcare organizations, homeless prevention/ housing organizations, consumer advocacy groups, probation, the Mental Health Board, and underserved ethnic communities. Translators are available at the meetings, including one for American Sign Language.

There is meaningful stakeholder involvement in all aspects of the planning process for MHSA-funded services. This includes: program selection, budget allocations for types of services, quality improvement, and program evaluation. In addition to the MHSA Steering Committee, there is a Community Action Advisory group made up of an ethnically diverse group of consumers and family members. This group meets monthly and provides input into the MHSA planning process.

Last year, the Steering Committee adopted a new structure to enhance the planning process and provide additional opportunities for MHSA Steering Committee members and the public to provide input. The Steering Committee developed Subcommittees that are organized by MHSA component and by each of the age groups within Community Services and Supports (CSS). The role of each Subcommittee is to make recommendations on services and level of funding for MHSA programs.

The four Subcommittees are:

- CSS Children and Transitional Aged Youth (TAY)
- CSS Adults and Older Adults
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET) and Innovation (INN)

Members of the MHSA Steering Committee and Alternates may join up to two Subcommittees of their choice. Members of the public who would like to become Subcommittee members may apply to become members of one or two Subcommittees. Subcommittee members are expected to make a commitment to participate for at least one year. Meetings are held on even numbered months, and additional meetings are held as needed. Meetings are open to the public. The Steering Committee as a whole meets on odd number months.

Community Program Planning

As part of the MHSA FY 13/14 Planning Process, data on budgets, program expenditures, people served and other relevant topics was presented to each Subcommittee for the components/age groups within their area of interest.

Subcommittee recommendations were based on the premise that the total amount available in FY 13/14 will be approximately the same as the amount in FY 12/13. Adjustments were made in various component budgets, so that they would more closely resemble spending patterns. There was a small number of programs that had not been implemented due to a variety of issues including hiring freezes, lack of interested contractors, and recognition that the program services could be incorporated into existing programs. The Subcommittees recommended that available resources should be used on existing programs.

The Prevention and Early Intervention Subcommittee conducted a major restructuring of the programs within this component. The restructuring addressed areas of program/service overlap, inconsistencies, and unsuccessful solicitations due to a lack of community response. The goal was to simplify the plan by streamlining the existing projects/programs so that it would better meet the prevention and early intervention needs of the community and take advantage of economies of scale, where available.

The original PEI Plan had eight different project/service areas and consisted of 33 programs. The repackaged plan maintained all services, but reorganized them into three Service Areas consisting of 23 programs. The Service Areas are: Community-Focused Services, School-Focused Services, and System Enhancement Services. Efforts continue to be taken to ensure that the programs are implemented in a culturally and linguistically competent manner.

Another component that engaged in an extensive planning process this year was Innovations. The original Innovations Plan contained 10 projects centered on a common theme of using peers to provide services. Due to a series of issues, including a county freeze on hiring, down turn in the economy, and budget uncertainty in other county programs, the implementation of the original projects was delayed. However, currently all but one have now been implemented, and the community decided the best use of FY 13/14 Innovation (INN) funding would be to establish new INN Projects.

A planning process was initiated for additional Innovations Projects, including but not limited to training workshops, community input processes and a committee review standards. Trainings were held in several languages to describe what constitutes an innovative project. These trainings were offered in person and virtually through workshops and webinars. The County developed a form that community members could use to submit an idea for a new Innovations Project. Twenty ideas were submitted and two ideas from the original planning process held in 2010 were also considered. A planning committee reviewed the forms submitted and ranked them in priority order. This committee recommended that the top five ideas be funded in FY 13/14. When this proposal was reviewed by the Steering Committee; it was amended to add three ideas to the five projects already approved for funding. These three proposals will be implemented if any of the original five cannot be implemented or, if there is funding left over after implementation.

Community Program Planning

The project ideas submitted to the MHSA Steering Committee by the subcommittees were approved by consensus on January 7, 2013. Staff then commenced writing a detailed Plan based on the approved programs and budgets. As part of this process, it was noted that the one-time Workforce Education and Training (WET) funds were not sufficient to maintain the approved WET programs through FY 13/14. To sustain the programs, CSS unspent funds from previous years were allocated to Workforce Education and Training. This is a permissible use of CSS funding as long as the amount does not exceed 20% of the current year's CSS allocation. The amount allocated was within the stated limits.

The Plan was posted by the Clerk of the Board of Supervisors for Public Comment for 30 days, April 12, 2013 through May 12, 2013. The draft Plan Update was also posted on the Orange County MHSA website and the Network of Care website. In addition, copies were made available at Orange County libraries.

The Orange County Mental Health Board (MHB) held a Public Hearing on May 23, 2013. The Plan Update was accepted by the MHB (see Appendix I: Minutes From Mental Health Board Public Hearing). On June 18, 2013 the Orange County Board of Supervisors unanimously approved the FY 13/14 MHSA Plan Update. See Appendix II for the Minute Order from the Board.

Community Services and SUPPORTS (CSS)




"What you get by achieving your goals is not as important as what you become by achieving your goals ." - Henry David Thoreau

Community Services and Supports (CSS)

A. Component Information

Community Services and Supports was the first component to be implemented and is the largest of all five components. Currently, 80% of each year's MHSA allocation is budgeted for CSS. Services provided by CSS have the goal of improving access to underserved populations, bringing recovery approaches to the current systems, and providing "whatever it takes" services to those most in need. New programs offered under CSS programs are integrated recovery-oriented mental health treatment, offering case-management and linking to essential services such as housing, vocational support, and self-help.

CSS programs are available for all age groups, and some programs serve more than one age group of clients. A balanced approach was taken to meeting the mental health services and supports needs of:

- Children (ages birth to 15)
- Transitional Age Youth (ages 16-25)
- Adults (ages 26-59) and
- Older Adults (ages 60 and above)

CSS Funds are also divided into three functional categories:

- Full Service Partnerships (FSPS): Intensive Team approach, 24/7, with flex funding, for those homeless or at high risk of homelessness. (More than 50% of CSS funds must be spent on FSPs.)
- Outreach and Engagement (O&E): Identify and engage unserved or underserved individuals living with mental illness and link them to services.
- General Systems Development (GSD): Improve programs, services and supports for all clients and families.

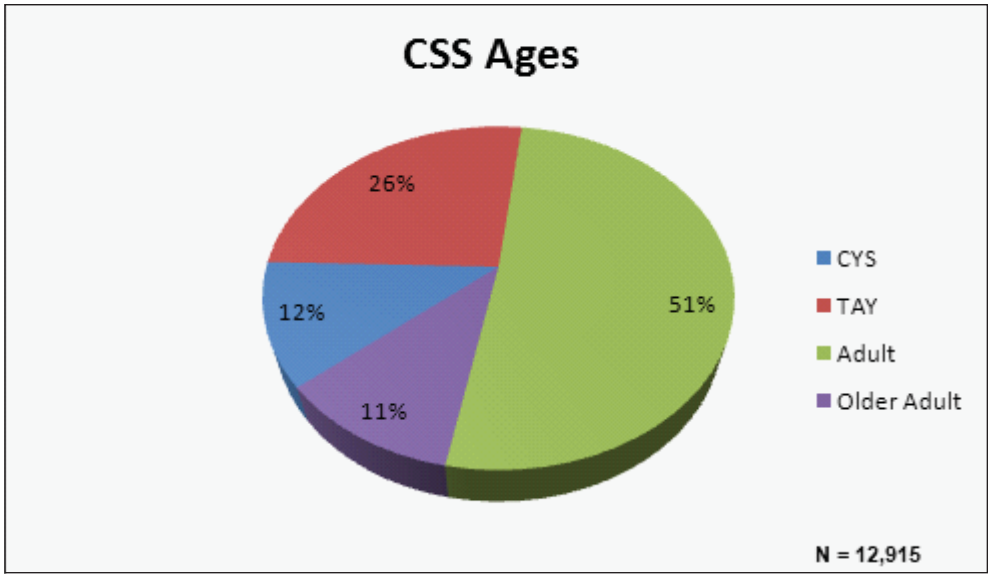
    - Examples of General Systems Development programs include:
        - Children's Outreach and Engagement
        - Children's In-Home Stabilization
        - Children's Crisis Residential
        - Children's Centralized Assessment Team (CAT)
        - Transitional Age Youth (TAY) Crisis Residential
        - TAY Mentoring
        - TAY CAT
        - TAY Program of Assertive Community Treatment (PACT)
        - Recovery Center Program
        - Supportive Employment
        - Adult Crisis Residential
        - Adult Centralized Assessment Team and Psychiatric Evaluation Team (CAT/PERT)
        - Wellness Center
        - Adults and Older Adults PACT

Community Services and Supports (CSS)

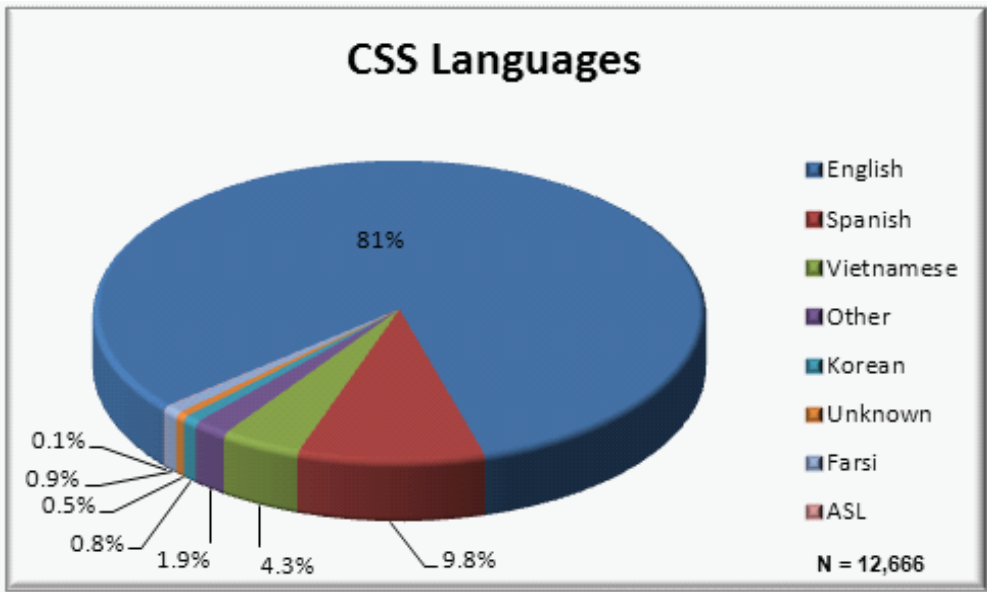
CSS FY 11/12 Demographic Data

The population served in CSS programs is described below.

Ages: The majority of individuals served by CSS are adults (26-59). The next largest population is Transitional Age Youth also known as "TAY" (16-25), which makes up 26% of the population served. The remaining 24% of clients served are made up of Children (0-15) 12% and Older Adults 11%.

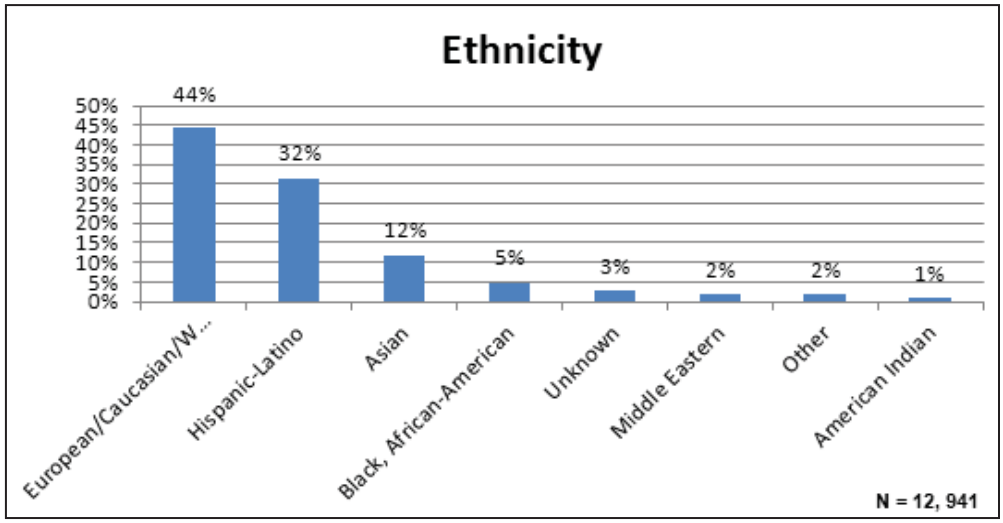


Languages: The vast majority of clients served speak English as their primary language. Spanish accounts for nearly 10% of the population with Vietnamese rounding out the top three languages with just above 3%. The remainder of languages spoken account for less than 5% of the population served.



Community Services and Supports (CSS)

Ethnicity: The largest ethnic group is European/Caucasian/White with 44% of the population, followed by members who self-identify as a Hispanic or Latino with 32% of the population served. Those who identified themselves as Asian comprise 12% while the remaining percentages account for less than 14% of the population served.



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Community Services and Supports (CSS)

B. CSS Program Information

Children's Full Service Partnership

Program Name: C1: Children's Full Service Partnerships (FSP)	**Funding:**
Actual number served in FY 11/12: 453	Actual funds expended in FY 11/12: $3,256,861
Projected number to be served in FY 12/13: 475	Estimated funds to be expended in FY 12/13: $5,904,579
Estimated number to be served in FY 13/14: 475	Budgeted funds for FY 13/14: $5,954,575
Estimated Cost Per Client FY 12/13 (FSPs only) $10,253	

1. Program Description

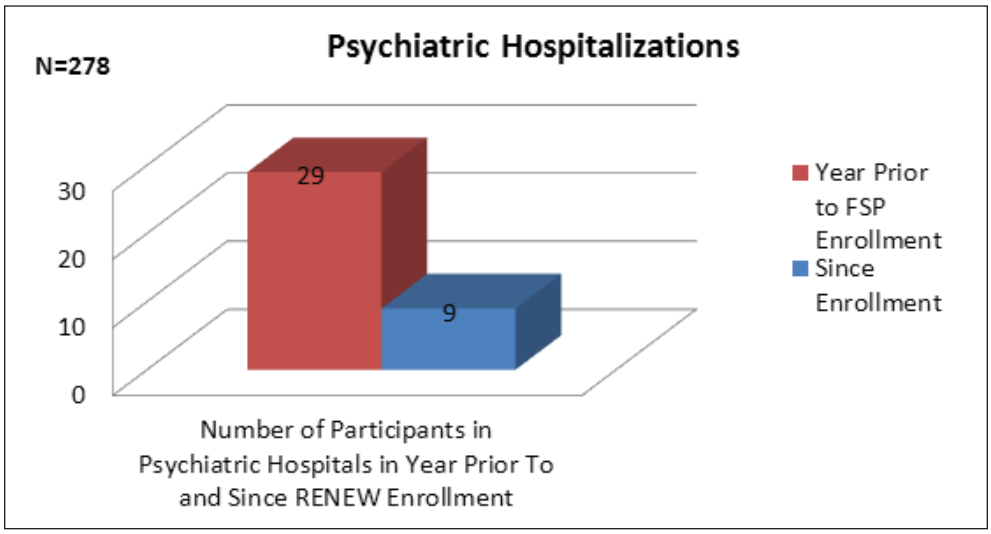
The four Children's Full Service Partnership (FSP) programs focus on several areas prescribed in the original legislation and several defined by local need within the broader targets. One FSP focuses on the more general community. This program takes referrals from the Outreach and Engagement teams, Centralized Assessment Team, and County and contract clinics. Prominent among their referrals are the homeless or those at risk of homelessness. Parents frequently need job assistance, especially when the needs of their Seriously Emotionally Disturbed child impact their ability to maintain employment. The second FSP program focuses on the culturally and linguistically isolated, particularly those in the Vietnamese and Korean Communities. The third program serves a small number of children who entered the juvenile justice system at a younger age, and after in-custody rehabilitation, need support reintegrating into the community. The fourth children's FSP is a program for those young people who come to the attention of the Juvenile Court, especially those who require the services of specialized collaborative courts.

Community Services and Supports (CSS)

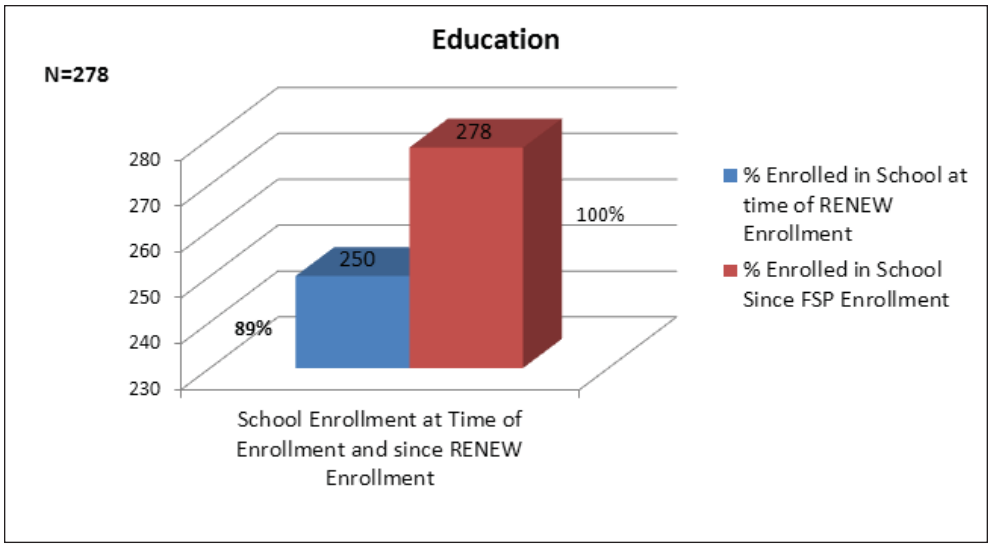
2. Outcomes

In the broadest based program, the results in the areas of reducing hospitalizations and increasing access to education are illustrated below.

Psychiatric Hospitalizations—One of the goals of an FSP is to reduce the number of hospitalizations participants experience. Reaching Everyone Needing Effective Wrap (Project RENEW) is the children's FSP that serves the general population. In the year prior to enrollment in Project RENEW, 29 participants reported being admitted to a psychiatric hospital. Since RENEW enrollment, nine participants were hospitalized. Throughout FY 11/12, RENEW participants have had a 69% decrease in psychiatric hospitalization.



Education—At the time of enrollment in Project RENEW, 250 participants were enrolled in a school setting. Since enrollment in RENEW, 278 participants have enrolled in school. There has been an 11% increase in school enrollment.



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Community Services and Supports (CSS)

3. Process Indicators

The process indicator that has become a new metric for FSPs is tracking the progress for all discharges. The process measure is the percent children FSP members who leave the programs after making satisfactory progress toward treatment goals. In the most recent quarter, those who left the Children's FSPs for any reason averaged 39% making progress toward treatment goals. This measure indicates that the programs are making an impact even in those with less desirable outcomes.

4. Future Plans for Change

No significant changes are expected for next year. There may be some growth for those minors who are in collaborative courts and are both wards and dependents.

A Success Story

D'S STORY

(D's Mother):

I'd like to thank Project RENEW. The program was a big change in our lives, especially in a time of need. It was a very difficult process, there were times where we would go forward and then take a step back. However, with RENEW's support we began to progress little by little, step by step.

The financial and most importantly the emotional support we received from the PSC (personal service coordinator), the Parent Partner and Youth Partner were more than helpful.

I was the only support for my son, "D", and it was extremely hard for me when D wanted to commit suicide. I will never forget what the PSC always said to me, "Problems will always come and go". The PSC was a great support for myself and D, especially in school since he had been suspended.

I am thankful for the Parent Partner because the parenting classes she gave were a huge help, and I learned a great deal on how to overcome our problems together.

RENEW was a huge positive change. For years we had therapists, and things were always the same, but the Project RENEW program did help. Within six months things changed in a good way.

I want to thank the Peer Partner for giving my son the support he needed. My son and the Peer Partner had a close connection.

I want to also thank the RENEW Therapist for helping me create goals not only for me, but for my family.

I can see the changes in my son. I can see the changes in me, and I can see a positive future for my family. I have learned through RENEW that anything is possible.

Community Services and Supports (CSS)

I would like to also thank the Director for helping us and welcoming us to your program. I will be forever grateful. Project RENEW thank you for all your help and support.

"D" (the participant):

I owe a lot to the program. If I would have never met the PSC, Peer Partner, and Therapist, I don't know where I would have been. I thank you guys for helping me get my life straight. I got my first "A" on a report card, and I owe it to the program. I have goals to get out of Continuation school and to return to regular school. I also want to continue my ROP classes. The relationship between my mother and I is so much better. I owe it to you guys. Thank you RENEW.

Picture drawn for RENEW by "D":

Community Services and Supports (CSS)

CSS Program Information
Children's Outreach and Engagement

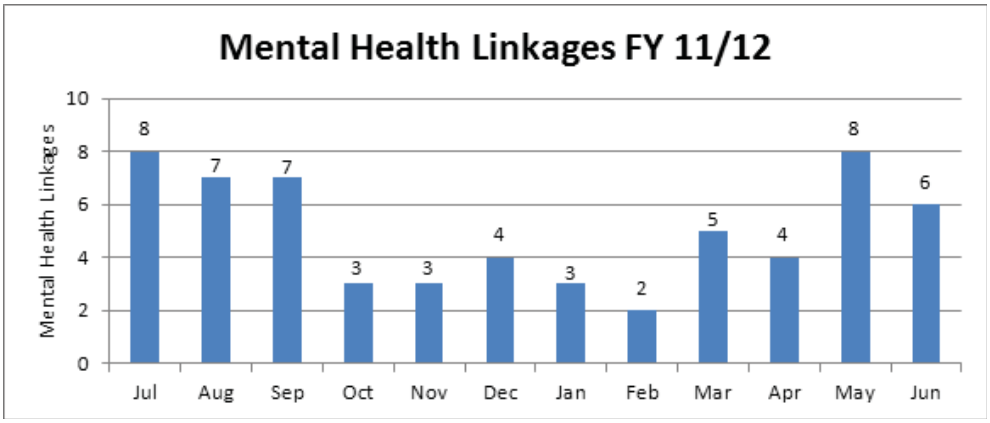
Program Name: C2: Children's Outreach and Engagement	Funding:
Actual number served in FY 11/12: 60	Actual funds expended in FY 11/12: $95,848
Projected number to be served in FY 12/13: 56	Estimated funds to be expended in FY 12/13: $123,594
Estimated number to be served in FY 13/14: 70	Budgeted funds for FY 13/14: $123,594

1. Program Description

The Mental Health Services Act (MHSA) Children's Outreach and Engagement program serves Seriously Emotionally Disturbed (SED) and Seriously Mentally Ill (SED/SMI) children ages birth to 18 whose families are homeless or on the verge of homelessness. The program assists the unserved or underserved children and their families with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or linkages with other needed community resources. The program also focuses on reducing the stigma associated with mental illness and increasing the acceptance of treatment and services that improve the quality of life and stability of children/families in the community of choice. Outreach is conducted in schools and other locations by establishing engaging activities in neighborhoods throughout the County.

2. Outcomes

The program is relied upon to handle community referrals of delicate and difficult cases, where a serious mental illness and homelessness (or at risk of homelessness) is involved. Throughout the year, the team participated in various special projects and activities in schools and the community which provided greater access to the target population and increased community awareness of available services. The corresponding graph displays data on the number of successful linkages to service during FY 11/12. The number of linkages varies from two per month to eight per month.



3. Process Indicators

Community awareness increased, leading to children and families being linked to needed mental health services and Full Service Partnerships.

4. Future Plans for Change

No changes expected at this time.

Community Services and Supports (CSS)

CSS Program Information
Children's In-Home Crisis Stabilization

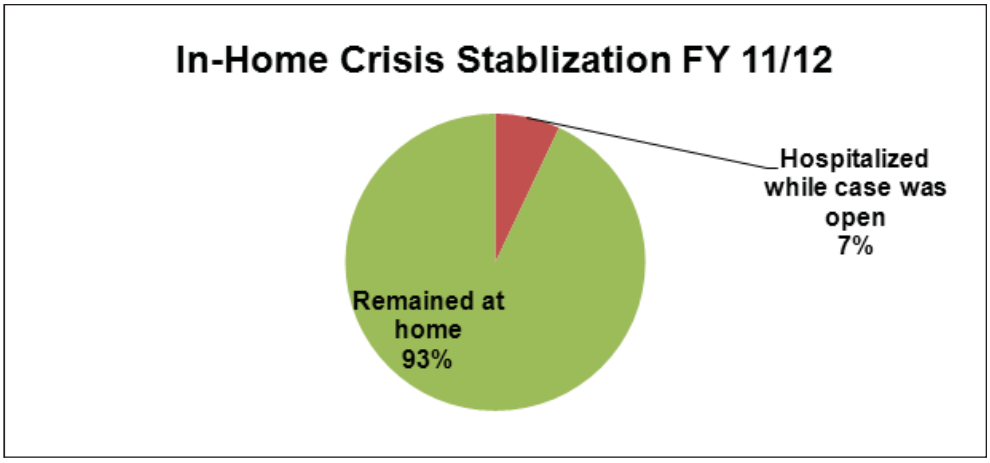
Program Name: C3: Children's In-Home Crisis Stabilization	**Funding:**
Actual number served in FY 11/12: 272	Actual funds expended in FY 11/12: $485,480
Projected number to be served in FY 12/13: 300	Estimated funds to be expended in FY 12/13: $647,062
Estimated number to be served in FY 13/14: 300	Budgeted funds for FY 13/14: $485,480

1. Program Description

The target population is youth up to their 18th birthday who are being considered for psychiatric hospitalization, but who don't meet criteria for admission. This program consists of teams of professionals and staff with lived experience who are available 24/7 to meet with families in crisis and assist in stabilization. Typically a Children and Youth Services (CYS) staff person is asked to evaluate a youth for possible hospitalization. Once it is determined that the youth does not meet criteria for hospitalization but it is clear that the family needs assistance, the evaluator calls the crisis stabilization team who come to the site of the evaluation and begin to (1) work out a plan to identify causes of the current crisis and (2) begin to work on healthful ways of avoiding future crises. There are times when families are drained by the crisis and the evaluation process, and in those incidents, in-home appointments are made for the next day to begin the stabilization process. The team targets a brief intervention period, usually three weeks, occasionally extending to six. The In-Home Crisis Stabilization Team helps the family and child develop coping strategies and linkages to on-going support.

2. Outcomes

During FY 11/12, 7% of the clients that the In-Home Crisis Stabilization Team worked with required psychiatric hospitalization. Given the starting point of these youths and families this is a very positive outcome. It does not factor in families that dropped out of services nor those linked to ongoing services in the community.



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3. Process Indicators

Experience with the program indicates that the sooner services begin the better chance they have of being successful. If the family gets distance from the crisis for even a day or two, many of their dysfunctional coping mechanisms reemerge, and it is difficult to motivate them to change.

4. Future Plans for Change

The plan is to expand these services with additional teams when sustainable funding becomes available.

Community Services and Supports (CSS)

CSS Program Information
Children's Crisis Residential Program

Program Name: C4: Children's Crisis Residential Program (CRP)	**Funding:**
Actual number served in FY 11/12: 76	Actual funds expended in FY 11/12: $1,035,800
Projected number to be served in FY 12/13: 76	Estimated funds to be expended in FY 12/13: $1,124,883
Estimated number to be served in FY 13/14: 76	Budgeted funds for FY 13/14: $1,089,966

1. Program Description

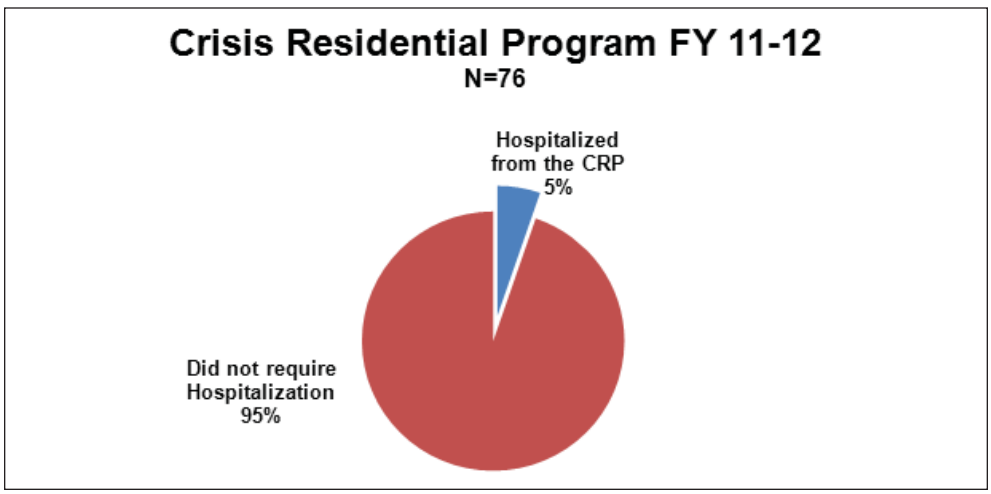
This is another program developed to address a system gap. An alternative to hospitalization or In-Home Crisis Services was needed. The target population is youth up to their 18th birthday who are at risk of psychiatric hospitalization. This need arises when the following occur:

- A youth in crisis is evaluated for psychiatric hospitalization;
- The youth does not meet in-patient criteria;
- The home situation is volatile; and
- A "cooling off" period would benefit both youth and family.

Referrals are accepted on a 24/7 basis. The target is a three-week stay, which may be expanded to six if the clinical situation warrants. The youth are provided a structured setting where they maintain their school work and are introduced to problem solving techniques which they can employ in family therapy. Parent education and skill building are important components of the program. The youth interact in structured groups and participate in activities like meal prep and clean-up.

2. Outcomes

During FY 11/12, 5% of the clients living in the crisis residential program required psychiatric hospitalization. Given the starting point of these youths and families, this is a very positive outcome. It does not factor in families that dropped out of services or those linked to ongoing services in the community after leaving the Crisis Residential Program (CRP).



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Community Services and Supports (CSS)

3. Process Indicators

Parental involvement is always a crucial component. If the parent adopts a "fix them" attitude, little permanent change can be accomplished. This issue is an essential part of the intake process where parental involvement is an important element in program commitment. Also closely monitored are those youth who come to the program for a very short stay and leave before treatment goals are completed. This is done to provide feedback to the referring sources, as well as part of self-study around the program's admission procedures or engagement techniques.

4. Future Plans for Change

The hope is to increase the number of beds available for this service as sustainable funds become available.

Community Services and Supports (CSS)

CSS Program Information
Mentoring for Children

Program Name: C5: Mentoring for Children	**Funding:**
Actual number served in FY 11/12: 117	Actual funds expended in FY 11/12: $352,620
Projected number to be served in FY 12/13: 122	Estimated funds to be expended in FY 12/13: $332,495
Estimated number to be served in FY 13/14: 135	Budgeted funds for FY 13/14: $352,620

1. Program Description

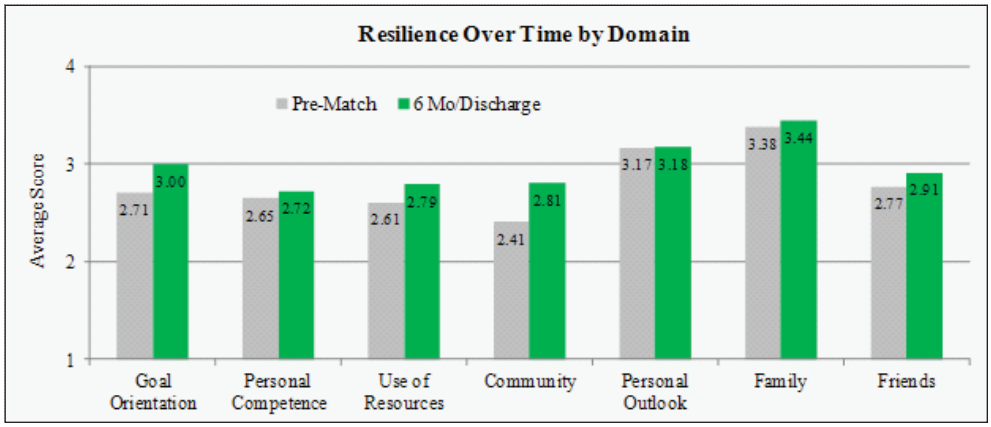
The Mentoring Program is a community-based, individual and family centered program that recruits, trains and supervises responsible adults to serve as positive role models and mentors for seriously emotionally disturbed (SED) children and youth who are receiving outpatient services through Children and Youth Services (CYS) and its contractors. Parents/caregivers of SED children and youth may also receive parent mentoring services.

One-to-one mentoring has the potential to impact youth in a positive way as strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills and resiliency. Children and Youth Services has an extensive history of using mentors as an adjunct to formal treatment for children receiving mental health services. It provides the youth an opportunity to practice the skills learned in therapy in a controlled and supportive environment. Mentoring is a logical, cost-effective strategy that provides youth with positive reinforcement and caring role models.

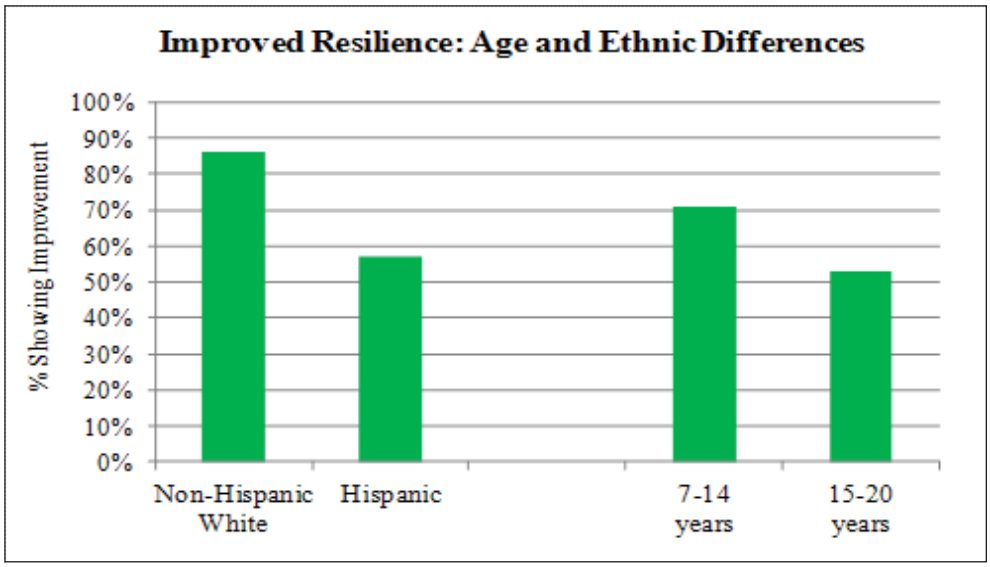
Community Services and Supports (CSS)

2. Outcomes

It is difficult to start with a common base for measuring improvement in youth involved with the mentoring program. Thus, it was decided to use a Resilience Scale developed to measure the trait included in the general goals for MHSA programs with youth. The graph below captures the growth in this key area for youth involved with the mentoring program.



It would appear that the growth in resilience is more pronounced in younger non-Hispanic white children. However, it is early in the evaluation process.



3. Process Indicators

N/A

4. Future Plans for Change

No significant changes are anticipated.

Community Services and Supports (CSS)

CSS Program Information
Centralized Assessment Team

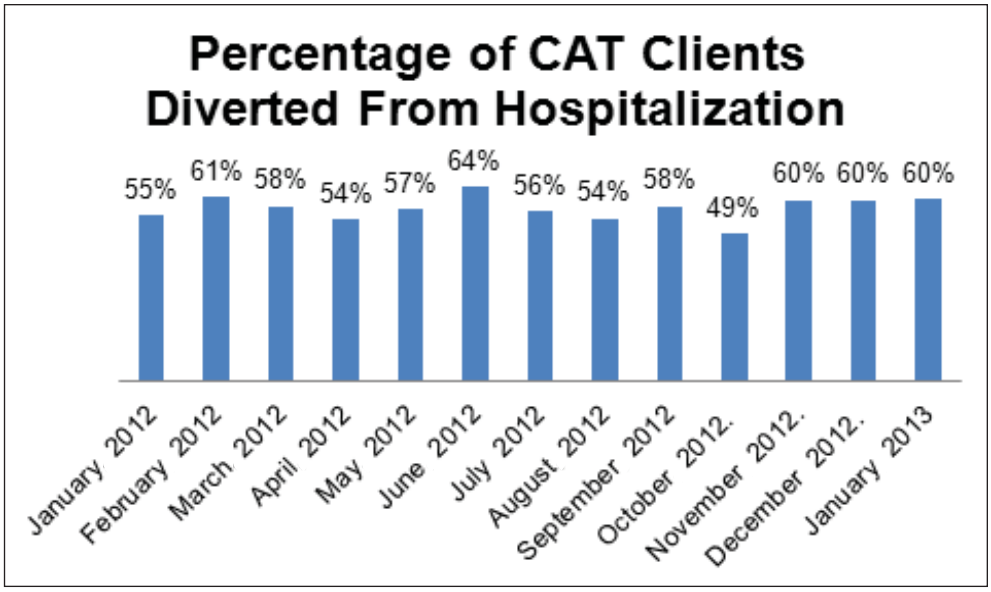
Program Name: C6: Children's Centralized Assessment Team (CAT)	**Funding:**
Actual number served in FY 11/12: 1,085	Actual funds expended in FY 11/12: $839,619
Projected number to be served in FY 12/13: 1,500	Estimated funds to be expended in FY 12/13: $1,120,320
Estimated number to be served in FY 13/14: 2,400	Budgeted funds for FY 13/14: $1,594,904

1. Program Description

The Children's Centralized Assessment Team (CAT) responds to psychiatric emergencies for any youth under 18 years of age, anywhere in the County. The team operates 24 hours a day, 365 days per year. The scope of the CAT teams charge shifted in April 2012 when it expanded its responses to home-based assessments (with police accompaniment) and to any youth regardless of insurance coverage (if requested to assist). Prior to that time, evaluations were restricted to emergency rooms, police stations, schools and group homes and only unfunded or MediCal clients were seen. The purpose of the team is to intervene in crisis situations. If safety cannot be assured, the CAT member will write a 72-hour hold and facilitate the child's placement in a psychiatric hospital. If the child can be successfully treated at a less restrictive level of care, the team member will assure that the linkage is made. The team has been expanded as the workload has increased.

2. Outcomes

The CAT is currently focusing on a major outcome measure, specifically, the number of clients diverted from hospitalization. Many of these diversions are to the In-home Crisis Stabilization Program, the Crisis Residential Program, and to various full service partnerships (FSPs) and more traditional outpatient programs.

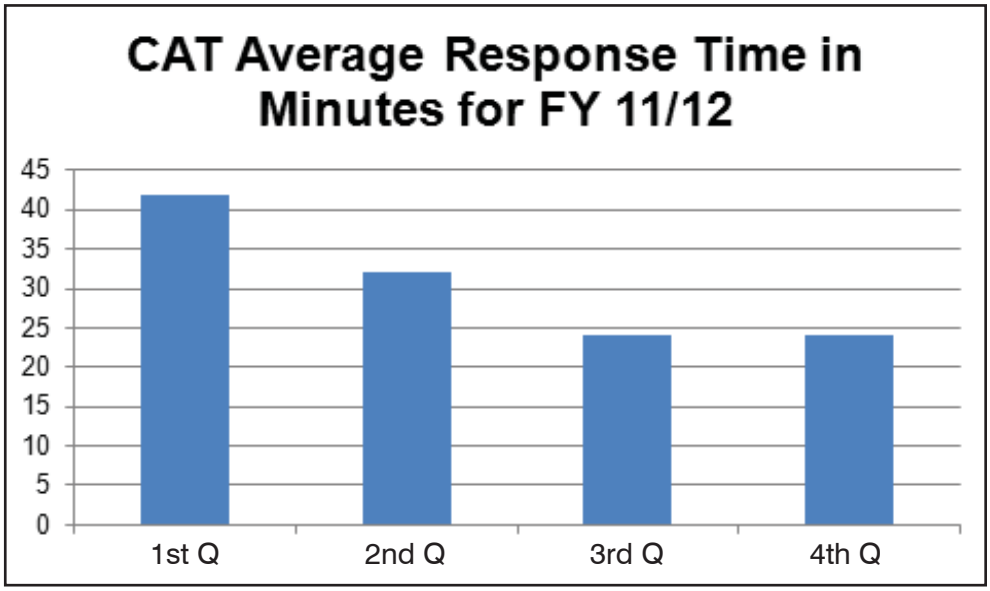


The target is 60% and a variety of factors impact the result, especially the availability of the diversion target.

Community Services and Supports (CSS)

3. Process Indicators

One powerful measure of CAT team efficiency is the amount of time between dispatch and arrival at the location of the evaluation. The chart below shows a response time of less than 25 minutes in the last two quarters in FY 11/12.



4. Future Plans for Change

Workload will continue to be carefully monitored and additional staff will be added as the need grows. It is anticipated that this relatively new program reached its normal call level, however, the current trend is still up with no leveling detected. It appears that the community is not fully aware of this service and that demand for service goes up as awareness increases.

Community Services and Supports (CSS)

CSS Program Information
Full Service Partnerships for Transitional Age Youth

Program Name: T1: Full Service Partnerships for Transitional Age Youth	**Funding:**
Actual number served in FY 11/12: 627	Actual funds expended in FY 11/12: $7,816,464
Projected number to be served in FY 12/13: 655	Estimated funds to be expended in FY 12/13: $5,202,677
Estimated number to be served in FY 13/14: 700	Budgeted funds for FY 13/14: $5,916,424
Estimated Cost Per Client FY 12/13 (FSPs only) $12,466	

1. Program Description

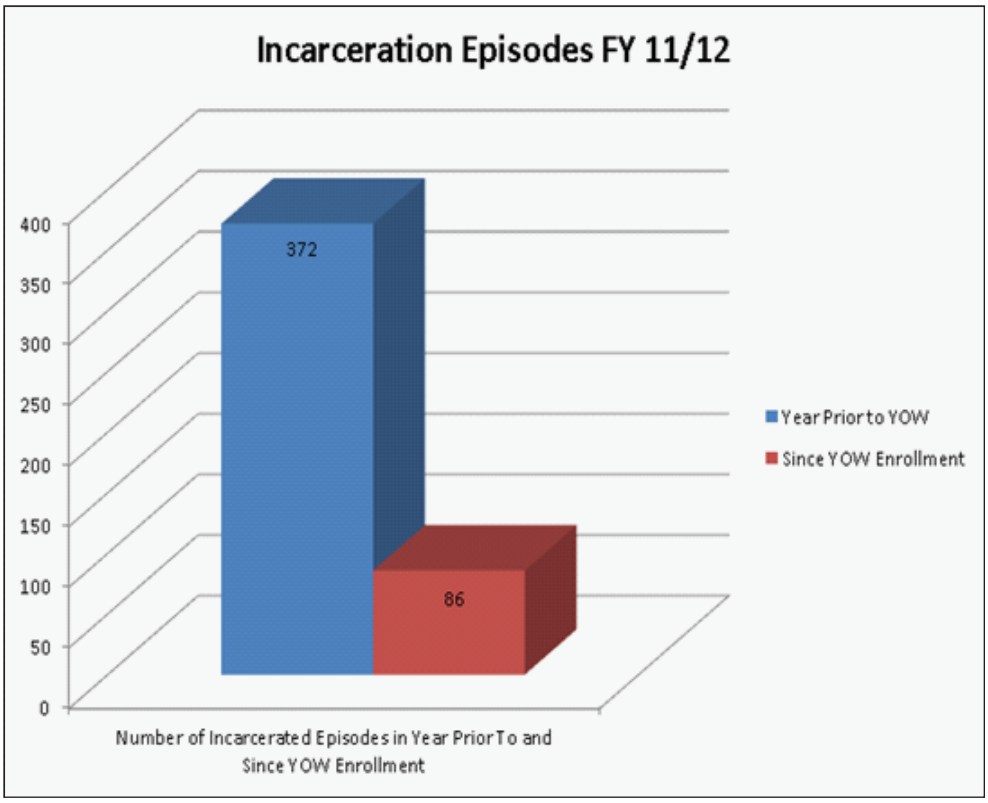
The target groups for these programs are youth who are: 16-25, homeless or at risk of homelessness, culturally or linguistically isolated, at risk of incarceration or psychiatric hospitalization because of mental illness, frequently complicated by substance use. There are four programs in this category. One FSP serves a broad spectrum of youth in the community including youth experiencing a first psychotic break and former foster youth, almost all at some risk of homelessness. A second focuses on the unique needs of the Pacific Islander community with particular focus on the Korean and Vietnamese populations. The third is a program designed to meet the needs of youth who had been exposed to significant rehabilitation attempts while in the custody of the Orange County Probation Department. The program focuses on maintaining the gains the youth has made and integrating back into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus. The fourth program was designed to meet the need of a variety of youth involved with the Juvenile Court. This program works with the Juvenile Drug Court, particularly to provide services once they graduate from the Court and are released from Probation. This program also serves youth who are Dual Status (i.e. both wards and dependents of the court). These are multi-problem youth who may require services well into early adulthood. This FSP also works with children and families who come to the attention of the Truancy Court. For many multi-problem youth, this is the first time they come to the attention of the "helping system."

