WELLNESS • RECOVERY • RESILIENCE

Orange County MHSA Plan Update FY 15/16




OC health CARE AGENCY

MHSA Annual Plan Update and Expenditure Plan
FY 2015/2016

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Table of Contents

Overview and Executive Summary

Overview and Executive Summary

California voters passed Proposition 63, also known as the Mental Health Services Act (MHSA), in November 2004 to expand and improve public mental health services. The intention of the Act is to expand and transform the mental health system in California to improve the quality of life for Californians living with or at risk of serious mental illness.

MHSA has been in California for ten years now, and more than $13 billion has been raised since passage of the Act. Approximately 1600 programs have been developed throughout the state and thousands of people have been served. Through stakeholder input, mental health programs and supports are tailored to meet the individual needs of the diverse clientele in each county in California. As a result, the community is experiencing the benefits of expanded and improved programs to assist consumers in becoming active members of society. Counties are receiving funding and are able to provide "whatever it takes" treatment for people with serious mental illness.

Orange County Behavioral Health Services has used a robust stakeholder process to develop a behavioral health system of care that ranges from outreach and engagement services to crisis residential care. The current array of services totaling $163,749,392 was created based on the extensive planning efforts of thousands of stakeholders from 2005 to the current day. Through planning efforts in FY 13/14, a three-year plan was developed to cover fiscal years 14/15 through 16/17, and that plan serves as the basis for this current update.

The Orange County Mental Health Services Act Three-Year Plan for fiscal years 14/15 through 16/17 was approved by the Board of Supervisors in May 2014. That plan anticipated level funding for the three years covered by the plan. This current Annual Plan Update retains level funding for the vast majority of programs that were operational during FY 14/15, but includes some new or expanded programs based on available funding.

Community Services and Supports (CSS):

The majority of Prop 63 money provides treatment for individuals with serious mental illness, using a "whatever it takes" approach. Full Service Partnerships provide wraparound services to clients/consumers. Prop 63 also helps counties fund housing by leveraging the funds in local partnerships to build and renovate thousands of housing units for people with serious mental illness, many of whom are homeless.

Within the CSS component, the following program had changes in funding:

Funding for new Crisis Residential location: The Crisis Residential Program provides short term crisis intervention services to meet the needs of adults who are at risk of psychiatric hospitalization. At their February meeting the MHSA Steering Committee recommended to provide an additional $600,000 for Adult Crisis Residential expansion.

In addition to the above funding change, two Group 1 Innovation projects that demonstrated positive outcomes, and which were consistent with the CSS Plan were recommended for continuation using available CSS funding: Integrated Community Services and Volunteer to Work.

Integrated Community Services (ICS): ICS is a collaborative program between County mental health programs, community medical clinics, and substance abuse services that provides access to integrated medical and behavioral health services to County and community participants. This Innovation Project is reaching the end of Innovation funding. This program offers integrated services, with peer specialists to engage participants and act as liaisons between their behavioral health and medical care providers. The goal of this program is to fully integrate participants' physical and behavioral health care needs.

Volunteer to Work (VTW): VTW is a supported employment program that provides a "stepping stone" for individuals who need additional support in entering or re-entering competitive employment. It provides peer mentor support, skill development trainings and connections to volunteer opportunities. This Innovation Project has funding through June 30, 2015, and was recommended for one year of additional funding through CSS in the amount of $541,510.

Prevention and Early Intervention (PEI):

PEI programs are designed to prevent mental illness from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. Within the PEI component, the following programs have had changes in funding or implementation:

Expansion of OC Links: During FY 14/15, the funding for Information and Referral Services was increased by $200,000 because of the expanded efforts to increase access to all behavioral health services. Funding for Training, Assessment and Coordination Services decreased by $200,000. Besides these approved changes, the recommendation for level funding for all other PEI programs was approved at the February MHSA Steering Committee meeting.

In addition to the above changes, two Group 1 Innovation projects that demonstrated positive outcomes, and which were consistent with the PEI Plan were recommended for continuation using available PEI funding.

OC Accept: OC ACCEPT provides LGBTIQ specific behavioral health services to address behavioral health issues disproportionately faced by the LGBTIQ community. This program offers LGBTIQ specific behavioral health services and peer support services. In addition, LGBTIQ identified or allied peer specialists provide case management services, advocacy, and outreach and engagement activities. The goals of the program are to provide a safe environment to express feelings, build resilience, become empowered, and connect with others for support and to raise awareness and reduce stigma by providing education about the LGBTIQ population to the community at large.

OC4Vets: OC4Vets provides a participant-focused environment for veterans or families within the local military and veteran community to receive an integrated, holistic approach to address veteran behavioral health issues and facilitate a smooth transition back to civilian life. This program offers co-located veteran's services and peer support services, as well as peer navigators familiar with veteran and military culture who provide support and case management services.

Innovation:

The Innovation component funds and evaluates new approaches that increase access to the unserved and/or underserved communities; promotes interagency collaboration and increases the quality of services. Five percent of MHSA funding is designated as Innovation to allow counties to test new and improved approaches to mental health service delivery with time-limited pilot programs. Because the funding is time limited, projects that are recommended to continue after their initial pilot phase would need to have CSS, PEI or other funding identified in order for them to continue. Such was the case for four Group 1 projects. Integrated Community Services (ICS), Volunteer to Work, OC4Vets and OC Accept were all recommended for additional funding. Those programs are described above in the PEI and CSS sections.

The Innovation component undertook a substantial community planning process to identify projects for Group 3 funding. The planning process is described in detail in the Community Program Planning section of this Plan Update. Through the planning process 31 projects were submitted to the MHSA Office. After thorough review and MHSA Steering Committee input, 11 proposals were recommended to move forward. Below is a brief description of the proposed Group 3 Innovative Projects:

INN01 Continuum of Care for Veteran & Military Children and Families: This project will identify, screen, and treat veterans and their families, utilizing collaborations with community partners who specialize in community-based support, basic needs and homeless prevention, domestic violence prevention, mental health and trauma treatment, and research and evaluation.

INN02 Community Employment Services Project: This project will provide a paid, supported employment program for individuals with severe mental health conditions. Participants will work alongside peer support specialists for on-site job training and coaching.

INN03 Employment and Mental Health Services Impact: This project will provide mental health, education, and counseling services within local employment centers to support job seekers' emotional and mental health needs.

INN04 Veteran Student Needs Assessment and Treatment: This project will design, distribute, and tabulate surveys to identify needs, problems, and potential solutions for veterans. Based on findings, a series of workshops will be offered to address PTSD symptoms and behavioral modification techniques. In addition, mental health providers will visit with veteran students on a social basis to create a trusting environment to facilitate referrals for needed services.

INN05 Shared Housing Program: This project will offer a database of shared housing for consumers seeking affordable housing. This project will create a committee of consumers and providers to help establish voluntary standards of key elements of shared housing and a process to review homes to ensure they meet these basic standards. A listing of homes that have completed the process would be available through currently existing behavioral and mental health databases.

INN06 Faith Based Mental Health Education for Children: This project will train ministers of all faiths to provide mental health support and referrals for children with mental illness and their families. Project proposes to offer educational resources and workshops to families, engage in outreach during congregational events, and establish a referral network that enables pastors and/or their designees to link families to services.

INN07 Job Training and On-site Support for TAY: This project will create a food services business that provides hands-on job training and experience to transitional age youth who are diagnosed with a serious mental illness combined with on-site support staff who builds participants' confidence in the workplace and help manage mental health symptoms and behaviors while on the job.

INN08 Developing and Testing Effective EBPs for Children: This project will combine the manuals for Trauma-Focused Cognitive Behavioral Therapy (TFCBT) and Integrative Treatment of Complex Trauma (ITCT) into a single manual for the treatment of trauma among children and teens.

INN09 LGBTIQ Homeless Project: This project will address housing needs of those who are homeless or at-risk of homelessness within the LGBTIQ community. Staffed with peer mentors and clinicians, project will assist with housing resources, mediation work, employment assistance, and substance abuse treatment and support.

INN10 Immigrant Screening and Referrals: This project will combine various support services for newly arrived immigrants and offer a 12-week program that will provide home visits, family support, mental health screenings, and referrals for services, as needed.

INN11 Whole Person Initiative: This project will integrate physical, mental, and spiritual health to treat mild to severe mental illness. This project proposes to use a multidisciplinary team of professionals (i.e., medical doctor, physician assistants, spiritual leaders, mental health workers, licensed clinicians) to address the whole person in mind, body, and spirit.