Community Services and Supports (CSS)

2. Outcomes

Among the most powerful indicators of program success is to look at a group of young people who have traditionally high recidivism rates – severely ill offenders – and examine how their rate of re-arrest looks after intervention.

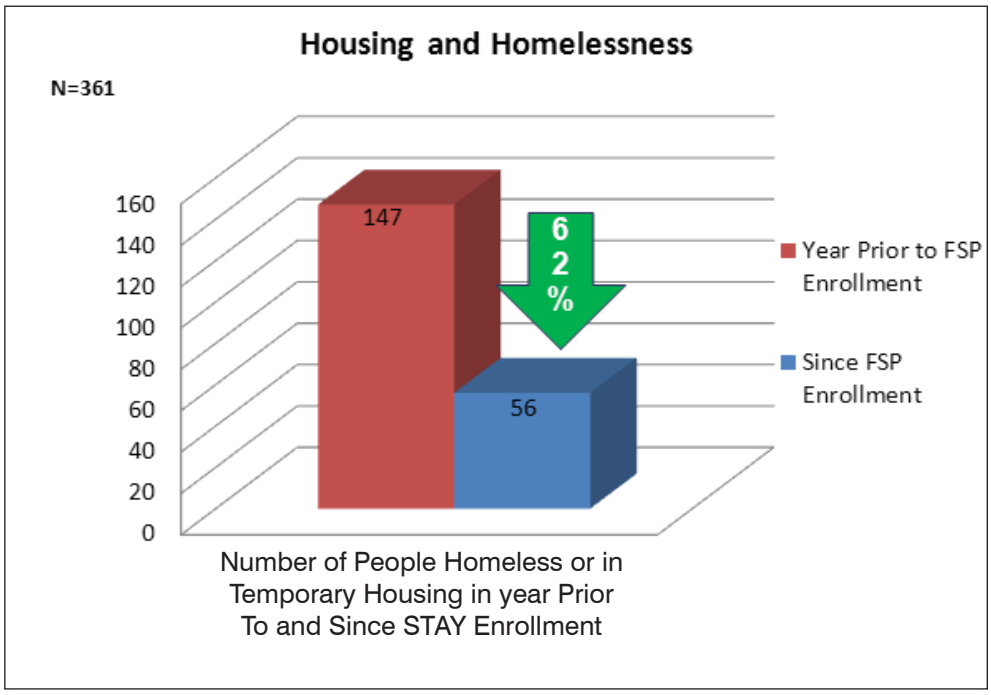
Incarceration Episodes—A goal of this type of program is to reduce the number of times (episodes) consumers are incarcerated. In the 12 months prior to enrollment there were 372 episodes of incarceration. Since enrollment, consumers have only been incarcerated 86 times. Data is from the Youthful Offender Wraparound (YOW) Full Service Partnership.



Community Services and Supports (CSS)

Another area of significant FSP impact is homelessness. See below.

Housing & Homelessness—In the year prior to enrollment, 147 participants had been homeless, in temporary emergency housing, or living in a shelter. Since enrollment, 56 participants were found to be at least one day homeless or in a temporary housing category at any given time during FY 11/12. That is a 62% decrease in homelessness since enrollment in the Serving Transitional Age Youth (STAY) FSP.



3. Process Indicators

The current process measure is the percent Transitional Age Youth (TAY) FSP members who leave the programs making satisfactory progress toward treatment goals. In the most recent quarter, those who left the TAY FSP for any reason averaged 39%, making progress toward treatment goals. This measure indicates that the programs are making an impact even in those with less desirable outcomes.

4. Future Plans for Change

No program changes are anticipated. Some growth is expected for dual-jurisdiction youth served in the girls' and boys' collaborative courts.

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Community Services and Supports (CSS)

Client Success Story

TAY FSP

I was 19 years old and homeless. I lived in my car and was struggling to go to school. Eventually, I had to drop out because there was no way I could keep going to school while living in my car. Everything was just so hard. I'd had it with everything. I felt like I was alone, and though I had friends and family, no one could help me with my living situation. It was always, "Oh I'm so sorry this is happening," or, "I'd help you if I could."

It frustrated me so much. I was sad and angry. I knew people, but no one could help. I swore to myself that if I ever had a friend that was homeless, I'd take them in ... or at least help them in some way. Besides that, my family was far away and I knew my mom couldn't afford to have me back at the house.

Getting a job is hard when you're living in your car. I felt like I had lost just about everything and that no one cared. I'll be honest, mentally things weren't going too well, but before things became too overwhelming (not like it wasn't already), I was referred to stay in a crisis residential home. It was nice and I had a place to stay, but it would only be for six weeks. As my time was ending there, I was set up with a TAY Specialist from a TAY FSP. They got the ball rolling soon after, and I was transitioned out of that crisis home to a Room and Board.

In addition to housing, the FSP provided me with help paying my rent, counseling, and a job. I'm not going to sugar coat anything and say that it's perfect, but it's definitely worth the time I spent on the waiting list. The TAY Specialists checked on me on a weekly basis to see how I was doing. They're almost like a friend; someone that you can talk to about your problems. And they listen! Sometimes, you can hang out and they guide you through your goals to help you complete your process at the FSP.

I'm almost on my way out of the program after being enrolled only a little over a year. In that time I've gotten pretty far in my journey with the help from this FSP. If I hadn't received their help and guidance, I honestly don't know where I'd be.

Community Services and Supports (CSS)

CSS Program Information
Transitional Age Youth, Outreach and Engagement

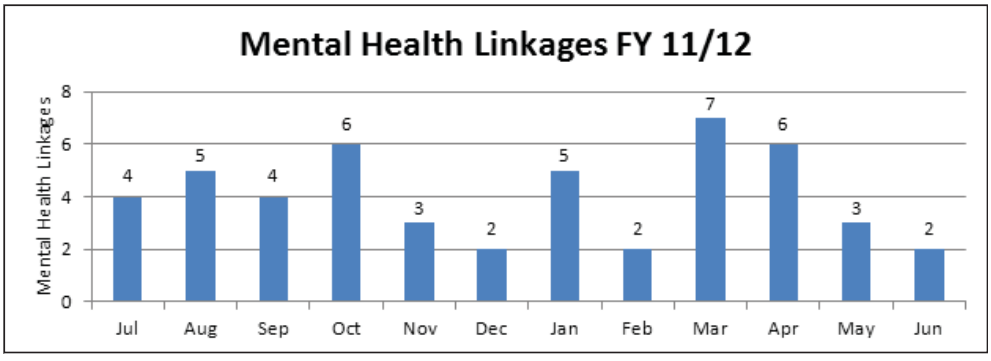
Program Name: T2: Transitional Age Youth, Outreach and Engagement	**Funding:**
Actual number served in FY 11/12: 49	Actual funds expended in FY 11/12: $156,384
Projected number to be served in FY 12/13: 46	Estimated funds to be expended in FY 12/13: $128,638
Estimated number to be served in FY 13/14: 50	Budgeted funds for FY 13/14: $128,638

1. Program Description

The Mental Health Services Act (MHSA) Transitional Age Youth (TAY) Outreach and Engagement program serves Seriously Mentally Ill (SMI) adults with co-occurring disorders from ages 18 to 25 that are homeless or on the verge of homelessness. The program assists the unserved or underserved TAY with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or with other linkages to community resources. The program adheres to a "best practice" model by offering services using a strength-based and recovery-based approach that focuses on resiliency and the establishment and growth of local support systems. On-going Street Outreach is conducted to increase the acceptance of treatment and services and improve the stability of the individual in the community of choice.

2. Outcomes

The program is relied upon to handle community referrals of delicate and difficult cases where a serious mental illness and homelessness (at risk) is involved. The team participated in activities throughout the county which provided greater access to the target population and increased community awareness of available services.



3. Process Indicators

Collaborations among service providers increased, leading to an increase in TAYs being served by FSPs.

4. Future Plans for Change

The team will target "High Utilizers" of urgent care services and provide intensive engagement, such as engaging such individuals two to three times a week, in an effort to increase linkages to Full Service Partnerships and other mental health services.

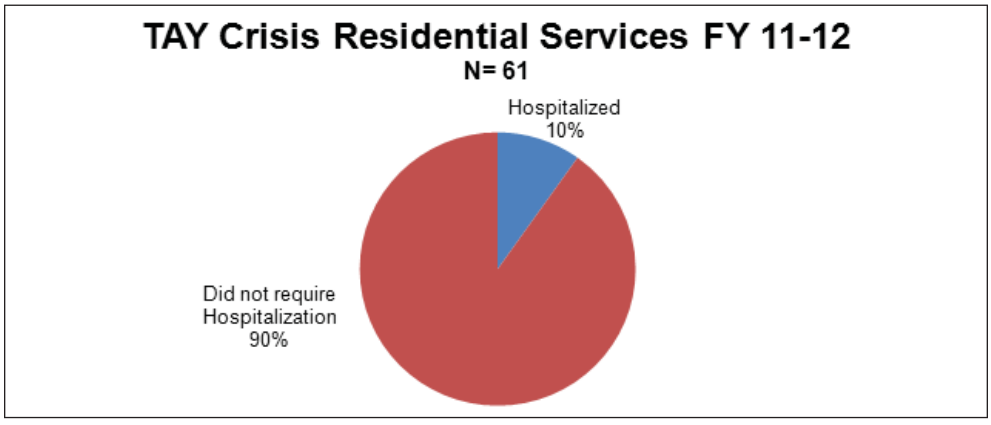
Community Services and Supports (CSS)

CSS Program Information
TAY Crisis Residential

Program Name: T3: TAY Crisis Residential	Funding:
Actual number served in FY 11/12: 70	Actual funds expended in FY 11/12: $1,185,352
Projected number to be served in FY 12/13: 95	Estimated funds to be expended in FY 12/13: $1,231,798
Estimated number to be served in FY 13/14: 95	Budgeted funds for FY 13/14: $1,198,950

1. Program Description
The target population for this program is youth 18-25 who are at risk of psychiatric hospitalization but do not meet criteria for involuntary holds. The program provides crisis residential services for this group. The program may also serve as an intermediate level of care between inpatient or out-of-state group home and living in the community. The program is licensed as a Social Rehabilitation Program by the State. The program is located in a suburban community and has six client beds. The typical stay in the program is three weeks with extensions up to six weeks when clinically indicated. Due to the difficulty with finding longer term structured and supervised housing for TAY, a second six-bed facility was opened under the same license and serves as a two-to-six-month placement when structure is clinically indicated, but the program does not require the emphasis on crisis and is designed to be a learning step before returning to programs in the community and more independent living.

2. Outcomes
Enable clients to adaptively function at a higher level in the community which is measured by a reduction of days they are psychiatrically hospitalized from program enrollment to sixty days post-enrollment. Only six clients were hospitalized in FY 11/12 between the time they were admitted and 60 days post hospitalization.



3. Process Indicators
The major process indicator is length of stay. If it is very short there are concerns about the appropriateness of the referral or the admission. If it is longer than anticipated, especially over six weeks, questions arise about discharge planning, effectiveness of interventions and/or communication with the referral source.

4. Future Plans for Change
This program is out for re-bid per County policy requiring periodic re-bidding of existing programs.

Community Services and Supports (CSS)

CSS Program Information
Mentoring Services for TAY

Program Name: T4: Mentoring Services for TAY	**Funding:**
Actual number served in FY 11/12: 50	Actual funds expended in FY 11/12: $145,456
Projected number to be served in FY 12/13: 57	Estimated funds to be expended in FY 12/13: $155,346
Estimated number to be served in FY 13/14: 65	Budgeted funds for FY 13/14: $147,380

1. Program Description

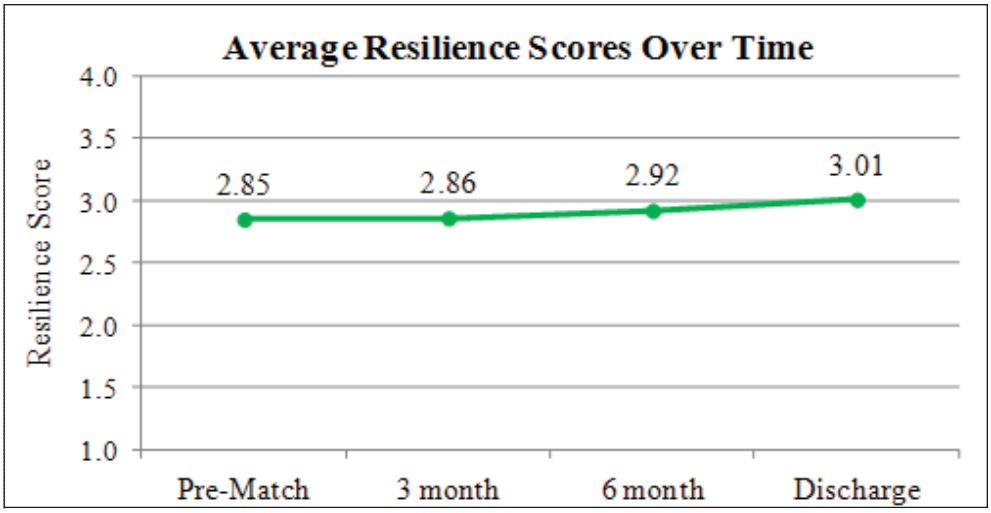
This program provides Mentoring Services for Transitional Age Youth (TAY) between 16 and 25 who are receiving outpatient services through CYS and its contractors. The Mentoring Program is a community-based, individual and family-centered program that recruits, trains and supervises responsible adults to serve as positive role models and mentors for seriously emotionally disturbed (SED) children and youth and severely mentally ill (SMI) transitional age youth.

One-to-one mentoring has the potential to impact youth in a positive way. Strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills, resiliency, and for TAYS, enhanced life skills. Children and Youth Services has an extensive history of using mentors as an adjunct to formal treatment for TAY receiving mental health services. It provides the youth an opportunity to practice the skills learned in therapy in a controlled and supportive environment. Mentoring is a logical, cost-effective strategy that provides youth with positive reinforcement and caring role models.

2. Outcomes

Building resilience is an MHSA stated goal. Tracking resilience over time indicates small but steady growth in overall resilience. Overall resilience remained relatively constant over the course of time in the mentoring program, with slight improvements after the first three months.

Community Services and Supports (CSS)



3. Process Indicators

The program monitors the length of time a mentor-mentee match is active. When a match ends prematurely or fails to begin, the program works with the referring source, the assigned mentor and the mentee to modify the program to meet treatment needs. A reassignment of mentors to find a better match is an option.

4. Future Plans for Change

No program changes are anticipated.

Community Services and Supports (CSS)

CSS Program Information
TAY Centralized Assessment Team

Program Name: T5: TAY Centralized Assessment Team (CAT)	**Funding:**
Actual number served in FY 11/12: 277	Actual funds expended in FY 11/12: $620,052 (includes children and adults)
Projected number to be served in FY 12/13: 310	Estimated funds to be expended in FY 12/13: $320,214
Estimated number to be served in FY 13/14: 250	Budgeted funds for FY 13/14: $320,314

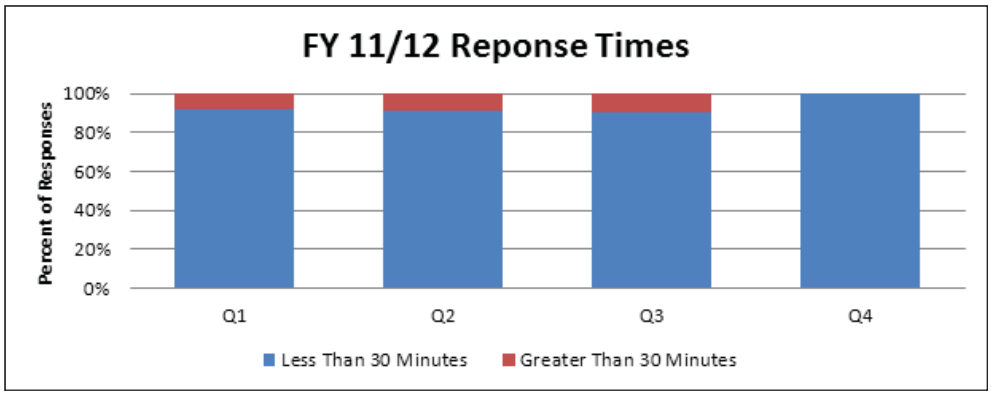
1. Program Description

The Centralized Assessment Team (CAT) provides mobile response, including mental health evaluations/assessment, 24 hours per day/7 days per week, for those who are experiencing a mental health crisis. In response to psychiatric emergencies, staff provide crisis intervention for hospital diversions, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies. Assessment/consultation services are provided in Hospital Emergency Departments (ED) for patients in need of, or waiting for, inpatient services. Bilingual/bi-cultural staff work with family members to provide information, referrals, and community support services.

The Centralized Assessment Team has a Transitional Age Youth (TAY) component that provides specialized services to adults from 18-25 years of age. This program currently has three staff members that have expertise and additional training in working with the TAY population.

2. Outcomes

The average response time was just under 16 minutes with 93% of the calls below 30 minutes. The data below is presented for each quarter in FY 11/12.



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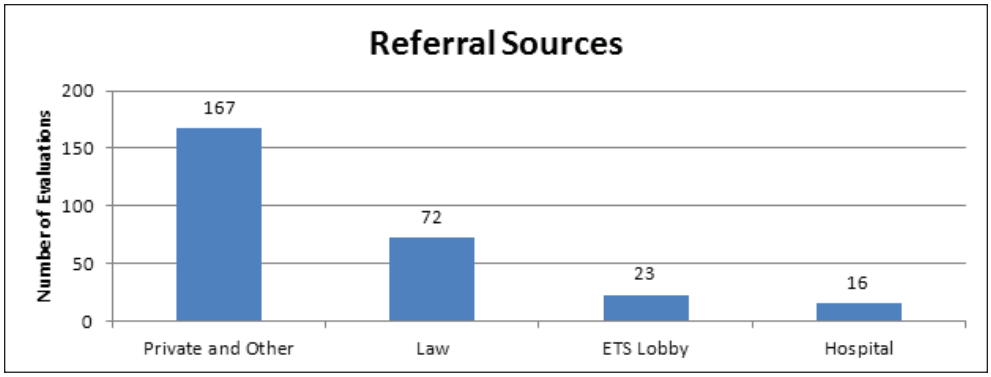
Community Services and Supports (CSS)

3. Process Indicators

Data on the source of referral shows that the largest referral source for CAT/TAY response was "Private and Other" at 62% which includes family/ significant others, clients, treatment centers, and others. The second largest referral category 26% was from law enforcement.



4. Future Plans for Change

The service delivery to Transitional Age Youth (TAY) will continue to be increased through collaboration with TAY service providers and increased linkages to TAY based community services. The CAT team will continue to be an integral part of the Health Care Agency's overall direction in providing services to those experiencing a mental health crisis. This will include trainings for Agency staff, law enforcement, and community providers. Increased collaboration with community partners will also enhance the level of services being provided to individuals needing immediate psychiatric intervention.

Community Services and Supports (CSS)

CSS Program Information
TAY Program of Assertive Community Treatment (PACT)

Program Name: T6: TAY Program of Assertive Community Treatment (PACT)	**Funding:**
Actual number served in FY 11/12: 147	Actual funds expended in FY 11/12: $896,092
Projected number to be served in FY 12/13: 150	Estimated funds to be expended in FY 12/13: $892,825
Estimated number to be served in FY 13/14: 150	Budgeted funds for FY 13/14: $896,092

1. Program Description

The Program for Assertive Community Treatment (PACT) teams in Orange County target high risk underserved populations such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth (TAY) community, and mentally ill adults and older adults. To qualify for PACT services, individuals have to have been psychiatrically hospitalized multiple times in the last year for being considered dangerous to people in the community and/or themselves, or because they were unable to avail themselves of basic food, clothing or shelter due to their mental illness. In addition, treatment at a lower level of care must have failed to keep the person stable. The target population for the Transitional Age Youth PACT program is diverse, chronically mentally ill TAY, ages 18 to 25. In particular, the program targets the underserved ethnic populations of Latinos, Vietnamese, Korean and Iranian, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing. Assertive Community Treatment is a best practices model and Orange County PACT teams work to further their fidelity to this model.

The program provides consumer focused, recovery-based services, and provides intervention primarily in the home and community in order to reduce access or engagement barriers. Collaboration with family members and other community supports are stressed in this multidisciplinary model of treatment. The treatment team is comprised of a multidisciplinary group of professional staff, including Clinical Social Workers, Marriage Family Therapists, Mental Health Specialists, Psychiatrists, and a Supervisor. This team provides medication services, individual and group therapy, substance abuse and family therapy. In addition, supportive services such as money management and linkage are offered. The focus of recovery for this population is to address age appropriate developmental issues such as re-integration into school and employment, developing and sustaining social support systems, and attaining independence. This program is sensitive to the individual needs of the Transitional Age Youth consumer, and staff is knowledgeable of the resources and issues for this population.

This population struggles with the onset of acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. This is a crucial developmental stage for these individuals in attaining independence and skills needed to be successful throughout their adult lives. Individuals eligible for this treatment model have been hospitalized and/or incarcerated prior to admission to the program. This population requires frequent and consistent contact to engage and remain in treatment. This multicultural population typically requires intensive family involvement.

2. Outcomes

Over the last year, participants in the TAY PACT programs have shown marked improvement in their quality of life and significant decreases in hospitalization (71% reduction in hospital days), incarceration (24% reduction in incarceration days), homelessness (19% reduction in days homeless) and other high cost services provided by the County.

3. Process Indicators

There has been a challenge helping clients progress in recovery and helping them navigate the system to access lower levels of care. Often it is difficult to transition throughout the system of care. Strides have been made over this fiscal year to improve the referral and linkage process in order to facilitate smoother transitions.

4. Future Plans for Change

No proposed changes at this time.

Community Services and Supports (CSS)

CSS Program Information
Adult Full Service Partnership

Program Name: A1: Adult Full Service Partnership (FSP)	**Funding:**
Actual number served in FY 11/12: 844	Actual funds expended in FY 11/12: $11,964,597
Projected number to be served in FY 12/13: 850	Estimated funds to be expended in FY 12/13: $13,871,496
Estimated number to be served in FY 13/14: 850	Budgeted funds for FY 13/14: $13,989,158
Estimated Cost Per Client FY 12/13 (FSPs only) $16,898	

1. Program Description

The MHSA Full Service Partnership (FSP) program serves adults in the 18-59 age range. The adult program provides 24 hour a day, seven days a week intensive case management/wrap-around-services, a peer to peer line, community based outpatient services, peer mentoring, supported education/ employment services, transportation services, housing, benefit acquisition, and co-occurring disorder treatment. These programs are linguistically and culturally competent, and provide services to the underserved cultural populations in Orange County, such as Latinos, Vietnamese, Koreans, Iranians, monolingual non-English speakers, and the Deaf and Hard of Hearing.

FSP programs in Orange County address those most in need: the homeless mentally ill, those with co-occurring disorders, those being released from jail with no place to go or support to turn to, and those who would be serving long jail sentences for minor crimes related to life style and/or their illness. There is also a focus on the underserved, including those in Institutes for Mental Disease (IMDs) who could come home if a support system were in place and those in Board and Cares who, given the opportunity, could regain control and independence and achieve enhanced recovery.

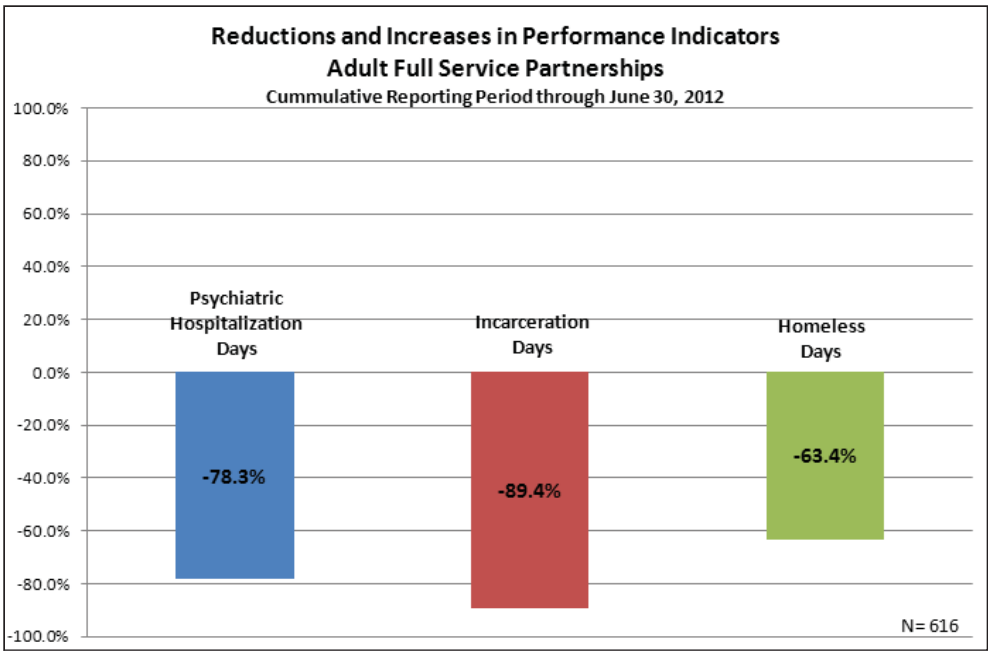
2. Outcomes

The MHSA FSP programs continue to learn and adopt new models of emerging and evidenced based practices. In addition, improving and expanding the quality and availability of data and data analysis to promote the dissemination of effective, evidenced based interventions and services to advance and identify better health outcomes for individuals, families and communities.

In February 2012, the FSP Programs, in collaboration with the California Institute for Mental Health (CIMH), coordinated with 16 other counties in applying Advanced Recovery Practices (ARP). ARP aims to promote mental health providers into making innovative changes that result not only in increased service system capacity, but will also reflect improved quality, appropriateness, and effectiveness of the clinical services provided to their

Community Services and Supports (CSS)

clients. Under the guidance of CIMH, the MHSA FSP Programs have implemented the core concepts of Transformational Care Planning (TCP). TCP is the understanding and development in the key building blocks of cultural inclusiveness, recovery, resiliency and wellness. TCP calls attention to "Person-first." Person-first is inclusive and identifies strengths and capabilities, nationality and ethnicity, sexual orientation, faith and spirituality, gender identity, age, social role, intellectual and cognitive abilities. TCP is recovery oriented care that challenges us to move past the maintenance of clinical stability to the true pursuit of living a meaningful life in the community.



As of June 30, 2013, ARP will be coming to an end. The project was guided by CIMH which highlighted the growth of the staff and the FSPs as a whole. In addition, the model has shown significant efforts in data collection and outcomes. Orange County implemented a quarterly DATA meeting where all FSPs and anyone interested in this data share current presentations and projects. The project has been so successful that the next step is implementation agency-wide.

3. Process Indicators

In FY 12/13, the Criminal Justice Full Service Partnership (FSP) was expanded. AB 109, which allows some non-violent prisoners to be monitored in their local community instead of state prison, addresses the immediate behavioral health recovery needs of the AB 109 client being released from custody.

The Health Care Agency seeks to implement Moral Recognition Therapy (MRT) an evidenced based practice which seeks to decrease recidivism among adult criminal offenders by increasing moral reasoning. MRT takes the form of group and individual counseling using structured group exercises and prescribed homework assignments.

Community Services and Supports (CSS)

4. Future Plans for Change

In FY 12/13, the Health Care Agency seeks to implement Transformational Care Planning (TCP) across the agency. TCP is the understanding and development in the key building blocks of cultural inclusiveness, recovery, resiliency and wellness. TCP calls attention to "Person-first."

Person-first is inclusive and identifies strengths and capabilities, nationality and ethnicity, sexual orientation, faith and spirituality, gender identity, age, social role intellectual and cognitive abilities. TCP is recovery oriented care that challenges us to move past the maintenance of clinical stability to the true pursuit of living a meaningful life in the community.

In December 2012, Orange County in collaboration with CIMH and leaders of Strength Based Models began the year in the Strengths Model. The Strengths Model was developed by the University of Kansas, School of Social Welfare in the mid-1980s as a response to traditional deficit oriented approaches. The Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery. While the tools are primarily geared for clinicians, case workers, and administrative staff, the principles of the model have agency-wide applications.

Community Services and Supports (CSS)

Client Success Story

ADULT FSP

This was the first program in my whole life where I felt valued, cared for, and they knew I didn't need tough love; I needed someone to have faith in me and guide me, offer referrals, and not tell me what to do. My goal was to not be homeless with my daughter. I was on the waiting list to every shelter you could imagine. During this time, I joined a Bible study that has grown from 70 women and children to a full blown ministry of 300 plus serving all. It is called Northeast of the Well and I am on the steering committee and for the first time in my life I am a valuable part of an outside community and it feels so good.

Since I have been clean and enrolled with the full-service partnership I have gone through homeless court and been able to get all of my tickets taken care of and got my Driver's License back. I got a car of my own (it took two years), and I got off formal probation a year early. I paid all of my restitution working minimum wage jobs.

I am doing so much better with counseling and proper medication. I started volunteering, when I could not find a job. I did that for nine months and almost got hired there until budget cuts froze the position. Importantly, however, it did give me the opportunity to sharpen my administrative skills and build up my confidence.

My accomplishments are:

1. I have been appropriately medicated for my mental illness
2. I got my grand theft auto dropped to a misdemeanor and dismissed
3. I have been gainfully employed for almost two years
4. I sponsor a girl
5. I have my own apartment through Shelter Plus Care because of the full-service partnership mentors who believed in me!

I want to add that I am no longer socially awkward, I have many friends, and since I have been on this journey of recovery I found out who I am and what I have to offer the world, and I am happy. I say this with tears of gratitude to those who helped me, thank you for helping to make my dreams turn into a reality. I am finally home. I have hope now to raise my daughter right and to get a better job now that I am not a felon on paper anymore. I want to say Thank You to all who have genuinely helped me and believed in me. If I can be of service let me know – I would be honored to still be a part of this great community. I truly thank you!

Community Services and Supports (CSS)

CSS Program Information
Centralized Assessment Team

Program Name: A2: Centralized Assessment Team (CAT)	Funding:
Actual number served in FY 11/12: 1,855	Actual funds expended in FY 11/12: $1,886,436
Projected number to be served in FY 12/13: 1,746	Estimated funds to be expended in FY 12/13: $2,577,741
Estimated number to be served in FY 13/14: 2,400	Budgeted funds for FY 13/14: $4,007,323

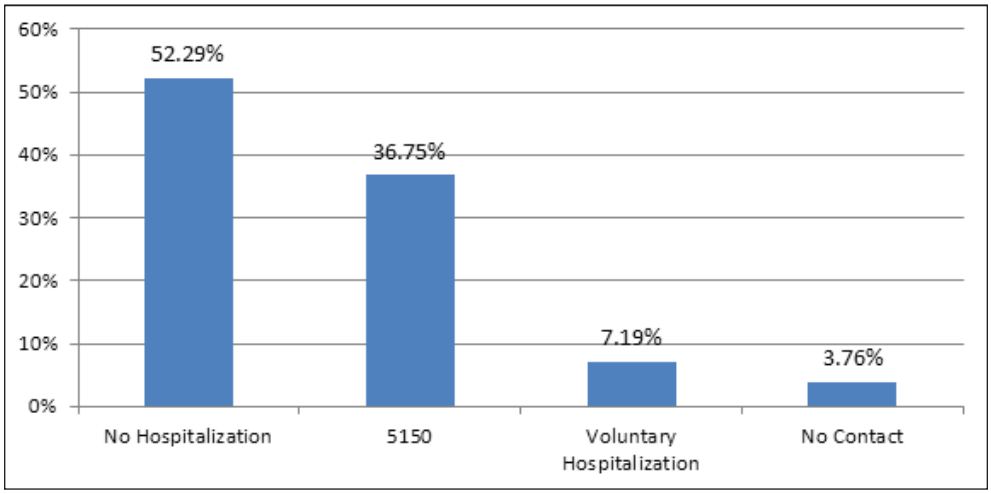
1. Program Description

The Centralized Assessment Team (CAT) provides mobile response, including mental health evaluations/assessment, for those who are experiencing a mental health crisis, 24 hours per day/7 days per week. In response to psychiatric emergencies, staff provides crisis intervention for hospital diversions, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies. Assessment/consultation services are provided in Hospital Emergency Departments (ED) for patients in need of, or waiting for, inpatient services. Bilingual/bi-cultural staff work with family members to provide information, referrals, and community support services.

The Psychiatric Evaluation and Response Team (PERT) is a partnership with law enforcement, which includes designated police officers and mental health staff that respond to calls from officers in the field. Mental health consultations are provided for individuals in an apparent mental health crisis. The program also provides outreach and follow up services to ensure linkage to ongoing services. Currently, PERT teams are located in Westminster, Garden Grove, Orange, Costa Mesa, and South Orange County Sheriff's Department.

2. Outcomes

The performance outcome data reflects the percent of clients assessed who were appropriate or not appropriate for inpatient hospitalization. The percent of total crisis response diverted from hospitalization continues to be monitored regularly.



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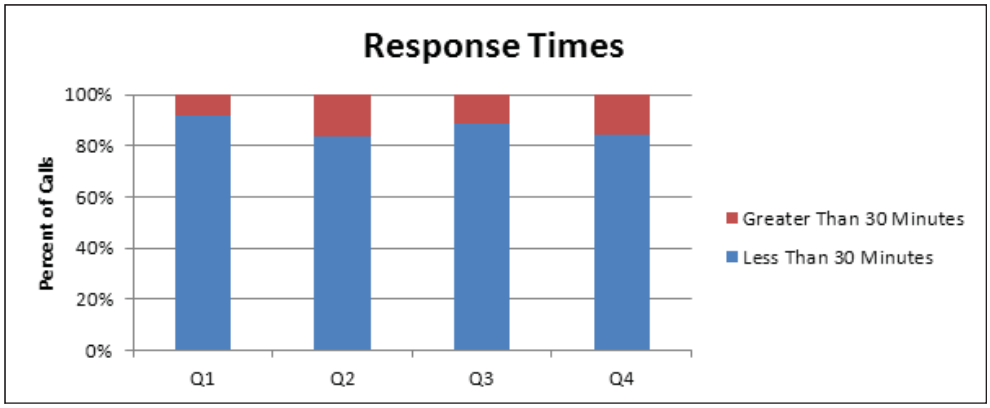
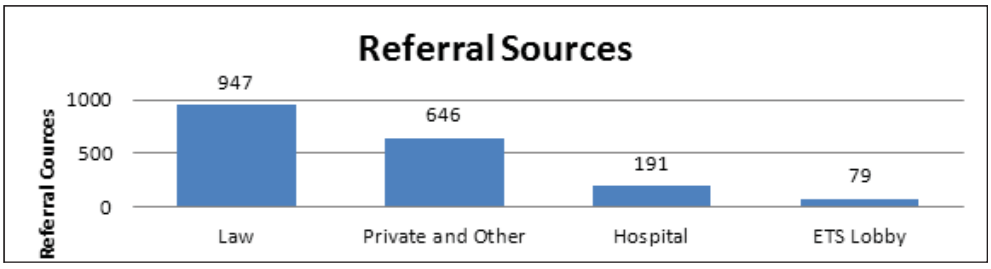
Community Services and Supports (CSS)

The average response time was just under 18 minutes with 88% of the calls below 30 minutes.



3. Process Indicators

The performance outcome data reflected the largest referral source for CAT response was law enforcement, at 45% of the calls. The second largest referral category at 41% was the category of "Private and Other" which includes family/significant others, clients, treatment centers, and others. Also of note is that 31% of the calls were received after hours from 5 p.m. to 7 a.m., when traditional services are usually not available.



4. Future Plans for Change

The recent addition of two Program Supervisors for the PERT team and evening staff has already promoted the plans for next year's enhanced service delivery. PERT teams have been effective in handling the needs of persons in immediate need of mental health crisis intervention and the expectation is that the next year will bring about additional PERT expansion to increase the number of law enforcement partnerships. Additional staff members will also increase the level of service provision during after-hours and weekends when traditional based services are unavailable. The CAT triage desk will soon implement an Electronic In-Out Board. This software will allow triage to instantly see who is available for dispatch in real time and quickly provide information on all staff for easy tracking. A Triage Data Base is also being incorporated to log all calls and the disposition of contact.

Community Services and Supports (CSS)

CSS Program Information
Adult Crisis Residential

Program Name: A3: Adult Crisis Residential	**Funding:**
Actual number served in FY 11/12: 160	Actual funds expended in FY 11/12: $1,527,402
Projected number to be served in FY 12/13: 334	Estimated funds to be expended in FY 12/13: $1,671,422
Estimated number to be served in FY 13/14: 322	Budgeted funds for FY 13/14: $1,651,229

1. Program Description

The Crisis Residential Program provides short term crisis intervention services to meet the needs of adults in a mental health crisis and who may be at risk of psychiatric hospitalization. The program emulates a home-like environment in which intensive and structured psychosocial recovery services are offered 24-hours a day, 7 days a week. Stays are voluntary and average 7-14 days. The program is client-centered and recovery-oriented and focuses on personal responsibility for the client's illness and reintegration into the community. Services include crisis intervention, development of a Wellness Recovery Action Plan (WRAP), group education and rehabilitation, assistance with self-administration of medications, case management and discharge planning.

The Crisis Residential Program also provides assessment and treatment services that include, but are not limited to, individual and group counseling; monitoring psychiatric medications; substance abuse education and treatment; and family and significant other involvement whenever possible. Each client admitted to the Crisis Residential Services Program has a comprehensive service plan that is unique, meets the individual's needs, and specifies the goals to be achieved for discharge. To effectively integrate the client back into the community, discharge planning starts upon admission.

The target population for this program is diverse adults (18-59) who are experiencing a mental health crisis. The program also provides dual diagnosis services for people who are experiencing a mental health crisis and also have substance use or abuse issues and may have a co-occurring disorder. These are clients who otherwise may have been admitted to an emergency room or hospitalized.

The current capacity expanded from six adults to fifteen adults in FY 12/13, when the program moved to a new facility in Orange.

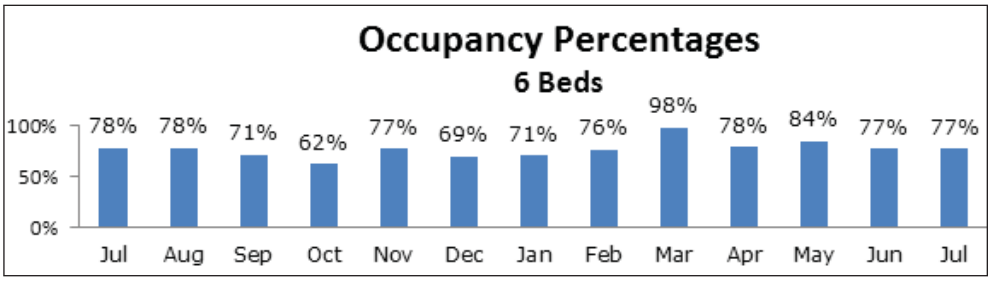
2. Outcomes

Ninety-four percent were discharged to a lower level of care. This demonstrated the program was successful in preventing the client from having an inpatient stay in a psychiatric hospital which is far more restrictive, can be disruptive to one's life and recovery, and is of course a significantly higher cost.

Community Services and Supports (CSS)

3. Process Indicators

The occupancy rate for the program was 77% for the fiscal year. The average daily census for the month ranged from a low of 3.7 to a high of 5.9. Filling the six bed facility to full capacity proved somewhat challenging due to the location. It was at the far north end of the county, and this factor discouraged many potential candidates. Moving the program to a new facility in central Orange County is expected to increase use of services.



4. Future Plans for Change

The future plan is to adjust to the new location and higher census now that it has been relocated to a central location that allows easier access for more clients. The new site is a two-story facility with an elevator and expanded program capacity from six beds to fifteen. Future plans include visiting potential referral sites to provide education about the expanded service and training on the referral process. Staff will continue reviewing performance monitors for trends and respond with refinements in monitoring as may be needed.

Community Services and Supports (CSS)

CSS Program Information
Supported Employment

Program Name: A4: Supported Employment	**Funding:**
Actual number served in FY 11/12: 353	Actual funds expended in FY 11/12: $1,007,970
Projected number to be served in FY 12/13: 350	Estimated funds to be expended in FY 12/13: $989,560
Estimated number to be served in FY 13/14: 350	Budgeted funds for FY 13/14: $1,021,417

1. Program Description

The Supported Employment program provides evidence-based services such as job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling, and peer support to individuals with serious and persistent mental illness and/or co-occurring substance abuse disorders. Services are provided in English, Spanish, Vietnamese, Farsi and American Sign Language.

Program participants work with a job developer (JD) to locate job leads using a variety of sources, including in-the-field employer canvassing, newspaper publications, online job search engines, job fairs, business mixers, regional job developer conferences and recruitments. The JD strives to build working relationships with prospective employers through cold calling and in-person presentations, and is the main liaison between the employer and the program participant. It is the responsibility of the JD to help the employer understand mental illness and combat stigmatization. In addition to locating promising job leads and potential employers, the JD assists consumers with application submissions and assessments, interviewing, image consultation, and transportation services.