Workforce Education and Training (WET):

WET funding is intended to increase the number of qualified individuals to provide mental health services, and improve the cultural and language competency of the mental health workforce. The original Workforce Education and Training funds have been spent, but the programs continue using Community Services and Supports funding. Within the WET component, the following programs have had changes in funding or implementation:

Orange County Mental Health Loan Assumption Program (OCMHLAP): The Health Care Agency is in strong competition with private sector organizations and other governmental agencies to recruit and retain community psychiatrists. The shortage of community psychiatrists has been discussed on a local, state, and national level. In response to this need, a Financial Incentive Program for psychiatrists recommended by the MHSA Steering Committee. The Financial Incentive Program will utilize Mental Health Services Act (MHSA) funds to develop a loan assumption program in order to recruit and retain qualified professionals working within the Public Mental Health System (PMHS). This program will help achieve staffing goals and enhance the quality of care that it provides to the County's population.

At the February meeting, the MHSA Steering Committee approved by consensus the recommended changes to the Workforce Education and Training Budget:

- Adding $99,187 to Workforce Staffing Support
- Adding $122,000 to Training and Technical Assistance
- Adding $50,000 to Mental Health Career Pathways Program
- Adding $228,814 for Administrative Costs to the WET Program
- Adding $1,500,000 in funding for Loan Repayment Program
- Reducing the Residencies and Internships by $500,000

Capital Facilities and Technology:

This component supports counties for a wide range of projects necessary to support service delivery. Progress has continued in the implementation of an Electronic Health Record (EHR), which is now live in six outpatient Behavioral Health locations impacting 28 separate programs, representing over 40% of Behavioral Health Services programs. An EHR is a digital version of a patient's medical record. EHRs are centralized, real-time patient records that make information available instantly and securely to authorized users. They allow programs at different locations to better coordinate services and stay up-to-date on patients' treatment. The goals of implementing an Electronic Health Record include: improving the quality and convenience of client care, increasing program efficiencies and cost savings, increasing client participation in their care and improving coordination of care. Ongoing efforts continue to focus on implementing the EHR in additional locations, and working towards interoperability and full compliance with meaningful use standards.

During the years since Proposition 63 was passed, the Mental Health Services Act has continued to go through changes to help better the lives of the clients and the entire Orange County community.

County Compliance Certification

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Orange

Local Mental Health Director	Program Lead
Name: Mary R. Hale	Name: Jeff Nagel
Telephone Number: 714-834-6032	Telephone Number: 714-667-5624
E-mail: mhale@ochca.com	E-mail: jnagel@ochca.com
County Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on _____.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

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

Mary R Hale 3/27/15
Signature Date

County: Orange

Date: _____

County Fiscal Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Orange

☐ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Mary R. Hale	Name: Eric Woolery
Telephone Number: 714-834-6032	Telephone Number: 714-834-2450
E-mail: mhale@ochca.com	E-mail: eric.woolery@ac.ocgov.com
Local Mental Health Mailing Address: Health Care Agency Behavioral Health Services 405 W. 5th Street Santa Ana, CA 92701	

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

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

Mary R. Hale
Local Mental Health Director (PRINT)

Mary R Hale 3/27/15
Signature Date

I hereby certify that for the fiscal year ended June 30, 2014, 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 12/18/14 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, 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.

Kim Engelby for Eric Woolery
County Auditor Controller / City Financial Officer (PRINT)

Signature 3/30/15
Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

Workforce Needs Assessment

Exhibit C: Workforce Needs Assessment

Methodology:

An electronic survey was conducted in 2012 within all areas of Behavioral Health Services (BHS). Survey participants 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 a threshold language (Spanish, Vietnamese, Farsi and Korean).

The survey assessed the County's needs in different areas, which included: needs in different occupational categories, needs across positions, and needs concerning language proficiency.

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 were in the areas of licensed clinical Social Workers, Licensed Substance Abuse Specialists, Mental Health Workers, Life Coaches and Employment Specialists/Job Coaches Based on the most recent needs assessment, 86% of the needed positions are currently filled. The current workforce for the directors or service chief category appears to be in line with the number needed to meet the current needs (Table 1). 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. Among the divisions, P&I and CYS have the greatest need for additional staff 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 individuals 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 or may not self-disclose, depending on their preference, the number is likely to have been under-reported. The majority (79%) of consumers/family members occupy positions in the direct service staff category, and this trend is true across all divisions of BHS (Tables 3 &4). These figures highlight the large number of positions (i.e. peer mentors) that were recently 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).

C. Language proficiency

There are four threshold languages in Orange County. These include, 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 rate (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 and 3).

At least 25% of 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%) (See Table 4 for details).

In addition, data was analyzed on the number of clients in our Integrated Records Information System (IRIS) during FY 11/12 who 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 number of 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, which was 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. It is expected that in the near future, Chinese will become a threshold language in Orange County, but that remains to be seen.

Table 1. Workforce needs assessment among Program Directors/Svc 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.

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.

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.

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	1880 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)

Table 5. Fiscal Year 11/12 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%