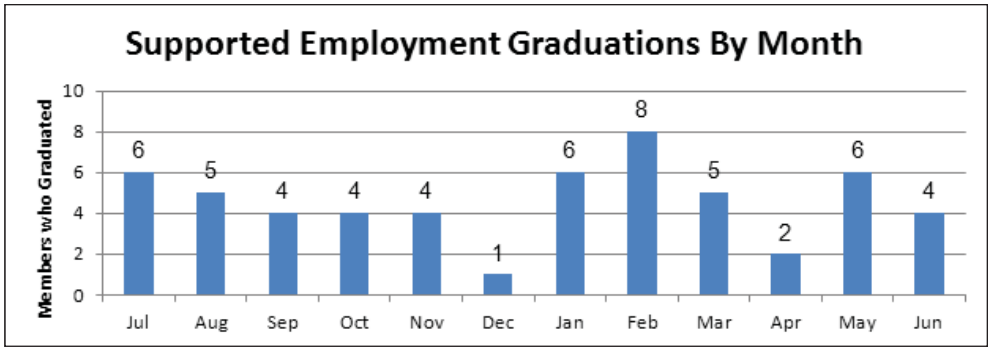
Each individual placed into competitive employment has the ongoing support of an Employment Training Specialist (ETS). The ETS is responsible for providing the consumer with one-on-one job support to ensure successful job retention. Specifically, the ETS models appropriate behavior, participates in the training of the consumer to ensure a foundational grasp of job responsibilities, communicates regularly with job site staff to recognize and address consumer successes and challenges, provides consistent encouragement, and practices conflict resolution. The ETS maintains ongoing, open communication with clinical care coordinators to promote positive work outcomes.

A significant change to the staffing model in FY 12/13, included combining the duties of the Job Developer with that of the Employment Training Specialist. This change has brought significant positive results in the first few months of FY 12/13. Maintaining the relationship with one staff member throughout the entire job development/placement process has resulted in greater client participation and fewer program dis-enrollments by maintaining consistency and familiarity throughout the entire program. Data is still being collected to determine the full outcome of this modification.

Community Services and Supports (CSS)

2. Outcomes

The Supported Employment Program served 353 program participants, which included 266 new enrollments. During FY 11/12, the program placed 107 program participants in competitive employment jobs and 6 participants in a paid traineeship. Additionally, 55 program participants graduated from the program after successfully reaching the State of California job retention benchmark (>90 days in paid employment).



3. Process Indicators

Combining the job duties of Job Developer and Employment Training Specialist has provided greater consistency in the relationship between participant and staff throughout the employment process.

4. Future Plans for Change

A pilot project that opened the Supported Employment program to a full service partnership program has resulted in three successful enrollments into the program since it began in the 2nd quarter FY 12/13. Because of the success of the pilot, the supported Employment Program will be opened to four additional Full Service Partnership programs, including programs with Transitional Age Youth (TAY) and Older Adult target populations, by the end of FY 12/13.

Community Services and Supports (CSS)

CSS Program Information
Adult Outreach and Engagement

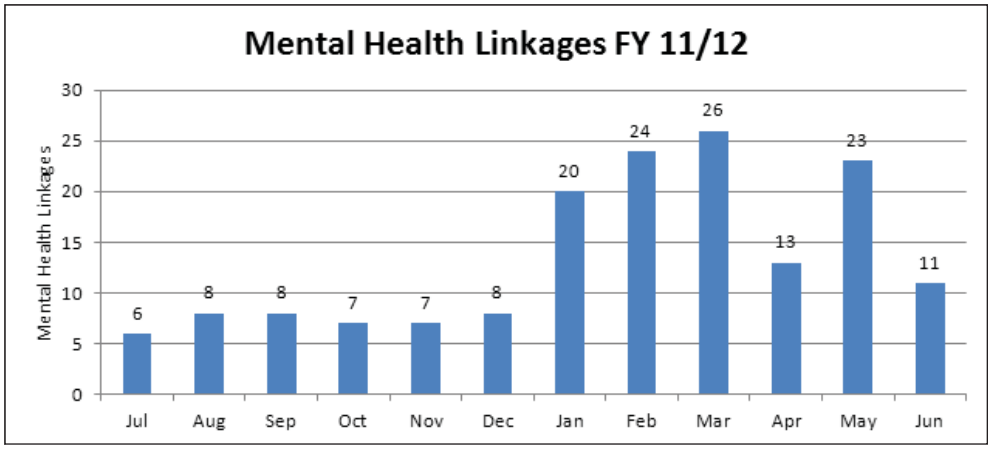
Program Name: A5: Adult Outreach and Engagement	Funding:
Actual number served in FY 11/12: 161	Actual funds expended in FY 11/12: $517,701
Projected number to be served in FY 12/13: 116	Estimated funds to be expended in FY 12/13: $505,308
Estimated number to be served in FY 13/14: 150	Budgeted funds for FY 13/14: $517,701

1. Program Description

The Mental Health Services Act (MHSA) Adult Outreach and Engagement program serves Seriously Mentally Ill (SMI) adults with co-occurring disorders from ages 26 and up that are homeless or on the verge of homelessness. The program assists the unserved or underserved adult with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or with other linkages to community resources. The program adheres to a "best practice" model by offering services using a strength-based and recovery-based approach that focuses on resiliency and the establishment and growth of local support systems. On-going Street Outreach is conducted to increase the acceptance of treatment and services and improve the stability of the individual in the community of choice.

2. Outcomes

The program is relied upon to handle community referrals of delicate and difficult cases where a serious mental illness and homelessness (or at risk of homelessness) is involved. The team participated in community activities throughout the County, which provided greater access to the target population and increased community awareness of available services.



3. Process Indicators

Community awareness increased leading to an increase in the number of Adults being served.

4. Future Plans for Change

The team will target "High Utilizers" of urgent care services and provide intensive Engagement, such as engaging such individuals two to three times a week, in an effort to increase linkages to Full Service Partnerships and other mental health services.

Community Services and Supports (CSS)

CSS Program Information
Program of Assertive Community Treatment

Program Name: A6: Adult Program of Assertive Community Treatment (PACT)	**Funding:**
Actual number served in FY 11/12: 685	Actual funds expended in FY 11/12: $4,249,893
Projected number to be served in FY 12/13: 700	Estimated funds to be expended in FY 12/13: $4,489,325
Estimated number to be served in FY 13/14: 700	Budgeted funds for FY 13/14: $4,531,926

1. Program Description

The PACT teams in Orange County target high risk underserved populations, such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth community, and mentally ill adults and older adults. To qualify for PACT services, individuals have to have been psychiatrically hospitalized multiple times in the last year for being considered dangerous to people in the community and/or themselves, or because they were unable to avail themselves of basic food, clothing or shelter due to their mental illness. In addition, treatment at a lower level of care has had to have failed to keep the person stable. PACT teams serve consumers who are most in need of help due to multiple hospitalizations or incarcerations and have not been able to access appropriate treatment. Assertive Community Treatment is a best practices model and Orange County PACT teams work to further their fidelity to this model.

The program focuses on delivering culturally competent services to adults in the community, to achieve their maximum recovery and independence in functioning. The program provides consumer-focused, culturally/linguistically competent, strength-based services. Interventions are usually provided in the home and community in order to reduce access or engagement barriers. A holistic team approach is stressed in this program, which is in and of itself culturally competent, in that it requires intense collaboration with primary care providers, family members, and other community supports. It is a multidisciplinary team model, comprised of Clinical Social Workers, Marriage Family Therapists, Mental Health Specialists, Psychiatrists, and a Supervisor. This team provides medication services, individual and group therapy, substance abuse and family therapy, as well as supportive services such as money management and linkage to community supportive services. The focus for this population is to address individual strengths and empower consumers to reach their highest potential. Re-integration into community institutions and organizations such as school, employment, and independent housing is stressed. Staff is sensitive to the individual needs of each adult consumer and is knowledgeable of the resources and issues for this population.

Community Services and Supports (CSS)

2. Outcomes

Over the last year, participants in the Adult PACT programs have shown marked improvement in their quality of life and significant decreases in hospitalization (62% reduction in hospital days), incarceration (55% reduction in incarceration days), homelessness (43% reduction in days homeless) and other high cost services provided by the County.

3. Process Indicators

There has been a challenge helping clients progress in recovery and helping them to navigate the system to access lower levels of care. Often it is difficult to transition throughout the system of care. Strides have been made over this fiscal year to improve the referral and linkage process in order to facilitate smoother transitions.

4. Future Plans for Change

No proposed changes.

Community Services and Supports (CSS)

CSS Program Information
Wellness Center

Program Name: A7: Wellness Center	**Funding:**
Actual number served in FY 11/12: 1,439	Actual funds expended in FY 11/12: $1,425,950
Projected number to be served in FY 12/13: 1,500	Estimated funds to be expended in FY 12/13: $1,268,489
Estimated number to be served in FY 13/14: 1,500	Budgeted funds for FY 13/14: $1,469,448

1. Program Description

The Wellness Center's mission is to provide a safe and nurturing environment for each individual to achieve his or her vision of recovery while providing acceptance, dignity and social inclusion. The Wellness Center is committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains. The Wellness Center facilitates over 100 groups weekly, including social outings, and has a growing number of members volunteering in the community as their way of giving back.

The Wellness Center supports clients who have achieved recovery by offering a program that is culturally and linguistically appropriate, while focusing on personalized socialization, relationship building, assistance maintaining benefits, setting employment goals, and providing educational opportunities. The Wellness Center is grounded in the recovery model and provides services to a diverse client base. These services facilitate and promote recovery and empowerment in mental health consumers.

Recovery interventions are client-directed and embedded within the following array of services, including individualized wellness recovery action plans, peer supports, social outings, and recreational activities. Services are provided by clients. The Wellness Center program is 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 clients to increase socialization and encourage 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 client's family, friends, and significant others.

The philosophy of the Wellness Center draws upon cultural strengths and utilizes service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. Wellness Center Program staff are consumers of mental health services. The Wellness Center uses a Member Advisory Board, a community town hall model, and member satisfaction survey results to make many of their decisions on programming.

Community Services and Supports (CSS)

The target group for the Wellness Center consists of those adults residing in Orange County, who are:

1. Over 18 years of age and have been diagnosed with a serious mental illness and may (or may not) have a co-occurring disorder;
2. Relatively stable and have achieved recovery;
3. Require a support system to succeed in remaining stable while continuing to progress in their recovery.

The program targets culturally/linguistically diverse groups such as Latinos, Vietnamese, Korean and Iranian, as well as non-English speaking monolingual individuals.

2. Outcomes

Increased efforts by Wellness Center staff to obtain new members has resulted in the average daily attendance increasing from 68 active members daily in the 2nd Quarter FY 12/13 to 75 active members daily in the 3rd quarter FY 12/13.

Focused efforts to increase participation by Wellness Center members in the semi-annual Members Satisfaction Survey increased participation from 72 members in June 2012 to 192 members in December 2012; results of the survey are forthcoming.

3. Process Indicators

Staff training on 'welcoming' members to the program has created an environment and culture of respect and dignity to all new and existing members participating in groups/activities offered at the center.

Open door policy by Wellness Center staff have created a collaborative environment for its members and instilled trust in their ability to approach staff to help resolve issues, as well as offer their input to group and activity programming.

Groups offered to members on public speaking and group facilitation have resulted in member-facilitated community meetings with at least 5 members presenting on a weekly basis.

Groups offered on volunteerism have resulted in members volunteering at food banks twice weekly with the goal of volunteering three days per week by the end of FY 12/13.

4. Future Plans for Change

No changes currently anticipated.

600 W. Santa Ana Blvd., Suite 510, Santa Ana, CA 92701 | (714) 667-5600 | MHSA@ochca.com | www.OCHealthinfo.com/MHSA

Community Services and Supports (CSS)

Client Success Story

I am very pleased to be able to share the success I have achieved through my involvement at the Wellness Center. I am a 58-year-old Caucasian, English speaking woman. I have participated in groups and activities at the Wellness Center since November 2009, roughly one month after the center opened.

It has been my privilege to be a member facilitator here at the Wellness Center, which I have been doing for quite some time. My current groups are Spirituality, World Religion, Famous Quotes, and Current Events. With the incredible opportunity I have been given to be a member facilitator here, I have been able to utilize my education in a way I never thought possible again.

I came to California to get a Ph.D from Claremont Graduate University, but my undiagnosed bipolar disorder made it very difficult for me to continue my studies, and I had to drop out of the Ph.D. program. During all the years when my bipolar disorder remained undiagnosed, I never, ever, thought that someday I would find, and rediscover the person – the scholar, with so much promise – that I once was. I thought that person was gone forever. Thanks to the incredible support, encouragement, affirmation, and validation I have received here at the Wellness Center, I have found that woman again.

Community Services and Supports (CSS)

CSS Program Information
Recovery Centers

Program Name: A8: Recovery Centers	**Funding:**
Actual number served in FY 11/12: 2,616	Actual funds expended in FY 11/12: $7,982,132
Projected number to be served in FY 12/13: 2,500	Estimated funds to be expended in FY 12/13: $8,372,533
Estimated number to be served in FY 13/14: 2,500	Budgeted funds for FY 13/14: $8,658,531

1. Program Description

The Recovery Center program provides a lower level of care for consumers who no longer need traditional outpatient treatment, yet need to continue receiving medication and episodic case management support. This program allows diverse consumers to receive distinct, mostly self-directed services that focus on consumer-community reintegration and linkage to health care. To a great extent, the program relies on client self-management. In addition, an important feature is a peer-run support program where consumers are able to access groups and peer support activities. These services are delivered along a continuum of care model that addresses individual needs of the client based upon their stage of recovery and are targeted to reduce reliance on the mental health system and increase self-responsibility with the ultimate goal of community reintegration. Services include, but are not limited to, medication management, individual and group mental health services, case management, crisis intervention, educational and vocational services, and peer support activities.

2. Outcomes

Overall, there has been a decrease in hospitalizations due to increased stability of consumers, as evidenced by higher Milestones of Recovery Scale (MORS) ratings, and when hospitalization was considered, the Recovery Centers have better utilized the Crisis Residential program services to help the consumers avoid inpatient care.

3. Process Indicators

Clients of the Recovery Centers are achieving a lower level of care and reintegration to the community. The Recovery Centers have shown consistent movement with graduations from their programs. Most clients have exited the system having completed their recovery goals.

4. Future Plans for Change

The Recovery Centers will continue to advance their services by evaluating their programs with the use of data outcomes and to test change ideas, a strategy acquired during the year-long California Institute for Mental Health (CIMH) initiative that occurred during this past year.

Community Services and Supports (CSS)

CSS Program Information
Adult Peer Mentoring

Program Name: A9: Adult Peer Mentoring	**Funding:**
Actual number served in FY 11/12: 275	Actual funds expended in FY 11/12: $282,199
Projected number to be served in FY 12/13: 300	Estimated funds to be expended in FY 12/13: $263,240
Estimated number to be served in FY 13/14: 300	Budgeted funds for FY 13/14: $332,179

1. Program Description

The Peer Mentoring program was created to build community support services that bridge existing gaps in the recovery continuum. The services target some of the most common reasons for re-hospitalization after discharge, including interruption of medication, lack of social support and unstable housing. These services include social support, assisting with basic household items, food, clothing, and transportation needs which have been identified to assist the consumer. The majority of the services provided by the peer mentors are in the field. Service locations include hospitals, consumer's homes, and various places in the community, such as primary care facilities. This program serves clients from diverse cultural groups such as Latinos, Vietnamese, Koreans, and Iranians as well as non-English-speaking monolingual individuals, and Deaf and Hard of Hearing.

The Adult Peer Mentoring Program pairs qualified, culturally/linguistically competent peer consumers with individuals in certain psychiatric hospitals who are soon to be discharged, and assists them in successfully transitioning to community living. Helping selected individuals to make a successful transition into the community is facilitated by providing assistance and support from qualified, trusted, and well-prepared peers. The goal is to ensure the client's continued recovery and successful transition to healthy and effective community living.

Peer Mentors support the individual's recovery goals and therapeutic needs. Examples of activities include: helping clients get to the first appointment; meeting with the individual's assigned Care Coordinator or Psychiatrist; assisting clients in picking up prescribed medications at a local pharmacy; and encouraging (and at times participating) in their recovery activities. Mentors will also assist in other needs of community living (e.g., acquiring benefits, food, and clothing; doing laundry; learning the bus routes, etc.). Peer Mentors have caseloads of six to eight individuals, and work a schedule that allows for some flexibility and rotational on-call in the evening and one weekend approximately every two months.

2. Outcomes

Consumers involved with the peer mentoring program describe increased satisfaction with their overall quality of life once completing the program. Both the peer mentors providing services and the referring clinician also provided high satisfaction ratings.

Community Services and Supports (CSS)

3. Process Indicators

As part of the program, consumers who are referred by clinicians are to be contacted by a peer mentor within 72 hours of receiving the referral. For FY 10/11, only one consumer was seen outside this time limit. Clinicians referring clients to peer mentoring describe the short amount of time between referral and linkage as a great value to the consumer.

4. Future Plans for Change

No proposed changes at this time.

Community Services and Supports (CSS)

CSS Program Information
Older Adult Recovery Services

Program Name: O1: Older Adult Mental Health Recovery Program	**Funding:**
Actual number served in FY 11/12: 478	Actual funds expended in FY 11/12: $1,755,211
Projected number to be served in FY 12/13: 500	Estimated funds to be expended in FY 12/13: $1,751,843
Estimated number to be served in FY 13/14: 500	Budgeted funds for FY 13/14: $1,668,135

1. Program Description
The Older Adult Recovery Program serves individuals 60 years of age or older who are seriously and persistently mentally ill. They show clear functional impairments as a result of the mental disorders. These consumers are in the most need of on-going services. The Recovery Program provides initial psychiatric services in the consumer's home. As clients progress in their recovery they are scheduled for follow-up appointments at the Recovery Clinic. Consumers have access to case management, crisis, medication, and therapy (individual, group, and family) services, both at home if needed and in the clinic.

This program serves clients from diverse cultural groups such as Latinos, Vietnamese, Koreans, and Iranians as well as non-English-speaking monolingual individuals, and Deaf and Hard of Hearing. The target population struggles with the acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. Individuals eligible for this program typically have a chronic mental illness that is complicated by at least one medical condition. Older adults receiving this service are often very isolated, homebound, and have limited resources. This population is disproportionately represented in the suicide statistics as well as victimization statistics.

2. Outcomes
The Older Adult Recovery Program continues to provide services to consumers in great need. The program is working to collect more complete data to study consumer satisfaction in the next year. In addition, staff plans to track the success of clients moving through the continuum of care by utilizing the peer mentoring program.

3. Process Indicators
Clients served by this program are in great need of services in the home and not in a clinic setting. The fact that most services provided by this program occur in the field, is seen by the community to be of great benefit to the clients served.

Also, when the program incorporates the older adults Milestones of Recovery Scale (MORS), it will be implemented as another tracking tool.

4. Future Plans for Change
There continues to be a problem with helping clients progress in recovery and linking to lower levels of care. At times, consumers in this program have had difficulty making the transition out of the public mental health system and return to services within a year. The program's goal over the next year is to increase utilization of the older adult peer mentoring program to help facilitate that linkage and to continue the consumer's progress in recovery.

Community Services and Supports (CSS)

CSS Program Information
Older Adults Support Intervention Systems

Program Name: O2: Older Adult Support Intervention Systems (OASIS) Older Adult FSP	**Funding:**
Actual number served in FY 11/12: 200	Actual funds expended in FY 11/12: $2,321,251
Projected number to be served in FY 12/13: 200	Estimated funds to be expended in FY 12/13: $2,323,944
Estimated number to be served in FY 13/14: 200	Budgeted funds for FY 13/14: $2,536,395
Estimated Cost Per Client FY 12/13 (FSPs only) $18,252	

1. Program Description

The Mental Health Services Act Full Service Partnership (MHSA FSP) Older Adults Program serves the target population of 60 and over. Services include 24 hour a day, seven days a week intensive case management/wraparound services, community-based outpatient services, peer mentoring, housing supports, meal services, transportation services, benefit acquisition, supported employment/education services, linkage to primary health care and integrated services for co-occurring disorder treatment. Full Service Partnerships provide an integrated team to work with the consumer to develop plans for and provide the full spectrum of community services, so that consumers can reach their identified goals. Programs are strength-based, with the focus on the person rather than the disease. Services are provided to those seniors who need them to maintain their current housing.

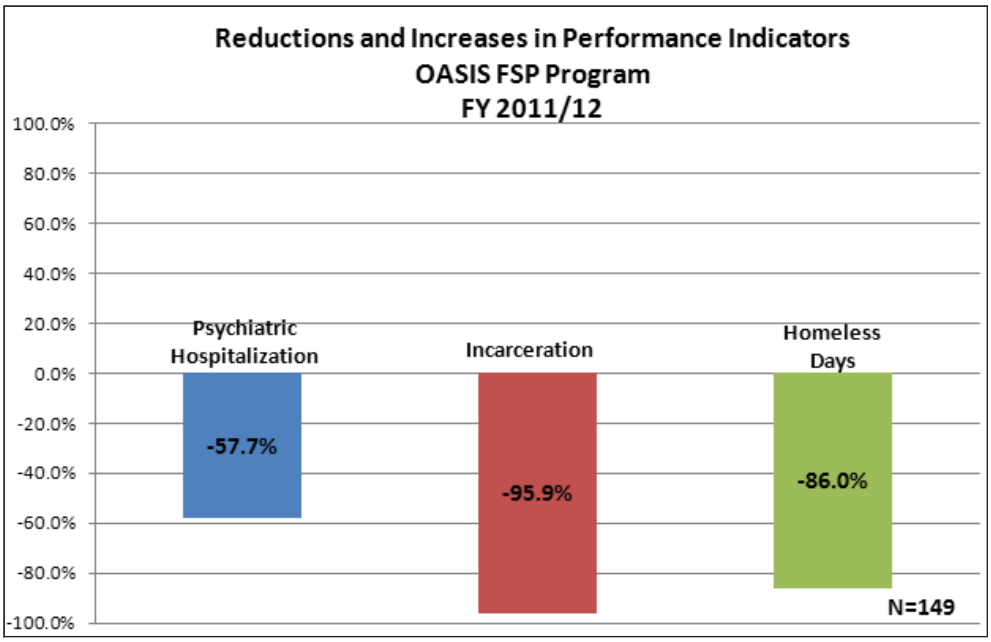
Services are delivered at the consumer's home, room and board, assisted living facility, or wherever the consumer resides. The program works with families and significant others to ensure that the client is able to remain in the lowest level of placement. These seniors are at risk of institutionalization, criminal justice involvement and are homeless or at risk of homelessness. The program is linguistically and culturally capable of providing services to the underserved ethnic populations in Orange County, including Vietnamese and Spanish-speaking consumers.

2. Outcomes

The MHSA FSP programs continue to learn and adopt new models of emerging and evidenced based practices. In addition, they work toward improving and expanding the quality and availability of data and data analysis to promote the dissemination of effective, evidenced based interventions and services to advance and identify better health outcomes for individuals, families and communities.

Community Services and Supports (CSS)

In September 2012, the Older Adults Program implemented Program to Encourage Active and Rewarding Lives for Seniors (PEARLS). The PEARLS Program was developed at the University of Washington in the late 1990s by a team led by Dr. Ed Wagner, who is a primary developer of the Chronic Care Model. During the past decade, it has been demonstrated that the PEARLS Program is effective in reducing depressive symptoms and improving the quality of life of older adults.



3. Process Indicators

In August 2012, the Older Adult Program began the process of training clinicians and peer mentors in Screening Brief Intervention, and Referral to Treatment (SBIRT) and Motivational Interviewing. Considering the focus on being co-occurring capable and standardization of assessment tools, these trainings are designed particularly for intake staff and staff who engage the member at the front door. This includes licensed professional staff who provide initial assessments and diagnostic impressions. Issues of accessibility have been identified as barriers. The program management has a good solid plan in addressing these issues by the use of evidenced based practices. All services are provided in a culturally sensitive manner, and all efforts are made to train and hire staff members who speak the languages that are reflected in the program population and threshold languages.

4. Future Plans for Change

In FY 12/13, the Health Care Agency seeks to implement Transformational Care Planning (TCP) across the agency. TCP is the understanding and development in the key building blocks of cultural inclusiveness, recovery, resiliency and wellness. TCP calls attention to "Person-first." Person-first is inclusive and identifies strengths and capabilities, nationality and ethnicity, sexual orientation, faith and spirituality, gender identity, age, social role intellectual and cognitive abilities. TCP is recovery oriented care that challenges us to move past the maintenance of clinical stability to the true pursuit of living a meaningful life in the community.

Community Services and Supports (CSS)

In December FY 12/13, Orange County, in collaboration with the California Institute of Mental Health (CIMH) and leaders of Strength Based Models, began the year with the Strengths Model. The Strengths Model was developed by the University of Kansas, School of Social Welfare in the mid-1980s as a response to traditional deficit oriented approaches. The Strengths Model is both a philosophy of practice and a set of tools and methods designed to enhance recovery. While the tools are primarily geared for clinicians, case workers and administrative staff, the principles of this model have agency-wide applications.

Client Success Story

Mr. H has been a member of the OASIS program since April 2007 and is a testament to the efforts of the human spirit for success, despite adversity. Prior to joining the program, Mr. H, who is a Veteran, served in the military, had been homeless for approximately eight years, had been enrolled in two Alcohol Recovery programs, and struggled to manage his Bipolar Disorder diagnosis. Since his admission, Mr. H has had to overcome additional significant obstacles such as spending 60 days in jail for driving an uninsured vehicle without a driver's license. He has also been battling a non-contagious form of lymph node tuberculosis for which he had to make trips to a clinic in Santa Ana for medication daily for six months. He recently received a completed certificate for the necessary medication regimen.

Despite all of these challenges, Mr. H has remained focused on his goal to secure gainful employment in a field of work of his choice, for at least another 10 years. In May 2009, he completed the Paraprofessional Training Program. After this major accomplishment, Mr. H determined that his goal was to work as a nurse so that he could be able to help others. He applied to the North Orange County Regional Occupation Program and was accepted for the Licensed Vocational Nurse (LVN) Program. He has since been taking the necessary prerequisite courses for the program and has begun full-time nursing school. Mr. H attributes his success and ability to overcome these major life obstacles to his faith in God and the assistance he has received from the OASIS program.

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Community Services and Supports (CSS)

CSS Program Information
Older Adult PACT

Program Name: O3: Older Adult Program of Assertive Community Treatment (PACT)	**Funding:**
Actual number served in FY 11/12: 85	Actual funds expended in FY 11/12: $464,317
Projected number to be served in FY 12/13: 100	Estimated funds to be expended in FY 12/13: $512,315
Estimated number to be served in FY 13/14: 100	Budgeted funds for FY 13/14: $521,632

1. Program Description

Older Adult Program of Assertive Community Treatment (PACT) teams in Orange County target high risk underserved populations, such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth community, and mentally ill adults and older adults. To qualify for PACT services, individuals must have been psychiatrically hospitalized multiple times in the last year for being considered dangerous to people in the community and/or themselves, or because they were unable to avail themselves of basic food, clothing or shelter due to their mental illness. In addition, treatment at a lower level of care must have failed to keep the person stable. PACT teams serve consumers who are most in need of help due to multiple hospitalizations or incarcerations and have not been able to access appropriate treatment. Assertive Community Treatment is a best practices model and Orange County PACT teams work to further their fidelity to this model.

The program focuses on delivering culturally competent services to seniors in the community, so that clients may achieve their maximum level of functioning and independence. The program provides consumer-focused, recovery-based services, and provides intervention, primarily in the home and community, to reduce access or engagement barriers. Collaboration with primary physical health care and providers of community and family supportive services is stressed in this multidisciplinary model of treatment.

The population struggles with the acute and chronic symptoms of mental illness and consumers often present with multiple diagnoses and multiple functional impairments. This population requires frequent and consistent contact to engage and remain in treatment. The target population is multicultural and includes Latinos, Vietnamese, Koreans and Iranians, and is disproportionately represented in the suicide statistics, as well as victimization statistics.

Community Services and Supports (CSS)

2. Outcomes

Over the last year, participants in the OAS PACT programs have shown marked improvement in their quality of life and significant decreases in hospitalization (35% reduction in hospital days), incarceration (88% reduction in incarceration days), 911 calls (92% reduction in calls), ER Visits (77% reduction in visits), homelessness (35% reduction in days homeless) and other high cost services provided by the County.

3. Process Indicators

There has been a challenge helping clients progress in recovery and linking to lower levels of care. Often consumers in this program have difficulty making the transition out of the public mental health system. The program's goal over the next year is to utilize the older adult peer mentoring program to help facilitate that linkage and to continue the consumer's progress in recovery.

4. Future Plans for Change

No proposed changes.

Community Services and Supports (CSS)

CSS Program Information
Older Adult Peer Mentoring

Program Name: O4: Older Adult Peer Mentoring	**Funding:**
Actual number served in FY 11/12: 61	Actual funds expended in FY 11/12: $673,435
Projected number to be served in FY 12/13: 70	Estimated funds to be expended in FY 12/13: $628,193
Estimated number to be served in FY 13/14: 70	Budgeted funds for FY 13/14: $792,709

1. Program Description

The Peer Mentoring program was created to build community support services that bridge existing gaps in the recovery continuum. The services target some of the most common reasons for re-hospitalization after discharge, including interruption of medication, lack of social support and unstable housing. These services include, social support, assisting with basic household items, food, clothing, and transportation needs which have been identified to assist the consumer. The majority of the services provided by the peer mentors are in the field. Service locations include hospitals, consumer's homes, and various places in the community, such as primary care facilities.

The Older Adult Peer Mentoring Program pairs qualified, culturally/linguistically competent peer consumers with individuals in certain clinical circumstances, including hospitalizations, and assists them in successfully transitioning to community living. Helping selected individuals to make a successful transition into the community is facilitated by providing assistance and support from qualified, trusted, and well-prepared peers to ensure the client's continued recovery and successful transition to healthy and effective community living.

Peer Mentors support the individual's recovery goals and therapeutic needs. Examples of activities include helping clients get to the first appointment; meeting the individual's assigned Care Coordinator or Psychiatrist; assisting clients in picking up prescribed medications at a local pharmacy; assisting clients to re-connect with family and friends or to develop a support network; and encouraging (and at times participating in) their recovery activities. Mentors also assist in accessing other needs of community living (e.g. assisting in acquiring benefits, food, and clothing; doing laundry; learning the bus routes).

2. Outcomes

Peer mentoring has been very successful in terms of the consumer and staff satisfaction scores. Consumers rated their satisfaction with services they received very highly. Clients also rated their satisfaction as high for both the peer mentors providing services and the referring clinician.

Community Services and Supports (CSS)

3. Process Indicators

As part of the program, consumers who are referred by clinicians are to be contacted by a peer mentor within 72 hours of receiving the referral. For FY 10/11, only one consumer was seen outside this time limit. Clinicians referring clients to peer mentoring describe the short amount of time between referral and linkage as a great value to the consumer.

4. Future Plans for Change

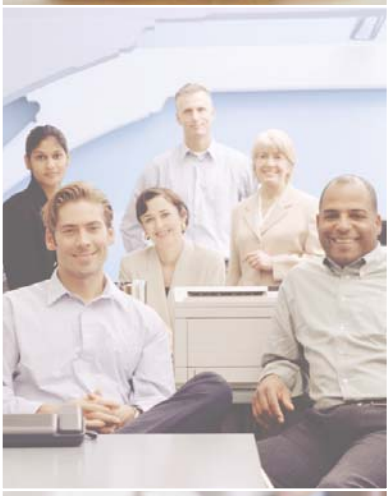
The Older Adult peer mentoring program is working to increase referrals by adding a track for older adults who need help linking to a lower level of care in the recovery continuum. There will be a peer mentor dedicated to this track. This is in response to staff having heard from the community and providers of services to older adults that this was needed. This track started last year, but has only had a few referrals so far.

Workforce Education and TRAINING




"The secret to getting ahead is getting started." - Mark Twain

Workforce Education and Training Services (WET)



A. Component Information

MHSA-Workforce Education and Training (WET) funds were allocated to address occupational community-based shortages in the public mental health system. The WET component is focused on training staff members with necessary skill sets to provide services in accordance with MHSA principals, offering education and training that promote wellness, recovery, and resilience to county staff and that of contracting community partners.

Skills building and education are also being provided to prepare and encourage the employment of mental health consumers and family members within the behavioral health system. Effort is also focused on developing and maintaining a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members, who are capable of providing consumer and family-driven services.

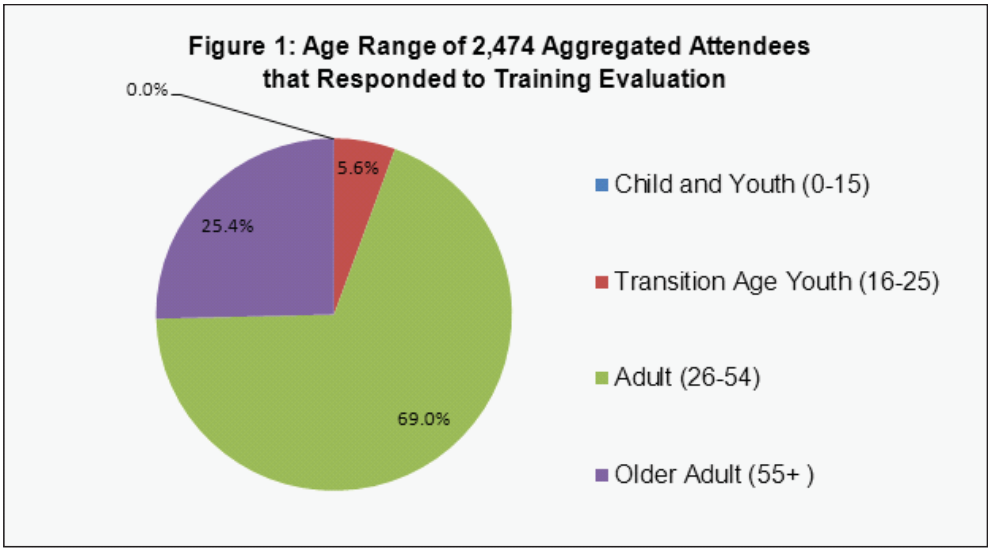
Programs were created to increase the capacity of postsecondary education through Master degree level to meet the needs of identified behavioral health occupational shortages, and to provide stipend programs for staff, as well as graduates from consumer training programs enrolled in academic institutions who want to be employed in the mental health system. Financial incentive programs for Associates of Arts, Bachelor's and Master's level offer stipends in return for a commitment to employment in the local public mental health system. A portion of WET was also used for training and to develop a child psychiatry residency program.

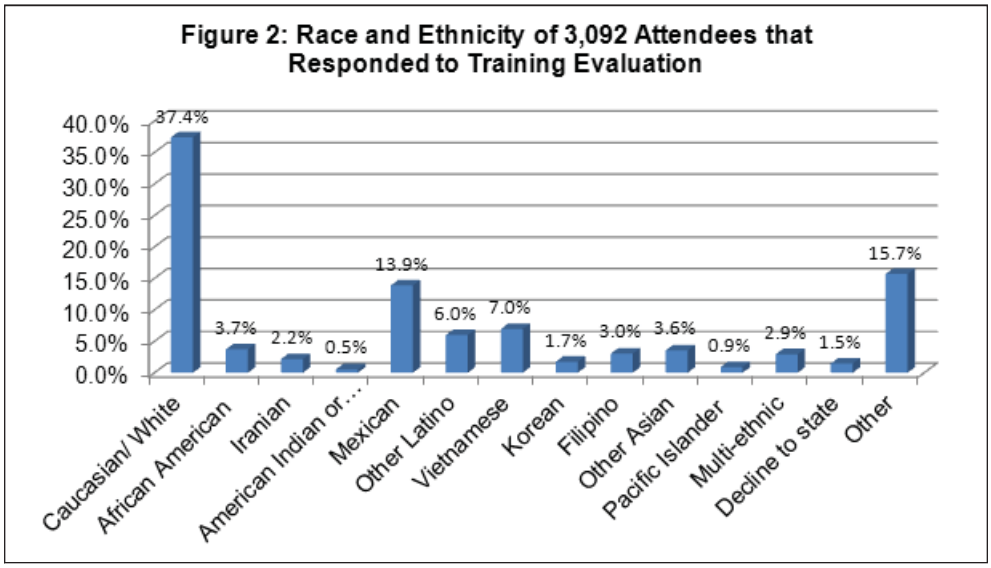
The WET allocation was one-time funding. Use of the WET funding was spread over several years. However, the one-time fund for the WET component was exhausted in June 2012 and unspent dollars from Community Services and Supports (CSS) are being used to support the programs. In the future, WET Programs will need to be maintained with CSS funding.

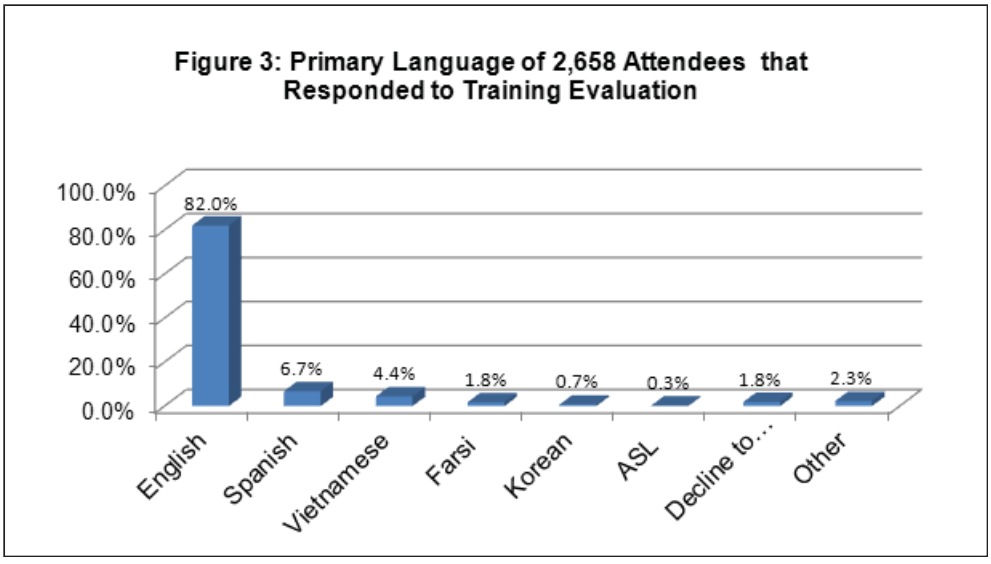
As discussed above, WET funds a variety of disparate programs/services. To get a better a picture of who is being served with WET funding, a decision was made to focus on Trainings/Conferences since that activity has by far the largest number of participants.

Of the total 6,783 individuals who attended 253 WET training activities in FY 11/12, less than half completed the training evaluation form. Presented in the aggregate, demographic data in Figure 1 represents the 39 percent who responded to the age survey question on the training evaluation. Figure 2 reports the race and ethnicity of the 48.7 percent who attended. Figure 3 indicates the primary language spoken at home for 41.9 percent of training participants, and Figure 4 reports the specific cultures of the three and a half percent who responded to this question on the evaluation.

Workforce Education and Training Services (WET)







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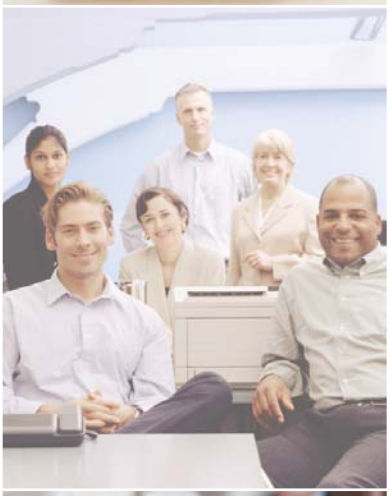

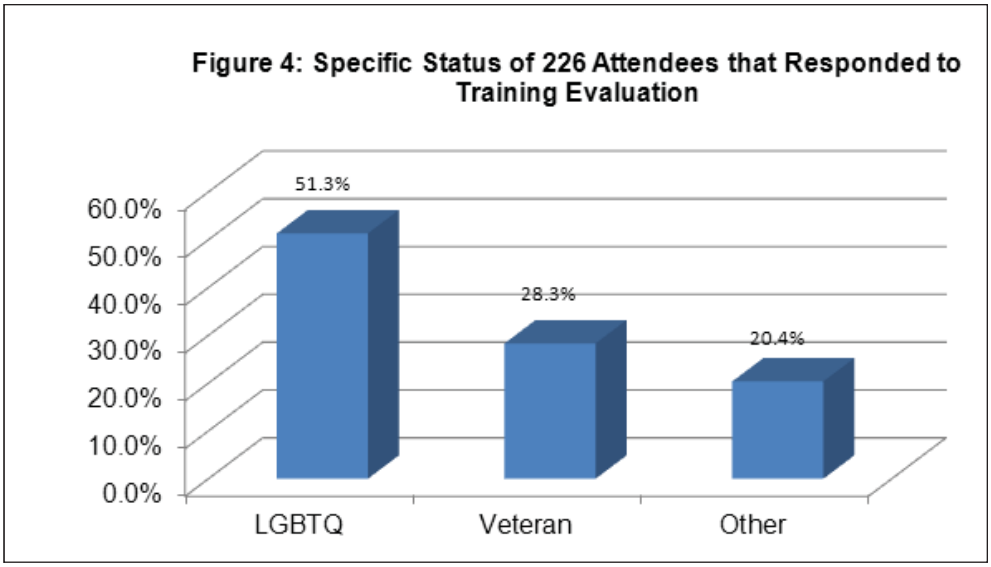

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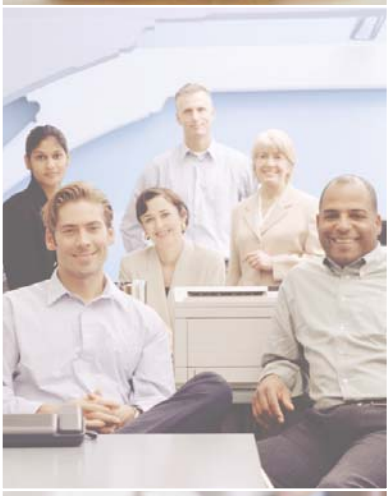


B. WET Program Information

Following are the program descriptions within the WET component and information on FY 11/12 program activities:

W1. Workforce Education & Training Coordination

This WET program provides a wide variety of trainings including recovery, disparity and stigma reduction to the community, consumers, family members, primary care and behavioral health providers. A total of 3,486 attendees participated in 76 trainings conducted in FY 11/12 that included Immersion, Clinical Supervision; Laws & Ethics; 5150 & 5585 Voluntary Hospitalization; Impact of Trauma & Coping Skills; Group Therapy; and Recovery Orientation Treatment Planning. Two large conferences "Eliminating Racial Disparity & Disproportionality" and "Veterans' Behavioral Health" were also implemented.

W2. Consumer Employment Specialist Services

Consumer Support Staff interfaces with Behavioral Health and its contract agencies and community partners to promote and support employment of consumers in the public mental health system. Thirty-six Ticket to Work and trainings on SSI/SSDI Work Incentives & Employment Training were offered to 355 consumers and providers in FY 11/12 to raise awareness on work incentives.

W3. Liaison to Regional Workforce Education & Training Partnership

Both the Orange County WET Coordinator and Assistant Coordinator work collaboratively with the Southern Region to plan training activities and increase work force diversity/opportunities in the public mental health system. They participate in regional conference calls and in-person meetings.

W4. Training on Evidence-Based Practices

Besides Cognitive Behavior Therapy (CBT), training emphasis has been focused on evidence-based crisis interventions and trauma-informed approach, Non-Violent Crisis Intervention (NVCI), Group and Individual Crisis Response and Trauma-Focused Cognitive Behavioral Therapy. Ten client-centered, community- and evidence-based best practices trainings were provided in FY 11/12 to a total of 463 attendees who are County and county-contracted staff, community partners, and consumers/family members. Staff effort was also put forth to collaborate with the Northern California Region to implement a Crisis Intervention Therapy (CIT) conference.