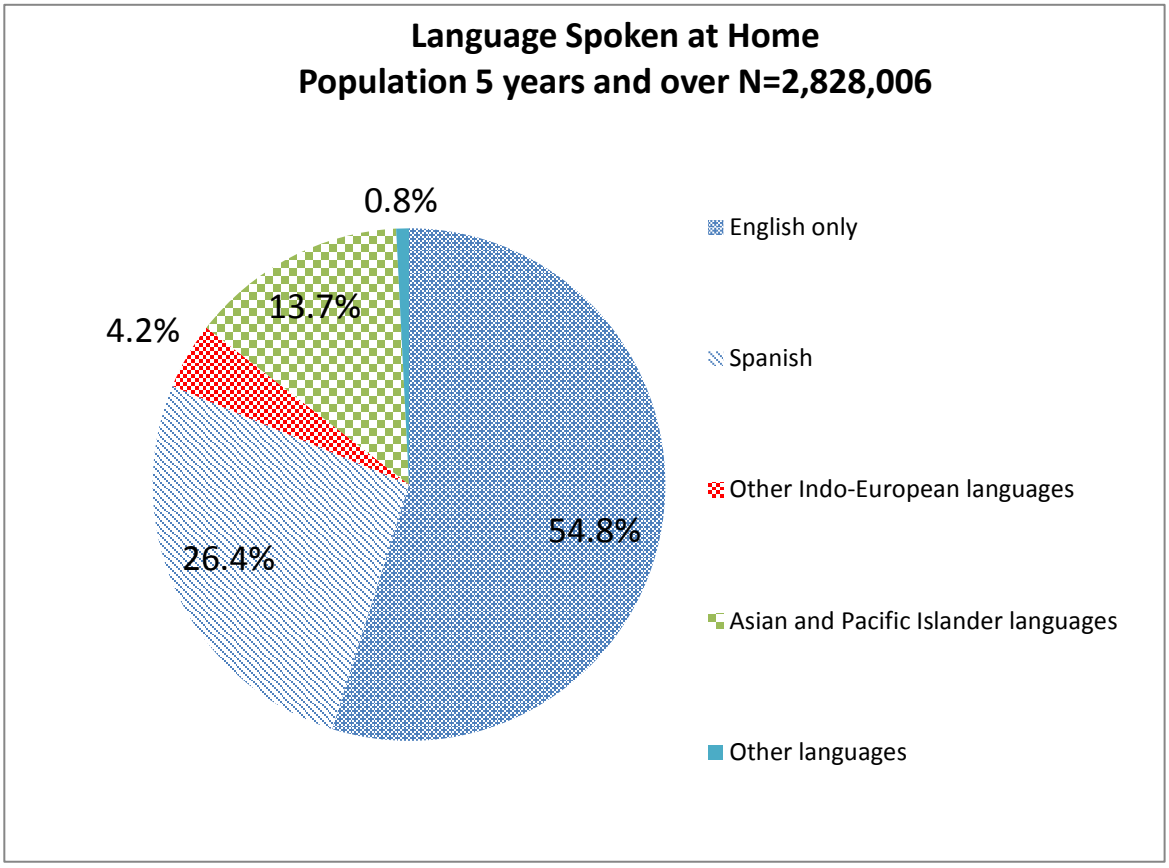
County Demographics

County Demographics

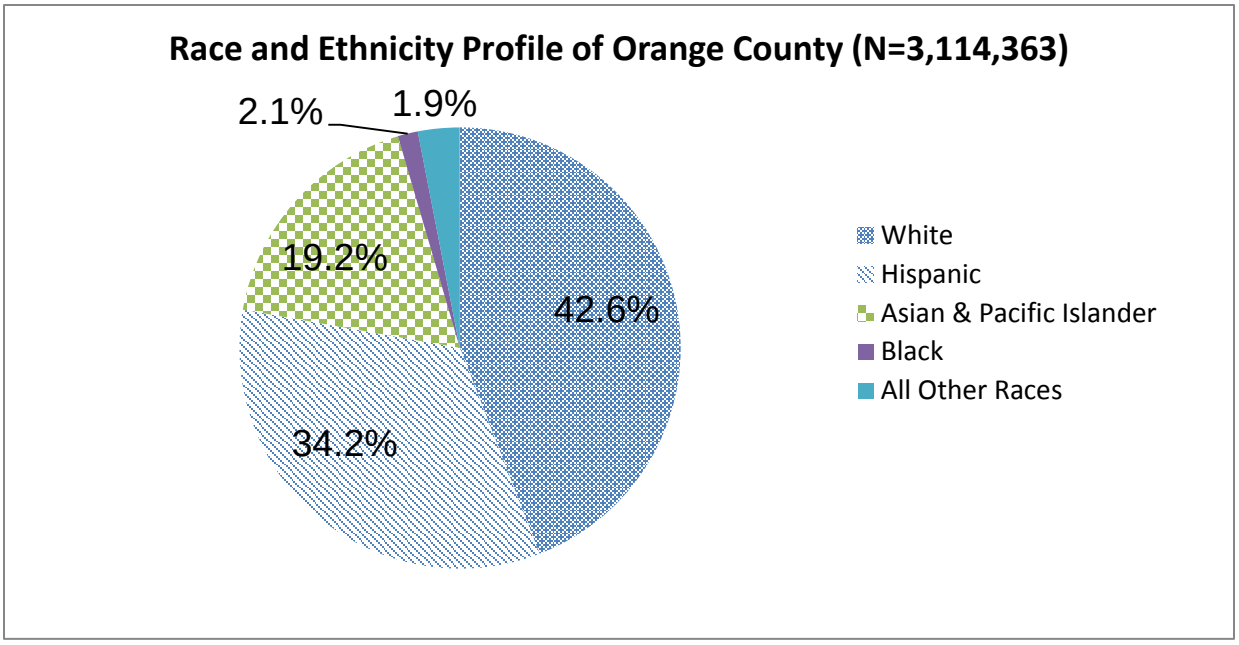
Geography and Racial/Ethnic Profile of Orange County

County of Orange is approximately 798.3 square miles in size and is comprised of 34 incorporated cities. It is home to a little over 3 million (3,114,363; 2013 Census estimate) people and is proud of its rich ethnic makeup.

Although many perceive Orange County as predominantly White and English-speaking, that is not accurate. Currently, Orange County has four threshold languages (Spanish, Vietnamese, Korean and Farsi). English is spoken at home by 54.8% of the population five years and over, followed by Spanish (26.4%) and Asian/Pacific Islander languages (13.7%). As of 2013, the county's population is comprised of four major racial/ethnic groups: Whites (42.6%), Hispanics (34.2%), Asian & Pacific Islanders (19.2%) and Blacks (2.1%). According to California Department of Finance projections, by year 2020 Orange County's population will become increasingly diverse with a rapid increase in the percentage of Hispanics (37.1%). By 2030, it is projected that Hispanics will become the majority (38.6%) ethnic group in the County, surpassing Whites (36.7%).



Source: U.S. Bureau of the Census, 2010 Decennial Census



Source: U.S. Bureau of the Census, 2013 Census

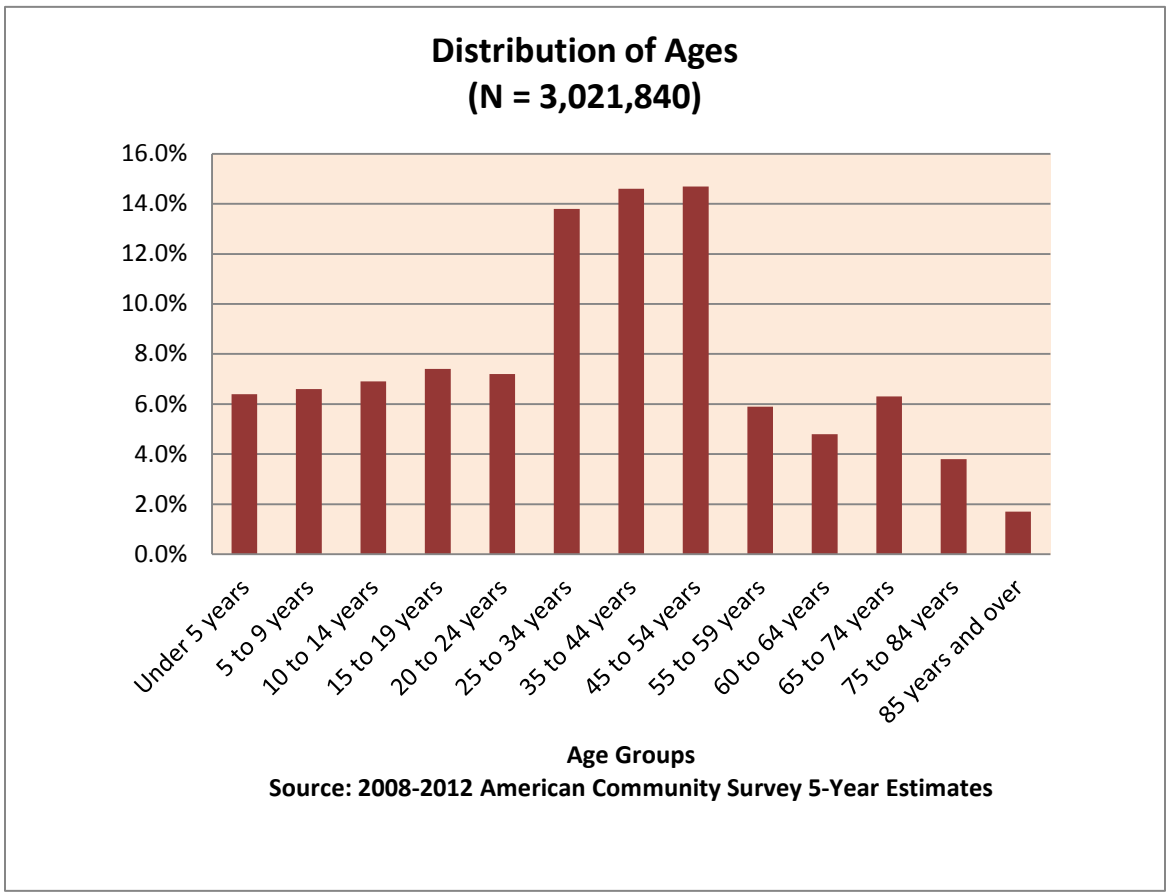
Social and Economic Indicators

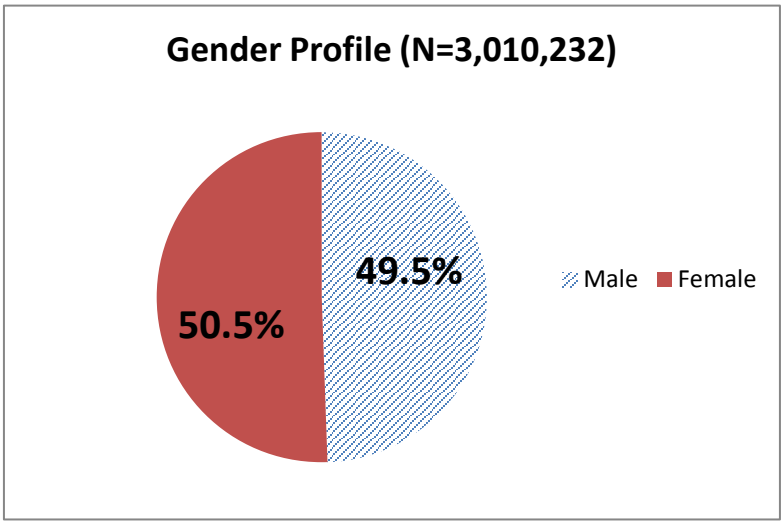
From 2009 to 2013, 12.4% of Orange County's population lived under 100% of the federal poverty level (FPL), which is $10,890 annual income for a single-person household size. In 2013, 5.7% of Orange County residents 16 years and older did not have jobs. In 2011, the Family Economic Self-Sufficiency Standard index was calculated for 156 family types ranging from a single adult with no children to three or more adults with four or more children. The Family Economic Self-Sufficiency Standard measures how much income is needed for a family of a certain size in a particular county to adequately meet its minimal basic needs including housing, child care, food, transportation, out-of-pocket medical expenses, taxes and other necessary spending. By this standard, a family of two adults with two school-age children living in Orange County would need $65,761 family annual income to meet its minimal basic needs. Since 2007, Orange County has consistently had the highest Cost of Living Index compared to neighboring areas. Although Orange County's cost of living measures for groceries, utilities, transportation and miscellaneous items tended to rank in the middle among similar jurisdictions, high housing costs significantly affected the index, making Orange County a very expensive place to live.