W5. Training Provided by Consumers and Family Members for Staff, Consumers/Family and Community

Recovery trainings were provided by and from the lived-experience perspectives of consumers/family members and non-English speaking communities to reduce stigma among staff in the mental health system and to raise awareness of behavioral health conditions across communities. Mental Health First Aid curriculum and NAMI Provider Education were also offered. The second Annual Institute for Peer Support Services conference was conducted to provide skills building and networking resources. In FY 11/12, a total of 11 trainings were implemented and 380 peers, peer mentors, providers, community partners and members participated in this program.

Workforce Education and Training Services (WET)

W6. Cultural Competence Training for Staff and Community

Trainings have been focused on a culturally responsive approach in working with the Deaf and Hard-of-Hearing consumers and under-served populations to raise awareness and acceptance of cultural diversity among behavioral health providers and community partners. Staff time is also dedicated to interpretation and translation of materials into Spanish, Vietnamese, and Farsi, and providing linguistically appropriate behavioral health information and resources to the underserved monolingual consumers and family members. Guided by a collaborative interfaith community and behavioral health advisory board, a workshop series was developed to include the integration of spirituality and a behavioral health treatment component. Client Culture, Understanding Vietnamese American Culture, Working Effectively with Sign Language Interpreters in Mental Health Settings, Integrating Spirituality and a Behavioral Health workshop series were offered. In FY 11/12, a total of 34 culturally responsive trainings were conducted and 977 people attended.

W7. Training for Foster Parents & Others Working w/ Foster Children & Youth

Trainings were provided to residential child care workers, Therapeutic Behavioral Coaches, direct service staff working with foster children, Transitional Age Youth (TAY), and foster parents to enhance their skill in interacting with foster children and youth. A Transitional Age Youth Conference was held in FY 11/12 that drew 142 attendees.

W8. Mental Health Training for Law Enforcement

The 16-hour curriculum was conducted by psychiatrists, subject matter experts, and contracted providers from a community college, along with the participation of mental health consumers and family members. In FY 11/12, 15 best-practice classes of the Crisis Intervention Training (CIT) curriculum were taught to a total of 480 Orange County law enforcement officers.

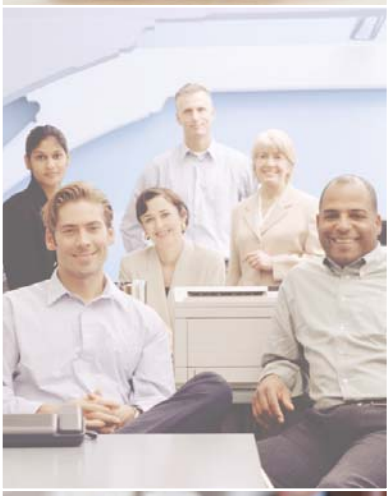
W9. Training Consumers & Family Members for Employment in the Mental Health System

With the goal of including people with lived experience as service providers in the public mental health system, this program was designed to enable consumers/family members to obtain a Mental Health Paraprofessional Certificate from a community college and become service providers or operators of consumer-run services. In FY 11/12, 89 consumer family members were trained. However, due to the economy downturn, only 21% of the total 500 consumers and family members trained since the inception of the program were able to obtain jobs. Thus, the program was discontinued at the end of June 2012, although similar training is available through other community resources.

W10. The High School Academy

The program was initially proposed to recruit high school students for mental health occupations and to enhance the prevalence of mental health occupations in high school career development programs. Due to a variety of factors, this program was never implemented.

Workforce Education and Training Services (WET)



W11. Community College and Undergraduate Certificate Program
This program was originally intended to promote a human services career pathway with community college and undergraduate students from Orange County universities to overcome the behavioral health workforce shortage. This program was not implemented due to the overlap of program offerings by the Recovery Education Institute in W12 and the financial incentive in W17.

W12. Recovery Education Institute
To prepare consumers and family members who aspire to a career in behavioral health, the Recovery Education Institute (REI) provides training on basic life and career management skills, academic preparedness and certified programs needed to solidify the personal and academic skills necessary to work in the system. REI employs Academic Advisors to mentor and Peer Success Coaches to tutor students. The program also collaborates with adult education programs and links students to local community colleges for pre-requisite classes, as well as providing accredited college classes and certificate courses. In FY 11/12, a total of 200 unduplicated students participated in 69 trainings. Wellness Recovery Action Plans, Peer Empowering Peer, and Self-Managing Wellness were among the variety of courses offered. The total (duplicated) number of attendees was 1,769.

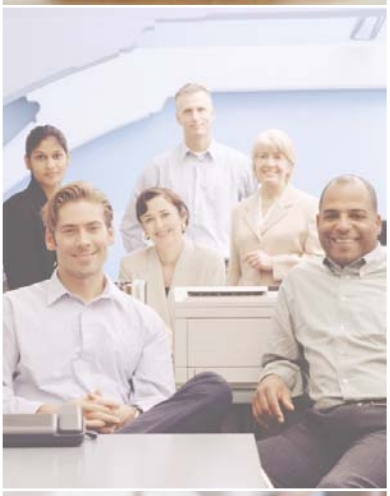
W13. Graduate Student Interns
To overcome shortages and increase a culturally diverse, bilingual work force committed to working in the public behavioral health system, clinical supervision is provided by county-licensed staff to graduate intern students who served in non-MHSA clinical programs and are on a clinical licensure track in social work, psychology, marriage and family therapy, or psychiatric nursing. In FY 11/12, a total of 185,920 of supervision hours were provided to 166 interns.

W14. Supervision for High School, Associate of Arts and Bachelor Level Interns
This program was originally designed to provide proper supervision to high school, Associate of Arts and Bachelor level students to intern in behavioral health services. The program has been inactive since the inception of implementing the WET component as there is a shortage of licensed supervisors.

W15. AA/BA/MA Program Recruiter
This position was intended to recruit students for mental health occupations to increase the prevalence of human services career development. Since the Recovery Education Institute already performs this task, the position was not initiated.

W16. Psychiatry Residencies and Fellowship
In order to overcome the shortage of child and community psychiatrists working in the public mental health system, supervision, multicultural and client-centered training are provided to psychiatry residents and fellows to recruit talented people, reduce stigma and enhance understanding from the consumer and family perspectives. In FY 11/12, WET funded eight residencies and four fellowships through the Psychiatry Department at UCI School of Medicine.

Workforce Education and Training Services (WET)



W17. Financial Incentives--Associate of Arts (AA) and Bachelor of Arts (BA) Stipends

The County of Orange collaborates with numerous colleges and universities to provide stipends to County and contracting staff, as well as graduates from consumer training programs to increase a diverse bilingual/bicultural workforce and the inclusion of consumer professionals. Stipend awardees are also required to work for County and contracting agencies in return. In FY 11/12, tuition incentives were provided to 12 potential staff to obtain the necessary educational skills for their AA and BA degrees.

W18. Financial Incentives--MA Stipends

Using an approach similar to that used in W17, this program is aimed at increasing a diverse bilingual/bicultural workforce and the inclusion of consumer professionals. Tuition incentives were provided to 19 potential staff in FY 11/12 to obtain the necessary educational skills toward their Master of Arts.

W19. Financial Incentives--20/20 Programs for Public Mental Health Employees to Attend Graduate School

The program was discontinued as there was insufficient workforce available to attend and sustain the program.

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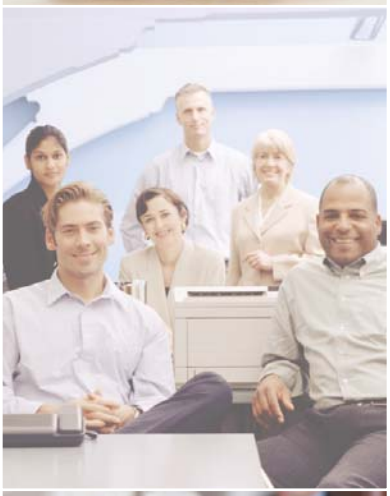
Workforce Education and Training Services (WET)

In FY 11/12, a total of 251 trainings were conducted and supported by WET with a record attendance of 6,343 individuals. Attendance is the primary process indicator used to measure success. FY 11/12 attendance by each WET program is summarized in the following table:

No.	WET Component	Number of Trainings	Number of Attendees
W1	Workforce Education & Training Coordination	76	3,486
W2	Consumer Employment Specialist Services	36	355
W3	Liaison to Regional Workforce Education & Training Partnership	0	2
W4	Training on Evidence-based Practices	9	463
W5	Training Provided by Consumers & Family Members for Staff, Consumers/ Family Members, & the Community	11	380
W6	Cultural Competence Training for Staff and Community	34	977
W7	Training for Foster Parents & Others Working w/ Foster Children & Youth	1	142
W8	Mental Health Training for Law Enforcement	15	480
W9	Training Consumers & Family Members for Employment in the Mental Health System	2	89/96
W10	High School Academy	N/A	Not implemented
W11	Community College & Undergraduate Certificate Program	0	Not active
W12	Recovery Education Institute	69	200 unduplicated 1,769 duplicated
W13	Graduate Student Interns	N/A	166 interns/ 185,920 hours
W14	Supervision for High School, AA & BA Interns	N/A	Not implemented
W15	AA/BA/MA Program Recruiter	N/A	Not active
W16	Psychiatry Residencies and Fellowship	N/A	8 residents/ 4 fellows
W17	Financial Incentives--AA and BA stipends	N/A	12
W18	Financial Incentives--Graduate Degree Stipends	N/A	19
W19	Financial Incentives—20/20 Programs	0	Not active
	Total	**253**	**6,783**

Workforce Education and Training Services (WET)



Below are some examples of recent WET program accomplishments:

1. Spirituality as an integrated component in Behavioral Health Services and assessment was formally introduced for the first time in FY 11/12 to Orange County providers, community partners and stakeholders. The Spirituality seminar series drew a strong response of 502 attendees.

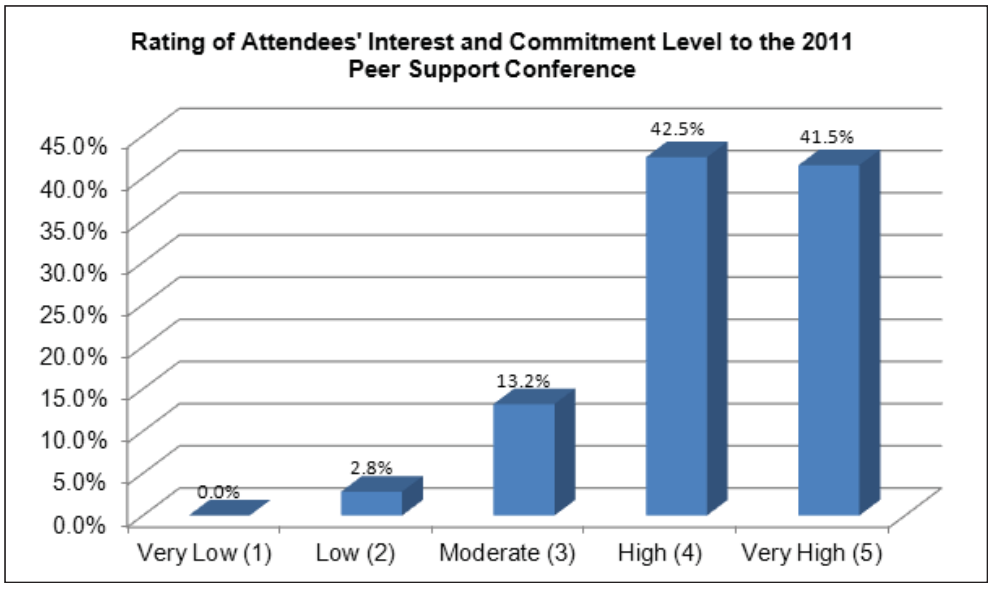
2. There has been a committed effort to train Law Enforcement in Orange County using the 16-hour curriculum modeled after the Crisis Intervention Training (CIT) model to reduce stigma against community members with behavioral health issues. This effort has been consistent and continuous, with 15 classes offered and 480 officers trained.

3. In FY 11/12, there has been a consistent objective to provide quality supervision by licensed staff to clinical interns. For that fiscal year, this program has provided 166 interns in non- MHSA clinical programs with 185,920 hours of supervision.

4. In spite of the economy's weakness and county job freezes, in FY 11/12, effort was focused on 36 trainings, which successfully reached 355 consumers/providers to promote the incentive for individuals with lived experience and on SSI to ultimately join the workforce. In a similar approach in preparing consumers for the potential revival of the job market, 69 academic and personal skill-building classes were also offered by the Recovery Education Institute to 200 unduplicated consumers.

With 253 WET trainings conducted in FY 11/12, each with its own specific training objectives, reporting outcomes for each individual training would not be feasible in this Annual Update. Since satisfaction with WET trainings mostly received above average to excellent ratings across the board, an example of a conference has been chosen to show data. The conference selected is the Second Annual Orange County Institute for Peer Support Conference that drew 173 attendees, and received 107 completed training evaluations.

Please see the figures below that are based on data from that conference.



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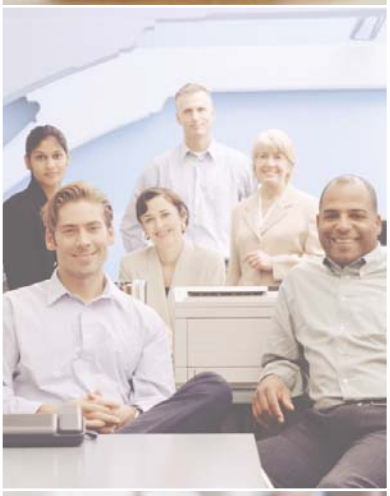
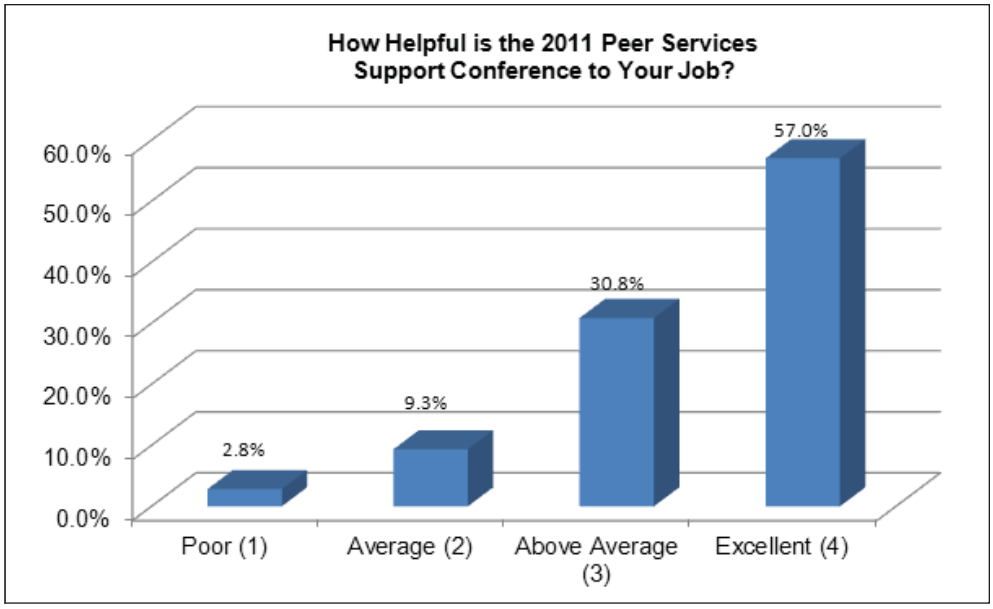
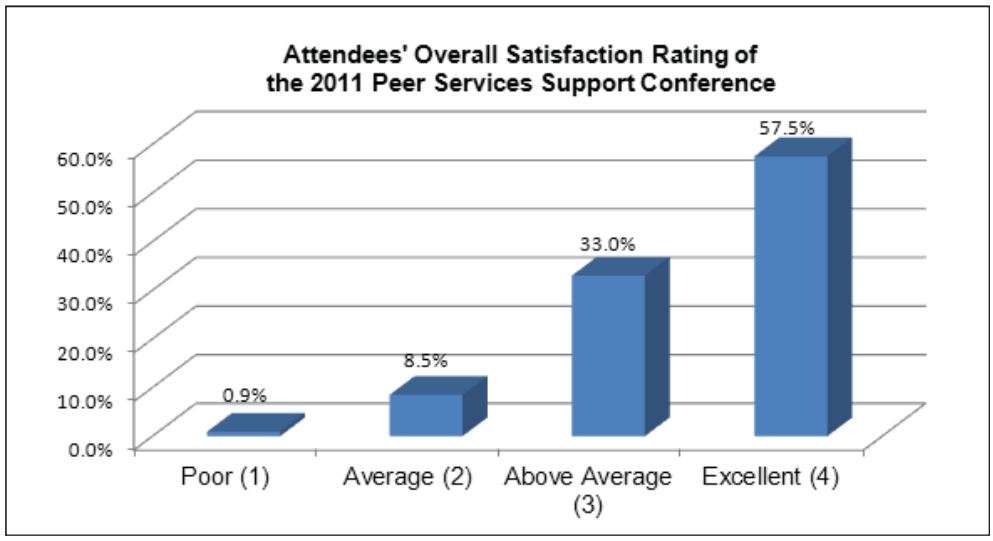
Workforce Education and Training Services (WET)







Workforce Education and Training Services (WET)

Future Plans

Original funding for WET has been used over the past few years and will be spent by some time in FY 13/14. Once WET funds are gone, education and training programs can be funded by CSS.

The training focus in FY 12/13 has been on quality of training versus quantity. Emphasis is being placed on strengthening practical and clinical core competency of providers along with improving their knowledge of county/community services and resources to improve system navigation and effective referrals.

Based on recent findings from the Centers for Disease Control that trauma is often the antecedent and a core basis for a wide range of behavioral health issues, training on evidence-based Trauma-Focused Cognitive Behavior Therapy is being offered so that services and clinics will become more trauma-informed. Other proven-to-work training modules, e.g., Anger Management, from SAMHSA Tool Kits are being adopted and condensed into practical applications and will be provided via in-service trainings at various clinics.

During the aftermath effect of drastic economic changes and stressors, a series of updated trainings from the front line Law Enforcement experts will be offered this year to providers, community partners, and other stakeholders on the current drug and gang trends among high-risk populations. Also included in these trainings is information on how to handle critical incidents in the workplace, community and county clinics. Certified Mental Health First Aid trainers are also offering trainings monthly to consumers/family members and community partners at the Recovery Education Institute.

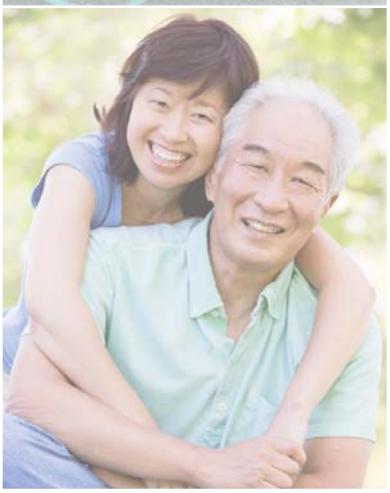
In FY 13/14, the first annual conference on Integrated Spirituality and Behavioral Health Services and Vietnamese-American Resilience and Recovery from History of Trauma will be offered. In addition, the 3rd Annual Institute for Peer Support Services Conference, a CIT conference and a Veterans' conference are also being planned. In collaboration with a southern-counties regional effort, a Supporting Lived Experience in the Workforce Conference will also be conducted. The focus on increasing core competency of clinical staff will continue.

Prevention and Early INTERVENTION




"Encourage your kids because you have no idea what they are truly capable of." - Unknown

Prevention and Intervention Services (PEI)



A. Component Information

The Mental Health Services Act (MHSA) represents a comprehensive approach to the development of community based mental health services and supports. The Act addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure to support the system. Prevention and Early Intervention approaches in and of themselves are transformational in the way they structure the mental health system to embody a "help first" philosophy. Prevention and Early Intervention services involve reducing risk factors or stressors, building protective factors and skills, and increasing resiliency.

The Orange County Health Care Agency, Behavioral Health Services, Prevention and Intervention (PEI) Division developed a PEI plan that makes resources available for addressing the earliest signs of mental health problems, and a service system that is accessible to diverse populations. As a continuum of care component, the plan builds capacity for mental health early intervention services at sites where people go for other routine activities such as health providers, education facilities and community organizations.

According to a 2009 study by the National Research Council and the Institute of Medicine, "Making use of some of the effective, evidence-based interventions already at hand could potentially save billions of dollars by addressing behavioral problems before they reach the threshold for a diagnosis and require expensive treatment." The PEI plan is a framework upon which protective factors can be built to decrease the need for costly, future mental health treatment.

Orange County's PEI Plan

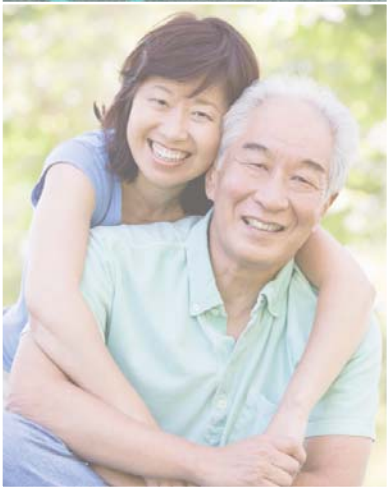
Orange County's Prevention and Early Intervention Plan was approved in April 2009. In that Plan, programs were divided into eight Projects, including:

1. **Early Intervention Services** were those directed toward individuals and families for whom a short-duration (usually less than one year), relatively low-intensity intervention is appropriate to measurably improve a mental health problem or concern very early in its manifestation.

2. **School-Based Services** provided outreach and education to children, youth, families, and school staff to increase awareness of mental health issues and reduce stigma and discrimination; build resiliency and increase protective factors in children and youth; foster a positive school climate; prevent suicide; expand early mental health intervention services; and provide professional development/training on mental health for those working with children and youth in schools.

3. **Outreach and Engagement Services** were those that proactively identify members of the PEI priority populations who are at risk of emotional, behavioral or mental health conditions and provide easy and immediate access, information, and referral assistance to culturally competent early intervention services as needed.

Prevention and Intervention Services (PEI)



4. **Parent Education and Support Programs** targeted mothers and fathers, as well as grandparents and others who have responsibility for caring for at-risk children and youth. These projects/programs fostered effective parenting skills and family communication, healthy identities and extended family values, child growth and development, and self-esteem.

5. **Prevention Services** were designed to reduce the likelihood that a mental health event or condition may occur. Research shows that prevention strategies share a common approach for many conditions. Simply stated, effective prevention focuses on those factors that can be changed.

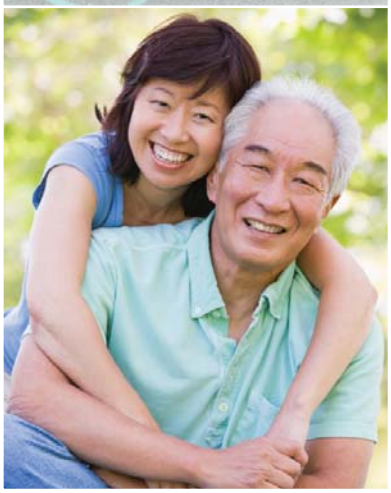
6. **Screening and Assessment** provided the means by which one can identify the existence of a mental illness, the stage at which that illness developed, and the links to provide the appropriate level of care. Evidence indicates that a critical point exists in the natural course of mental disorders, after which treatment is less effective. The first step in establishing successful early intervention is to ensure that the potential seriousness of unrecognized and poorly treated mental illness is identified and understood.

7. **Crisis and Referral Services** encompassed a wide range of culturally competent, population specific strategies aimed at reducing suicidal behavior and its impact on family, friends, and communities. Programs included crisis and referral services.

8. **Training Services** targeted staff and volunteers working in schools and universities, primary care settings and emergency medical services, refugee and recent immigrant programs, law enforcement, teen programs, violence prevention programs, sexual assault crisis centers, homeless programs, disaster assistance/response programs, and grief support programs.

Over time as services were implemented, it became apparent that the County could streamline the existing plan and increase efficiency. That restructuring took place last year. Thus, FY 13/14 is a transition year for Orange County. The data that the County collected last year is organized into the eight categories designated in the original Plan. However, the budget request for FY 13/14 is based upon the newly restructured Plan that includes just three categories. Data collected in FY 13/14 will be organized by these three new categories and the programs within those categories.

Prevention and Intervention Services (PEI)



FY 13/14 Restructured Plan - Prevention and Intervention Services

A restructuring of the Behavioral Health Services PEI plan was initiated in 2012 to address issues identified during the first three years of implementation. The restructuring addressed areas of program/service overlap, inconsistencies, and unsuccessful solicitations due to a lack of community response. The goal was to simplify the plan by streamlining the existing projects/programs so that it would better meet the prevention and early intervention needs of the community and take advantage of economies of scale, where available.

The repackaged plan maintained all services, but reorganized them into three Service Areas consisting of 23 programs. The Service Areas are: Community-Focused Services, School-Focused Services, and System Enhancement Services. Efforts continue to be taken to ensure that the programs are implemented in a culturally and linguistically competent manner.

This revised PEI plan continues to address the Community Mental Health Needs identified in the original plan (2009):

1. Disparities in Access to Mental Health Services
2. Psycho-Social Impact of Trauma
3. At-Risk Children, Youth and Young Adult Populations
4. Stigma and Discrimination
5. Suicide Risk

The revised PEI plan also continues to target the same Priority Populations:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
6. Underserved Cultural Populations

While MHSA requires that 51% of PEI funding be used to fund programs for individuals 0-25 years of age, the Community Stakeholders wanted to devote 75% of the funding to cover the 0-25 year age group. The original target percentages were:

Percentage of PEI Funding by Age Group

Age in Years	Target Percentage of Funding
0-25	75
26-59	10
60+	15

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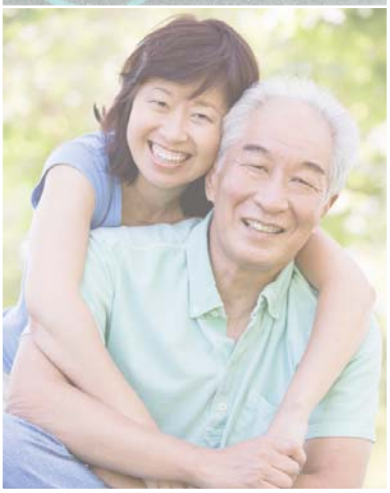
Prevention and Intervention Services (PEI)



The revised PEI plan includes the same target percentages (although there are inherent variances each year depending on the programs implemented and the participants served).

Please note that the re-structured PEI plan will be implemented for FY 13/14, so the projected numbers served and funding referenced for FY 13/14 will be reflective of the new structure. Since a few programs were combined under the new structure, in some cases there will not be a direct correlation between the outcomes for FY 11/12 and the projected outcomes for FY 13/14. The next annual update report will be based on the restructured PEI Plan and will include data generated by the programs within the new structure.

Populations Served

To provide a picture of who is served in PEI programs, the following charts have been developed.

FY 11/12 MHSA PEI Aggregate Demographic Data

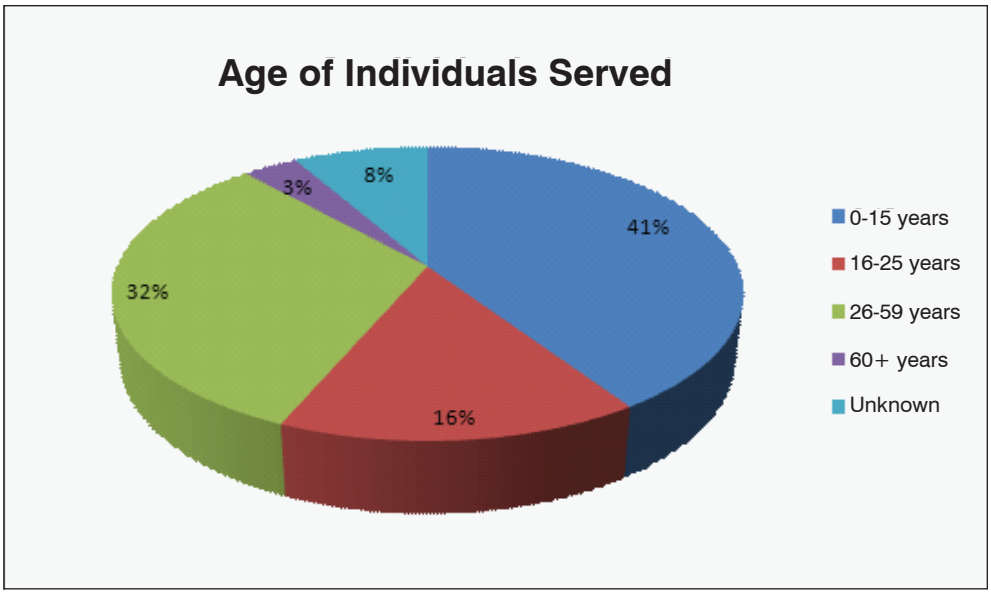
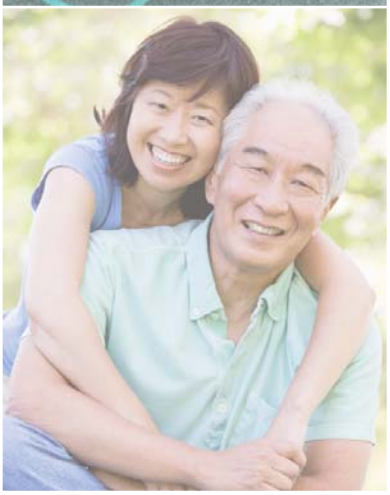


Figure 1. Age of individuals served (N=201,064)

All demographic data represents merged data among all MHSA PEI programs. Data represents all available data. However, in some instances, not all data may be reported.

Age Categories 26-59 and 60+ have been estimated for a number of programs in order to merge data among programs using various demographic age scales.

Prevention and Intervention Services (PEI)



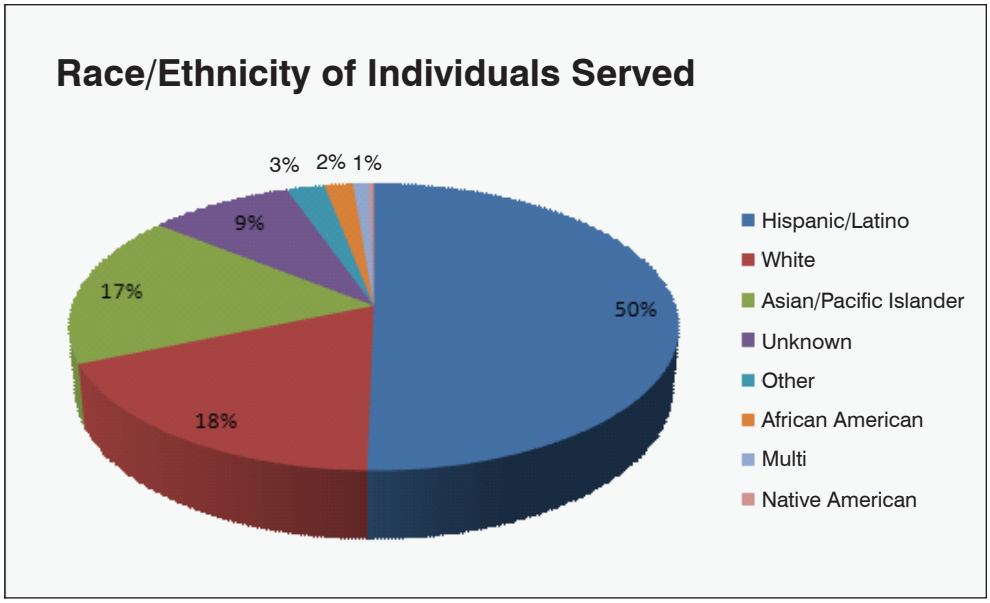


Figure 2. Race/Ethnicity of individuals served (N=198,488)

All demographic data represents merged data among all MHSA PEI programs. Data represents all available data. However, in some instances, not all data may be reported.

Race/ethnicity categories have been estimated for a number of programs in order to merge data among programs using various race/ethnicity categories.

The data displayed in Figure 2 show that 50% of clients served in PEI programs are Latino. An additional 17% are Asian Pacific Islander and Vietnamese is the predominant ethnicity among Asians in Orange County. Although Orange County is often perceived as a predominantly white, English-speaking population, the reality is that the County's residents are diverse. PEI programs are sensitive to the ethnicities represented in the clients served.

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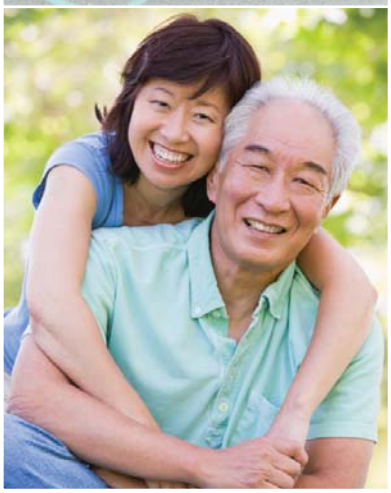
Prevention and Intervention Services (PEI)



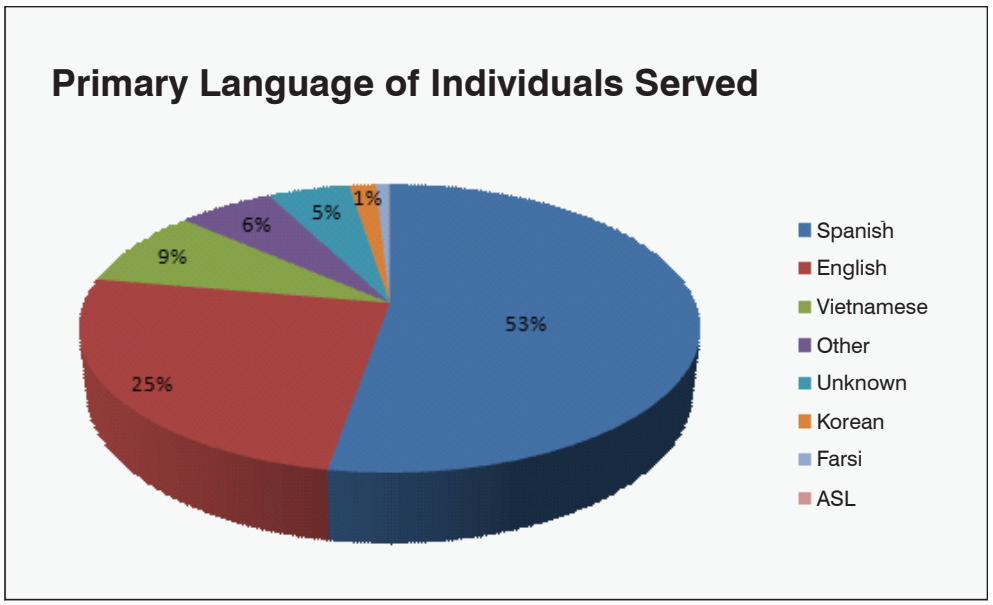


Figure 3. Primary language of participants (N=203,554)

All demographic data represents merged data among all MHSA PEI programs. Data represents all available data. However, in some instances, not all data may be reported.

Of clients for whom language data is available, 53% state that Spanish is their primary language. Only 25% identify English as their primary language. Orange County is a multi-ethnic and multi-language jurisdiction.

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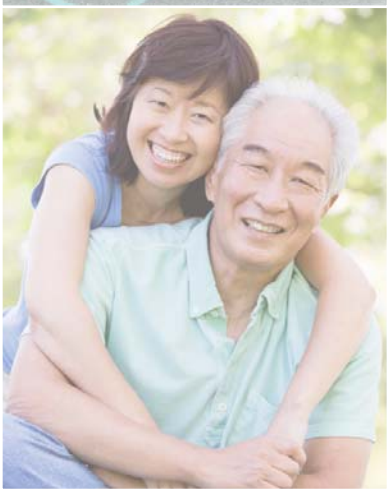

Individuals with Special Status

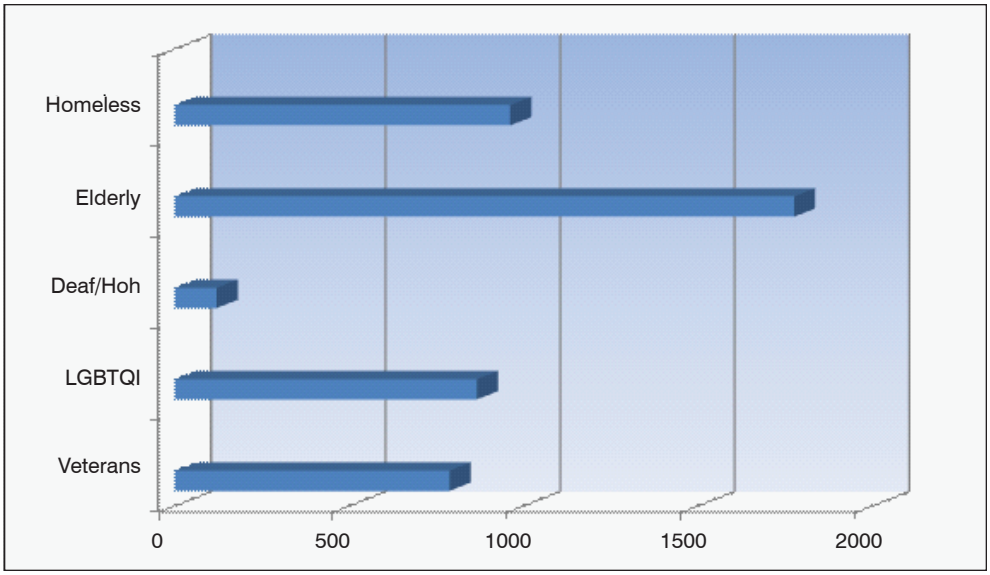

Figure 4. Special Status (N=5,400)

All demographic data represents merged data among all MHSA PEI programs. Data represents all available data. However, in some instances, not all data may be reported.

Individuals with Special Status data are based on self-reported figures only. However, a large number of special status individuals are unreported or unknown.

It can be seen that PEI programs serve a large number of individuals who are elderly, homeless, veterans, or Lesbian, Gay, Bisexual, Transgendered, Questioning, or Intersex. Many people in these categories do not disclose their status, so the data provides only a partial count of individuals in those categories. Orange County has made a substantial effort to outreach to these special needs populations, and the results of those efforts are reflected in the data shown above.

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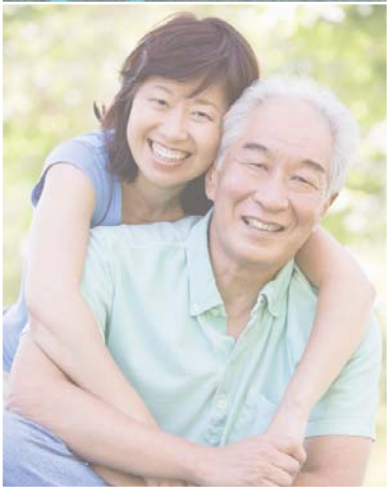

B. PEI Program Information

Project 1: Early Intervention Services

Programs within PEI 1 **Early Intervention Services:** • Orange County Post-Partum Wellness (OCPPW) • Orange County Center for Resiliency, Education and Wellness (OC CREW) • Stress-Free Families • Veterans' Services Campus Program (The "Drop Zone") • Socialization Program for Adults and Older Adults	**Funding:**
Actual number served in FY 11/12: • Orange County Post-Partum Wellness (OCPPW) - 165 • Orange County Center for Resiliency, Education and Wellness (OC CREW) - 34 • Stress-Free Families - 39 • College Veteran's Program - 20 • Socialization Program for Adults and Older Adults - 425	Actual Funds expended in FY 11/12: $841,245 $899,486 $234,290 $68,939 $1,300,138
Projected number to be served in FY 12/13: • Orange County Post-Partum Wellness - 225 • Orange County Center for Resiliency, Education and Wellness - 45 • Stress-Free Families - 65 • College Veteran's Program - 20 • Socialization Program for Adults and Older Adults - 530	Estimated funds to be expended in FY 12/13: $774,428 $935,415 $303,056 $118,339 $919,500
Estimated number to be served in FY 13/14: • Orange County Post-Partum Wellness - 300 • Orange County Center for Resiliency, Education and Wellness - 60 • Stress-Free Families - 80 • College Veteran's Program - 60 • Socialization Program for Adults and Older Adults - 550	Budgeted funds for FY 13/14: $1,213,072 $1,500,000 $534,693 $150,000 $919,500

Orange County Postpartum Wellness (OCPPW)

1. Program Description

The Orange County Postpartum Wellness (OCPPW) Program is an early intervention program that serves new mothers, up to one year postnatal, experiencing mild to moderate postpartum depression. Services include assessment, individual and family counseling, educational and support groups, case management, wellness activities and referral and linkage to community resources.

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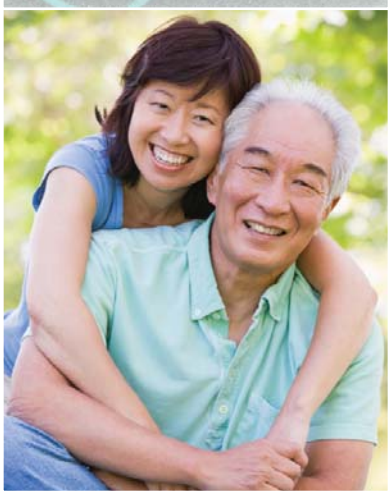


2. Outcomes

FY 11/12 outcomes data indicated that depression symptom severity decreased an average of 56%, as measured by self-reported pre-test and post-test Patient Health Questionnaire (PHQ-9) scores, showing improvement for 75% of the mothers enrolled into the program. On average, pre-test and post-test scores indicated that participants' moderate to moderately severe depressive symptoms decreased to mild depressive symptoms or to no depression severity.

Percent of Self-Reported Improvements/Declines in Depression Severity During FY 11/12

(n=129 Paired Pre/Post-tests)

PHQ-9 Total Score	% (#) of Participants	Average Pre & Post Score	% Change Pre to Post
Improved	75% (97)	14.5 > 6.4	↑56%
Did Not Change	5% (6)	8.5 = 8.5	n/a
Worsened	20% (26)	11.2 < 15.1	↓35%

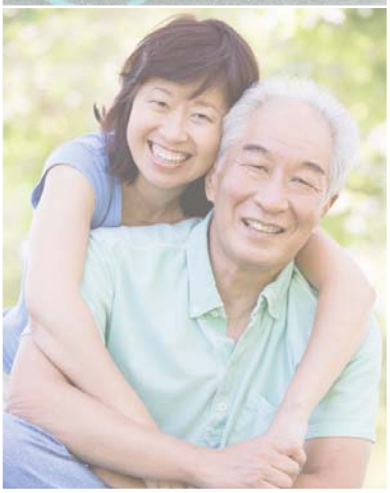
Pre-test scores for all participants ranged from 1-27 and the range of post-test scores was 0-26. The average PHQ-9 score for all participants was 13.5 at pre-test and 8.3 at post-test, showing an overall 39% improvement over time. The clinical cut off for PHQ-9 total score is >14. A score of 15 or higher likely indicates depressive illness of varying severity (5-9 = mild depression, 10-14 = moderate depression, 15-19 = moderately severe depression, and 20-27 = severe depression).

OCPPW Success Story

A 29-year old married mother of two boys, ages 3 and 1, was referred to OCPPW by a previous participant. At enrollment she reported daily crying spells, being easily overwhelmed with caring for her children, loss of interest in social gatherings with family and friends, and she had an overall sad outlook on her life. Her symptoms impaired her ability to work, take care of her children, and led to issues in her personal relationships. She also reported that it was becoming more difficult to leave her house due to the anxiety she was feeling. As a treatment goal, we agreed that having her therapy sessions in the office would be a good way to insure that she left the house at least once a week. Our sessions focused on ways to overcome her fears, cope with her sadness, and her feeling more capable of caring for her children.

After several months of treatment, she reports she has overcome the unexplained fears of something bad happening to her if she leaves her house. She now enjoys going to family functions, and she is excited about starting work soon. She continues to come in to the office and would like to transition to the wellness activities and support group to help her build supportive relationships with other mothers. At time of enrollment, this participant's depression severity score from the Patient Health Questionnaire-9 (PHQ-9) was 21, a severe rating, and currently her depression severity is down to 2, a mild rating.

Prevention and Intervention Services (PEI)



3. Process Indicators

OCPPW conducted extensive outreach and increased the average number of monthly referrals. Number of participants served annually increased 20% from FY 10/11 to FY 11/12, contributing to a waiting list. Despite the current wait to enroll into the program, participants are assessed for safety and linked to community services to ensure safety. The program has increased collaboration with the Social Services Agency, hospitals and community based organizations to better meet the needs of these families. As a result, the program has significantly increased the number of participants linked to services. The program has acquired staff to provide childcare which has contributed to an increase in participation in the wellness activities and support groups. Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population.

4. Future Plans for Change

Increased outreach to Asian and Farsi-speaking communities, as well as outreaching to fathers and family members impacted by postpartum depression and providing supportive services to them. Develop a role for a psychiatrist as a consultant to primary care doctors treating the participants.

Orange County Center for Resiliency, Education and Wellness (OC CREW)

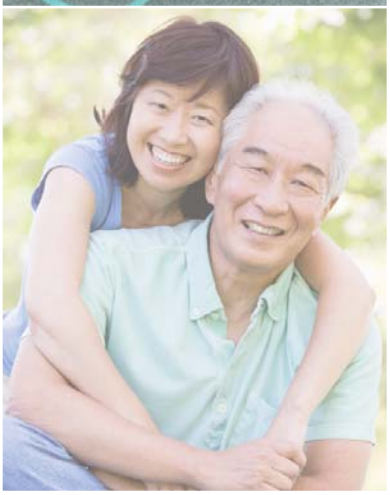
1. Program Description

The Orange County Center for Resiliency and Wellness (OC CREW) is an early intervention program that serves individuals age 14-25 who are experiencing the first onset of psychosis, with a Duration of Untreated Psychosis (DUP) of less than one year and provides educational and supportive services for their families. Services include: medication monitoring and assessment; psycho-education; individual and family counseling; multi-family groups; peer mentoring; vocational and educational support; opportunities for physical fitness activity; and services to address substance misuse and wellness recovery action plans.

2. Outcomes

OC CREW participated in a technical assistance program with the California Institute for Mental Health (CIMH). It was decided in July 2012, that the program would use the Positive and Negative Symptom Scale (PANSS) in addition to other outcomes measurement including the Milestones of Recovery Scale (MORS) and WHO-5 Well-being Index. Overall, initial data is shifting in a positive direction with participants experiencing fewer psychotic symptoms and actively engaging in services that enhance recovery. Specifically, the aggregate change in MORS scores across all paired pre/post-tests show that participants improved by an average of 27.3%. So far, 48.5% of participants have improved their MORS scores by an average of 65.1% between pre-test and post-test. Similarly, the aggregate change in WHO-5 scores across all paired pre/post-tests show that participants improved by an average of 30.8%. So far, 66.7% of participants have improved their WHO-5 scores by an average of 52.6% between pre-test and post-test. Family Participant Satisfaction Survey results showed that family members rated the OC CREW Program 9.56 on a 0-10 scale (where 10 is best) for overall satisfaction with family members indicating that the program is providing the needed assistance and is having a positive impact on family life.

Prevention and Intervention Services (PEI)



3. Process Indicators

In January 2012, OC CREW implemented the Psycho-educational Multi-Family Groups, and 100% of the participants had family members attend these groups. For FY 11/12, 34 participants were served in the program and 82 of their family members participated in the groups. Use of Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population.

4. Future Plans for Change

Program services will be expanded to provide trainings to persons and organizations most likely to encounter individuals presenting with early signs of mental disorders, including physicians, high school and college staff, probation and juvenile justice staff, and behavioral health providers in the community. Trainings will focus on helping providers learn to recognize and refer persons experiencing a first psychotic break, including training on how to recognize and refer persons from diverse ethnic/cultural groups.

Stress Free Families

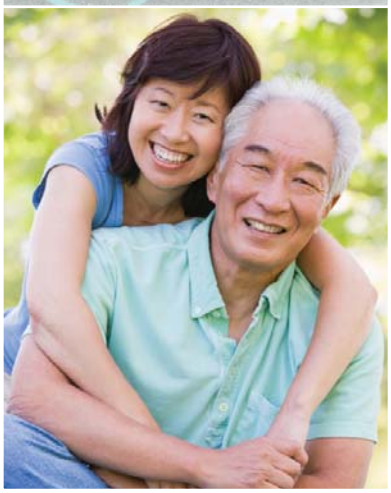
1. Program Description

Stress Free Families serves families that have been investigated by Child Protective Services for allegations of child abuse and/or neglect with their case closed, and the children have not been taken into protective custody. The program is designed to reach and support these families whose stressors make the children and parents more vulnerable to behavioral health conditions. Services consist of short term interventions including brief counseling, parent education and training, case management and referral and linkage to community resources.

2. Outcomes

Stress Free Families was implemented late December 2011 and the evaluation plan was finalized June 2012. It was decided that the Social and Occupational Functioning Assessment Scale (SOFAS) would be an outcome tool to measure program impact, in addition to other measures in the plan, including the WHO-5 Well-being index and the Protective Factors Survey. Initial SOFAS scores indicate that 86% of participating parents increased their functioning with an average of 14% improvement from pre-test to post-test, and an additional 9% of participants maintained their SOFAS score between pre-post assessments. Initial WHO-5 data shows that 70% of parents improved their well-being, with an average of 26% improvement from pre-test to post-test. Protective Factors Survey data showed improvements in each domain: 70% improved (50%) or maintained (20%) their *Family Functioning/Resiliency* score showing an average of 53% improvement pre-post; 80% improved (30%) or maintained (50%) their Social Support score with an average 61% improvement pre-post; 60% improved (50%) or maintained (10%) their *Concrete Support* score indicating an average 57% improvement pre-post; and 78% improved (67%) or maintained (11%) their *Nurturing and Attachment* score with an average 15% improvement pre-post. In addition, notable change was seen in responses to the item "I know how to help my children learn" – 67% improved their score by an average of 71% between pre-test and post-test.

Prevention and Intervention Services (PEI)



3. Process Indicators

The Stress Free Families start-up has been slow, and many of the initial referrals had a greater need for treatment than the program's early intervention services. The program's eligibility screening process has been modified to better capture the target population that will benefit from the early intervention services. Program staff has worked closely with Social Services Agency (SSA) staff to assist with linking participants to behavioral health services and have been available for consultation. Initially, the program only received referrals from SSA's Emergency Response Team but now is also taking referrals from the Differential Response Team. As a result, there has been an increase in referrals that are suitable for the lower intensity services. Use of Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population.

4. Future Plans for Change

Continue outreach to SSA Teams with goal of serving more families.

Veterans' Services Campus Program (The "Drop Zone")

1. Program Description

Veterans attending Orange County colleges are targeted participants for the Veterans' Services Campus Program. This program is primarily situated at Santa Ana College (SAC), but is available to all veteran college students and provides a variety of services. These services include assessment, case management and referral/linkage to community resources provided by the program clinician. Veterans in transition to school often require assistance with adjustment to college in order to maintain scholastic standards and to reintegrate to civilian life.

2. Outcomes

Tools and procedures for outcomes measurement were revised in the spring of 2012 for implementation July 1, 2012. Thus, data for FY 11/12 is not yet available.

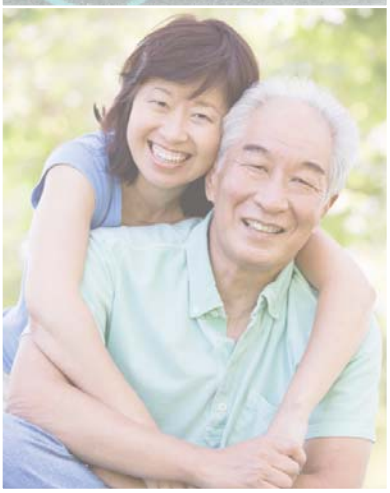
3. Process Indicators

Routine process measures have not been part of the outcome evaluation system for this program. Veteran students are routinely seen as walk-in appointments and follow-up appointments are arranged around the veteran student's availability.

4. Future Plans for Change

The program is currently in development with SAC staff to create a tool that will be administered to veteran students. It will contain questions about barriers to academic performance. This tool will then be administered at the end of each semester or upon discharge from the program.

Prevention and Intervention Services (PEI)



Socialization Program for Adults and Older Adults

1. Program Description

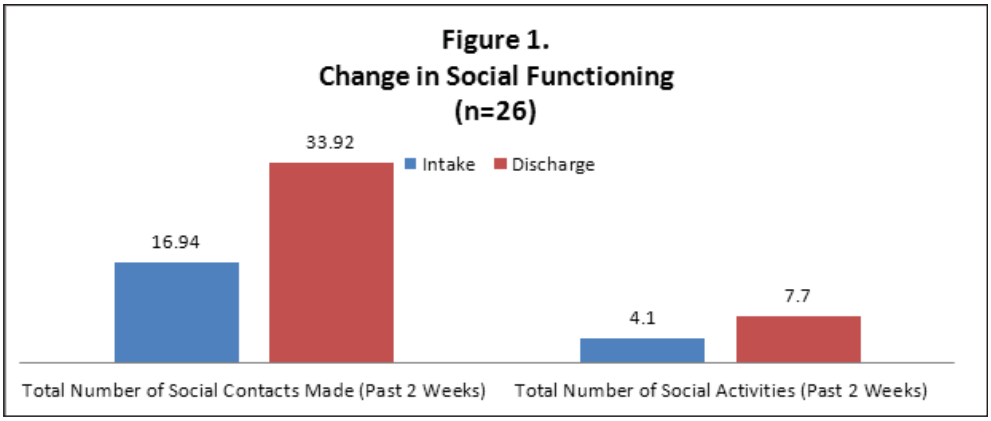
The Socialization Program serves adults and older adults who may be isolated and/or homebound but are experiencing the onset of serious psychiatric illness, particularly of those appearing later in life, including depression. The program brings trained, friendly, culturally/linguistically competent visitors to the homes of isolated adults and older adults with the task of decreasing the sense of isolation those individuals may feel, and increasing opportunities for them to socialize with others. Upon building a one-on-one relationship with an individual, the friendly visitor facilitates linkage between the individual and a local community-based socialization center or to any other mental health community resources that are needed. Services also include educational workshops, support groups, recreational activities and therapeutic arts and crafts.

2. Outcomes

FY 11/12 outcomes data indicated that the Socialization program served its overall goals and purpose of reducing isolation and increasing connectedness. Changes in the severity of depressive symptoms were measured using the Patient Health Questionnaire (PHQ-9). Preliminary data indicate that depression severity of the participants decreased on average by 52.8% from 14.2 (moderate depression) to 6.7 (mild depression).

Additionally, participants' frequency of social contacts (n=26), measured by total number of contacts with friends, neighbors, and family members during the past 2 weeks, more than doubled, and frequency of social activities during the past 2 weeks (e.g. religious participation, leisure activities) increased by 89% (See Figure 1). The results from the satisfaction survey (n=414) indicated that 99.5% of the participants were satisfied with the Socialization Program.

Figure 1.
Change in Social Functioning
(n=26)



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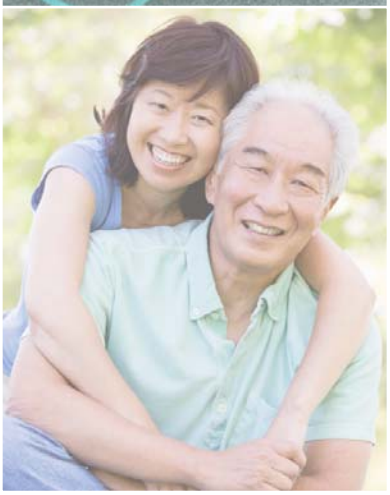

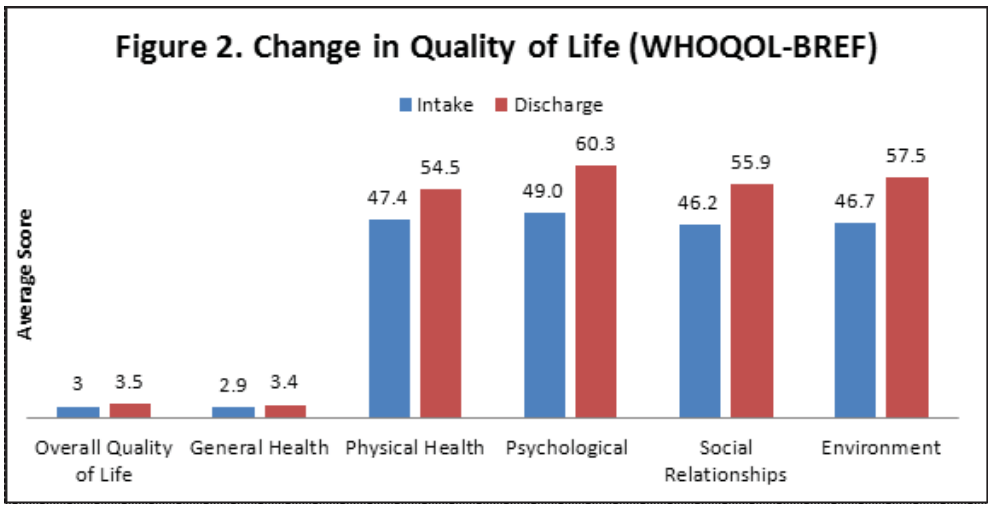

The World Health Organization Quality of Life – BREF (WHOQOL-BREF) Inventory was administered to program participants to assess emotional well-being. The WHOQOL-BREF Inventory is a 26-item scale that assesses the quality of life in six domains on a scale 0 to 100: Overall quality of life, general health, physical health, psychological, social relationships, and environment. Average scores of all six domains increased between pre and post-test. The domains that are most strongly related to the goals of the program and showed the largest improvement were Social Relationships, Environment, and Psychological. The average score for the Environment domain, which measures informational support, opportunities for leisure activities, and satisfaction with mode of transportation, showed the largest increase, increasing from 46.7 to 57.5, a 23.3% improvement. The average score for the Social Relationships domain, which measures satisfaction with personal relationships and social support, increased by 21.1% from 46.2 at pre-test to 55.9 at post-test. The average score from the Psychological domain improved from 49.0 to 60.0, showing a 22.9% improvement.

3. Process Indicators

The socialization programs conducted outreach at 658 community events and made 4,092 home visits. Based on participant's needs, programs made more than 1,500 linkages to community resources and services. Programs conducted 120 skill-building and educational classes, and coordinated 320 socialization group activities and events for participants. To increase access to services, more than 4,000 one-way transportation trips were provided to participants.

4. Future Plans for Change

There are no planned changes for FY 13/14.

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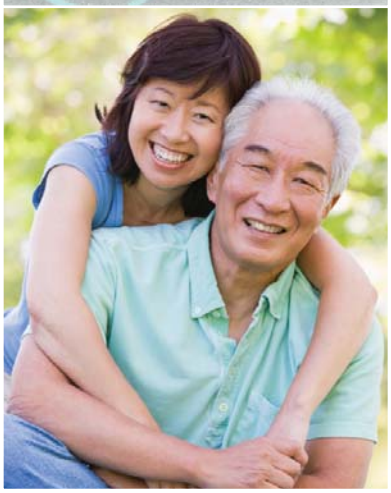


PEI Program Information
PEI Project 2: School-Based Services

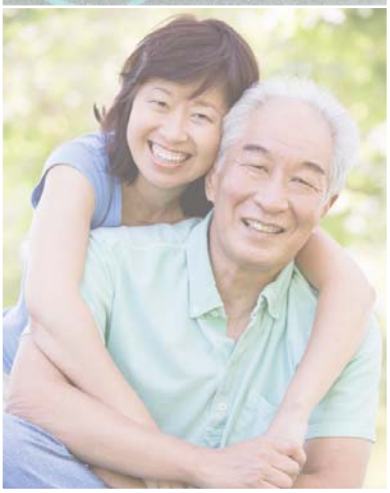
Programs within PEI 2 School-Based Services:	Funding:
• Connect the Tots • Positive Behavioral Intervention Services with University of California, Irvine (UCI) • Positive Behavioral Intervention Supports (PBIS) • Violence Prevention Education (VPE) • School Readiness	
Actual number served in FY 11/12: • Connect the Tots - 157 • Positive Behavioral Intervention Services with University of California, Irvine (UCI) - 47 • Positive Behavioral Intervention Supports (PBIS) - 55,490 • Violence Prevention Education (VPE) - 11,211	Actual Funds expended in FY 11/12: $549,958 $325,339 $1,432,776 $1,103,172
Projected number to be served in FY 12/13: • Connect the Tots - 170 • Positive Behavioral Intervention Services with University of California, Irvine (UCI) - 50 • Positive Behavioral Intervention Supports (PBIS) - 60,000 • Violence Prevention Education (VPE) - 11,820	Estimated funds to be expended in FY 12/13: $582,891 $400,000 $1,464,945 $1,285,409
Estimated number to be served in FY 13/14: • Connect the Tots - 300 • Positive Behavioral Intervention Services with University of California, Irvine (UCI) - 50 • Positive Behavioral Intervention Supports (PBIS) - NA • Violence Prevention Education (VPE) - 11,820 • School Readiness - NA • School Based Mental Health Services - NA	Budgeted funds for FY 13/14: $1,000,000 $400,000 $1,749,589 $1,287,751 $800,000 $2,000,000

Connect the Tots

1. Program Description

The Connect the Tots/School Readiness Expansion Program provides services to underserved families with children age 0-6 years who are exhibiting behavioral problems, putting them at increased risk of developing mental illness and experiencing school failure. The focus of these program services is to reduce risk factors for emotional disturbance in young children and to promote school readiness and prepare them for academic success. The Connect the Tots Program

Prevention and Intervention Services (PEI)



is one of the school readiness programs and services include children's and family needs assessment, parent education and training, case management and referral and linkage to community resources.

2. Outcomes

FY 11/12 outcomes data reported by parents indicated that frequency of problematic child behaviors decreased (35% improvement) during participation in the program, for 79% of participating children age 1-5, as measured by the Ages & Stages Questionnaires: Social-Emotional (ASQ:SE) pre-test and post-test scores. Parents also indicated that 93% of participating children ages 5 and 6 demonstrated fewer problematic child behaviors (14% improvement), as measured by the Eyberg Child Behavior Inventory (ECBI) pre-test and post-test scores, and 58% of these parents reported that these behaviors had improved (10% improvement) after participating in the program and were no longer a problem for the parents.

For children ages 0-5 years, the *Ages & Stages Questionnaires: Social Emotional* (ASQ:SE) was used to assess parent-rated frequency of child behaviors, using age-specific surveys (eight versions). Lower scores indicate less frequent problematic behavior.

Percent of Parent-Rated Improvements/Declines in ASQ:SE Score During FY 11/12
(n=19 Paired Pre/Post-tests)

ASQ:SE Score	% (#) of Participants	Average Pre & Post Score	% Change Pre to Post
Improved	78.9% (15)	83.7 > 43.7	↑48%
Worsened	21.1% (4)	55.0 < 75.0	↓36%

For children ages 6-7 years, the *Eyberg Child Behavior Inventory* (ECBI) was used to assess parent rating of current child conduct problem frequency (*Intensity* score: how often specific behaviors occur) and severity (*Problem* score: whether each behavior is currently a problem for the parent). Lower scores indicate less frequent/problematic behavior.

Percent of Parent-Rated Improvements/Declines in ECBI *Intensity* Score During FY 11/12
(n=27 Paired Pre/Post-tests)

ECBI *Intensity* Score	% (#) of Participants	Average Pre & Post Score	% Change Pre to Post
Improved	92.6% (25)	61.4 > 51.8	↑16%
Did Not Change	3.7% (1)	74.0 = 74.0	n/a
Worsened	3.7% (1)	58.0 < 68.0	↓17%

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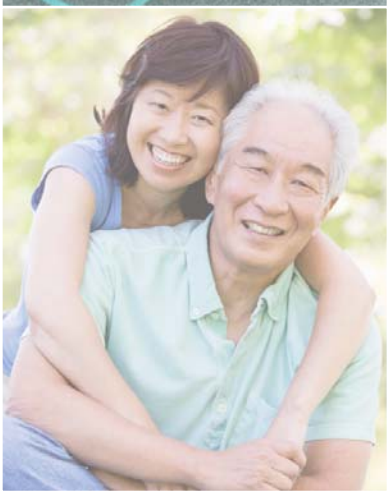

Percent of Parent-Rated Improvements/Declines in ECBI *Problem* Score During FY 11/12
(n=24 Paired Pre/Post-tests)

ECBI *Problem* Score	% (#) of Participants	Average Pre & Post Score	% Change Pre to Post
Improved	58.3% (14)	54.7 > 43.9	↑20%
Did Not Change	12.5% (3)	50.7 = 50.7	n/a
Worsened	29.2% (7)	53.6 < 56.1	↓5%

The 13-item *Parenting Scale* was used to measure parents' self-rating of dysfunctional parenting in discipline situations. Average total scores and subscale scores (Lax, Over-Reactive, and Hostile parenting) can range from 1-7, and lower scores indicate more effective discipline.

Percent Improvement in *Parenting Scale* Scores from Pre to Post During FY 11/12
(Paired Pre/Post-tests)

TOTAL Score % Improvement n = # paired pre/post Average Pre-test Score	Lax Parenting % Improvement n = # paired pre/post Average Pre-test Score	Over Reactive Parenting % Improvement n = # paired pre/post Average Pre-test Score	Hostile Parenting % Improvement n = # paired pre/post Average Pre-test Score
17.0%*** n=63 3.0	**18.3%**** n=63 2.9	**15.5%*** n=62 3.1	**21.0%**** n=61 2.1

***p<.001; **p<.01; *p<.05 = statistically significant differences

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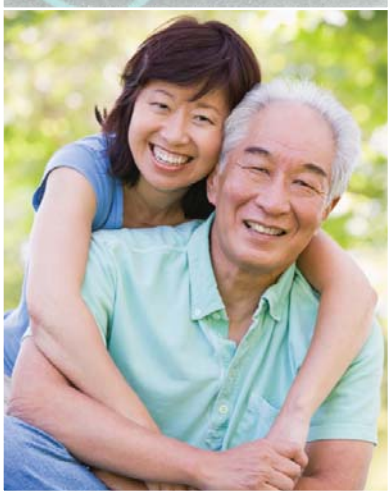


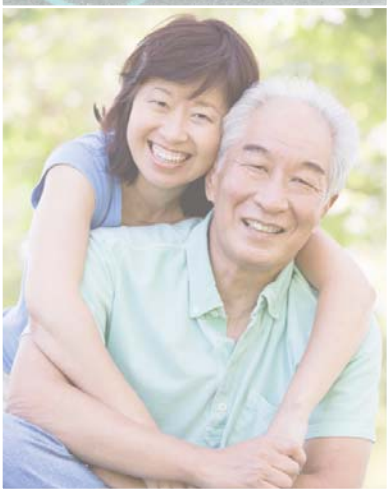
3. Process Indicators

The Connect the Tots Program has continued to increase annual numbers served to 157 enrolled children along with their 167 participating parents and care-givers in case-management services and 567 participants in 54 community parenting workshops. The number of parents attending the parent workshops doubled and the number of enrolled family members increased 43% from FY 10/11 to FY 11/12. To efficiently handle the steady stream of referrals, the referral process was modified to ensure that all participants referred were screened promptly to determine if appropriate for program, and if not, then given appropriate referrals right away and offered assistance linking with those resources. This change has contributed to significant decreases in waitlist. Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population.

4. Future Plans for Change

For FY 13/14, the program will focus more on increasing the number of families enrolled into services and will be providing fewer parenting workshops in the community referring to other programs that can provide these services; this will reduce the overall number of participants served, however it will further decrease the waitlist and increase the numbers of families receiving case management services. The program will increase outreach efforts targeting the Asian and Farsi-speaking communities.

Prevention and Intervention Services (PEI)



Connect the Tots Success Story

A five year-old child was referred for services with Connect the Tots, a School Readiness Program for families with young children. The child was exhibiting problematic behaviors and was at risk of developing an emotional disturbance. The father was having difficulties with handling his child's defiant, aggressive behavior at home with his siblings, and failing to listen to father's directions. This child was the youngest among six children, ranging in ages from 5 to 17, living in a home with a single father. Father, as it seemed, was at his wit's end, with the daunting task of single-handedly taking care of six children and working full time as a cook to make ends meet.

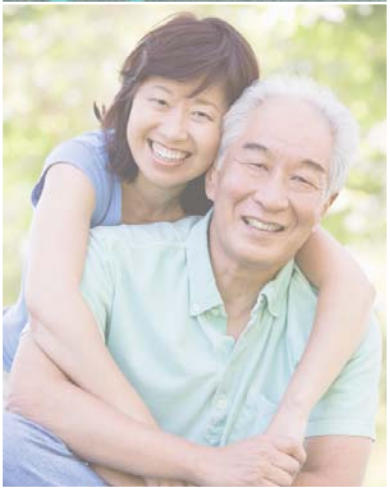
Coming home tired from work, father still had to clean the house, cook, do all the children's laundry, and make sure that the children "stayed out of trouble," etc. Father had a hard time implementing structure and routine in the house and was often too much of a "friend" to his children, who in turn, did not show him respect.

This family has received services with Connect the Tots for about six months. In addition to receiving individualized parent education training and case management services, staff has also participated in collaboration meetings with other community service providers to strengthen the family system.

With guidance, mentoring, and encouragement from Connect the Tots staff, the father was able to develop the basic house rules, as a result of family collaboration. These rules were written on a poster board which hung in the house. Family meetings have started to take place, where a safe environment was created for the entire family to voice their thoughts and ideas about ways to become stronger as a family unit. Father was observed in one recent meeting asserting his role as a parent and using a firm voice to redirect the attention of one of his children when not behaving; this was not done in the past and the father would let his children do/say anything. Father has acknowledged that he now realizes the importance of stepping up as a parent, implementing structure, rules and opening lines of communication with his children. Father has also started going back to school, getting certified to become a mechanic, one of the things he loves to do.

The five year-old child's behavior has improved significantly. He has reduced his defiant, aggressive behaviors and has learned to listen to the father's direction much better.

Prevention and Intervention Services (PEI)



Positive Behavioral Intervention Services with University of California, Irvine (UCI)

1. Program Description

The University of California, Irvine-Child Development Center offers a program for children K-5 on Positive Behavioral Interventions services that includes academic support, social skills development, parent training and academic transitional support services.

The program focuses on a regular education school experience while providing modifications and skill development to meet the psychosocial and academic needs of children and families with challenges in attention, behavior and learning and/or Attention Deficit/Hyperactivity Disorder (ADHD). The program is short term, 12-24 months, and then the child is transitioned to the next academic setting. The programs serve students and families that meet Title I eligibility or demonstrate financial hardship and meet program criteria.

2. Outcomes

This program aims to improve problem behaviors, academic achievement and parenting practices, which ultimately leads to improved well-being of the family as a whole. Children's improvement in this program was measured by using various assessment tools completed by parents and teachers. Examples include setting target behaviors for better behaviors, reducing parental stress level, academic improvement and a decrease in ADHD symptoms.

1. Target behaviors are customized to each child, with up to four identified challenges. As the child improves in one of the target behaviors, another may be identified.
   a. 66.7% of the student participants (N=10) showed an improvement in target behaviors in 11/12.
2. Utilizing the Parent Stress Index assessment tool, on average, parental stress levels decreased by 13.3%
3. Utilizing the Dynamic Indicators of Basic Early Literacy Skills (DIBLES) assessment, 87.5% (N=10) reported an increase in oral reading fluency level from the fall to the spring semester.
4. Level of improvement varied by the area of the ADHD symptoms (hyperactive/impulsive, ODD, and inattentive scores), but the overall decrease of the ADD symptoms ranged from 50-80%

Note: student participants entered the program at different times of the year; thus, there is only pre-post data for 10 student participants.

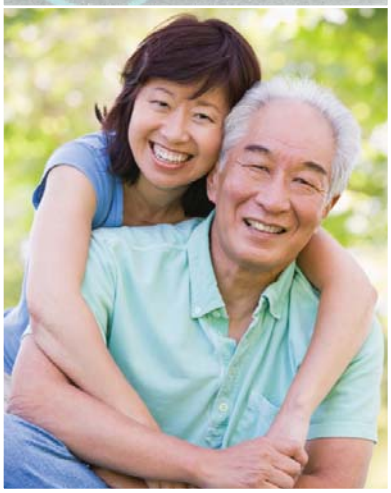
3. Process Indicators

N/A

4. Future Plans for Change

The program is planning to add classes for 6th and 7th graders for Fall 2013. MHSA funding will be available for students in those grades with the same eligibility requirements as in 2012.

Prevention and Intervention Services (PEI)



Positive Behavioral Intervention Supports

1. Program Description

Positive Behavioral Intervention Supports (PBIS) is a national, evidence-based program that offers a school-wide systems approach for preventing problem behaviors including, but not limited to, truancy, pervasive violence, acting out in class, negative behaviors due to limited cognitive development, and emotional stress for youth who are overwhelmed and may be experiencing anxiety or evidence of Post-Traumatic Stress Disorder (PTSD) for children K – 12th grade.

PBIS provides a continuum of interventions including, but not limited to, developing and disseminating training and procedures that on a school-wide level defines, teaches and rewards behavioral expectations and provides consistent, predictable consequences for problem behavior.

The PBIS program is a three-tiered, school-wide broad range approach for systemic and individualized strategies to achieve learning and social outcomes at a micro and macro level, while preventing problem behaviors, emotional stress and increasing academic achievement. The first of the three tiers is universal prevention which integrates the methods across the entire school, teaching every student, faculty and staff member about positive and negative consequences for appropriate and inappropriate behaviors. The second tier focuses on targeted prevention for groups, introduces more instructional strategies and supports to a smaller number of students. The third tier is individual prevention for those students who have serious and persistent behavioral and academic challenges.

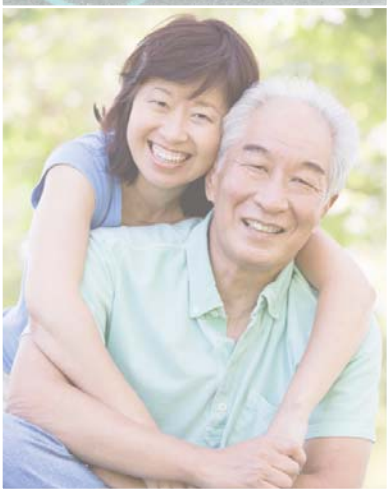
2. Outcomes

The major outcomes identified include participating schools reporting an increase in protective factors such as a positive learning climate, acceptance of diversity, higher learning expectations, improved student-teacher relationships and increased parent involvement. Schools also showed a decrease in school-related risk factors, such as suspensions/expulsions, trespassing, crimes, illegal drugs, bullying harassment, deteriorating conditions, and vandalism. The training participants for PBIS also indicated that they were satisfied with the training material and presenters. Of those trained, 91% reported an increase in PBIS knowledge, and 94% indicated a change in behavior after attending the trainings. After training was complete for the fiscal year, PBIS teams were surveyed to assess the PBIS impact in their schools. The results showed that 61% of schools felt they completely adopted PBIS, and that 83% felt that PBIS is well adopted in their schools. 81% also felt that PBIS assisted them in effectively dealing with student behavior issues.

3. Process Indicators

The PBIS program served a total of 28,514 students in group interventions, as well as 27,780 students in individual interventions in FY 11/12. The program has provided these services through a three tiered approach which encompassed 80 schools during FY 11/12.

Prevention and Intervention Services (PEI)



4. Future Plans for Change

This contract is currently in renewal status. An RFP was developed requiring that schools be offered a choice of interventions. The selected provider of these services is encouraged to use a continuum of evidence-based or promising practices such as, but not limited to, Positive Behavioral Interventions and Supports (PBIS), Safe and Civil Schools (SCS) and Collaborative Problem Solving (CPS). Creativity and innovation are encouraged in providing the menu of services to the schools and districts in Orange County. The goal of the provided service will be to assist teachers, parents, and students in assessing and managing students' problem behaviors, while providing prevention and early intervention services that show measureable outcomes based on the services provided.

At this time, the provider has not yet been selected. It is expected that the new contract will be implemented with a July 1, 2013 start date.

Violence Prevention

1. Program Description

The Violence Prevention Education (VPE) program's intent is to reduce violence and its impact in the schools, local neighborhoods and families. There are eight programs under the Violence Prevention Education component.

Safe from the Start

Safe from the Start is a program that disseminates scientific-based information on how exposure to violence, whether through direct physical impact or witnessing violence, can impact the neurological development of young children. The program offers a Train the Trainers certification and targets the following groups for training: parents, pregnant teens and/or parenting minors and teachers/staff.

Gang Prevention

The Gang Prevention program provides liaison, education and intervention services to schools (public, private, charter and alternative sites), law enforcement agencies, the Probation Department, local gang task forces, the District Attorney's Office, parents, students and community agencies. The program interfaces with children at risk of gang involvement and assists with gang mediation when called to a scene to intervene to reduce and/or eliminate an outbreak of gang activity.

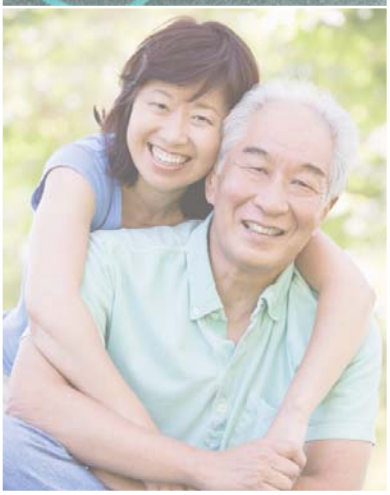
Crisis Response Network

The Crisis Response Network is a collaborative resource with dedicated community and school staff who can respond to critical crisis situations, threats and local emergencies that can negatively impact children in schools and in the community. The program offers a certification on Crisis Response for responders dedicated to the network, and provides training on individual and group interventions.

Bullying

The Bullying program provides education for staff, administrators and parents on prevention of bullying and cyber-bullying.

Prevention and Intervention Services (PEI)



Child Abduction
The Child Abduction program provides evidence-based curriculum and training for school-based personnel, parents and student populations.

Conflict Resolution
The Conflict Resolution program trains other trainers on how to deal with conflict on a school campus. The instruction uses a peer model. In addition, conflict mediation workshops are offered for school personnel, parents and student groups.

Hate Crimes
The Hate Crimes program provides prevention strategies for the student population. Education presentations are offered for school personnel and parents on how to prevent and identify hate crimes.

Teen Dating Violence
The Teen Dating Violence program offers evidenced-based curriculum to address prevention and early intervention strategies for students, school personnel and parents.

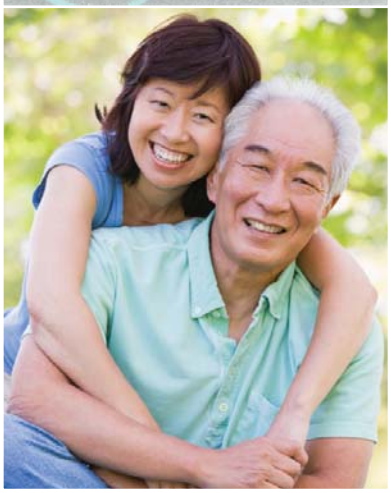
2. Outcomes

Of the 4,963 participants that responded to evaluation questionnaires, the participants of the VPE programs reported an increase in knowledge that ranged from 88% to 98%, depending on the program. Participants also reported a change in their behaviors, such as applying what they learned to real-life situations. This score ranged from 85% and up, with the conflict resolution program having the highest ratings in increase in knowledge and change in behavior. In the child abduction program, a significant increase was noted between pre and post-tests. The results for the radKIDS student assessment showed a significant increase in students' knowledge of safety, self-defense techniques, and their acknowledgement of deception by strangers. Child abduction was also one of the programs that had the highest rates in participation with a total of 1,684 participants served in FY 11/12. In the teen dating program, pre and post-tests showed a significant increase in knowledge. The knowledge increase was seen in identifying warning signs of abusive relationships, ways to protect oneself from sexual assault, and calming strategies to defuse anger. In the gang prevention program, participants showed positive improvements in the targeted domains of the Parents on a Mission (POM) training. This includes positive improvements in increasing family cohesiveness, improving parenting efficacy, and improving child behavior. The most statistically significant improvement in this program was seen in the increase of parents' self-awareness and self-esteem.

3. Process Indicators

The VPE programs have served a total of 5,469 students, 2,921 parents and 2,821 teachers and staff in FY 11/12.

Prevention and Intervention Services (PEI)



4. Future Plans for Change

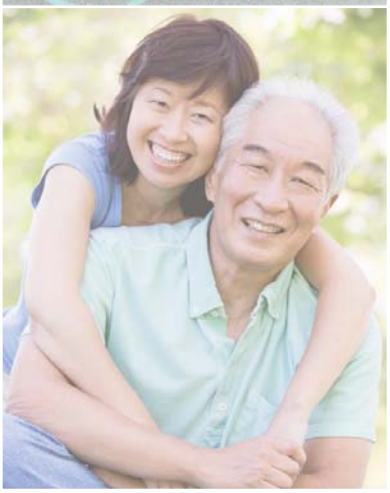
This contract is currently in renewal status. A Request for Proposal was developed requiring that the provider be responsible for creating a menu of services that would be available to the schools and districts of Orange County. The Violence Prevention Education program will focus on five core areas of violence prevention. This will include: gang prevention, safe and healthy lifestyles, character education, media literacy, and conflict resolution. These core areas are broadly defined to allow for a systems approach that will encourage creativity and innovation. The menu of services will result in a comprehensive Violence Prevention Education Model that will address a broad spectrum of school and community behavioral health issues, including stress, violence, trauma, developmental concerns, and the onset of serious mental illness. The overall goal is to build resilience, personal empowerment, and capacity to maintain healthy lifestyles while working to decrease the impacts of emotional, developmental, and behavioral concerns. At this time, the provider has not yet been selected. It is expected that the new contract will be implemented with a July 1, 2013 start date.

Success Story

David, a 9 year-old boy who lives in Orange County, was riding his bike home from school. He realized that he was being followed by someone in a car. He made a quick decision to ride his bike directly to the local police station instead of riding home. David had received training from the radKIDS program at his school. During radKIDS training, each student creates a safety plan to be used when faced with potentially dangerous situations.

David relied on what he had learned and on his own safety plan. The decision David made to go to the police station was a result of learning how to deal with potentially dangerous situations and possible predators.

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 3: Outreach and Engagement

Programs Within PEI 3 Outreach and Engagement: • Outreach & Engagement Collaborative	Funding:
Actual number served in FY 11/12: • Outreach & Engagement Collaborative - Outreach – 83,899 (duplicated) - Engagement – 28,363 (duplicated)	Actual Funds expended in FY 11/12: $3,496,079
Projected number to be served in FY 12/13: • Outreach & Engagement Collaborative - Outreach – 84,500 (duplicated) - Engagement – 29,000 (duplicated)	Estimated funds to be expended in FY 12/13: $3,400,575
Estimated number to be served in FY 13/14: • Outreach & Engagement Collaborative - Outreach – 84,500 (duplicated) - Engagement – 29,000 (duplicated) • Information and Referral	Budgeted funds for FY 13/14: $3,819,044 $400,000

Risk Reduction, Education and Community Health (REACH)

1. Program Description
The REACH Outreach and Engagement Team serves individuals experiencing homelessness, in transitional living situations, and/or at risk of homelessness, all of whom are at greater risk of behavioral health problems. Services include street outreach, individual and group interventions for enhancing coping skills and safety, case management, wellness screens and referral and linkage to community resources.

2. Outcomes
FY 11/12 outcomes data for participants in the life skills group, Seeking Safety, indicated that 86% of participants improved in general self-efficacy after completing the group. For these participants, average pre-test and post-test scores indicated a 41% improvement in self-ratings in regards to confidence that they can cope with a variety of difficult demands in life, indicating improved problem solving skills and resourcefulness. Participant Satisfaction Survey results showed that participants rated case management services 9.55 on a 0-10 scale (where 10 is best) for overall satisfaction, and participants indicated that they feel more positive about themselves as a result of program participation and will likely use in the future what they learned in REACH services.

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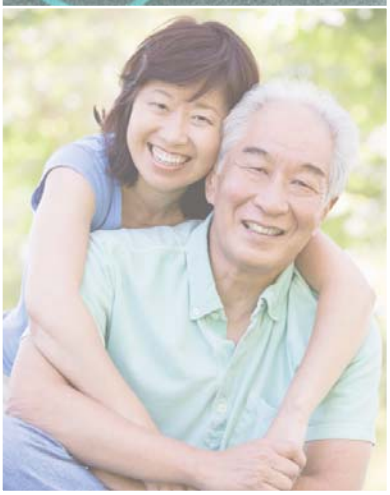
Prevention and Intervention Services (PEI)



3. Process Indicators

In FY 11/12, the REACH Outreach & Engagement Team implemented Wellness Screens using nursing staff, increased the number of participants served in case management services and significantly increased numbers served to 2,519 participants in FY 11/12. This includes 293 served in group interventions, 27 served in case management services, 612 provided wellness screens and 1,587 served in street outreach. This over-all number doubled from the number of participants served in FY 10/11.

4. Future Plans for Change

Future plans are to provide group intervention in Spanish, as well as increasing outreach to the Asian and Farsi-speaking communities. Program will focus on increasing number served in case management services and will look at increasing street outreach sites.

Outreach & Engagement Collaborative

1. Program Description

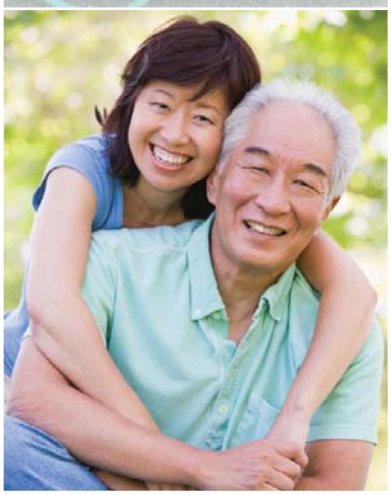
The Outreach and Engagement Collaborative provides mental health preventative services to the unserved and underserved mentally ill population. It is designed for those people who have had life experiences that may make them vulnerable to mental health problems, but who are hard to reach in traditional ways because of cultural or linguistic barriers. Identification with potential target groups or individuals is accomplished through already established relationships with community organizations, (e.g., non-profits, schools, community agencies, health care providers, first responders, judicial system, correctional system, etc.) that have developed trust with the community and have contact with the individuals, families or groups who require assistance in accessing prevention and/or early intervention services. Staff asks respected members of the community organization to introduce them to those needing information and assistance and maintain the contact with that individual or family until no further assistance is needed. Mental health interventions and wellness activities at community sites focus on coping with the impact of trauma and provide easy and immediate access, information, and referral assistance to culturally competent, early intervention services as needed.