In 2012, 23.6% of the County's population was under the age of 17, 38.1% were 18-44 years of age, 26.0% were 45-64 years of age, and 12.3% were 65 or older. The percentage of County population age 65 or older is expected to increase over the next 20 years. As the percentage of seniors grows, the need for mental and physical health care is expected to rise.

Age, Gender and Household Characteristics

The median age is 36.2 years distributed almost equally between males and females. The average household size is 2.9 with 1,048,907 housing units and a homeless population of just over twelve thousand individuals (Point in Time Survey, 2013).





Source: U.S. Bureau of the Census, 2010 Decennial Census

Other Unique Characteristics

During the past ten years, Orange County also became a minority majority county, meaning the non-Hispanic white population no longer comprises more than 50% of the county population (Orange County Change: Census 2000-2010 by CSU Fullerton CDR). Orange County is also home for an emerging Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) population. Specific services are available in the County to address the unique needs of this population. Accurate statistics on the LGBTQ population in the County are not available. However, based on 2000 census data and other available resources, an estimated 4% of males and 2% of females in Orange County are gay or lesbian. The census 2000 reported 2,901 same sex *male* couple households and 2,623 same sex *female* couple households in Orange County. Approximately 6.0% (2,282,766) of the civilian population over 18 years are veterans. The County has a well-educated population, with 83.6% of the population age 25 years and over being a high school graduate or higher and 36.6% having a bachelor's degree or higher.

Community Program Planning

The Planning Process for the Mental Health Services Act (MHSA) Plan Update for FY 15/16 built 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, community providers and representatives of unserved and underserved populations.

The MHSA planning process is guided by a Steering Committee composed of approximately 60 local stakeholders, including representatives from the following groups or organizations: seniors, adults and TAY representatives with severe mental illness, family members, law enforcement agencies, education, criminal justice system, veterans and veteran organizations, providers of alcohol and substance abuse services, social services agencies, healthcare organizations, homeless prevention/housing organizations, consumer advocacy groups, members of the Mental Health Board and underserved ethnic communities. Interpreters are available at the meetings, including 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 Committee made up of an ethnically diverse group of consumers and family members. This group meets monthly and provides their input into the MHSA planning process through an advisory role to the Steering Committee.

In 2012, 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. The role of each Subcommittee is to make recommendations to the Steering Committee on services and level of funding for MHSA programs within the purview of the Subcommittee.

The current Subcommittees are:

- CSS Children and Transitional Aged Youth (TAY)
- CSS Adults and Older Adults and Workforce Education and Training (WET)

- Prevention and Early Intervention (PEI)
- Innovation (INN)

The MHSA Steering Committee meets monthly, with several meetings a year focused specifically on subcommittee activities. Additional meetings or workgroups are held as needed and all meetings are open to the public.

Community Services and Supports (CSS)

The Innovations Subcommittee made a recommendation at their November meeting to continue funding of three Group 1 Innovation Projects. The Integrated Community Services (ICS) project was consistent with the CSS Plan and was approved for CSS funding by the Steering Committee at the December meeting. In addition, at the February meeting, the MHSA Steering Committee approved by consensus the CSS subcommittee recommended actions to fund the following new or expanded programs:

- Approved an additional $600,000 for Adult Crisis Residential Expansion
- Approved to fund the Volunteer to Work Program for 1 additional year with available funding through Community Services and Supports for $541,510.

Workforce Education and Training (WET)

At the February meeting, the MHSA Steering Committee approved by consensus the recommended changes to the Workforce Education and Training Budget:

- Adding $99,187 to Workforce Staffing Support
- Adding $122,000 to Training and Technical Assistance
- Adding $50,000 to Mental Health Career Pathways Program
- Adding $228,814 for Administrative Costs to the WET Program
- Adding $1,500,000 in funding for Loan Repayment Program
- Reducing the Residencies and Internships by $500,000

Prevention and Early Intervention (PEI)

The Innovations Subcommittee made a recommendation at their November meeting to continue funding of three Group 1 Innovation Projects. The OC4Vets and OC Accept projects were consistent with the PEI Plan and were approved for PEI funding by the Steering Committee at the December meeting. In addition, at the February meeting, the MHSA Steering Committee approved by consensus the PEI subcommittee recommended actions to fund the following new or expanded programs:

- Approved of recommended action to move $200,000 in funding from the Training ASO to the Information and Referral Services to be added to the MHSA Plan Update FY 15/16.

Innovation

The Innovation component engaged in an extensive planning process this past fiscal year. During Fiscal Year 14/15, community planning occurred to identify potential projects for funding through the Innovation component.

Funding: Consistent with the estimate provided in the Orange County Mental Health Services Act Three-Year Plan FY 14/15 – 16/17, approximately $24 million in Innovation funding will be available over three years to fund the approved Group 3 Innovative Projects. Any approved projects demonstrating positive outcomes would require another funding source to be identified if they are to continue beyond the initial Innovation funding.

Planning process: The planning process for Group 3 Innovative Projects built on the previous planning for Group 1 and 2 projects, and took into account the lessons learned from previous approaches to the solicitation of community input for Innovative Projects. Starting in early July 2014, the MHSA Office staff and Innovations staff started a series of planning meetings to develop the stakeholder process to be used for Group 3 Innovative Projects. Innovation submissions from stakeholders for Group 1 and 2 projects lacked important details about the ideas being submitted for consideration. In particular, the ideas lacked learning objectives, budget details, and program descriptions. In addition, many of the submitted ideas were for services that were already being provided – either in Orange County or elsewhere – and therefore did not meet the criteria for funding as an Innovative Project.

To address the shortcomings mentioned above, three specific strategies were developed:

1. Increase the education provided in the stakeholder meetings to provide clear definitions of the process and criteria to be used for vetting and approving Innovation Projects.
2. Provide stakeholders with a template for submission of ideas that requires submission of specific program elements (learning objective, budget, startup costs, program description, etc.)

3. Provide Technical Assistance to stakeholders to provide guidance and direction consistent with regulations and answer specific questions about proposals under development

Stakeholder meetings and marketing: To solicit community input, the MHSA office and Innovations staff held a series of stakeholder meetings starting in September 2014 that both educated stakeholders and solicited new ideas from the community. Two stakeholder meetings were held specifically targeting organizations and individuals providing direct services within the community: one meeting for Health Care Agency's Behavioral Health Services staff, and the second meeting for community-based service providers. For this latter meeting, letters of invitation were sent through the MHSA Steering Committee, and to all contracted entities providing behavioral health services. Community providers unable to attend the provider specific meeting were encouraged to attend one of the regional stakeholder meetings described below.

Community Stakeholder meetings: In addition to the provider-focused meetings described above, a series of five community stakeholder meetings were held across the county. Participation in these regional meetings included consumers, family members, providers, and individuals representing the larger health care community in Orange County that have an interest in mental health care. Invitations for participation were sent to consumers and consumer organizations as well as to individuals who represent safety (Probation and Sheriff), education, faith communities, physical healthcare providers (CalOptima, hospitals, community clinics), welfare (Social Services Agency), among others. Interpretive services were available for each of the meetings to remove barriers for participation to those whose primary language was not English.