2. Outcomes

To measure improvement in the quality of life of participants, the WHO 5 Well-Being questionnaire was administered to participants who received services at three different community-based organizations. There was a 50% increase in well-being of participants.

Of participants who received services from these three providers, 87% reported satisfaction with the program services. Over 90% of the participants served by another provider reported that they enjoyed the activity, would recommend the activities to a friend or relative, and would come back to a similar activity in the future.

Prevention and Intervention Services (PEI)



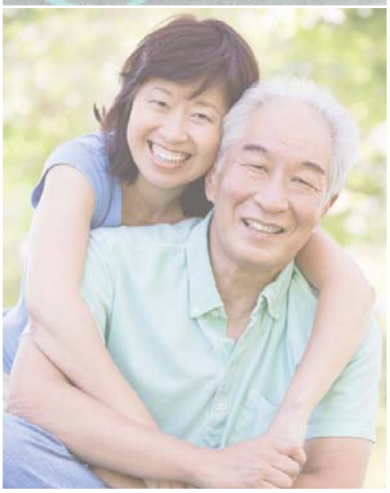
3. Process Indicators

The outreach and engagement contracted programs conducted outreach at 3,452 community events and made 72,556 individual contacts. More than 13,000 participants received 20,936 individual interventions such as case management, short term counseling or skill building and educational services. Out of 20,936 referrals, 4,013 successful linkages were made to other resources and services in the community. Programs conducted 1,204 educational or skill building classes and facilitated 679 support groups. To increase access to services, programs provided participants with 3,425 one-way trips.

4. Future Plans for Change

There are no planned changes for FY 13/14.

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 4: Parent Education and Support Programs

Programs within PEI 4 Parent Education and Support Programs: • Youth As Parents • Promotora • Family Support Services • Parent Education Support Services	**Funding:**
Actual number served in FY 11/12: • Youth As Parents - 71 • Promotora - 49,250 • Parent Education Support Services - NA	Actual Funds expended in FY 11/12: $355,604 $959,003 $66,556 (partial year)
Projected number to be served in FY 12/13: • Youth As Parents - 70 • Promotora - 29,922 • Family Support Services - 1400 • Parent Education Support Services - 2500	Estimated funds to be expended in FY 12/13: $414,531 $510,714 $503,750 $287,703
Estimated number to be served in FY 13/14: • Youth As Parents - 100 • Family Support Services - 1740 • Parent Education Support Services - 2500	Budgeted funds for FY 13/14: $500,000 $718,424 $507,590

Youth as Parents

1. Program Description

The Youth as Parents Program serves pregnant and parenting youth who are at risk of behavioral health problems and their children. Services are designed to prevent or mitigate the onset of behavioral health issues in the teen parents and to identify such issues in their children early in their development. Services include case management, brief counseling, parenting training and education groups, and referral and linkage to community resources.

2. Outcomes

FY 11/12 outcomes data for depression symptom severity decreased, as measured by pre-test and post-test Patient Health Questionnaire (PHQ-9) scores, showing improvement for 84% of the teen parents participating in the program. Since the depression severity level was generally low for the pre-test scores, this measurement tool has been discontinued and replaced with a Risk Factors Acuity tool, as well as other measures.

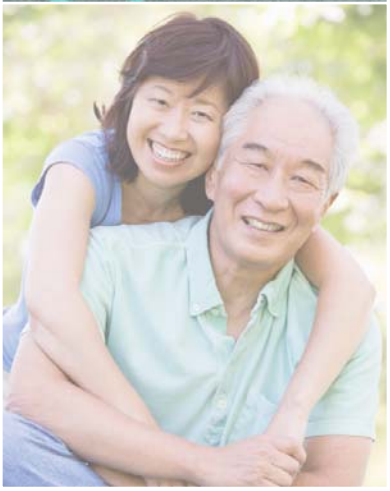
3. Process Indicators

Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population.

4. Future Plans for Change

The program will continue outreach efforts targeting fathers, as well as the Asian and Farsi-speaking communities.

Prevention and Intervention Services (PEI)



Promotora

1. Program Description

The Promotora Model program uses a community health educator approach to educate and provide parenting education, skill development, and case management services for parents or caregivers of children at risk of developing a mental illness or who are displaying signs of emotional, behavioral, or mental instability. Services also address the needs of parents/caregivers who are displaying early signs of emotional, behavioral, or mental instability. This model of community outreach reaches underserved populations through peer education and trusted community members who are already entrenched in specific communities (Native American, API, Older Adult, etc.). Promotoras connect with the community in small groups at community centers, family resource centers or recreation rooms of apartment complexes, churches/mosques/temples, or individually with families in their homes, motels, or other preferred locations in the language/s of their community, respecting and drawing upon the strengths of the culture, of the parent and family. This program trains and builds capacity of interested community organizations in developing or enhancing preventive behavioral health education services within their own communities.

2. Outcomes

Outcomes data demonstrates that over half of the participants reported an improvement in parenting skills and practices such as disciplining their children, building resiliency of the family, and nurturing their children. Also, a total of 471 Quality of Life questionnaires were collected and the results show an average increase of 4.3 points (out of 25 points) between pre- and post-test. The majority of the participants were satisfied with the program. For the support groups, the average overall satisfaction score was 24.5 (out of 26). For the individual interventions, the average overall satisfaction score was 16.3 (out of 18), indicating satisfaction with program impact, cultural competency of the staff, and access to care.

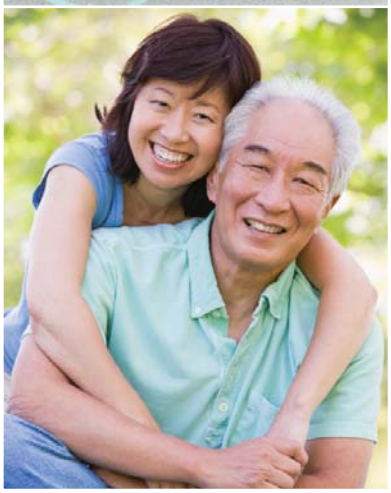
3. Process Indicators

The Promotora Model program contacted 26,435 individuals. The Health workers provided 50 educational group presentations for 1,948 unduplicated participants. They also held 42 parent education workshops (4-part series) for 911 unduplicated participants. Other services provided were 74 group sessions with 551 unduplicated participants, and 841 individual meetings with 304 participants. Additionally, 354 people from 22 organizations across the county were trained in the Promotora community outreach model.

4. Future Plans for Change

This contract is not being renewed; however the services will continue to be provided as part of the Outreach and Engagement Program contract.

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 5: Prevention Services

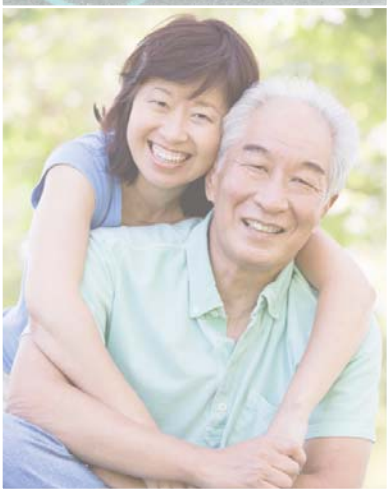
Programs within PEI 5 Prevention Services: • Children's Support and Parenting Program (CSPP) • Stop the Cycle • Transitions	**Funding:**
Actual number served in FY 11/12: • Children's Support and Parenting Program (CSPP) - 414 • Stop the Cycle - 211 • Transitions - 1,043	Actual Funds expended in FY 11/12: $728,777 $525,135 $256,548
Projected number to be served in FY 12/13: • Children's Support and Parenting Program (CSPP) - 425 • Stop the Cycle - 200 • Transitions - 1,500	Estimated funds to be expended in FY 12/13: $794,412 $490,495 $546,213
Estimated number to be served in FY 13/14: • Children's Support and Parenting Program (CSPP) - 800 • Stop the Cycle - 400 • Transitions - 2,500 • Mental Health Consultant	Budgeted funds for FY 13/14: $1,400,000 $1,000,000 $915,236 $400,000

Children's Support and Parenting Program (CSPP)

1. Program Description

The 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. Program serves families that have a common parental history of serious substance abuse and/or mental illness; children living with family members who have developmental or physical illnesses/disabilities; children living in families that are impacted by divorce, domestic violence, trauma, unemployment, homelessness, etc.; and children of families of active duty military/ returning veterans. This program focuses on reducing risk factors for children and youth and increasing protective factors through parent training and family-strengthening programs. Services include family assessment, group interventions for children, teens and parents, brief individual interventions to address specific family issues, referral/linkage to community resources, and workshops.

Prevention and Intervention Services (PEI)



2. Outcomes

FY 11/12 outcomes data reported by parent pre-test and post-test surveys indicated that 77% of parents reported improvement in parenting skills and knowledge. Significant improvement between pre-test and post-test was reported in several areas by parents, including feeling more confident in their efforts to help their child (26% improvement), being consistent with consequences (16% improvement), having the support they need to address issues with their child (14% improvement), arguing with their child (13% improvement), their child completing all homework (10% improvement), and a 10% improvement related to child-parent communication (i.e., "My child tells me what's happening in his/her life."). Youth-reported pre-test and post-test surveys indicated improvements in areas such as having a family member or friend who listens to them when they have something to say (12% improvement), parents spending time or playing with them (11% improvement), parents praising them or letting them know when they have done a good job (10% improvement), and parents talking to them about the rules in their house (9% improvement).

3. Process Indicators

The number of family members served has increased steadily over the last three years (increased 9% from FY 10/11 to 11/12) as the community has become familiar with the program services. In addition, the program provided the group intervention at three new community locations in FY 11/12 further increasing community access to services. The program has acquired staff to provide childcare which has contributed to eliminating barriers for families to participate in services.

4. Future Plans for Change

Further expand community sites for providing intervention, especially in South Orange County. Expand services for families with members with physical disabilities.

Stop the Cycle

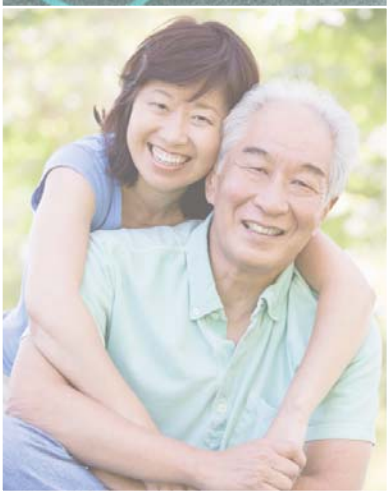
1. Program Description

The Stop the Cycle Program serves a broad range of people from different backgrounds whose family member's actual or potential involvement in the juvenile justice system may make them vulnerable to behavioral health problems. This program focuses on reducing risk factors for children and youth and increasing protective factors through parent training and family-strengthening programs. Services include family assessment, group interventions for children, teens and parents, brief individual interventions to address specific family issues, and referral/linkage to community resources.

2. Outcomes

FY 11/12 outcomes data reported by parent pre-test and post-test surveys indicated that 85% of parents reported improvement in parenting skills and knowledge. Significant improvement between pre-test and post-test was reported in several areas by parents including their child completing all homework (55% improvement), their child skipping school (49% improvement), arguing with their child (46% improvement), their child hitting others (37% improvement), their child verbally threatening to harm others (33% improvement), feeling more confident in their efforts to help their child (23% improvement), having the support they need to address issues with

Prevention and Intervention Services (PEI)



their child (21% improvement), and spending time together as a family (18% improvement). Youth-reported pre-test and post-test surveys indicated improvements in areas such as having goals and plans for the future (15% improvement), parents talking to them about the rules in their house (11% improvement), and having hope about their life (8% improvement).

3. Process Indicators

The number of family members served has increased steadily over the last three years (increased 60% from FY 10/11 to 11/12) as the community has become familiar with the program services. Spanish-speaking staff has allowed the program to effectively serve the Hispanic/Latino population. Program graduates have continued to meet to support network sustaining efforts of the program.

4. Future Plans for Change

Expand program focus beyond parents and siblings of youth in the juvenile justice system to also target the youth in the juvenile justice system. The program has been provided at the two Youth Reporting Centers with an exception of one Family Resource Center. Program will start providing services at Juvenile Hall this year.

Client Comments on Stop the Cycle

"The program is very positive; there is no judgment from anyone. Everyone respects each other's opinions. The program gave me confidence and knowledge to work with all my kids. Before I used to scream at them and now I have learned to talk with them. Everyone in the house is more cooperative and relaxed. I love this program and feel so happy to have been a part of it. This program helps so many parents."

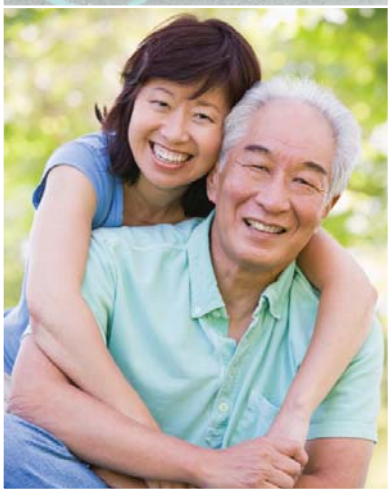
Soon after successfully completing the 12 week program, this client decided to volunteer her time and become a mentor for the participating families. "I volunteered because this program helped me a lot and changed my life. This program has changed the lives of many families, and I hope it always stays here."

Transitions

1. Program Description

The Transitions Program is designed to help youth successfully cope with the academic and social pressures that take place during the teenage years. Of particular concern are those at risk of, or experiencing, issues related to life change, bullying, academic failure, drug use, relational problems, early onset of mental health disorders, and juvenile justice involvement. Transitions is designed to work with youth experiencing a variety of transitions including students going from middle school to high school, high school to college, juvenile detention to traditional or alternative school, foster care to independent living, school to employment, or back to school. Services include: life skills and self-awareness education, effective communication and decision making training, facilitation of referrals and linkages to community resources. There is also a parenting component which includes workshops to support the growth and changes that the youth may be experiencing.

Prevention and Intervention Services (PEI)



2. Outcomes

The evaluation plan was finalized in June 2012 and at that time the existing pre/post-test was replaced with a new measure to better capture changes in the students' knowledge, attitudes and behaviors, as well as positive changes in the school climate. Initial School Climate Survey data from six high schools indicates a slight 3.4% improvement overall (based on aggregate total scores at pre-test and post-test), as well as a 9.3% improvement in school staff perceptions of physical and emotional safety at the school. Initial Youth Satisfaction Survey data showed that students rated the Transitions program 7.4 on a scale of 0-10 (where 10 is best), students felt that the staff were nice to them (average score = 3.6 out of 4, or 90%) and listened when they had something to say (average = 3.2, 80%), they were treated fairly at Transitions (average = 3.3, 83%), and they feel good about themselves (average = 3.1, 78%).

Students wrote that the things they liked best about Transitions were the nice and helpful staff, talking, interacting, the videos, the talk show and game show class sessions, and learning new things. Initial data from the new survey of students' knowledge, attitudes and behaviors showed an overall average of 8% improvement from pre-test to post-test. A few items that showed notable improvements were the statement "I try to work out problems by talking or writing about them" (14% improvement pre-post), and knowledge items regarding ways to communicate effectively (13% improvement), signs of substance abuse withdrawal (13% improvement), and being assertive for the most successful communication (52% improvement).

In April 2012, the Assistant Principal of Valencia High School summarized positive impacts of the Transitions program to include (1) increased communication among students about personal struggles and adversity that they had to overcome, (2) built stronger peer relationships and mutual respect among students, and (3) helped students in making a personal connection with the literature being studied in the class. In addition, several letters of recommendation have been received from school officials during this first year of implementation. In FY 11/12, eight students were linked to the school counselor because of behavioral health concerns revealed from students' participation and several students verbalized commitments to stop using alcohol and drugs.

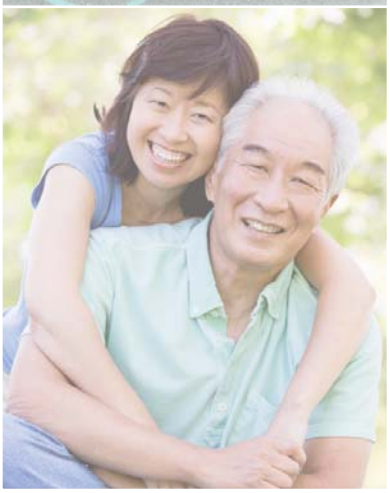
3. Process Indicators

In FY 11/12, 956 students and 87 parents were served. Transitions staff has learned a lot in this first year of implementation. Several changes have been implemented to increase numbers served with more locations, increase parent participation, better engage students and further collaborate with schools in linking students to behavioral health services.

4. Future Plans for Change

Transitions will be expanded to work with additional school districts and develop programs to work with youth experiencing other transitions. Curriculum will be revised and updated based on feedback. Increased efforts will be made to outreach to parents to further strengthen program's impact.

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 6: Screening and Assessment

Programs within PEI 6 Screening and Assessment: • Professional Assessor's Programs	Funding:
Actual number served in FY 11/12: • Professional Assessor's Programs - 277	Actual Funds expended in FY 11/12: $26,166
Projected number to be served in FY 12/13: • Professional Assessor's Programs - 55	Estimated funds to be expended in FY 12/13: $139,509
Estimated number to be served in FY 13/14: • Professional Assessor's Programs - NA (to be expanded in FY 13/14) • Mobile Assessment Team - NA	Budgeted funds for FY 13/14: $536,136 $346,552

Veterans' Services Court Programs

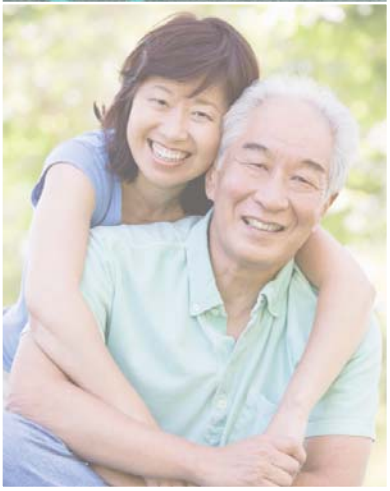
1. Program Description
There are two court programs: The Non-Criminal Domestic Violence (DV) Veterans' Program; and the Veterans' Combat Court, 'Track Two' program. The Non-Criminal DV Program case manages veterans who are respondents in non-criminal DV cases. These veterans are assessed and enrolled in appropriate therapy and/or programs. Their progress is monitored by the programs' clinician who reports back to the court. The 'Track Two' Veterans' Combat Court program consists of participants who were not admitted to the Veterans' Administration (VA) Veterans' Combat Court. They are assessed and case managed by a program clinician. They are referred and linked to appropriate programs and community resources.

2. Outcomes
Data tools and procedures were revised in the spring of 2012 for implementation on July 1, 2012. Thus, data for FY11/12 is not available.

3. Process Indicators
Process measures for these programs indicate that participants are routinely contacted on their first court appearance and offered services. Service delays occur due to court processes, or participant's availability for appointments.

4. Future Plans for Change
The Non-Criminal Family Court program is currently (Feb-Mar 2013) under discussion as to program revision with the Family Court. As of November 2011, the Veterans' Combat Court reached maximum capacity (50). The decision was made to only admit VA eligible participants. This has created a significant change in the program. HCA Veterans' Services now does not screen all prospective clients as in the past. Only the few participants who are referred but are not VA eligible are screened, and then case managed. The numbers served show the impact of less screening and assessments performed. The numbers served now and in the future are primarily composed of those who are case managed (which is an actual larger number than in previous years).

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 7: Crisis and Referral Services

Programs within PEI 7 Crisis and Referral Services:	Funding:
• Crisis Prevention Hotline • Survivor Support Services • Warm Line Network Services	
Actual number served in FY 11/12: • Crisis Prevention Hotline - 27,489 • Survivor Support Services - 25,628 • Warm Line Network Services - 10,581 • Crisis Response	Actual Funds expended in FY 11/12: $244,448 $259,551 $315,344 $7,370
Projected number to be served in FY 12/13: • Crisis Prevention Hotline - 27,476 • Survivor Support Services - 15,669 • Warm Line Network Services - 8,214 • Crisis Response	Estimated funds to be expended in FY 12/13: $272,533 $270,693 $365,014 $51,203
Estimated number to be served in FY 13/14: • Crisis Prevention Hotline - 30,000 • Survivor Support Services - 18,000 • Warm Line Network Services - 12,000 • Emergency/Crisis Response Team • Law Enforcement Partnership	Budgeted funds for FY 13/14: $272,533 $270,693 $365,014 $500,000 $400,000

Crisis Prevention Hotline

1. Program Description

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention service available to anyone in crisis or experiencing suicidal thoughts. Services include immediate, confidential over-the-phone assistance for anyone seeking crisis and/or suicide prevention services for themselves or someone they know. Callers who are not experiencing a crisis will be triaged and offered access to a Warm Line or other appropriate resources.

2. Outcomes

Twenty nine percent of the calls were information/referral only calls, and 71% were suicide/crisis calls. Callers were asked to rate their suicidal intent on a scale of 1 (an expressed intent to die) to 5 (an attempt in progress) at the start and end of the call. The participants' average suicidal intent score was 2.6 at the beginning of the call, but decreased to 1.9 by the end of the call. The suicidal intent of the callers with a moderate risk decreased by 38%, and for those with a high and imminent risk decreased by 57%.

3. Process Indicators

A total of 5,918 calls, from 4,629 unduplicated callers, were received in 2011-12.

4. Future Plans for Change

There are no planned changes for FY 13/14.

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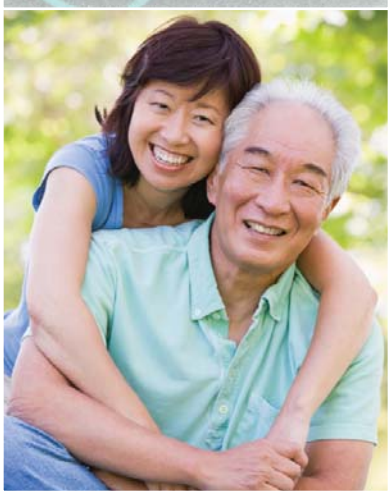
Prevention and Intervention Services (PEI)



Success Story

N., 56, from Irvine had a clear plan for overdosing on her many medications. She is treated for schizophrenia and has had multiple hospitalizations. Her feelings of paranoia and losing her job were overwhelming and she was in great distress. Counselor Jeremy worked very hard to build some rapport and eventually got N. to talk a little about her daughter and her job. She eventually revealed her city of residence but negated expressions of concerns and offers of help. Irvine PD was able to locate her and called in CAT for an evaluation. N. was transported to a local hospital.

Survivor Support Services

1. Program Description

Survivor Support Services provides support for those who have lost a loved one to suicide, and educates the community on suicide prevention and intervention. These services include outreach, crisis support, bereavement groups, individual support, and training. Trainings on suicide prevention and survivor support groups are available to Orange County residents and serve a broad range of people whose lives have been impacted by mental illness and, in particular, suicide. Culturally appropriate follow-up care, education, referrals and support target those who have attempted suicide and those who have lost someone to suicide. The goal of the program is to reduce traumatic grief and suicidal ideation/behavior and the impact on family, friends, and communities. Through a peer-led group support model, this program aims to provide education and information regarding the personal and social impact of suicide, and to address survivors' emotions and needs. The service is also designed to improve family functioning/communication, identify and understand the factors that promote a survivor's resilience and strength, provide bereavement services and support, and address issues of stigma and shame.

2. Outcomes

Participants showed a decreased level of traumatic grief after an 8-week Survivor Support Group. There were six on-going support groups with group size ranging from 2-8. The Traumatic Grief Inventory was used with participants, with a scale from 0-76 where a score over 32 indicates severe traumatic symptoms. On average, the participants' scores decreased from 35.1 (severe risk) at intake to 31.9 (low risk) at discharge. Suicidal ideation was also measured by asking how often each participant thought about ending his/her life (0=Never, 1=Rarely, 2=Sometimes, 3=Often, 4=Always). Average score of the participants decreased 46.4% from 2.0 at intake to 1.5 by the end of the eight sessions.

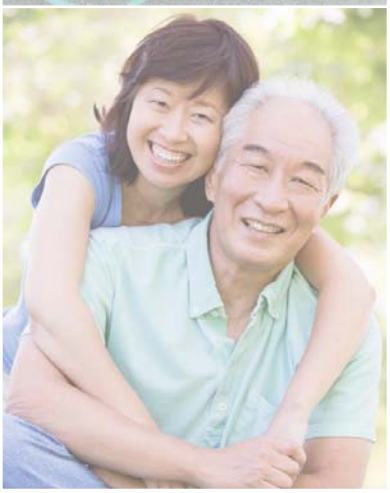
3. Process Indicators

Program staff conducted 95 group sessions and 209 individual sessions. They held 37 training activities and participated in 208 outreach events. They also provided 874 follow-ups, with 903 referrals and linkages. In total, 25,628 participants were served in 2011-12.

4. Future Plans for Change

There are no planned changes for FY 13/14.

Prevention and Intervention Services (PEI)



Warm Line Network Services

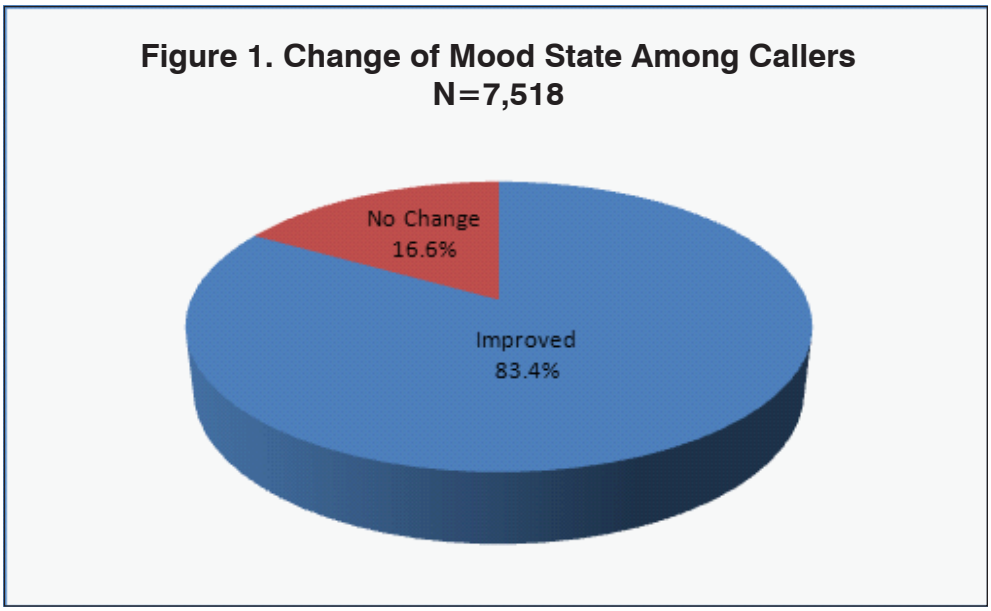
1. Program Description

Warm Line Network Services is telephone-based, non-crisis support for anyone struggling with mental health and substance abuse issues. The staff providing the services has been through a similar journey, either as a mental health or substance abuse services consumer, or as a family member of an individual receiving these services.

2. Outcomes

Profile of Mood State (POMS) was used to measure affective mood state at the beginning and the end of each call. Data on mood state is collected by a mentor at the beginning and the end of the call by assessing whether the caller feels agitated, annoyed, anxious, confused, depressed, helpless, overwhelmed, uncertain, and/or worried. Of the 7,518 callers, 6,268 (83.4%) experienced an improved mood at the end of the call.

Figure 1. Change of Mood State Among Callers
N=7,518



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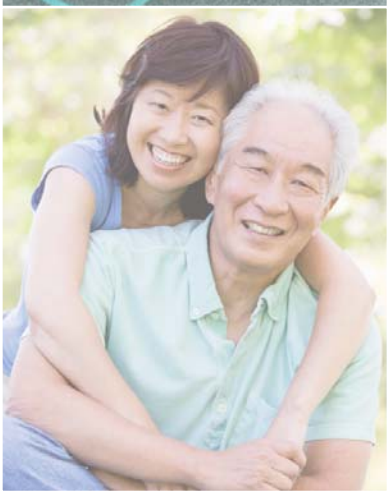
Prevention and Intervention Services (PEI)



Caller's Mood	Beginning of the Call	Caller's Mood	End of the Call	% of Callers with Improvement in Mood
Agitated	789	Less Agitated	534	67.7%
Annoyed	753	Less Annoyed	604	80.2%
Anxious	1,595	Less Anxious	1,432	89.8%
Confused	764	Less Confused	600	78.5%
Depressed	1,786	Less Depressed	1,521	85.2%
Helpless	435	Less Helpless	360	82.8%
Overwhelmed	394	Less Overwhelmed	339	86.0%
Uncertain	244	Less Uncertain	220	90.2%
Worried	731	Less Worried	658	90.0%

Table 1. Improvement in Mood by Mood State

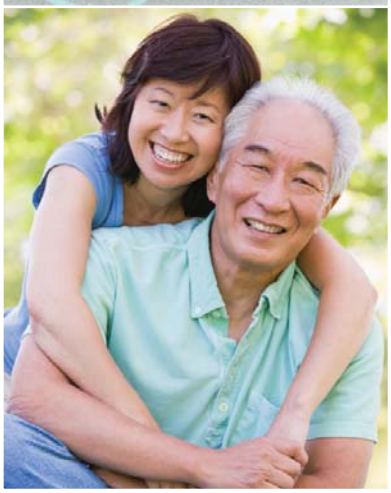
3. Process Indicators

A total of 10,581 calls were received in 2011-2012.

4. Future Plans for Change

There are no planned changes for FY 13/14.

Prevention and Intervention Services (PEI)



PEI Program Information
PEI Project 8: Training Services

Programs within PEI 8 Training Services: • Training and Technical Assistance • Child Development Training • Training in Physical Fitness and Nutrition • Community-Based Stigma Reduction	**Funding:**
Actual number served in FY 11/12: • Training and Technical Assistance - 245 • Child Development Training - 292 • Training in Physical Fitness and Nutrition - 129 • Community-Based Stigma Reduction - 416	Actual Funds expended in FY 11/12: $136,417 $6,000 $14,365 $56,207
Projected number to be served in FY 12/13: • Training and Technical Assistance - • Training in Physical Fitness and Nutrition - 129 • Community-Based Stigma Reduction - 3,020	Estimated funds to be expended in FY 12/13: $13,260 $265,483
Estimated number to be served in FY 13/14: • Training Assessment & Coordination Services • Training in Physical Fitness and Nutrition - 150 • Community-Based Stigma Reduction - 3,500	Budgeted funds for FY 13/14: $1,034,777 $50,000 $214,333

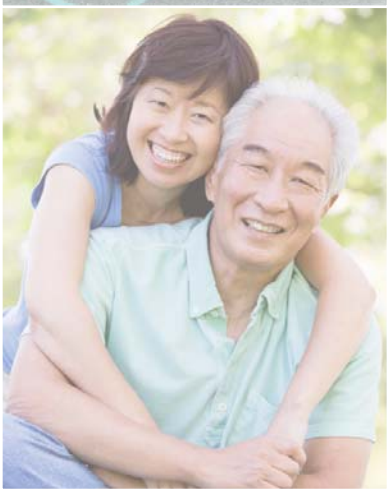
Training and Technical Assistance

1. Program Description

This program focuses on providing multi-disciplinary conferences and training to community providers, partners, and care providers across systems with models of prevention and early intervention best-practices. The program is designed to assist local community partners/providers who are implementing the Prevention and Early Intervention plan. The Bullying Prevention Conference took place as part of this program in June 2012.

Bullying Prevention Conference (one-time event)
Twelve speakers from the mental health, education, and legal/law enforcement fields held workshops where they trained community educators and other professionals on how to detect and identify different types of bullying (including cyber-bullying), how bullying situations are manifested within the school culture, and their detrimental physical and psychological effects on the victim. Speakers emphasized risk protective factors, practical strategies and presented tools for preventing bullying and managing the aftermath of bullying incidents.

Prevention and Intervention Services (PEI)



2. Outcomes
A satisfaction survey administered at the conclusion of the conference indicated that 97% of the respondents were satisfied with the event.

3. Process Indicators
In FY 11/12 the conference took place after the conclusion of the traditional school year when most educators were on summer break. The conference was attended by 245 persons. The Bullying Prevention Conference for FY 12/13 will take place in May (during the school year) so the attendance of educators is likely to increase.

4. Future Plans for Change
Increase attendance of educators; add workshops for the prevention and intervention of workplace bullying and senior abuse.

Child Development Training

1. Program Description
This program includes co-sponsored, one-time training events designed for those persons who are in a decision-making capacity regarding family unity and child placement. Although the program is focused on resiliency and protective factors common to all families, there will be a special focus on how these are best supported in families from underserved cultural populations. The Amazing Adolescent Brain Conference took place as part of this program in October of 2011.

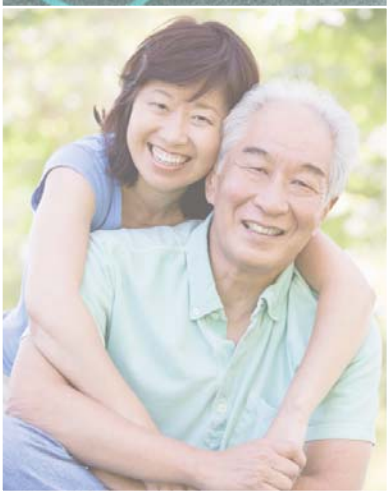
> **The Amazing Adolescent Brain: Opportunities and Vulnerabilities Conference (one-time event):** This training for behavioral health care professionals and educators provided an overview of neurobiology to demonstrate how adolescence is another window of opportunity in brain development. Describing areas of the brain that show the most profound changes during adolescence, the implications of these changes on adolescents' thought processes, behaviors, and vulnerability to neurotoxins were presented through dialogue and case studies. Strategies to enhance communication, maximize healthy brain development, and promote a more peaceful adolescence were discussed along with evidence-based programs that are making a difference in servicing the teen population.

2. Outcomes
A satisfaction survey administered at the conclusion of the conference indicated that 80% of the respondents rated the overall quality of the event as excellent.

3. Process Indicators
The conference was attended by 292 individuals.

4. Future Plans for Change
N/A

Prevention and Intervention Services (PEI)



Training in Physical Fitness and Nutrition

1. Program Description

The Training in Physical Fitness and Nutrition program is designed to serve those individuals receiving behavioral health services and for whom training in physical fitness and nutrition is consistent with their recovery plan. Providing training on lifestyle modifications, risk factors, and early intervention in the lives of persons with newly developing serious mental illness may lessen the morbidity associated with these disorders. The program provider is a state-of-the-art gym that designs individualized physical fitness programs that include cardiovascular training and strength training. Nutrition education services are offered in the form of classes/workgroups/support groups.

2. Outcomes

In FY 11/12, the program had 129 active members who completed at least one physical fitness workout. This is 50% of the total number of individuals that were referred to the program. A self-reporting pre and post-test measurement tool indicated that 50% of respondents learned to better manage their weight.

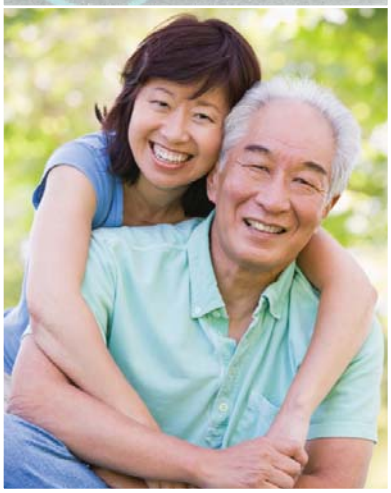
3. Process Indicators

Due to the inconsistent attendance patterns of the members and their reluctance to answer personal questions, the center could not obtain verifiable health/lifestyle information on a pre and post basis from a majority of the members. Although offered on a weekly basis, the nutrition classes were not attended due to members' lack of interest and inability to obtain reliable transportation.

4. Future Plans for Change

Future plans include closer collaboration with the case managers and program administrators that refer individuals to the center to ensure they are motivated to actively participate. This will also encourage more regular attendance, enabling the center to gather the post program data needed to report outcomes. The Health Care Agency is planning an "Invitation for Bid" for FY 13/14. It is hoped that through the solicitation process, one or more fitness centers with multiple locations will be available to address the accessibility/transportation constraints of members.

Prevention and Intervention Services (PEI)



Community-Based Stigma Reduction

1. Program Description

This program includes co-sponsored, one-time training events designed to reach out to community members for the purposes of increasing community (a) awareness about the prevalence of mental illness; (b) knowledge of adaptive help-seeking behavior; (c) awareness of mental health resources in the community; and (d) tolerance and compassion toward persons with a mental illness. This program serves a broad range of people of different backgrounds and ages. Underserved cultural populations, where the stigma of mental illness is even greater than that of the general population, are a focus. Events include:

Disparity & Disproportionality in Human & Health Services Conference: Bridges Out of Poverty (one-time, 2-day event held in Oct/Nov 2011): *Bridges Out of Poverty*, is a nationally recognized training based on Ruby Payne's book, *A Framework For Understanding Poverty*. The conference trainer helped equip staff and community providers with the understanding of cultural aspects of poverty and the barriers people face in accessing and utilizing self-sufficiency services. The conference featured a series of breakout sessions on poverty as a vital factor in influencing the disparities and disproportionalities observed in behavioral health, criminal justice, education, and community and social service systems.

Meeting of the Minds Conference (one-time event held in May 2012): The objectives of the conference were to bring together the full spectrum of the "mental health community" of Orange County, to raise awareness, learn skills, increase cultural sensitivity, network, reduce stigma, share information and resources, strengthen existing relationships, develop new alliances, improve patient care, and quality of life for persons impacted by mental illness. The conference was available to mental health professionals, community agency staff, consumers and families, school personnel, religious leaders, volunteers, community advocates, private practitioners, law enforcement, emergency medical personnel, public health providers, and elected officials.

2. Outcomes

Disparity & Disproportionality in Human & Health Services Conference: Bridges Out of Poverty (one-time, 2-day event held in Oct/Nov 2011): A satisfaction survey administered at the conclusion of the conference indicated that 93% of the respondents were satisfied with the event.

Meeting of the Minds Conference (one-time event held in May 2012): A satisfaction survey administered at the conclusion of the conference indicated that 91% of the respondents were satisfied with the event.

3. Process Indicators

The Disparity & Disproportionality in Human & Health Services Conference was attended by 254 individuals. The Meeting of the Minds Conference was attended by 162 individuals.

4. Future Plans for Change

A contract has been issued for a new Community-Based Stigma Reduction Art Event Services program; data for this new program will be presented in future updates.

INNOVATION

“If you can dream it, you can do it.” - Walt Disney

Innovations (INN)

A. Component Information

An innovative project is defined, for purposes of the California Department of Mental Health (DMH) guidelines, as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an innovation contributes to learning in one or more of the following three ways.

1. Introduces new mental health practices/approaches including
2. Prevention and early intervention practices/approaches that have never been done;
3. Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community;
4. Introduces a new application to the mental health system of a promising community driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings.

The Innovation (INN) Program cultivates research projects to evaluate the effectiveness of new practices and approaches. By their very nature, not all INN projects will be successful. Innovation projects are expected to operate between one to three years. A thorough evaluation of each project will be conducted and the findings disseminated and in some instances the length of the project may be extended. Those projects deemed "unsuccessful" will be discontinued. Continuation of projects showing positive outcomes, are contingent upon identification of alternate funding sources.

In addition to contributing to learning, all of the current Orange County Innovation Projects serve one or more of the following purposes:

1. Increase access to underserved group
2. Increase the quality of services, including better outcomes
3. Promote interagency collaboration
4. Increase access to services.

All 10 current Innovation projects share a common theme, which is the involvement of consumers and family members working as Peer Specialists to provide services and/or direct the activities involved in the projects. In some cases, it is precisely this consumer and family member involvement in implementing the project that is the greatest innovation. In other cases, nearly all aspects of the project, including the involvement of consumers and family members, are innovative. In addition to project specific learning goals, a common goal for all the Innovation Projects is to increase paid employment opportunities for our trained consumers and family members Peer Specialists, and to assess how well this innovative project component works within each project.

Innovations (INN)

The overarching question we seek to answer from the 10 projects is: "Can a well-trained consumer/family member be an effective paraprofessional in all clinical settings?"

The ten current Innovation projects are:

1. Integrated Community Services
2. Collective Solutions (formerly Family Focused Crisis Management and Community Outreach)
3. Volunteer to Work
4. OC ACCEPT (formerly OK to Be Me)
5. OC4Vets (formerly VetConnect)
6. Community Cares Project
7. Education, Training, and Research Institute
8. Project Life Coach
9. Training to Meet the Mental Health needs of the Deaf Community
10. Brighter Futures (formerly Consumer Early Childhood Mental Health)

At the time of reporting, eight of the ten projects have been implemented and a 9th (Volunteer to Work) will be implemented shortly. The Education, Training and Research Institute has not been implemented. Efforts to find a contractor willing and able to implement the Education, Training and Research Institute project have been not been successful.

In general, it has taken longer than expected to implement the projects; thus, data for FY 11/12 is incomplete.

During Fiscal Year 2011/2012, Innovation Projects served 367 participants. This number included the five projects that were providing services at that time- Integrated Community Services, Collective Solutions, OC ACCEPT, Community Cares Project, and Brighter Futures.

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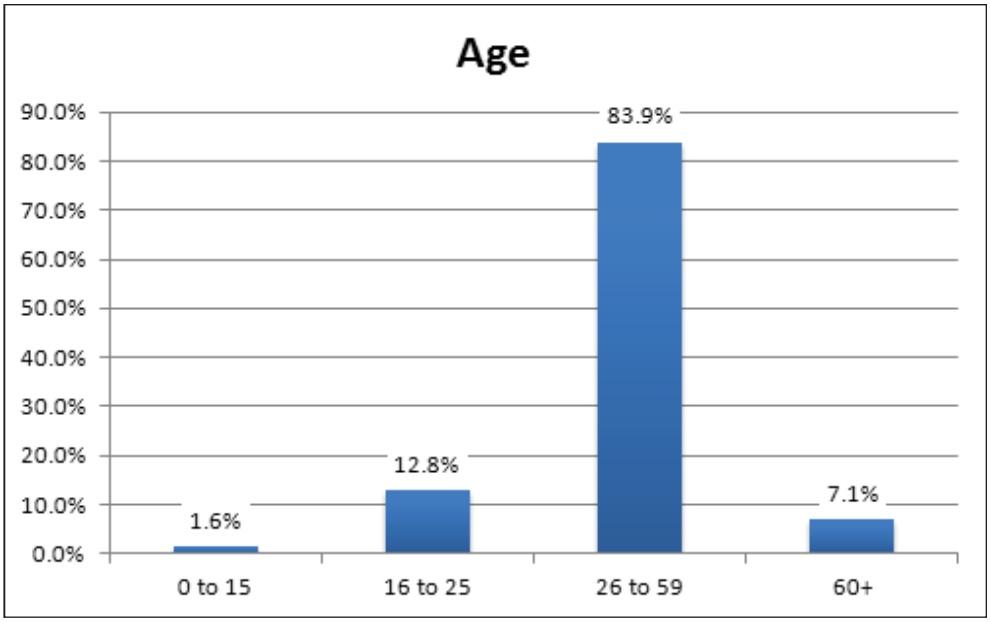
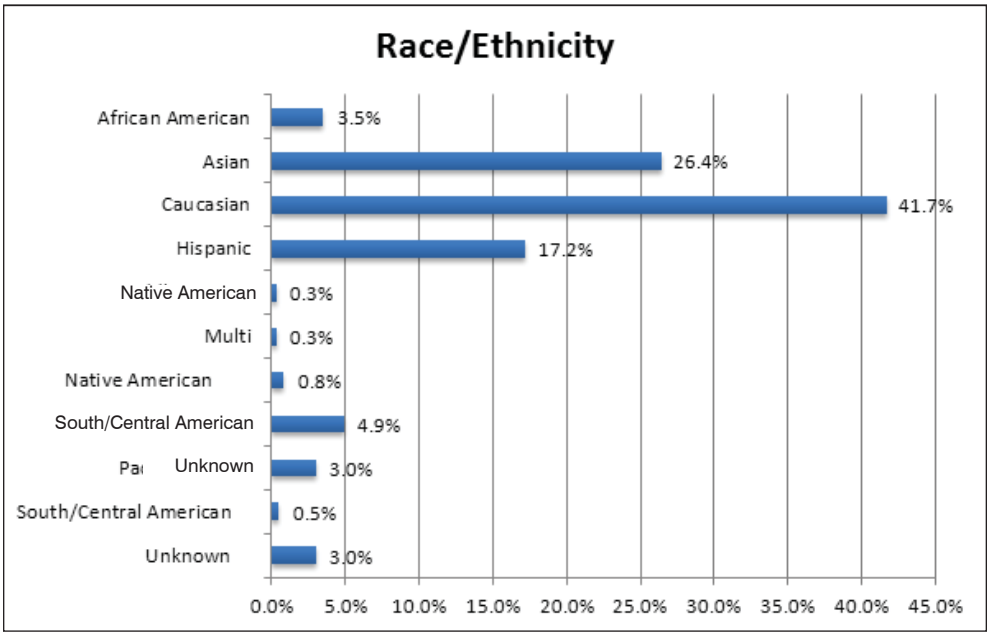
Innovations (INN)

Please see the following charts for the demographic information for these participants.

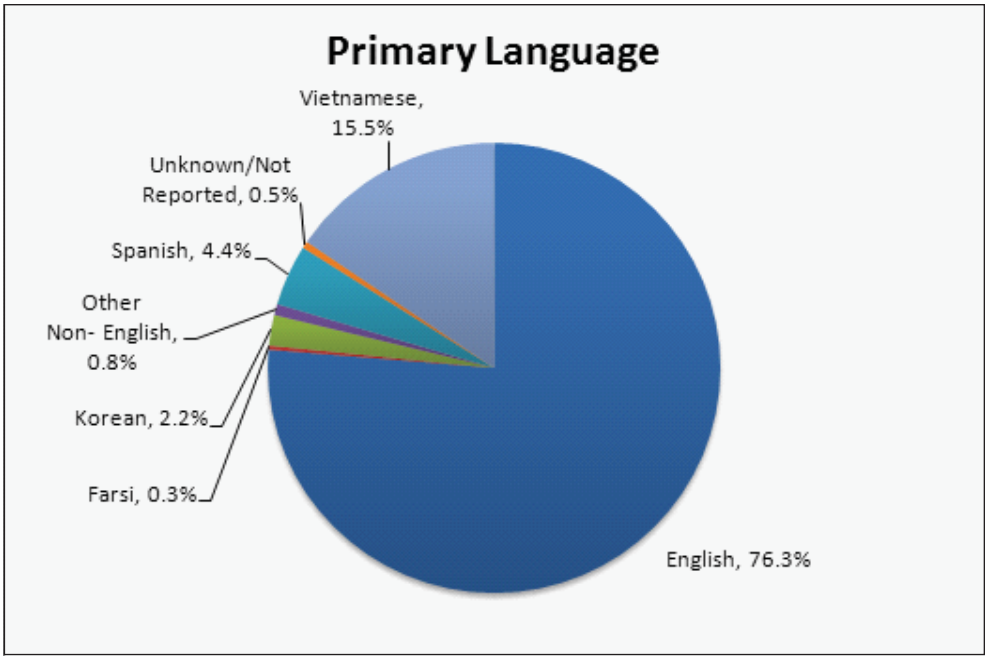


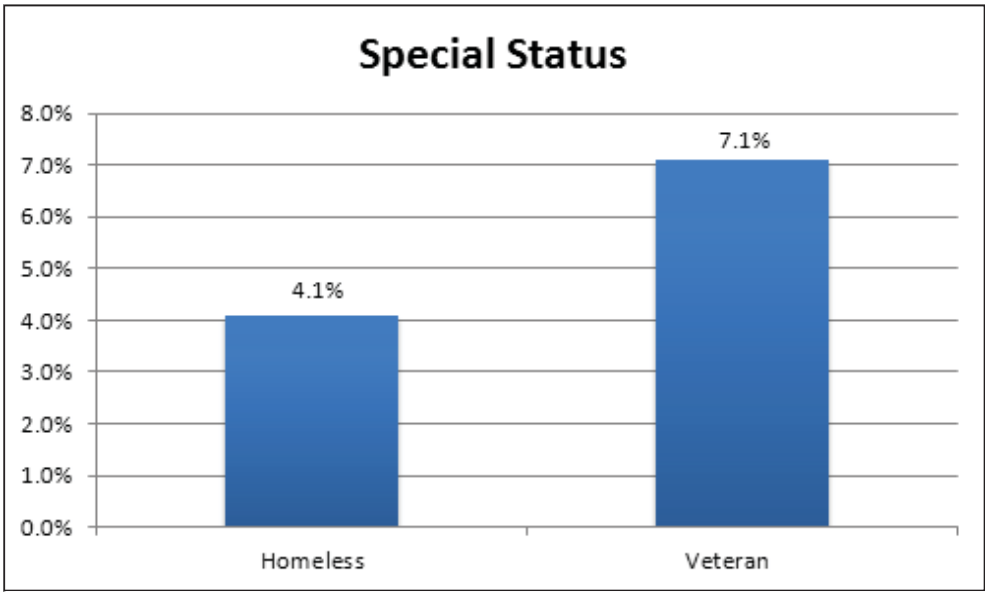
The majority of clients served in INN Projects are adults between the ages of 26-59. They constitute nearly 84% of the population served in FY 11/12. In terms of race/ethnicity, about 42% of the project participants were Caucasian. The second largest ethnicity served was Asian, comprising approximately 26% of the project participants. Latino/Hispanic project participants constituted 17% of the total served.

About 76% of the participants stated that English was their primary language; 15.5% identified Vietnamese and slightly more than 4% specified Spanish as their primary languages. About 7% of project participants were identified as veterans, and 4% self-reported being homeless. Those participants that were identified as veterans were referred to the INN project (OC4Vets) which offers services to veterans.



Innovations (INN)





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Innovations (INN)

B. Project Information: Group 1 (Original 10 Projects)
INN Project #1 Integrated Community Services (Group 1)

Program Name: INN1: Group 1: Integrated Community Services	**Funding:**
Actual number served in FY 11/12: 283 community and county combined	Actual funds expended in FY 11/12: $1,573,507
Projected number to be served in FY 12/13: 588	Estimated funds to be expended in FY 12/13: $1,686,876
Estimated number to be served in FY 13/14: 800	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status

The Integrated Community Services (ICS-Community and County) pilot project provides outreach to the medical community to facilitate multi-directional services to fully integrate primary care, mental health and substance abuse services. This collaboration with community medical clinics and county mental health programs is a healthcare model that will prove to bridge the gaps in service for the underserved low-income community and increase better overall health outcomes for the patients involved.

There are two components to the project: ICS **Community** Home and ICS **County** Home. In the ICS **Community** Home project, a Mental Health Team (Psychiatrist, BHS Clinician and Mental Health Caseworker/ Peer Specialist) is brought into existing community health clinics – Asian Health Center and KCS Health Center. Bringing in such a team to complement existing patient services allows full integration of patient care in each location. This project provides services to Orange County residents who are Medi-Cal or MSI enrolled or eligible and have both primary care and mental health care needs. The project provides services in English, Spanish, Vietnamese and Korean.

The ICS-**County** Home pilot project provides primary medical care services to transitional age youth, adults and older adults who are residents of Orange County, are Medi-Cal or MSI eligible, have a chronic health problem and are currently receiving behavioral health services at the Orange County Adult Mental Health (AMHS) Clinics or the Alcohol and Drug Abuse Clinics in Santa Ana, Westminster or Anaheim. A Medical Doctor, Registered Nurse and a Medical Care Coordinator/Peer Specialist provide medical care case management, care coordination, supportive counseling, educational groups, medication consultation, peer-led support groups and linkage to community resources. The project provides services in English, Spanish, Vietnamese and Korean. The ICS project began providing services to participants in November 2011.

Innovations (INN)

2. Outcomes

A variety of measures are used to determine the effectiveness of the Integrated Community Services project. The measures used are listed below. During FY 11/12, the project was developing a data registry into which all of these measures would be entered. Development of the data registry has been completed, but project staff is still in the process of entering information into the system, therefore outcome data is limited at this time. However, data is currently available for scores on the PHQ 9 (depression multi-purpose self-reporting instrument used for screening, diagnosing, monitoring and measuring the severity of depression).

The measures include:

Behavioral Health Indicators – The ICS Program administers the Generalized Anxiety Discorder-7 scale (GAD-7), the Patient Health Questionairre-9 (PHQ-9).

The World Health Organization Quality of Life – Brief Version (WHOQOL-BREF), and the Participant Satisfaction Survey to all participants.

Physical Health Indicators – All project participants are monitored at each medical visit for indicators related to their health such as Body Mass Index, Blood Pressure, waist circumference, smoking status, exercise levels, etc. Lab results are measured as needed to monitor cholesterol levels, hemoglobin levels, TSH levels, etc.

Staff/Peer Satisfaction Indicators – The Peer Specialists also complete a satisfaction survey about their experience working in the project. Staff members who work along side the Peer Specialists will also be asked to complete a satisfaction survey to monitor their experience in working with the Peer Specialists.

Analyses based on changes in PHQ 9 scores – When looking at information from 177 participants in the data registry during the month of January 2013, it was found that participants that had at least two PHQ-9 administrations showed statistically and clinically significant reductions in their depression. Twenty-nine percent of participants were in the severe range of depression at their first PHQ-9 administration and this had dropped to eighteen percent by the last administration. The mean length of time between the first and last administration was 162.5 days or 5.3 months.

Innovations (INN)

3. Process Indicators

Community Home – Since information is still being entered into the ICS data registry, complete process information is not available. According to the Orange County Integrated Records Information System (IRIS), during this time period there were 959 hours of therapeutic services rendered. This includes both clinical therapy and psychiatric services.

County Home – Since information is still being entered into the ICS data registry, complete County Home process information for FY 11/12 is not available at this time. However, using data from the first two quarters of Fiscal Year 2012/2013 may provide a reasonable estimate of services provided. During those two quarters, the Medical Doctor/Registered Nurses had 465 participant visits (432 service hours) and the Medical Care Coordinators/Peer Specialists had 1,255 visits (289 service hours) with project participants.

4. Future Plans for Change

The completion of entry into the ICS data registry is a priority, as is compiling and analyzing data from the registry. A new assessment tool SBIRT (Screening, Brief Intervention and Referral to Treatment), will be utilized to screen for alcohol and substance use, anxiety, depression and domestic violence in order to more effectively treat project participants. New ideas are being tested in order to streamline the process of entering large amounts of participant data in a more timely and efficient manner.

Client Success Story

One County Home participant wrote a glowing letter about the project. In part, it stated, "I believe Integrated Community Services was an integral part of my recovery. I received essential treatment for my medical issues. Moreover, the peace of mind that ensued helped in my mental and emotional well-being. The entire staff deserves recognition for their professionalism and authentic desire to help. I am profoundly grateful for Integrated Community Services. It is my hope that others who need a hand-up in this sometimes difficult life will be able to benefit from this worthy project."

Innovations (INN)

Project Information
Inn Project #2 Collective Solutions (Group 1)

Program Name: INN2: Group 1: Collective Solutions	**Funding:**
Actual number served in FY 11/12: 5	Actual funds expended in FY 11/12: $129,014
Projected number to be served in FY 12/13: 36	Estimated funds to be expended in FY 12/13: $181,920
Estimated number to be served in FY 13/14: 300	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
Collective Solutions, (formerly Family Focus Crisis Management and Community Outreach) is a 16-week program that provides community-based supportive services to family members of individuals who have a mental illness. Collective Solutions assists families by teaching them how to manage crisis situations related to mental illness. Services are provided by Peer Specialists and clinicians who deliver culturally and linguistically appropriate assessments, case management, discussion groups and counseling services.

Staff facilitates positive communication between family members to help reduce future crisis situations and need for hospitalization. They educate families about mental illness and assist family members and their loved ones with developing an action plan to better manage future crises. This project also creates a community-based support network for individuals and families in crisis and facilitates linkage to mental health services among ethnic communities. Services are provided to Orange County residents who are family members of individuals age 16 and older who are newly or previously diagnosed with a mental illness. In addition, mental illness must have resulted in a crisis situation for their support system and/or family. The project provides services in English, Spanish, Farsi and Armenian.

2. Outcomes
To measure outcomes, Collective Solutions administers a variety of measurement tools. Including but not limited to, the PHQ-9, GAD-7, WHOQOL-BREF, Protective Factors Survey and a Participant Satisfaction Survey to all participants. Collective Solutions began serving participants on April 4, 2012. Prior to this, project staff focused on program development. During fiscal year 2011/2012, the project hired one Peer Specialist in May of 2012.

No outcome information was submitted for this time period due to the small number of participants and the short period of time that they had been receiving services.

3. Process Indicators
During this time period there were 35 participant sessions conducted for a total of 32.1 service hours.

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Innovations (INN)

4. Future Plans for Change

In order to better meet the needs of the participants, the project will begin implementing support/discussion groups and educational groups. Project staff members will also increase their outreach efforts to NAMI Family to Family groups around Orange County as these families may have a need for more individualized support.

Client Success Story

I was fortunate to learn about Collective Solutions about nine months ago when my adult son was in the middle of a devastating bout of mania during a cycle of his bipolar disorder. I was at my wit's end. I was under an extreme level of stress and was desperate for practical advice so that I could handle my family's difficult situation. I had attended many family support groups and had made numerous phone calls to various county mental health agencies, but none could give me the exceptional level of ongoing support and advice that I have received at Collective Solutions. I have attended weekly or every other week sessions there along with other family members for the past several months.

Our counselor at Collective Solutions has helped us weather several phases of my son's cyclic illness. She has given us a sounding board for our concerns and feelings, and has made us realize that our own health is a priority so that we can deal with the difficult decisions that have to be made when a family member has a mental illness. She has offered us essential information about the nature of mental illness and practical advice for handling many challenges, often providing information about other community resources that might be helpful to us.

During the past few months my son has been attending our family sessions, and our counselor has been very understanding and patient in allowing him to express his deep feelings and frustrations, and in guiding him toward accepting the help he needs to manage his condition.

I know my family and I couldn't have endured the stresses of this past year without Collective Solutions. Many other families are in desperate need of similar support. It is a very essential component of mental health services for families in Orange County.

Innovations (INN)

Project Information
Inn Project #3 Volunteer to Work (Group 1)

Program Name: INN3: Group 1: Volunteer to Work	**Funding:**
Actual number served in FY 11/12: 0	Actual funds expended in FY 11/12: $0
Projected number to be served in FY 12/13: 0	Estimated funds to be expended in FY 12/13: $0
Estimated number to be served in FY 13/14: 100	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
Volunteer to Work is a consumer-run project that utilizes trained Peer Specialists to facilitate the preparation and involvement of program participants in volunteer and paid jobs in the community. The focus of this project is the development of stepwise volunteer positions as opportunities to "try out" employment roles, while being supported by fellow consumers. The purpose is to obtain a gradual and flexible work role program with a continuing supported employment model. Volunteer to Work had not yet begun implementing services during FY 11/12.

2. Outcomes
Volunteer to Work had no outcomes to report during this time period. However, once implemented, outcomes will include the number of participants placed in paid or volunteer jobs, client satisfaction, and quality of life.

3. Process Indicators
During this time period no participant sessions were conducted.

4. Future Plans for Change
Orange County is in the process of contracting with a community provider for these services.

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Innovations (INN)

Project Information
INN Project #4 Acceptance through Compassionate Care, Empowerment, and Positive Transformation (OC ACCEPT) (Group 1)

Program Name: INN4: Group 1: OC ACCEPT	**Funding:**
Actual number served in FY 11/12: 68	Actual funds expended in FY 11/12: $201,005
Projected number to be served in FY 12/13: 153	Estimated funds to be expended in FY 12/13: $391,594
Estimated number to be served in FY 13/14: 400	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status

OC ACCEPT (formerly OK to Be Me) provides community-based mental health and supportive services to individuals struggling with and/or identifying as LGBTIQ (Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning) and the important people in their lives. The project specializes in addressing issues that are common in the LGBTIQ community, such as confusion, isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medication with drugs, high risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness, and lack of familial support. OC ACCEPT seeks to provide a safe environment with acceptance and compassion for individuals to express their feelings, build resilience, become empowered and connect with others for support. The project also raises awareness and reduces stigma by providing education about the LGBTIQ population to the community at large. The project provides services to Orange County residents in English, Spanish and Vietnamese. OC ACCEPT began serving participants in June of 2011. During the fiscal year 2011/2012, the project hired one Peer Specialist in May of 2012.

2. Outcomes

OC ACCEPT is a community-based mental health program for LGBTIQ individuals. The project administers the PHQ-9 to measure depression, GAD-7 to measure anxiety, and WHOQOL-BREF to measure quality of life to all participants. Initial data were available for 102 participants; follow-up scores were available for 47 of these individuals for the time period of September 2, 2011 to January 17, 2013. The mean age of participants was 31 and 77% graduated high school. The breakdown included 49% Caucasian, 31% Latino, 11% Asian. Gender distribution was 64% male, 18% female, with the remainder identifying as transgendered or other.

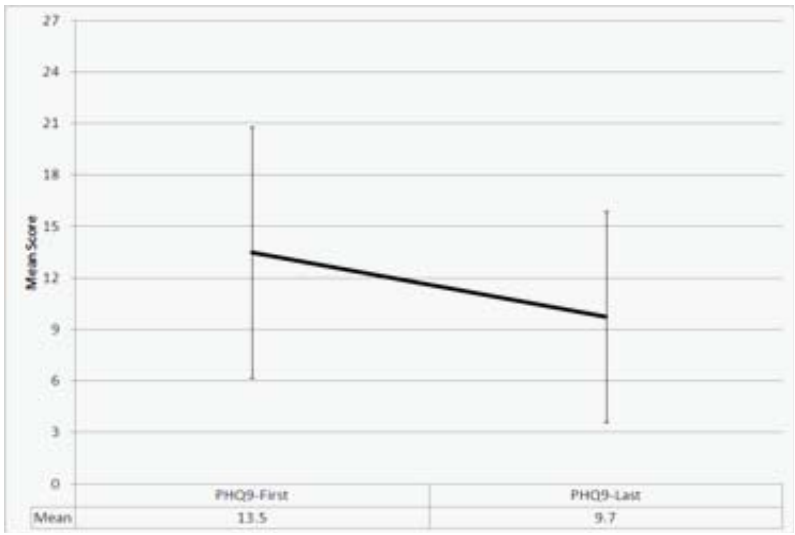
Innovations (INN)

There was an average of eight months between the first and last administration of scales to measure depression, anxiety, and quality of life. Over this period, there were significant reductions in anxiety and depression, and significant quality of life improvements, especially in the physical and social domains. Participants who initially scored in the severe ranges of anxiety or depression saw marked improvements, moving, on average, into the moderate ranges. Significant improvements were noted for the three measures for which paired data was available. Please see **Figures 1** through **3** below.

Changes in PHQ-9, GAD-7, WHOQOL-BREF
(First to Last Administration)

The PHQ-9 was administered at least twice to 46 participants. There was a mean of 234 days between the first and last administration, with a standard deviation of 117 days, and a range of 76 to 458 days. On average, scores decreased by 3.7 points, a statistically significant improvement, t = 3.14

Figure 1. Change in mean PHQ-9 score from first to last administration (n = 46, error bars show std. dev.)



The GAD-7 was administered at least twice to 47 participants. There was a mean of 236 days between the first and last administration, with a standard deviation of 130 days, and a range of 0 to 460 days. On average, scores decreased by 2.3 points, a statistically significant improvement, t = 2.31

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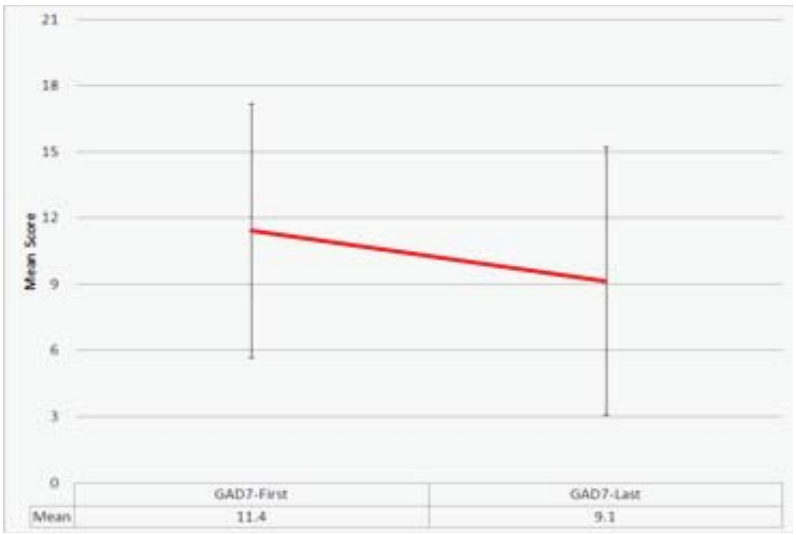
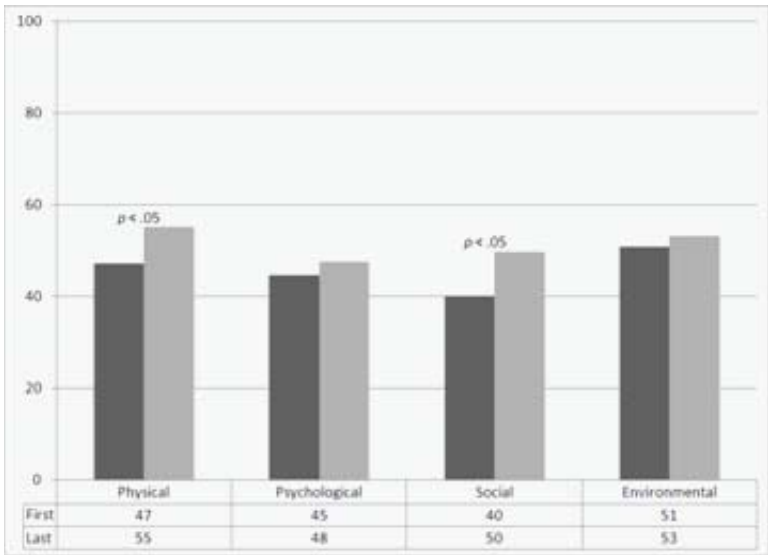
Innovations (INN)

Figure 2. Change in mean GAD-7 score from first to last administration (n = 47, error bars show std. dev.)



The WHOQOL-BREF was administered at least twice to 47 participants. There was a mean of 236 days between the first and last administration, with a standard deviation of 122 days, and a range of 76 to 460 days. Scores on the Physical and Social Quality of Life scales increased significantly.

Figure 3. Change in mean WHOQOL scales from first to last administration



Innovations (INN)

3. Process Indicators

During the fiscal year 2011/2012, 68 participants were served in the OC ACCEPT Program. Project staff conducted 365 sessions for a total of 511 service hours.

4. Future Plans for Change

OC ACCEPT will implement several new components and/or add on to the existing components of the program. First, the project will continue to increase promotion activities in the community, specifically high schools, colleges, and veteran programs. They will continue to provide LGBTIQ trainings to the community to promote health equity of LGBTIQ individuals. Third, they will add a Senior Outreach component to the project with the hope of outreaching and engaging LGBTIQ seniors to accept services with OC ACCEPT. Next, there will be on-site confidential HIV testing to provide access to testing services and to help decrease risky health related behaviors. Additionally, OC ACCEPT will be holding the first LGBTIQ Conference in Orange County targeting health care professionals, community members, and stake holders.

Innovations (INN)

Project Information
INN Project #5 OC4VETS (Group 1)

Program Name: INN5: Group 1: OC4VETS	**Funding:**
Actual number served in FY 11/12: 0	Actual funds expended in FY 11/12: $283,553
Projected number to be served in FY 12/13: 139	Estimated funds to be expended in FY 12/13: $541,126
Estimated number to be served in FY 13/14: 100	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
OC4Vets (formerly known as VETConnect) officially started July 1, 2012 (FY 12/13). OC4Vets is a unique collaborative model program using existing community agencies with expertise in overcoming barriers to veterans obtaining behavioral health prevention, early intervention, or treatment. OC4Vets is co-located with the County's Veterans' Service Office. HCA/BHS Veterans' programs supplies the leadership and the clinical expertise for this project. OC Community Resources (OCCR) supplies the Veterans' Service office staff, who have the knowledge and experience to process all aspects of veteran's benefits and compensation claims, as well as the Workforce Investment Board's staff with the experience in job skill enhancement, job search, and housing.

The core of the OC4Vets project is to use peer veterans (most of whom have experienced themselves, or have a family member with behavioral health issues), as Peer Specialists to provide navigation and solid connection with existing community resources. These Peer Specialists use the 'buddy system' that is familiar to all military veterans to provide assistance without creating a sense of dependence on the veteran. The program serves Active, Retired, or Veteran Members of the US Armed Forces and their families who have screened positively for behavioral health issues. Program Services are provided in English.

2. Outcomes
OC4Vets did not yet provide service during FY 11/12 and subsequently does not have project outcomes to report during this time period.

3. Process Indicators
During this time period OC4Vets did not yet provide any services.

4. Future Plans for Change
During FY 11/12 the project was in preparation to begin implementing services. During FY 12/13, the project has begun to enroll participants and hire clinical staff, veteran peers, and support personnel. Training for all staff and for the collaborative partner staff in the Veterans' Service Office and the Workforce Investment Board will begin and continue. Office procedures, databases, equipment, and data maintenance and reporting will be implemented. Veteran Peer Specialists will be provided weekly training. Participants will also attend weekly meetings with all team members. Monthly administrative meetings will facilitate and insure communication between HCA, OCCR and contracted providers. A one-day Veterans and Military family conference (open to the community providers, and veterans and family members) will be held. Networking with other providers will occur, participation in community veterans' and behavioral health events will begin and resource lists will be compiled.

Innovations (INN)

Project Information
INN Project #6 Community Cares (Group 1)

Program Name: INN6: Group 1: Community Cares	**Funding:**
Actual number served in FY 11/12: 8	Actual funds expended in FY 11/12: $119,976
Projected number to be served in FY 12/13: 32	Estimated funds to be expended in FY 12/13: $221,702
Estimated number to be served in FY 13/14: 100	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
Orange County Community Cares Project (OC CCP) strives to improve access to mental health services and decrease the negative effects of mild to moderate symptoms of depression and or anxiety. The project provides a referral-based system for individuals to receive short-term pro-bono mental health treatment by a multidisciplinary team including: project lead, clinicians, and Peer Specialists. Project staff deliver culturally and linguistically appropriate assessments, case management, individual psychotherapeutic services, and follow-up services to evaluate the effectiveness and satisfaction with services.

All individuals who are referred to the OC CCP project are initially evaluated by project staff during the intake interview. If eligible, the participant will be linked to a mental health provider in the community who best meets their need for a total of 12 therapy sessions. Project services are provided to Orange County residents with no insurance or benefits who need access to therapeutic services and possess mild to moderate symptoms of anxiety and/or depression. The project provides services in English, Spanish and Vietnamese.

Community Cares Project began serving participants in December of 2011. Prior to this, project staff focused on program development. During the fiscal year 2011/2012 the project did not yet have their Peer Specialist staff hired. All intake, assessment and case management services were provided by the project lead.

2. Outcomes
Community Cares Project administers the PHQ-9, GAD-7, WHOQOL-BREF, and a Participant Satisfaction Survey to all participants. No outcome information was submitted for this time period due to the small number of participants and the short length of time that they had been receiving services.

3. Process Indicators
During this time period there were 85 participant sessions conducted for a total of 64 service hours.

4. Future Plans for Change
A large part of the project involves collaborating with therapists in the community to encourage them to donate their services to participants in need. Project staff plans to increase their efforts to include local colleges and their counseling centers, as well as community agencies and Masters' degree level Interns.

Innovations (INN)

Project Information
INN Project #7 Education, Training and Research Institute (Group 1)

Program Name: INN7: Group 1: Education, Training and Research Institute	**Funding:**
Actual number served in FY 11/12: 0	Actual funds expended in FY 11/12: $0
Projected number to be served in FY 12/13: 0	Estimated funds to be expended in FY 12/13: $0
Estimated number to be served in FY 13/14: 0	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
The Education, Training and Research Institute (ERT) will have an Advisory Board consisting of at least 51% consumers and family members and will provide an ongoing vehicle for leveraging non-MHSA funds to support education and training activities that fall within the scope of MHSA recovery principles.

This project did not implement program activities during this time period. Despite differing and diligent efforts to implement the project, no contractor with the ability and interest has been found to implement the project to date. It has been decided that this project will not be pursued further at this time.

2. Outcomes
The ERT Institute had no outcomes to report during this time period.

3. Process Indicators
During this time period no measures were collected.

4. Future Plans for Change
Not applicable.

Innovations (INN)

Project Information
INN Project #8 Project Life Coach (Group 1)

Program Name: INN8: Group 1: Project Life Coach	**Funding:**
Actual number served in FY 11/12: 0	Actual funds expended in FY 11/12: $316,401
Projected number to be served in FY 12/13: 84	Estimated funds to be expended in FY 12/13: $442,265
Estimated number to be served in FY 13/14: 250	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
Project Life Coach provides assessment and linkage to supportive employment services to individuals that have been diagnosed with mental illness. The target population is monolingual Latino, Iranian, and Asian Pacific Islanders with limited English proficiency, but services are open and available to the greater community as well. Culturally and linguistically appropriate assessments, case management, groups, brief counseling and support services are provided by Peer Specialists and clinicians.

The project utilizes an innovative approach for job searching, placement and retention, and linkage to mental health services in the ethnic communities. It also creates a community-based support network for individuals and families. The Project Life Coach project considers all referrals from the community via phone, fax, e-mail, or walk-in to provide intake and initial assessment. Project services are provided to Orange County residents of Latino, Iranian, Asian Pacific Islander background, ages 16 and older, who have been diagnosed with a mental illness, are stable in their mental health and employable. Project services are provided in English, Spanish, Farsi, Vietnamese and Korean.

Project Life Coach had not yet begun implementing services to participants during this time period. They had one Peer Specialist who was hired in May of 2012.

2. Outcomes
Project Life Coach had no outcomes to report during this time period.

3. Process Indicators
During this time period no participant sessions were conducted.

4. Future Plans for Change
During this time period, project staff prepared to begin implementing services. They were preparing to hire Peer Specialists and were collaborating with local business to compile employment resources.

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Innovations (INN)

Project Information
INN Project #9 Training to Meet the Needs of the Deaf Community (Group 1)

Program Name: INN9: Group 1: Training to Meet the Needs of the Deaf Community	**Funding:**
Actual number served in FY 11/12: 0	Actual funds expended in FY 11/12: $0
Projected number to be served in FY 12/13: 10	Estimated funds to be expended in FY 12/13: $0
Estimated number to be served in FY 13/14: 25	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
This project provides education on mental illness and recovery for members from the Deaf and Hard of Hearing community, including consumers and family members. The project is aimed at enhancing the skills necessary to meet the mental health needs of that community. This is done through participation in a formal mental health worker training program which includes the use of ASL (American Sign Language) as the primary language. In Orange County, the Deaf and Hard of Hearing community is considered an underserved population. It is difficult to find therapists who can communicate in American Sign Lanuage (ASL). Training people who are deaf and already know ASL to provide paraprofessional mental health services is expected to increase access to care for this population and improve quality of life. This project had not yet begun implementing services during this time period.

2. Outcomes
This project had no outcomes to report during this time period.

3. Process Indicators
During FY 11/12 no project services were conducted.

4. Future Plans for Change
In May 2012, Orange County agreed to contract with Saddleback College for the implementation of this project. The contract started on July 1, 2012.

Innovations (INN)

Project Information
INN Project #10 Brighter Futures (Group 1)

Program Name: INN10: Group 1: Brighter Futures	**Funding:**
Actual number served in FY 11/12: 3	Actual funds expended in FY 11/12: $66,312
Projected number to be served in FY 12/13: 56	Estimated funds to be expended in FY 12/13: $280,414
Estimated number to be served in FY 13/14: 200	Budgeted funds for FY 13/14: No new funding

1. Program Description and Implementation Status
Brighter Futures: (formerly Consumer Early Childhood Mental Health) provides community-based services to families with children who experience social, emotional, and behavioral health problems. The goal is to reduce isolation and form a supportive network with other families. The project offers brief interventions; helps build personal resiliency and healthy relationships between parents and children. A multidisciplinary clinical team provides culturally and linguistically appropriate peer-mentorships, case management, parent education, psychotherapeutic services and linkages to supportive community services. Services are provided to Orange County residents, parents/families with children ages 6-13 who are experiencing social, emotional, and behavioral health problems. The project provides services in English, Spanish, and Mandarin.

Brighter Futures began serving participants on April 4, 2012. Prior to this, project staff worked on program development. During the fiscal year 2011/2012 the project did not yet have its Peer Specialists hired, as this process took longer than expected. All services were provided by the clinical staff.

2. Outcomes
Brighter Futures administers the GAD-7, WHOQOL- BREF, Youth, Satisfaction Survey, Participant Satisfaction Survey and the Protective Factors Survey to all participants. A Satisfaction Survey is also administered to the parents of project participants. No outcome information was submitted for this time period due to the small number of participants and the short period of time that they had been receiving services.

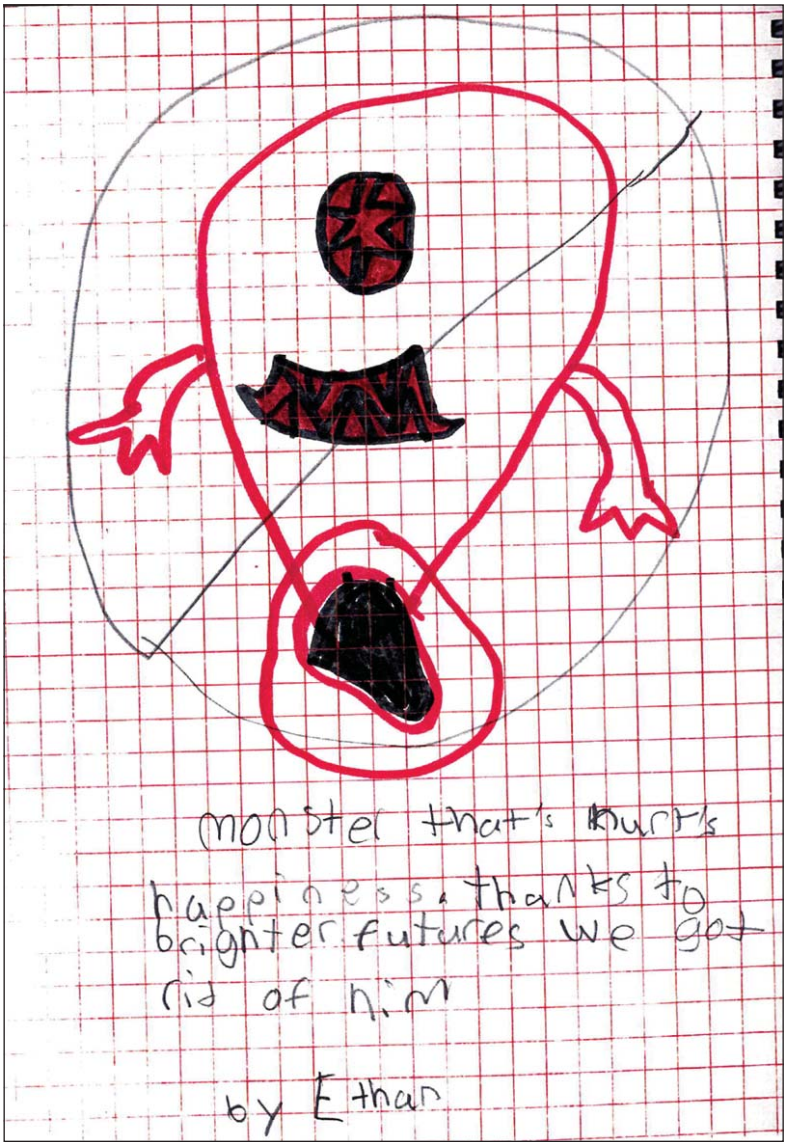
3. Process Indicators
During this time period there were 12 participant sessions conducted, for a total of 10 service hours.

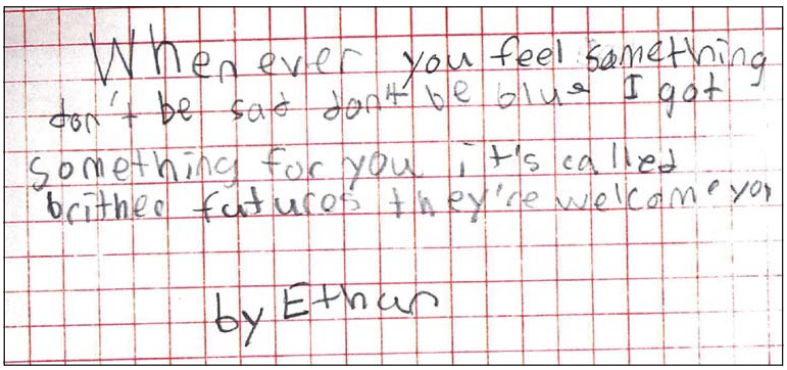
4. Future Plans for Change
In order to better meet the needs of the participants and the parents, the project will begin implementing parent workshops. These will be run by Peer Specialists. They will also decrease the number of clinical sessions for those participants who are more stable and will utilize the Peer Specialists for more service delivery. The project staff will also increase their outreach efforts to local schools, health fairs, local trainings, etc. to increase community knowledge of the project.

Innovations (INN)

Client Success Story

"The project Brighter Futures has helped us with the grieving process of losing my wife. I feel my kids are more emotionally stable now, with all these sessions, has made us stronger and closer. We help each other out. I recommend the program for anybody grieving for a loved one."





Innovations (INN)

B 2: New Innovation Projects Proposed for FY 13/14

Introduction to Group #2 (New Projects)

Information on each of the eight new Innovation Projects proposed to be implemented in FY 13/14 is presented below. Each Project is planned to operate for three years and is based on the assumption that for the next three years (FY 13/14, FY 14/15, and FY 15/16) $5 million dollars ($15 million total for the three-year period) funding will be available for these same eight projects. The projects are presented in the order that they were ranked by the MHSA Steering Committee. At that meeting it was noted that the first five projects were of highest priority and that the next three on the list would be implemented if funds were sufficient. The Innovation budget reflects funding for all eight projects because it is believed that there will be sufficient dollars available to fund all eight.

Project Information

INN #1 "Proactive On-site Engagement in the Collaborative Courts" (Group 2)

Program Number and Name: New Project #1 "Proactive On-site Engagement in the Collaborative Courts"	**Funding:**
Number to be served in FY 13/14: 300	**FY 13/14:** $198,551

1. Program Description

There is a growing need for more integration of education and services between the criminal justice system and the mental health community. With the development of the mental health criminal courts, participants are now being given an opportunity to reduce the severity of their sentence by completing court ordered requirements, one of which is to attend a community based program to obtain a better understanding of their mental health condition. This project is designed to increase access to mental health services by offering mental health education and peer support with the belief that these services will significantly reduce recidivism.

Bringing a community mental health representative on-site increases and eases access to provide a unique opportunity to engage and offer educational programs that the participant and/or their family members would not otherwise have had exposure to. Through active engagement, the participant can learn about various programs and services that will help them not only increase their understanding of their mental illness but also learn how to "live well" and productively with their illness.

The physical presence of a community mental health representative not only increases and eases access to resources and services but also helps display the support of the court and community to help de-stigmatize mental illness. This integration of mental health services demonstrates to the participants that the court recognizes and values theses services.

Innovations (INN)

The participant will have many opportunities to connect with the community mental health representative through the various stages of the probation program. During the initial contact with the mental health representative, each participant will complete an intake form. If the participant is not ready to participate and join the educational program, the participant will continue to check-in with the mental health representative each time they return to court and update their status in the court program, current contact information and desired date and location to take the mental health educational classes.

This project will create positive change in the participant and his/her family's understanding of mental health and how it may affect their daily living. This project uses an innovative approach to reach and provide mental health education and peer support. Employing trained peers (consumers and family members) as community mental health representatives, increases the rapport between the participant and worker which helps reduce the stigma of mental illness through example and empathy. This personal connection increases the likelihood that the participant will stay engaged through intake, enrollment and ultimately, the completion of the educational program. The re-occurring connection also helps to keep in contact with the participant, and update contact information, should they be in the midst of moving between residences as they get settled.

2. Outcomes

Outcome measures will focus on recidivism rates of those participants served in this project compared to individuals who do not receive services from this project.

3. Contribution to Learning

This project fits the definition of innovation by introducing a new mental health practice that has not been done previously. Preliminary research shows that no formal on-site engagement project with the capability of tracking outcomes has been proposed or carried out in collaboration with the criminal justice system or our local collaborative court.

What makes this proposal unique is the on-site proactive engagement and enrollment of a probation client into a mental health education program by a community peer representative. All collaborative court clients must complete a community program as a requirement of graduation from probation. Having community mental health program resources readily available, and engaging participants on-site, may be the first time these individuals have been exposed to the available mental health resources in the community.

This project goes one step further than just the participant; it engages the family. Project progress and success will be tracked to report the expected decrease in recidivism rates for those participants enrolled in the mental health educational programs.

The success or lack of success of this collaboration will contribute to our learning about the potential use of the community mental health resources to supplement the probation and court systems. Specifically the court input, probation officers, family members and the participants' willingness to participate and engage in this project will answer the question as to whether such a collaboration is feasible as a long-term partnership between the courts and mental health.

Innovations (INN)

Project Information
INN #2 "Religious Leaders Trained in Mental Health First Aid" (Group 2)

Program Number and Name: New Project #2 "Religious Leaders Trained in Mental Health First Aid"	**Funding:**
Number to be served in FY 13/14: 30	**FY 13/14:** $189,855

1. Program Description

Surveys reveal that some individuals would prefer to first turn to family and friends for help with mental health problems, religious leaders are ranked second, and lastly to mental health professionals. Most religious leaders have little to no training on mental health issues. A promising direction to increase access to mental health care, reduce stigma and improve community collaboration is to bring Mental Health First Aid training to consumers through the religious community.