Technical Assistance (TA): Following the Stakeholder sessions, a series of Technical Assistance sessions were offered throughout the month of November. These TA meetings reinforced the requirements for an Innovative Project, and provided guidance to stakeholders to assist them in submitting timely and thorough proposals. Interpretation was available at the TA sessions, and HCA staff from the MHSA Office, Innovations Program, Research and Financial and Program Support was present at the meetings. At these meetings individuals with innovative ideas received the guidance they needed to help them understand criteria for funding, and the process for researching their idea, articulating their idea, and submitting a completed Round 3 Innovative Idea Form.

Approval Process: Thirty-one ideas were submitted to the MHSA Office by the December 1, 2014 deadline. Following submission of the form, a thorough review was conducted to determine if the submissions were complete and met criteria for an

Innovative Project. This review process included an initial review by MHSA Office staff and Innovation staff to determine if submissions were complete and consistent with Mental Health Services Oversight and Accountability Commission (MHSOAC) criteria. A second level of review was conducted by Research Analysts to examine available literature and internet based sources to determine if the proposed ideas had been implemented in other locales, and if so whether an element of the proposal differentiated it from other implemented programs (e.g., unique learning objective, unique target population, etc.). Proposals that made it through the first two levels of review were then reviewed by BHS managers to determine feasibility of the projects and any potential duplication within the Orange County Public Behavioral Health system of care.

MHSA Steering Committee Approval: Of the 31 submitted ideas, 13 met criteria for an Innovative Project and were reviewed by the full MHSA Steering Committee. At the January meeting the 13 proposals were presented to the full committee to prioritize the proposals. At the subsequent MHSA Steering Committee meeting, the prioritized proposals were reviewed for consideration of funding, and 11 of the 13 submitted proposals were approved to move forward as recommended Innovation Projects for Group 3. The MHSA Steering Committee approved by consensus the Innovations budget as reflected in the Annual Plan Update for FY 15/16.

Annual Plan Update Public Review and Approval Process

Following the February Steering Committee meeting, where budget recommendations were approved, the Orange County MHSA Plan Update for FY 15/16 was written by staff and reviewed internally by BHS staff, managers, Directors and executive management. After executive approval, the Plan was posted on the MHSA website for 30 days, March 30 through April 29, 2015 and notice for the Public Hearing was posted by the Clerk of the Board of Supervisors. Copies were made available at Orange County libraries. Notification of the posting and public hearing was sent to the MHSA Steering Committee, Mental Health Board, community advisory committees and other interested parties. The Public Hearing was also advertised in local newspapers in Orange County threshold languages.

The Orange County Mental Health Board (MHB) will hold a Public Hearing on May 12, 2015. A summary and analysis of any substantive recommendations will be included after the 30 day posting. On June 2, 2015 the MHSA Plan Update for FY 15/16 will be on the Board of Supervisors' Agenda for their approval.

Community Services and Supports (CSS)

Community Services and Supports

A. Component Information

Community Services and Supports (CSS) was the first MHSA component to be implemented and is the largest of all five components. The CSS component is focused on community collaboration; cultural competence; client and family driven services and systems; wellness focus, which includes concepts of recovery and resilience; and integrated service experiences for clients and families as well as serving the unserved and underserved.

The Mental Health Services Act (MHSA) allocates 80% of the Mental Health Services Fund to counties for CSS, which provides comprehensive mental health treatment for people of all ages with serious mental illness. The goal of this component is to develop and implement promising and proven practices designed to increase access to services by underserved groups, increase the quality of services and improve outcomes, and to promote interagency collaboration.

New programs offered under CSS programs are integrated recovery-oriented mental health treatment, offering case-management and linkage to essential services such as housing, vocational support, and self-help.

Orange County's CSS Plan

Orange County's CSS programs, services, and strategies are identified and approved through its stakeholder process, with an emphasis on addressing disparities and serving unserved and underserved populations.

CSS Funds are 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.
- Outreach and Engagement (O&E)
- General Systems Development (GSD) - Improve programs, services and supports for all clients and families.

Half of CSS funding is designated for Full Service Partnerships (FSPs). FSPs provide a spectrum of "whatever it takes" treatment to support recovery for those with a severe mental illness. FSP services seek to help the most severely mentally ill clients and their families, twenty-four hours a day, seven days a week. Included as

part of the treatment process are case management, transportation, housing, crisis intervention, education, vocational training and employment services, and socialization and recreational activities.

Initial evaluations conducted by independent evaluators as well as our own outcome data have documented significant benefits of FSPs, including decreases in homelessness, use of emergency room services for mental health crises, acute psychiatric hospitalizations and arrests, and increases in education, employment, independent living, and life functioning.

CSS also helps counties fund housing by leveraging the funds in local partnerships to build and renovate housing units for people with serious mental illness, many of whom are homeless.

The Outreach and Engagement (O&E) funds of CSS are used to fund activities that reach, identify and engage unserved individuals and communities in the mental health system and reduce disparities identified by the Orange County Steering Committee.

The General Systems Development (GSD) funds are used to improve services and infrastructure. Examples of GSD 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

Orange County's CSS programs are available for all age groups, and some programs serve more than one age group of clients. CSS programs are divided into the following age groups:

1. Children (ages birth through 15) – 8 programs
2. Transitional Age Youth (ages 16-25) – 6 programs
3. Adults (ages 26-59) – 18 programs
4. Older Adults (ages 60 and above) – 4 programs

FY 14/15 Changes to the Plan

This current Annual Plan Update retains level funding for the vast majority of CSS programs that were operational during FY 14/15, but includes some new or expanded programs based on available funding.

The Steering Committee recommended an additional $600,000 for Adult Crisis Residential expansion which provides short term crisis interventions services for adults who are at risk of a psychiatric hospitalization.

Besides this approved change, the recommendation for level funding for all other CSS programs was approved with available dollars to be utilized to sustain two Innovation Projects that were recommended for continuation. These Innovation projects were determined to be effective, and Innovation funding for these projects will end. Shifting the funding to CSS allows for the continuation of these projects.

The Integrated Community Services (ICS) project was consistent with the CSS Plan and was approved for CSS funding by the Steering Committee at the December meeting. In addition, the MHSA Steering Committee approved to fund the Volunteer to Work Program for one additional year with available funding through Community Services and Supports for $541,510 at the February meeting.

Example of Notable Community Impact

Assisted Outpatient Treatment (AOT) provides mental health treatment for individuals with a history of refusing mental health help. Their mental health issues have led to previous hospitalizations or incarcerations, or have resulted in actual or attempted acts of harm to self or others in the past. Without help, it would be unlikely for these individuals to survive in the community without supervision. AOT allows a family member, friend, hospital director, or an officer of the law to request a psychological

evaluation for that person. Orange County was the second county to implement AOT in California and the first large county to do so.

To date (3/25/15), there have been 226 referrals for AOT. Of those 226 referrals, 50 have voluntarily accepted treatment and are now linked to voluntary services in Full Service Partnerships. Without AOT, it is very likely that these individuals would have become hospitalized or incarcerated, or have hurt themselves or others. Two additional individuals had petitions filed for court-ordered treatment, but both individuals voluntarily accepted a settlement agreement to receive services through a Full Service Partnership.

A. CSS Program Information & Outcomes

C1. Children's Full Service Partnership	
Estimated annual number to be served in FY 15/16	**371**
Annual Budgeted funds for FY 15/16	**$5,954,575**
Estimated Annual Cost Per Client	**$16,050**

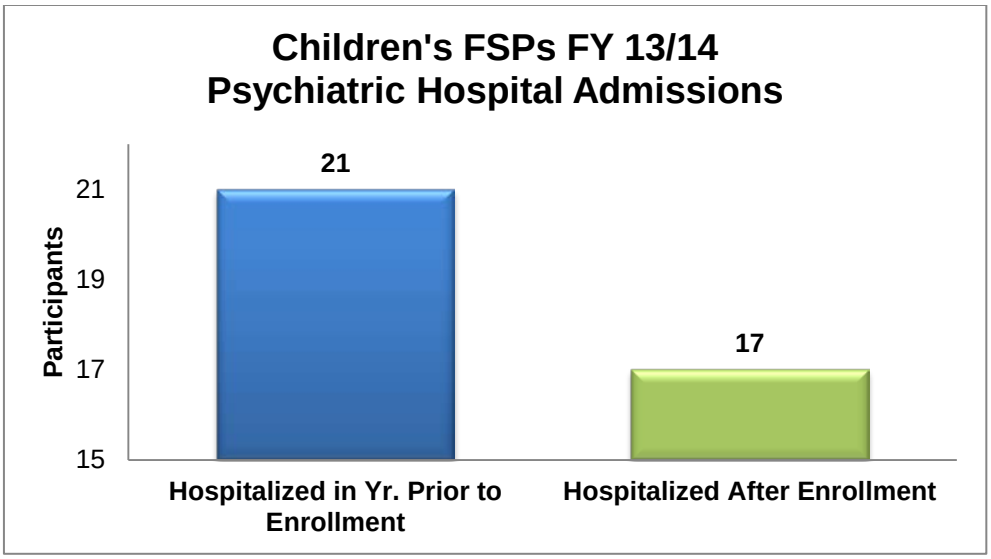
1. Program Description

The four Children's Full Service Partnership (FSP) programs focus on the areas prescribed in the original legislation and several areas of local need within the broader targets. There are four distinct programs within the Children's FSP category, which serve particular target populations. 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 who are at risk of homelessness. Parents frequently need job assistance, especially when the needs of their Seriously Emotionally Disturbed (SED) 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.

Additional funds have been set aside for Children's FSPs. These dollars will be distributed among the existing programs based upon the history of program spending and the impact of shifting costs in the community. Programs will be able to serve more clients and more funds will be available to cover raising costs, especially in housing.

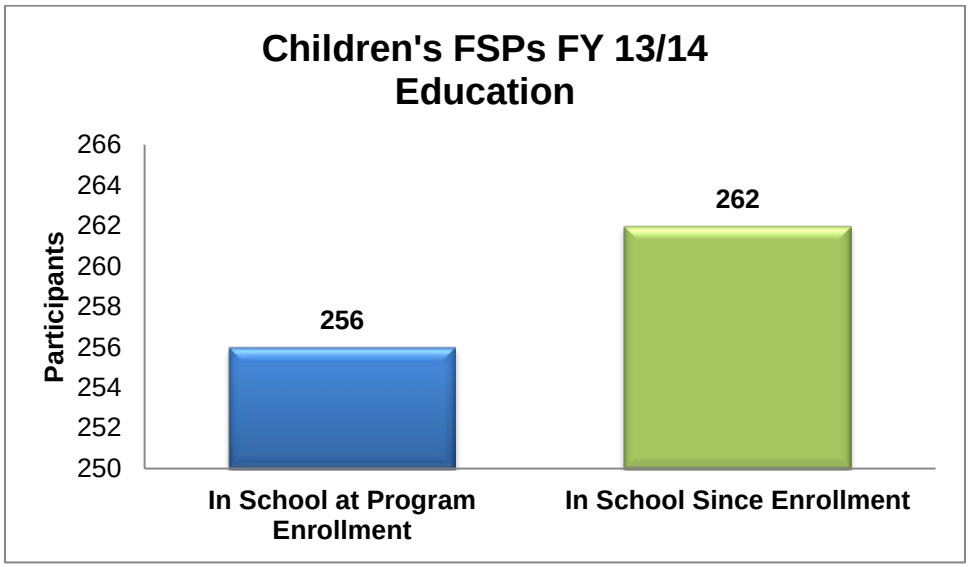
2. Outcomes

One of the goals of the FSPs is to reduce the number of psychiatric hospitalizations that the participants experience. In the year prior to enrollment in an FSP, 21 out of 269 (8%) children reported that they had been hospitalized. Since enrollment in an FSP, 17 (6%) of these children were hospitalized, resulting in a 19% decrease in the hospitalization rate during FY13/14 (see graph below).



In addition to a decrease in the overall hospitalization rate, there was a corresponding 38% decrease in the total number of days the children were hospitalized after enrolling with an FSP (i.e., 338 days during the year prior to enrolling and 208 days after enrolling in an FSP).

At the time of enrollment in an FSP during FY13/14, 256 (95%) children were enrolled in school. Since joining an FSP, 262 out of 269 (97%) children were enrolled. This represents a 2% increase and, even more importantly, reflects that nearly all school-aged children were enrolled in school (see graph below).



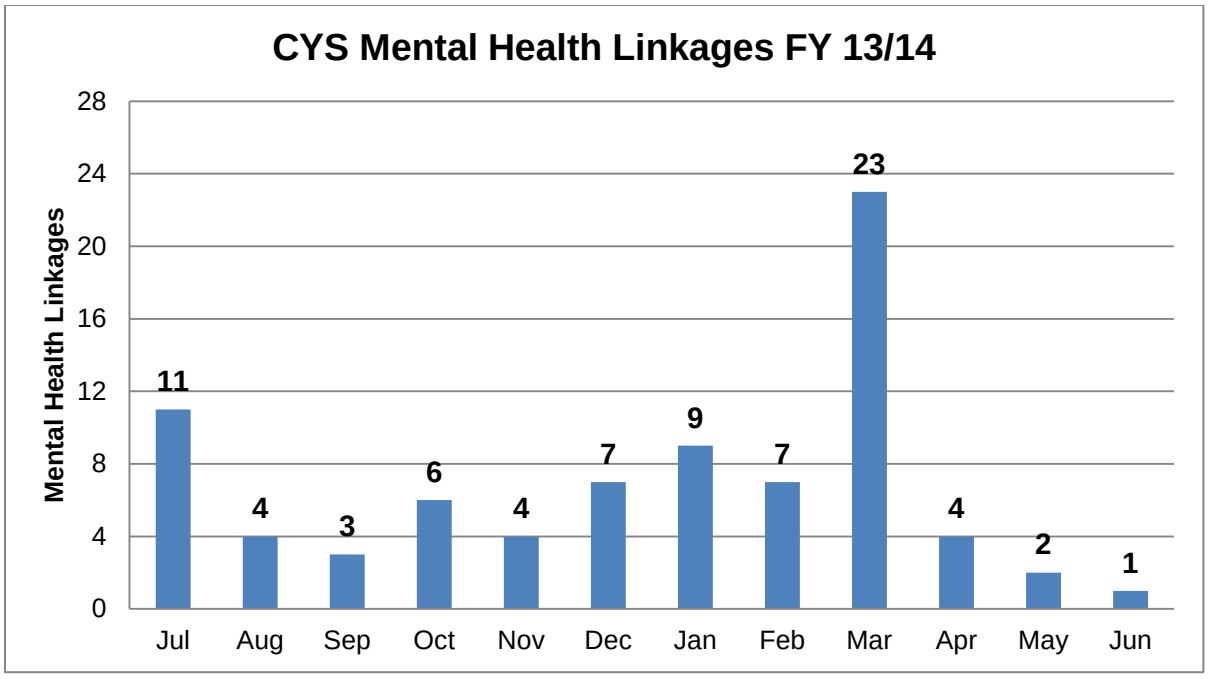
C2. Children's Outreach and Engagement	
Estimated annual number to be served in FY 15/16	**50**
Annual Budgeted funds for 15/16	**$123,594**
Estimated Annual Cost Per Client	**$2,472**

1. **Program Description**

This Outreach and Engagement program serves Seriously Emotionally Disturbed (SED) and 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 where a serious mental illness and homelessness (at risk) is involved. The program assists families with accessing mental health services and/or linkages with other needed community resources. The graph on the following page displays data on the number of successful linkages to mental health services during FY 13/14. The number of linkages varies from one to 23 per month, with an average of approximately 7 successful linkages per month.


CYS Mental Health Linkages FY 13/14
Mental Health Linkages
28
24
20
16
12
8
4
0
11
4
3
6
4
7
9
7
23
4
2
1
Jul
Aug
Sep
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Nov
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Apr
May
Jun

C3. Children's In-Home Crisis Stabilization	
Estimated annual number to be served in FY 15/16	**400**
Annual Budgeted funds for 15/16	**$1,085,480**
Estimated Annual Cost Per Client	**$2,714**

3. Program Description

The program's target population is youth up to their 18th birthday who are being considered for psychiatric hospitalization, but who don't meet criteria for inpatient 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 Behavioral Health (CYBH) 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 work out a plan to identify causes of the current crisis and begin to work on healthful ways of avoiding future crises. There are times when families are drained by the crisis and the evaluation process. In those incidents, in-home appointments are made for the next day to begin the stabilization process. The team targets a brief intervention period of usually three weeks, occasionally extending to six based on clinical need and linkage to more permanent support programs. The In-Home Crisis Stabilization Team helps the family and child develop coping strategies and transition to on-going support.