This project will use a train the trainer technique, where those in the mental health field (along with peer specialists) will help to train religious leaders in Orange County on Mental Health First Aid (an evidence-based program) with basic skill sets including, but not limited to, basic listening, suicide prevention and supportive skills. Religious leaders will be trained and certified in Mental Health First Aid practices and, in turn, train other congregants with mental health first aid skill sets.

This project is designed to increase access to mental health services by introducing mental health into the religious community, which will thereby:

1. Increase the number of lay persons trained in Mental Health First Aid.
2. Increase access to mental health services through religious communities.

At minimum, this project will target a variety of 30 faith-based organizations and religious establishments and their leaders. It is proposed that two leaders from each of the organizations will be trained and certified in Mental Health First Aid. In turn, each religious leader must hold three trainings per year to maintain his/her certification. Thus, the number of congregants and community members that each religious leader is estimated to train annually is about 60 (20 per class at three classes per year).

Having this type of support available in the religious community breeds a supportive environment and provides a unique opportunity to engage the participant and/ or their family members to address mental health issues that they might not otherwise have had exposure to. It is important to note that congregants/community members trained are not intended to replace professional support, but merely to assess the person for risk of harm or suicide, listen non-judgmentally, give reassurance, and encourage the person to follow up and seek professional help. They will keep someone safe and stabilized until the professional help is available. The physical presence of

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Innovations (INN)

a trained mental health first aider not only increases and eases access to resources and services but also helps display the support of the religious community to help de-stigmatize mental illness. This integration of mental health services demonstrates to the participants that the religious community recognizes and values theses services.

2. Outcomes

This project will collect data that will help evaluate the utilization and completion rates of the training program. The success or lack of success of this collaboration will contribute to our learning about the potential use of community mental health first aiders in religious communities. Specifically, the religious leaders and the congregations' willingness to engage in this project will answer the question as to whether such a collaboration is feasible as a long-term partnership between the religious communities and the field of mental health. It is the hope that successful "graduates" of the training will in turn become certified trainers themselves, contributing to sustaining and promoting the continuation of the project.

3. Contribution to Learning

This project expects to contribute to learning by introducing a mental health training that has not been done previously with this target population (religious leaders). Bringing certified Mental Health First Aid training to religious communities introduces practices that have been highly successful in other target populations.

"Mental Health First Aid is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Mental Health First Aid is offered in the form of an interactive 12-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments. Those who take the 12-hour course to certify as Mental Health First Aiders learn a 5-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care". (2009 National Council for Community Behavioral Healthcare).

This training has a proven track record in various settings including but not limited to primary care contexts, corporations, business communities, schools, police, corrections and nursing homes, as well as the general public.

Innovations (INN)

Project Information
INN #3 Access to Mobile/Cellular/Internet Devices in Improving Quality of Life (Group 2)

Program Number and Name: New Project #3 Access to Mobile/Cellular/Internet Devices in Improving Quality of Life	**Funding:**
Number to be served in FY 13/14: 50	**FY 13/14:** $171,015

1. Program Description
This project is designed to improve health outcomes and the quality of life of adults living with severe and persistent mental illness through the use of mobile devices, cellular technology and the internet.

A recent survey found that the majority of residents living in low-income housing lacked technological connectivity, including but not limited to cellular phones and internet access. Residents of low-income housing in Orange County statistically have less access to technology than those in similar housing situations in other areas. Fewer than 50% of Orange County's supportive housing residents own a cellular telephone and approximately only 25% own a computer with internet connectivity.

In comparison, the Pew Internet and American Life Project (2011-2012) found that 88% of all U.S. adults own a cellular phone (of which 53% own a smart phone with internet connectivity). The Pew Research Center also found that 27% of adults living with a disability in the U.S. are significantly less likely to actively use the internet.

This project strives to connect those on the other side of the digital divide with the capability and resources needed for success, one of which is access to technology. This project will imbed the proposed innovation into its existing programming and community partnerships, using the following methodology:

a. Connecting consumers with affordable digital devices and cellular/internet services utilizing bulk purchasing and government/private sector subsidies for accessing affordable technology.
b. Training consumers and persons in their social networks, on the use of technology.
c. Engaging peer specialists (employed and volunteer) in the training and support of consumers.
d. Creating networks of emotionally supportive friends and peers on-line.

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Innovations (INN)

2. Outcomes

This project seeks to evaluate effects of increased access to technology on mental health outcomes, including:

a. Reducing barriers to mental health and physical health services;
b. Improving personal safety;
c. Reducing social isolation and increasing support networks;
d. Determining whether or not program participation leads to empowerment, self-reliance and increased compliance with mental health treatment.
e. Evaluating the impact of a peer specialist within the scope of a technology-based program.

3. Contribution to Learning

This innovative project will contribute to learning through the development of new and improved mental health approaches. The success or lack of success of this project will contribute to our learning about the role technology could have on improving mental health outcomes.

Several variables will be significant in this project, including but not limited to:

a. Technology - Will increased access to technology lead to improved mental health outcomes?
b. Peer Engagement - Will the use of a peer engagement model within a technology-based program yield greater success than a program with non-peer engagement?
c. Social Capital - Will the increased connectivity through technology, improve access to both traditional and non-traditional forms of social support networks (i.e. in person support groups/facebook)?.
d. Social Isolation - Will the increased connectivity through technology, decrease social isolation?
e. Income and Employment - Will increased connectivity and technology skill sets lead to increased employment and income?

Innovations (INN)

Project Information
INN #4 Veterans Services for Military/Veteran Families and Caregivers (Group 2)

Program Number and Name: New Project #4 Veterans Services for Military/ Veteran Families and Caregivers	**Funding:**
Number to be served in FY 13/14: 50	**FY 13/14:** $559,420

1. Program Description

OC4Military Families will expand on the current HCA/Behavioral Health Services (BHS) Veterans programs, especially the OC4 Vets program. Experts agree that the entire family unit should be considered when dealing with people in 'recovery'. Using the principles of Recovery-Based Care, it is not practical to only serve the veteran/military member without assisting the other members of the family unit. The tension and stress associated with multiple deployments, discharge from the military, and return to civilian life impacts the entire family and must be addressed for the veteran/military member to be successful. The OC4Military Families will be an adjunct to the current OC BHS programs that have focused primarily on the veteran.

The proposed program will provide trained behavioral health clinicians and peers to provide services to family members of veterans who are currently being seen in a behavioral health program (county, VA, or private) or who have direct family members or caregivers that are in need of increased understanding of behavioral health and principles of recovery. Referrals may come from veterans participating in either BHS Veterans programs such as OC4Vets, the Non-Criminal Domestic Violence Veterans' Court, or the Veterans' Courts program, and the 'Drop Zone program. Additionally, referrals will be accepted from the entire community and on a self-referral basis. These family members may also need linkage to resources or require either personal behavioral health intervention, and prevention (i.e., resiliency) or family intervention.

Those eligible to participate in the program will be family units/members who have a close family member (i.e. spouse, child, father, or mother) who has served in the U.S. Armed Forces. Each family member enrolled in this program will be screened and a Family (Individual/Caregiver) Service Plan detailing goals, objectives, and Interventions will be developed for him/her. Peers will provide participants with a "warm linkage" to appropriate services. Peers will also provide individual or direct support groups, as well as psycho-social education either individually or in groups to facilitate understanding of behavioral health issues and family dynamics (especially with family members suffering from PTSD). Using peers to provide individual or group support classes will encourage family members to participate. An effort will be made to match peers with similar race/ethnicity and language backgrounds.

The current innovation project OC4Vets is co-located with OCCR's Veterans' Service Office. It is anticipated that the OC4Military Families will also be located in proximity to this site in order to take advantage of support elements from the OC4 Vets program.

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Innovations (INN)

2. Outcomes

Data will be collected from standardized tests such as the PCL-C, SBIRT, GAD 7, PHQ9, WHO5/or WHOQLBREF, and Participation Satisfaction Surveys. Numbers and types of referrals, and successful linkages will be collected and analyzed. Demographic data will be collected on all participants. Peer satisfaction and the satisfaction of participants with peer navigators will be studied.

3. Contribution to Learning

This project will provide information on access to care for underserved groups. Veterans are among the underserved populations in Orange County and have unique needs that may be addressed through Innovative programs. Veterans often are reluctant to admit to having issues either because of concerns about stigma, career, or 'Warrior Mentality".

The following types of information will be tracked.

a. The number of veteran/military families (and direct caregivers) in need of behavioral health support and types of interventions needed;
b. The number/type of linkages needed and whether available in OC; and
c. How using peers positively impacts compliance with program and satisfaction with program.

Innovations (INN)

Project Information
INN #5 The Brain and Your Health Education, Exhibition and Resource Center (Group 2)

Program Number and Name: New Project #5 "The Brain and Your Health Education, Exhibition, and Resource Center"	**Funding:**
Number to be served in FY 13/14: 600,000	**FY 13/14:** $2,184,058

1. Program Description

Despite the fact that 70-90% of mental illnesses are treatable, many people do not access care. There is a substantial need to educate the general population about mental illness and its relationship to the brain. This project is intended to reach new audiences, unserved by traditional methods of outreach. It is also expected to help overcome the barriers to treatment. One of the most impactful barriers is social stigma which stems from misconceptions about the scientific basis of mental illness and treatment.

Preliminary research shows that there are no permanent hands-on exhibitions about the brain and mental illness existing to the scale and scope being proposed for this project. This Innovative idea proposes the creation of an educational exhibit with engaging, experiential and hands-on exhibits to educate visitors about the anatomy of the brain, its functions and how it works. Here they will learn about the scientific basis of mental illness and other illnesses associated with brain health.

"The Brain and Your Health" Educational Exhibition and Resource Center, will be composed of three primary stages and includes a peer mentor to staff the Exhibit.

a. **Active, Experiential Learning:** Through fun and engaging hands-on exhibits, visitors will become active participants in their own learning. A variety of exhibits will educate about the anatomy of the brain, its functions and how it works. Here they will learn about the scientific basis of mental illness and other illnesses associated with brain health.
b. **Inspiring Journey Through the Brain:** From here, guests will board a gondola for an exciting immersive journey through the brain. Using an onboard computer, the visitor will select an illness which they want to learn more about. Then, they will fly through a large scale model of the brain while the on board computer integrated with the model of the brain educates guests about the illness they selected. Along the journey guests will learn that mental illness is treatable.

Innovations (INN)

c. **Taking Action in the Resource Center:** Inspired by their amazing journey, guests will feel empowered to take immediate action for themselves or a loved one. As they disembark the gondola in the resource center, each guest will have the option to learn more and be provided with information about services available from collaborating agencies to screen for illnesses and secure treatment. The auditory, visual and kinesthetic learning that occurs through hands-on immersive exhibits reaches all the senses, creating a richer experience. Guests will experience cause and effect as a result of their own actions.
d. **A well-trained peer mentor** will be present at the Exhibition and will provide information, as well as answer questions. The inclusion of a peer docent at the Exhibit will enhance the learning and provide a comfortable opportunity to ask questions and engage in discussion.

2. Outcomes

The purpose of this project is to create positive change in reducing stigma through understanding of mental illness by using an innovative approach to reach and provide mental health education and resources. Although outcome tools have yet to be determined, measures will address education of the community at-large about mental illness. It is also expected that this Project will reduce the barriers to treatment, including but not limited to social stigma, misconceptions, lack of awareness and lack of understanding. Science cannot be learned through visual means alone.

3. Contribution to Learning

The hands-on, interactive activities will deliver valuable lessons based on scientific discoveries and facts. “The Brain & Your Health” will demonstrate that mental illness has no socioeconomic limits and does not discriminate between racial and ethnic groups. It will also help guests realize the importance of early intervention and preventions.

In addition, knowledge will be gained on the ability of such an approach, in fact, to reduce stigma and increase access to mental health and supportive.

Innovations (INN)

Project Information
INN #6 Developing Skills Sets for Independent Living (Group2)

Program Number and Name: New Project #6 Group 2-Skills Sets for Independent Living Project	**Funding:**
Number to be served in FY 13/14: 100	**FY 13/14:** $411,594

1. Program Description

This project will provide a foundation for independent living skill sets to empower participants with the confidence for a successful transition to independent living.

The target population will include, but not be limited to, individuals who typically have been dependent on others to manage their day-to-day needs; individuals who have not had the opportunity or circumstances to live in a residence without supervision; and/or individuals who have had a history of homelessness/transiency.

This project will target underserved, chronically ill, adult participants who have been homeless or are at risk of homelessness to provide them with an opportunity to learn independent living skills prior to being placed in publically subsidized housing or other living situations. The independent living skills learned will improve the likelihood of the participants retaining their housing and remaining in stable residences and living situations for longer periods of time. Overall, this would reduce the participant's tendency to return to homelessness or transient lifestyles.

The SAMHSA Homeless Resource Center report (2009) indicates that a primary barrier to moving from homelessness to more permanent housing was the lack of functional independent living skills. This project will teach participants independent living skills, including but not limited to: medication management, mental health management, transportation, cooking, shopping, cleaning, personal hygiene, organization and scheduling, pet care, safety and problem solving. The project will link the participant with community resources as needed.

This project seeks to do the following:

a. Increase independent living skill sets to identified participants
b. Help identified participants understand daily living skills involved in maintaining stable housing
c. Provide mental health education to give participants a better understanding of their mental health issues as well as the tools and skills necessary to self-manage their mental health independently
d. Link participants to resources and services to promote independent living that the participant would not otherwise have had exposure to. Through active engagement, the participant can learn about various programs and services that will help them live well, independently.

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Innovations (INN)

This project will create a positive change in each participant's ability to live independently by increasing their understanding of daily living skills, including their mental health and how it may affect their daily living. Employing trained peers (consumers and family members) will engage the participants and serve as a model of competency that participants may achieve. It increases and eases access to independent living with the expectation that increased independent living skills and an understanding of their mental illness will empower clients to retain stable housing for longer periods of time. This project highlights the participant's strengths and the development of resilience in the promotion of recovery and total wellness.

2. Outcomes

This project is focused on wellness, recovery and resilience. Although outcome tools have yet to be determined, outcomes will focus on the effectiveness of peer support through use of participant satisfaction surveys, as well as participants' ability to maintain compliance with treatment, reduce hospitalizations, and maintain independent living status.

Examples of the types of analyses that will be done include:

a. Evaluation of the impact of a peer-mentor (teaching independent living skills to homeless or at risk of homeless participants) on the mental health of clients;
b. Evaluation of participants' ability to obtain or retain stable housing with the use of peer-mentors;
c. Evaluation of the length of time participants are able to remain in housing once suitably housed.

3. Contribution to Learning

Employing peers to teach independent living skills and providing outreach and engagement to the targeted population is in itself a truly innovative practice. A preliminary review of State-funded programs and a scholarly review of academic literature confirmed that although there are some independent living skills programs, none utilize peers as the driving force behind the project.

Innovations (INN)

Project Information
INN #7 Healthy Ideas Partners: A Community Collaboration Addressing Depression in Older Adults (Group 2)

Program Number and Name: New Project #7 Healthy Ideas Partners: A Community Collaboration Addressing Depression in Older Adults	**Funding:**
Number to be served in FY 13/14: 200	**FY 13/14:** $342,347

1. Program Description

The National Institute of Mental Health (NIMH, 2007) reports that "Depression is one of the conditions most commonly associated with suicide in older adults, and is a widely under-recognized and undertreated medical illness. Studies show that many older adults who die by suicide — up to 75 percent — visited a physician within a month before death. These findings point to the urgency of improving detection and treatment of depression to reduce suicide risk among older adults. Suicide is a growing problem in America where people age 65 and older account for about 13 percent of the population but almost a fifth of all suicides".

Seniors are at a greater risk for depression because many seniors are isolated where they live and lack social support. With Healthy IDEAS Partners, this project will strive to create a model for project sustainability and replication through the innovative and cost-effective use of peer mentors and para-professionals for conducting outreach, screening and implementing behavioral-activation practices using the following methodology:

a. Testing the implementation of a community-based peer mentor innovation within an existing Evidence-Based Pracice, including the potential of replicating the model beyond affordable home communities;
b. Creating networks of emotionally supportive friends and neighbors for each client;
c. Reaching out to traditionally unserved/ underserved populations including, but not limited to, Latino, Persian, Vietnamese and Korean immigrant communities;
d. Leveraging existing program resources, including affordable home community centers and base-level program funding.

Bringing a peer mentor on-site increases and eases access to provide a unique opportunity to engage and offer educational programs that the client would not otherwise have had exposure to. Through active engagement, the client can learn about various programs and services that will help them not only increase their understanding of their own depression but also learn how to "live well" and productively with their depression.

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Innovations (INN)

This project will create a positive change in each client's understanding of depression/ mental health and how it may affect their daily living. This project uses an innovative approach to reach and provide mental health education to those that may not have access. Employing trained peers (consumers and family members) as peer mentors increases the rapport between the client and worker which helps reduce the stigma of depression through example and empathy. This personal connection increases the likelihood that the client will stay engaged throughout the project.

This project is focused on wellness, recovery, and resilience. It increases and eases access to depression/mental health education and resources, with the expectation that increased understanding of mental illness will empower clients to be engaged and proactive in the management of their mental health. This project focuses on the participant's strengths and the development of resilience in the promotion of recovery and total wellness.

Healthy IDEAS Partners will develop a community collaboration and peer mentor model project to help low-income and minority elders get the help they need to manage the symptoms of depression and live full lives.

This project will target underserved, chronically ill, older adults in the community in an effort to address commonly recognized barriers to mental health care. A structured depression program will prepare case managers and care coordinators to identify depression in at-risk elders and facilitate access to treatment.

This project is designed to empower clients to manage their depression through a behavioral-activation approach that encourages involvement in meaningful, positive activities. Healthy IDEAS is designated as an evidence-based program by the Administration on Aging and has been recommended for national replication. Program outcome results are published in the Journal of Applied Gerontology, 26(2), 139-156 (Quijano et al. 2007).

2. Outcomes

The following outcomes are anticipated:

a. Increased detection of depression in older adults
b. Increased client understanding that depression is treatable
c. Increased education to give clients a better understanding of their depression, as well as the tools and skills to self-manage their depression
d. Linking clients to resources and services for primary care, mental health care and social service assistance

The PHQ-9, as well as satisfaction surveys will be used in evaluating peer effectiveness.

Innovations (INN)

3. Contribution to Learning

Bringing in peers and providing outreach and engagement in settings involving mental health consumers is in itself a truly innovative practice. Preliminary review of state-funded programs and a thorough scholarly review of academic literature as well as discussion with the Healthy IDEAS national implementation coordinator confirms that no similar programs have used a peer employment program for either screening or behavioral-activation.

The learning objectives for this project include, but are not limited to:

a. Evaluation of the impact of a peer-mentor on the mental health outcomes of older adults living with depression, as applied to an existing evidence based practice;
b. Evaluation of the impact on the county mental health system of increased leveraging of existing community collaborations and natural networks that are outside of the traditional framework of funded agencies;
c. Evaluation of increased engagement of senior/ older adult clients resulting from the use of peer-mentors.

Innovations (INN)

Project Information
INN #8 Retreats for the Caregiving Families (Group 2)

Program Number and Name: New Project #8 Retreats for the Caregiving Families	**Funding:**
Number to be served in FY 13/14: 100	**FY 13/14:** $290,986

1. Program Description

This project will be a respite residential program for the caregivers/family members of consumers with severe and persistent mental illness. It is designed to provide critical and timely intervention, supportive, and crisis intervention services to keep safe those involved in a volatile situation. A respite program with a residential component may be especially beneficial for the family members of an immigrant family with limited English speaking fluency. An adult child who may be more fluent in English and savvy to the mental health system sometimes manipulates his/her parents to avoid necessary mental health treatment, including needed 51/50 involuntary hospitalizations. As a result, there have been some cases where Korean elderly parents were murdered by their adult child suffering from mental illness, who (in hindsight) should have been hospitalized. The parents failed to have their child hospitalized and did not have a safe place to stay and seek supportive services.

The respite residential program aimed at providing supportive services and crisis intervention to caregivers and family members of mental health consumers will relieve crisis and potentially volatile circumstances on a short-term basis. This project will provide caregivers and family members a safe place to stay on a short term basis, while receiving supportive services to handle the crisis at hand, as well as to learn how to cope and manage caregiving stresses. In addition to providing short term respite, the project will link the participants with community resources as applicable and needed.

This project seeks to do the following:

a. Provide a respite residential program for caregivers/ family members
b. Offer supportive services to the caregivers/ family members to help manage stressful and crisis intervention
c. Provide mental health education to give caregivers and family members a better understanding of the mental health system and advocacy resources

This project will create positive change in each caregiver/family member's ability to remain safe and active in the care provided to mental health consumers. This project uses an innovative approach to reach and provide mental health supportive services to those that may not have access. Services will be provided in a culturally and linguistically diverse manner.

Employing trained peers (consumers and family members) will help caregivers and family members reduce stigma and understand the mental health consumer's point of view in receiving services and care.

Innovations (INN)

2. Outcomes
Outcomes include:

a. An improvement in quality of life for caregivers/family members;
b. A reduction in anxiety for caregivers/family members;
c. An increase in knowledge of coping mechanisms;
d. An increase in knowledge of community resources;
e. Satisfaction with using peer mentors to provide services.

3. Contribution to Learning
This project fits the definition of innovation by introducing a new mental health practice that has not been done previously. Employing peers to work with caregivers and family members is in itself a truly innovative practice. Preliminary review of state-funded programs, and a thorough scholar review of academic literature confirmed that while there are projects with supportive services for mental health services consumers and their families, none specifically target respite residential services for the caregiver/ families.

The learning objectives for this project include, but are not limited to:

a. Evaluation of the impact of residential respite services for caregivers/ families on the safety/well-being of caregivers;
b. Evaluation of the impact on the quality of life those people living with a mental health diagnosis who are cared for by family members;
c. Evaluation of the use of peers, both on the peer and on the caregivers participating in the project.

Capital Facilities and TECHNOLOGY




"We must open the doors of opportunity. But we also must equip our people to walk through those doors." - Lyndon B. Johnson

Capital Facilities and Technological Needs

Capital Facilities and Technological Needs

The Capital Facilities and Technological Needs (CFTN) component of the Mental Health Services Act (MHSA) was designed to enhance the existing public mental health services infrastructure. It provides resources for two types of infrastructure:

1. Capital Facilities funding may be used for the delivery of MHSA services for mental health clients and their families or used for MHSA administrative offices.
2. Technology funding may be used to modernize and transform clinical and administrative information systems and increase consumer and family empowerment by providing the tools for secure consumer and family access to health information.

CFTN funding is one-time funding. Counties were given one allocation to cover both purposes, and were given the discretion to divide the funding between Capital and Technological needs. Orange County received slightly more than $37 million for this component. Of that amount, 35% was allocated to Capital Facilities and 65% was allocated to Technology.

Use of Capital Facilities Funds

In May 2012, the Health Care Agency completed the construction of a Capital Facilities-funded project on County-owned property located at 401 S. Tustin Street in Orange. The completed project occupies approximately three acres and includes three facilities designated for use by three different MHSA programs, surface parking, underground utilities, sidewalks, landscaping, landscape irrigation, fire lanes, recreation areas, amphitheater, area lighting, building security, signage, and perimeter fencing. The official ribbon-cutting ceremony was held on April 19, 2012. The first program took occupancy and became operational on May 19, 2012 and the remaining two programs were in place and operational by August 2012.

Programs that occupy the Tustin Street Facility include:

1. Adult Crisis Residential Program, which serves as an alternative to hospitalization for acute and chronic mentally ill persons.
2. Wellness/Peer Support Center, which offers assistance with benefits, employment, socialization, and self-reliance.
3. Education and Training Center, which provides support to consumers and their families who aspire to a career in mental health.

Capital Facilities and Technological Needs

Requirements for Use of Technology Funds
Any MHSA funded technology project must meet certain requirements to be considered appropriate for this funding.

1. It must fit in with the State's long term goal to develop an Integrated Information Systems Infrastructure where all counties have integrated information systems that can securely access and exchange information.
2. It must be part of and support the County's overall plan to achieve an Integrated Information Systems infrastructure through the implementation of an Electronic Health Record (EHR).

Use of Technology Funds
County of Orange Behavioral Health Services (BHS) plans to implement a fully integrated EHR system that supports the goals of MHSA (promote wellness, recovery and resiliency). It will also comply with the federal requirements for Meaningful Use, which will benefit the county's clients. Implementation involves two stages. Orange County has completed the 1st stage of upgrading its infrastructure to provide the necessary platform upon which to develop the functionality needed to further enhance its EHR.

The County has now begun the 2nd stage: building the enhancements to its EHR, Integrated Records Information System (IRIS), which will provide clinical documentation and decision support. This is a large project and will be accomplished in three phases. The 1st phase will be implemented at a select number of Mental Health Outpatient clinics. The 1st phase enhancements include the core clinical documentation management system with clinical decision support; medication and prescription management; mobile access to the EHR; and kiosks in selected locations to afford increased consumer/family access to computers and the internet. Additional technical improvements to Orange County's EHR include document imaging (which includes such functionality as electronic signature pads and the ability to scan documents); compliance auditing, monitoring, and reporting. In later phases, the County will include consumer access via a portal and the ability to securely interface with contract providers and to participate in Health Information Exchanges outside County BHS, as appropriate. Further enhancements will be made to the disaster recovery system and ensure continued control over clinical data security and privacy.

Housing Program UPDATE




"The ache for homes lives in all of us, the safe place we can go and not be questioned." - Maya Angelou

MHSA Housing Program Update

Purpose of component and types of housing for which funds may be used

MHSA Housing funds are to develop new housing options for MHSA enrolled or eligible clients. MHSA eligible clients are people diagnosed with a serious and persistent mental illness and homeless or at risk of homelessness. Housing can be new construction, rehabilitated properties, or shared housing units. New construction projects can be either 100% MHSA occupied, or can include some MHSA units within a larger community. MHSA Housing funds are restricted to one third of total development costs (TDC.) At the time the MHSA Housing Program started in Orange County, the projection was that 185 total MHSA units could be created using the funds available.

Update on Projects Completed and in Process:

Project	Total Units Built Or To Be Built	Total Occupied Or To Be Occupied
One-Time Money (all complete):		
Diamond	25	24
Doria I	60	10
Total:	***85***	***34***
Cal HFA –Assigned (complete):		
Avenida Villas	29	28
Cumulative Total:	***114***	***62***
Cal HFA –Assigned (Early Construction):		
Doria II	74	10
San Clemente Seniors	76	15
Sub-total:	***150***	***25***
Cumulative Total:	***264***	***87***
Cal HFA –Assigned (Construction to start 2013):		
Cerritos Family Apartments	60	19
Cumulative Total:	***324***	***106***
Applied to State Pending Approval:		
Anesi Apartments	104	11
Shared Housing Units	16	16
Sub-total:	***120***	***27***
Cumulative Total:	***444***	***133***

Apartment units are planned for a variety of geographic locations throughout Orange County. Diamond Apartment Homes is located in Anaheim, not far from Disneyland and other employment opportunities and amenities, including a Walmart, Starbucks, and public transportation.

Doria Apartments is located in Irvine near schools and shopping. OCTA built a bus stop nearby; however, it is not yet functioning. In the meantime, MHSA service providers arrange or provide some transportation and the auxiliary service provider onsite has arranged for a van to transport individuals to appointments or events at the service provider's offices at regularly scheduled times and by appointment.

MHSA Housing Program Update

Avenida Villas is also in Anaheim and is located near schools, shopping, and public transportation.

Residents are served on and offsite by primary service providers such as Full Service Partnerships (FSP) County Adult Mental Health Services Clinics, or licensed professionals in the community. Services are optional, but virtually everyone in MHSA Housing is receiving services at this time. Typical services include psychiatry, medication support, case management, substance abuse services, life skills training, vocational and educational training, and socialization opportunities. Services are individualized with a goal of linking residents eventually to full independence and integration into their new communities.

Demographics

All units so far are occupied by adults ages 18 to 59. Several units have included children in the households. The residents are diverse in terms of race/ethnicity. Non-English speaking clients are among those housed. Physically disabled are also served in this program. All projects are required to provide a percentage of the units that are Americans with Disabilities Act (ADA) accessible and a smaller number of units available for those with sensory disabilities, such as vision impairment. Clients include those with serious mental illness who are homeless or at risk of homelessness.

Those at risk of being homeless may be:

1. Transitional Age Youth (TAY) exiting the child welfare or juvenile justice systems.
2. Individuals released or discharged from institutional settings such as:
    a. Crisis and transitional residential settings
    b. Hospitals, including acute psychiatric hospitals; psychiatric health facilities; skilled nursing facilities with a certified special treatment program for the mentally disordered; and mental health rehabilitation centers.
    c. Local city or county jails
3. Individuals temporarily placed in a Residential Care Facility upon discharge from one of the institutional settings cited above.
4. Certification by the county mental health director as an individual who has been assessed by and is receiving services from the county mental health department and who has been deemed to be at imminent risk of being homeless.

Total amount for program and amount spent thus far/ amount remaining

The MHSA Housing Program allocation from the State was $33 million, of which $22 million was designated for construction-related costs and $11 million was designated for Capitalized Operating Subsidies (COSR.) Diamond Apartment Homes and Doria Apartments were financed out of an additional one-time allocation of CSS funding. The following is a breakdown of the MHSA Housing Program $33 million funding to date:

Total construction funds committed: $11,641,326
Total Capitalized Operating Funds (COSR) Committed: $9,050,647
Total construction funding available: $10,464,174
Total COSR available: $1,999,153
Total Funds Available: $12,463,327

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MHSA Housing Program Update

Client Success Story

The following story is an example of a family that lived in one of our units. With the gains made, they were able to successfully move on:

K.K. was a 28 year-old female with two children, ages four and 10, when she applied to an MHSA-funded apartment complex. Prior to the onset of Major Depression, she was a nursing student and raising a family with her husband. As her psychiatric illness worsened, this client dropped out of school, was separated from her husband and children and became homeless. Before she began to receive treatment and wrap-around services at a Full Service Partnership (FSP) program, this woman was staying in the Armory Cold Weather Shelter program during the winter.

As the client had no income at the time, the FSP placed her into a group home for people dually diagnosed with both mental illness and substance use. The FSP paid for her housing until it helped her obtain Social Security benefits. The client moved in to the MHSA-funded apartment complex in January 2009. Due to her new stable housing and improved mental and physical health, she was able to regain shared custody of her children. In order for her children to return to their prior school, this resident applied for tenant-based Section 8 and moved into a mainstream apartment with her children in early 2012, and they remain stably housed there today.

MHSA
BUDGET

Exhibit D:
MHSA Funding Summary

FY 2013/14
MHSA FUNDING SUMMARY

County: Orange

Date: 4-1-13

	MHSA Funding					
	CSS	WET	CFTN	PEI	INN	Local Prudent Reserve
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$30,290,243			$39,180,995	$18,177,872	
2. Estimated New FY 2013/14 Funding	$81,661,185			$21,776,316	$5,444,079	
3. Transfer in FY 2013/14a'	-$790,974	$790,974				
4. Access Local Prudent Reserve in FY 2013/14	$0			$0	$0	
5. Estimated Available Funding for FY 2013/14	$111,160,454			$60,957,311	$23,621,951	
B. Estimated FY 2013/14 Expenditures	$69,830,199			$29,073,894	$5,000,000	
C. Estimated FY 2013/14 Contingency Funding	$7,674,815					

a' Per 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 funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$70,921,582
2. Contributions to the Local Prudent Reserve in FY13/14	$0
3. Distributions from Local Prudent Reserve in FY13/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$70,921,582

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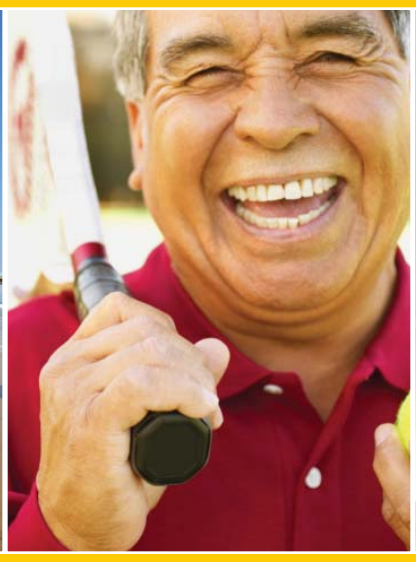
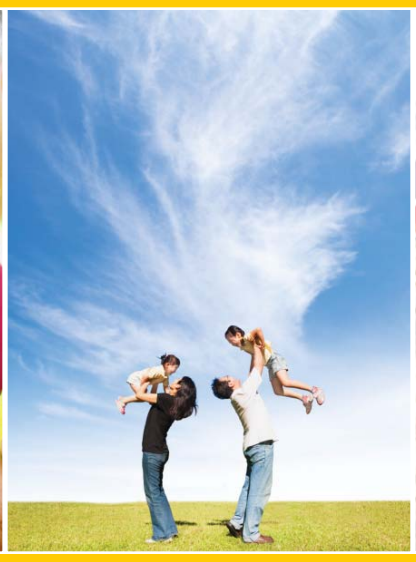
APPENDICES


"Every day, a new opportunity to decide where your next step will go is given to you. Your future will be determined by the accumulation of these daily decisions. You control your steps and therefore your destiny, so choose wisely." - Kevin Ngo

Appendix I:
Minutes from Mental Health Board Public Hearing

County of Orange
Mental Health Board

405 W. 5th Street, Ste 405
Santa Ana, CA 92701
TEL: (714) 834-5481 / FAX: (714) 796-0194
Email: ddaniels@ochca.com

Thursday, May 23, 2013
7:00 p.m. – 8:10 p.m.

Orange County Department of Education
200 Kalmus Drive, Building A – Board Room
Costa Mesa, CA 92626

MINUTES

The regular meeting of the Orange County Mental Health Board was held on Thursday, May 23, 2013, at the Orange County Department of Education, 200 Kalmus Drive, Costa Mesa, CA 92626.

During the regular meeting, a Public Hearing was held to consider the Mental Health Services Act Fiscal Year (FY) 2013/14 Annual Update to the Three-Year program Expenditure Plan. There were approximately 30 people in attendance.

At the conclusion of the Public Hearing the Mental Health Board, with seven members in attendance, voted in favor of accepting the Mental Health Services Act FY 2013/14 Annual Update to the Three-Year Program Expenditure Plan.

Officially submitted by:

Danielle Daniels

Danielle A. Daniels, Mental Health Board Liaison
Reporting Secretary

Upcoming regular meeting: The next regular Mental Health Board meeting will be held on June 26, 2013 from 9:00 a.m. – 10:30 a.m., Hall of Administration, Planning Commission Hearing Room, 333 W. Santa Ana Blvd., Santa Ana, CA 92701.

Appendix II:
Minute Order from the Board of Supervisors

ORANGE COUNTY BOARD OF SUPERVISORS
MINUTE ORDER
June 18, 2013

Submitting Agency/Department: HEALTH CARE AGENCY

Approve Plan Update for provision of Mental Health Services Act/Proposition 63 Programs, 7/1/13 - 6/30/14 ($103,904,093); and authorize Director or designee to execute Plan Update - All Districts (Continued from 5/21/13, Item 66)

The following is action taken by the Board of Supervisors:

APPROVED AS RECOMMENDED ☒ OTHER ☐

Unanimous ☒ (1) NGUYEN: Y (2) MOORLACH: Y (3) SPITZER: Y (4) NELSON: Y (5) BATES: 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. 54

Special Notes:

Copies sent to:

HCA - Thu Do
6/19/13

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.
Susan Novak, Clerk of the Board

By: _____
Deputy

1

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Appendix II:
Minute Order from the Board of Supervisors

Revision to ASR and/or Exhibits/Attachments

Date: May 30, 2013
To: Susan Novak, Clerk of the Board of Supervisors
CC: County Executive Office
From: Mark A. Refowitz, Director, Health Care Agency
RE: Agenda Item(s) for the 6/18/13 Board Meeting
ASR Control #(s): # 13-000371 (Continued from BOS 5/21/13)
Subject: Mental Health Services Act Plan Update FY 2013/14

2013 JUN -4 PM 2:25

15A1

Explanation:

This item was continued from BOS 5/21/13 to allow more time for Public Hearing

☐ Revised Recommended Action(s)

☐ Make modifications to the:

☐ Subject ☒ Background Information ☐ Summary

Replace the following sentence:

"At the close of the public comment period, a public hearing by the Mental Health Board was held on May 14, 2013 and the Plan Update was approved."

With:

"At the close of the public comment period, a public hearing by the Mental Health Board was held on May 23, 2013 and the Plan Update was "accepted."

☒ Revised Exhibits/Attachments (attached

Appendix II:
Minute Order from the Board of Supervisors

Agenda Item 6b

AGENDA STAFF REPORT

ASR Control 13-000371

MEETING DATE:	05/21/13
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):	Mary Hale (714) 834-6032

SUBJECT: Mental Health Services Act Plan Update FY 2013/14

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	N/A	Discussion 3 Votes Board Majority

Budgeted: Yes **Current Year Cost:** N/A **Annual Cost:** FY 2013/14: $103,904,093

Staffing Impact: No **# of Positions:** **Sole Source:** N/A

Current Fiscal Year Revenue: N/A

Funding Source: State: 100% (Mental Health Services Act/Proposition 63)

Prior Board Action: 12/13/05 #23, 3/4/08 #21

RECOMMENDED ACTION(S):

1. Approve the Plan Update for the provision of Mental Health Services Act/Proposition 63 programs and services for the period of July 1, 2013 through June 30, 2014 in the amount of $103,904,093.
2. Authorize the Health Care Agency Director or designee, on behalf of the Board of Supervisors, to execute the Plan Update as referenced in the Recommended Action above.

SUMMARY:

The Health Care Agency requests approval of the Plan Update for the provision of Mental Health Services Act/Proposition 63.

BACKGROUND INFORMATION:

In November 2004, the California voters approved Proposition 63, the Mental Health Services Act (MHSA). MHSA provides the State of California, Department of Mental Health (DMH), now the

Department of Health Care Services, the opportunity for increased funding, personnel, and other resources in support of county mental health programs. The goal of these programs is to reduce the long-term adverse impact of untreated serious mental illness and serious emotional disturbance through the expanded use of successful, innovative, and evidence-based practices. Components of MHSA include Community Services and Supports, Workforce Education and Training, Capital Facilities and Technology, Prevention and Early Intervention, and Innovation.

On December 13, 2005, your Honorable Board approved the Health Care Agency's (HCA) Community Services and Supports Plan, and DMH approved the plan on April 1, 2006. Subsequently, an amendment to the contract with DMH allowed DMH to modify a Plan Update submitted by the County. The purpose of this amendment was to reduce the processing time required for revisions to the Plan. It was approved by your Board on March 4, 2008.

In prior years, final approval of a MHSA Plan or Plan Update was given by DMH and the state's Oversight and Accountability Commission. The Welfare and Institutions Code (WIC) was recently amended so that plans and plan updates must now be approved at the local level, rather than by the State. WIC § 5847 now states that the County mental health program shall prepare and submit Annual Updates adopted by the County Board of Supervisors. Thus, final approval of MHSA Plans is now the responsibility of the Board of Supervisors.

Sections of the Plan Update were approved in the community planning process by relevant subcommittees and recommended to the MHSA Steering Committee. The 65 member MHSA Steering Committee approved, by consensus, the proposed Plan at the monthly meeting on January 7, 2013.

The County of Orange FY 2013/14 MHSA Plan Update was posted and distributed throughout the community on April 12, 2013 for a 30-day public comment period. At the close of the public comment period, a public hearing by the Mental Health Board was held on May 14, 2013 and the Plan Update was approved.

The FY 2013/14 MHSA Plan Update will provide revenue to support expanded and enhanced mental health and supportive services, prevention and early intervention services, and innovations projects. The budget remains at the same level as that for FY 2012/13.

The Health Care Agency requests your Board approve the FY 2013/14 MHSA Plan Update as referenced in the Recommended Action.

FINANCIAL IMPACT:

Appropriations and revenues have been included in the budgeting process for FY 2013/14.

STAFFING IMPACT:

N/A

EXHIBIT(S):

County of Orange Health Care Agency FY 2013/14 Mental Health Service Act Plan Update

Appendix III: Public Comments

Public Comment

Orange County received Public Comment from one member of the public. She sent in several comments.

Her comments centered on the need of the serious mentally ill for additional services, particularly Mental Health Court programs. She asked that 50% of all MHSA funding (not just CSS) be expended to identify and target high-risk non-engaged clients. She also expressed her belief that certain Innovation Projects should not be a priority. In addition, she advocated for a higher proportion of funding for adults as opposed to children and youth.

Orange County responded to her comments in two separate emails.

Response to Public Comment

Response #1

Thank you for your comments on the FY 2013/14 MHSA Plan Update.

As you may know, this Plan was developed through a community planning process and was approved by the relevant MHSA subcommittees and the whole MHSA Steering Committee.

The MHSA contains five components: Community Services and Supports, Workforce Education and Training, Prevention and Early Intervention, Innovation, and Capital Facilities & Technology.

The law provides separate rules and regulations for the use of the money in each of these five components. The money provided under some of these components precludes their use directly for client services. The Act addresses the needs of the mental health community as a whole by providing funding for a variety of purposes, each making a different contribution to the development of a strong public mental health system.

A component of the Act which does directly fund client services is Community Services and Supports (CSS). A requirement for this component is that at least 50% of the funding must be used to provide Full Service Partnership Programs, which provide intensive services for those people who are at the highest level of need. Orange County meets this requirement.

In Orange County, MHSA funding supports many other services that help the most severely impacted individuals. These include, but are not limited to, crisis services, outreach and engagement, Older Adult Recovery Services, services for individuals suffering their first psychotic break, post-partum mental health services, and services for veterans who live with post-traumatic stress symptoms.

You recommend that 50% of the MHSA funding be used to identify and target high-risk patients. For CSS, much more than 50% of that component's funding is used for that purpose. For other components, different rules and restrictions apply, and Orange County complies with the requirements for each section of the Act.

Outcome data provided in this Plan Update indicates that these programs are effective. We agree that there is more need than can be met by current resources. Mental Health Services Act has been essential in making progress in meeting the needs of the community, but we still have a long way to go.

We appreciate your input and acknowledge your passion about meeting the needs of those who are living with severe mental illness.

Response #2

Thank you for all of your additional comments.

Your preference for increased funding for some MHSA-funded programs has been noted. While we may agree with some of statements about additional funding needed in specific areas, the budgets of all the programs in the FY 13/14 MHSA Plan Update were established by a an extensive Public Planning Process guided by an MHSA Steering Committee and subcommittees.

The Steering Committee is composed of representatives from a wide-range of ethnicities, age groups, agencies providing services for the mentally ill, and advocacy organizations. Under current statute, there are certain groups that must be represented, such as education, social services etc. Orange County meets those requirements.

The FY 13/14 MHSA Plan Update is based on an assumption of level funding for FY 13/14. It includes funding to maintain existing programs and to add new Innovations projects. The funding levels provided in the Plan Update were all approved through the MHSA Steering Committee and the relevant subcommittees. A change in the Plan cannot be made based on an individual's personal preferences.

There may be an increase in funding during FY 13/14. Should that happen, Behavioral Health Services will conduct a planning process to determine unmet community needs and how the increase in funding will be allocated to meet those needs.

Again, thank you for sharing your perspective. We know that you are a strong advocate for those living with mental illness and appreciate hearing your point of view.

ORANGE COUNTY
HEALTH CARE AGENCY