The program was expanded beginning in January 2014, effectively increasing direct service clinical staff from eight to 14. For FY 15/16 the goal for a fully staffed program is to serve 400 children and their families.

2. Outcomes

Outcomes for the program are measured in two ways. First is the number of clients served. During FY 13/14 the expectation was that a minimum of 240 clients be served. The program served 267. During FY 13/14 the program showed an 87% rate of keeping youth in the community during the time that the program had the case open and for 60 days post-discharge.

C4. Children's Crisis Residential Program	
Estimated annual number to be served in FY 15/16	**200**
Annual Budgeted funds for FY15/16	**$3,289,966**
Estimated Annual Cost Per Client	**$16,450**

1. Program Description

The Children's Crisis Residential Program was developed to address a system gap. A highly structured alternative to in-patient services and in-home crisis services was needed. The target population is youth up to 18 years old who are at risk of psychiatric hospitalization. This need arises when the following occur:

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

Referrals are accepted on a 24/7 basis. The plan is for a three week stay, which may be expanded to six weeks 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 preparation and clean-up.

Throughout FY 12/13 and the early parts of FY 13/14 the program had many more referrals than it could serve. As a result, a waiting list was established for this crisis program. Many potential referrers were discouraged by this and did not attempt to place their client on the waiting list. When additional funding became available, negotiations began to expand the program. During FY 14/15 the program doubled the size of the program's capacity from 6 to 12 beds. Because the demand for services remains high, the plan for FY 15/16 is to add an additional 4 beds resulting in 16 total Crisis Residential Beds.

2. Outcomes

This program is expected to serve a minimum of 200 clients per year when all the beds are available. During FY 13/14 the program served 116 clients with an average length of stay of 17 days. The target was to serve children and their families in the community and avoid inpatient hospitalization when safe and viable. 83% percent of clients met the criteria of being able to function in the community between admission to the program and sixty days post-discharge.

C5. Mentoring for Children	
Estimated annual number to be served in FY 15/16	**146**
Annual Budgeted funds for FY 15/16	**$352,620**
Estimated Annual Cost Per Client	**$2,415**

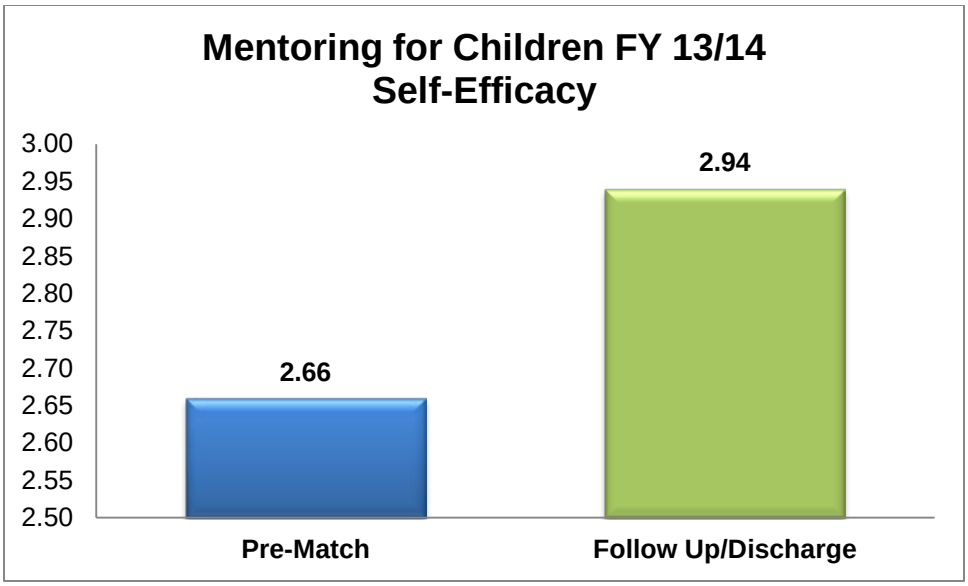
1. Program Description

The Mentoring Program is a community-based, individual and family centered program that recruits, trains and supervises 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 Behavioral Health (CYBH) and its contractors. Parents/caregivers of SED children and youth may also receive parent mentoring services.

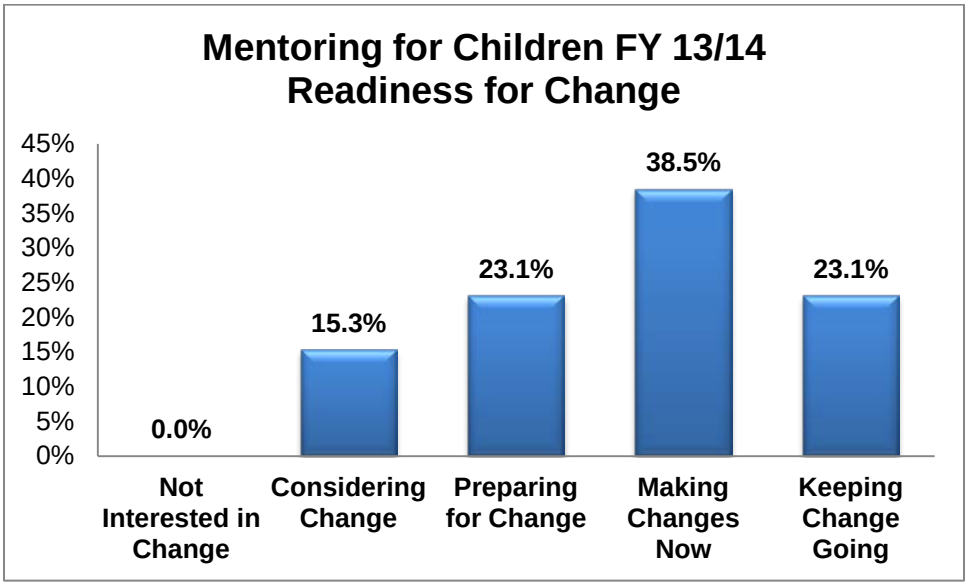
One-to-one mentoring has the potential to impact youth in a positive way as strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. 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. CYBH has an extensive history of using mentors as an adjunct to 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.

2. Outcomes

Youth in the Mentoring program are asked to complete a Resilience Scale prior to being matched with a mentor and once again after being in the program for 6 months (which typically coincides with discharge). As can be seen in the graph below, during FY13/14, youth showed gains in self-efficacy, one of the primary resilience subscales, after being matched with a mentor. (Of note, over the course of FY13/14, a new version of the Resilience Survey was adopted. This new version is currently being tested for reliability, validity and comparability to the original scale).



The referring clinicians and/or mentors complete a Readiness for Change measure at discharge, which reflects the extent to which they believe the youth is ready to make positive changes in his/her behavior. Almost 62% of children were described as making or keeping positive changes going and another 23% were rated as preparing for change, suggesting that the majority of children were mobilized to make and/or maintain positive changes in their lives following their involvement with the mentor program. In addition, another 15% were considering making positive changes, whereas no children reported that they were uninterested in making any changes.



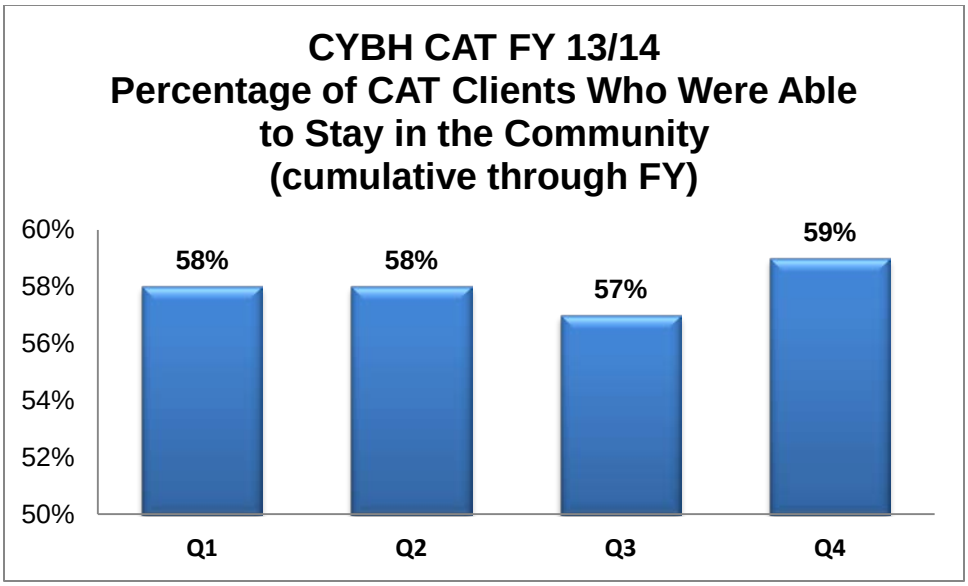
C6. Children's Centralized Assessment Team	
Estimated annual number to be served in FY 15/16	**2,140**
Annual Budgeted funds for FY 15/16	**$1,594,904**
Estimated Annual Cost Per Client	**$745**

1. Program Description

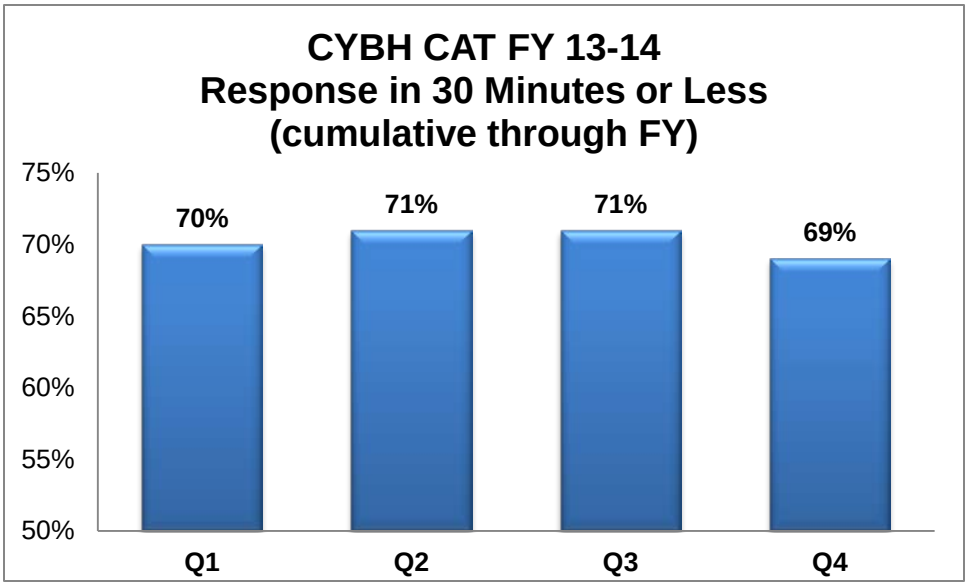
The Children's Centralized Assessment Team (CAT) responds to psychiatric emergencies for any youth under 18 years of age, anywhere in the county. The team operates 24 hours a day, 365 days per year. The scope of the CAT teams charge shifted in April 2012 when it expanded its responses to home-based assessments (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 Medi-Cal 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

One of the primary outcomes for the CAT team is the number of clients referred to services that are less restrictive than hospitalization. Many of these referrals are referred to the In-Home Crisis Stabilization Program, the Crisis Residential Program, and the various full service partnerships (FSPs), as well as more traditional outpatient programs. In FY 13/14, just under 60% of the clients seen by the CAT team were referred to services other than hospitalization. The referral rate may be accounted for by the especially high number of calls seen by CAT during this fiscal year (i.e., over 2200 calls) and because several programs that were designed to provide less-restrictive options were not operational until late in the fiscal year. With the expansion of In-home Crisis Stabilization and Crisis Residential programs, additional resources will be available for making referrals in the coming fiscal year.



In addition, the efficiency of the CAT team is measured by the amount of time between dispatch and arrival at the evaluation location. The chart below shows the percent of dispatch-to-arrival times that were 30 minutes or less during FY13/14. The goal is 70%, which was met or exceeded in three out of four quarters during FY13-14 despite the high call volume (i.e., over 2200 calls for FY13-14) and having a higher than planned staff vacancy rate during the 4th quarter.



C7. OC Children with Co-occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs, or Eating Disorders	
Estimated annual number to be served in FY 15/16	**200**
Annual Budgeted funds for FY 15/16	**$500,000**
Estimated Annual Cost Per Client	**$2,500**

1. Program Description

During the MHSA public planning process, young people with physical disease complicated by their mental health issues were identified as an un-served or underserved group. For many in this group, their mental health issues exacerbate their health condition. As a result, these youths' physical recovery is complicated by their mental health issues and may have reactions to physical health issues that exacerbate their mental health issues. Also included in this group are clients with severe eating disorders where physical deterioration is intertwined with mental health to the extent of life threatening risk. It is anticipated that many of these youth will have Medi-Cal and the MHSA funds will serve as match to draw down federal funds. This contract is currently being negotiated with a target implementation of June/July 2015.

2. Outcomes

Outcomes will be measured using the Youth Outcomes Questionnaire (YOQ), which is a 64-item measure that assesses functioning in the following domains: Intrapersonal Distress, Somatic Symptoms, Interpersonal Relations, Social Problems and Behavioral Dysfunction. The YOQ takes approximately 10 minutes to complete and is available in English, Spanish, Vietnamese, and Korean. In addition to this overall measure of functioning, symptom-specific measures (e.g., eating disorders, pain, etc.) will be administered as appropriate.

As the State develops Performance Outcomes for Medi-Cal specialty mental health services for children and youth, those measures will be incorporated into the outcome plan for this project.

C8. Children and Youth Outpatient Services Expansion	
Estimated annual number to be served in FY 15/16	**250**
Annual Budgeted funds for FY 15/16	**$500,000**
Estimated Annual Cost Per Client	**$2,000**

1. Program Description

This program expands services to children and youth from birth through 20 in the 15 contracted outpatient clinics serving Medi-Cal beneficiaries throughout Orange County. Children and youth who suffer from a wide variety of behavioral health disorders will be provided services that include individual, collateral, group and family therapy, medication management, and case management. These funds will act as a "match" to allow for drawdown of Federal Financial Participation funds, which will essentially double the number of youth served for the MHSA funds spent.

Services are needed for the following reasons:

1. Increased need for psychiatric medication management for children due to expanded benefits under the Affordable Care Act.

2. Increased caseloads due to Healthy Families transition to Medi-Cal and need for services by therapists beyond normal business hours.

3. Expanded services to foster youth under "Katie A" services.

2. Outcomes

As a result of these funds, contractors providing out-patient Mental Health Services to SED children were able to add 8 FTE direct service positions. These positions are projected to add a minimum 10,000 hours of direct services to an additional 250 clients and their families. As the State develops Performance Outcomes for Medi-Cal specialty mental health services for children and youth, those measures will be incorporated into the outcome plan for these services.

C9. Dual Diagnosis Residential Treatment	
Estimated annual number to be served in FY 15/16	**9**
Annual Budgeted funds for FY 15/16	**$300,000**
Estimated Annual Cost Per Client	**$33,333**

1. Program Description

During the community planning process, a need for additional treatment beds for adolescents who are SED and have experienced Substance Use Disorder was identified. These MHSA funds are used to supplement Block Grant funds to purchase treatment beds for youth with co-occurring issues. This level of funding provides services for about 4.5 clients in the 180 day program.

2. Outcomes

Effective treatment will be measured by retention rates (calculated by using the number of participants currently enrolled in or successfully completing the treatment program divided by the total number of participants served) and completion rates (calculated by using the number of pparticipants successfully completing the treatment program divided by the total number of pparticipants discharged).

C10. Medi-Cal Match: Mental Health Services	
Estimated annual number to be served in FY 15/16	**50**
Annual Budgeted funds for FY 15/16	**$127,500**
Estimated Annual Cost Per Client	**$2,550**

1. Program Description

In reviewing service gaps, a need to provide additional services to youth who were experiencing both SED and Substance Use Disorder (SUD) was identified. These youth were participating in residential substance abuse programs but their SED was interfering with them getting maximum benefit from rehabilitation. These dollars purchase additional group, family and individual treatment that supplement their residential services.

2. Outcomes

During FY 13/14 a total of 61 clients received just over eight hundred hours of mental health services as a supplement to their substance use rehabilitation

T1. Transitional Age Youth Full Service Partnership	
Estimated annual number to be served in FY 15/16	**900**
Annual Budgeted funds for FY 15/16	**$6,334,468**
Estimated Annual Cost Per Client	**$7,038**

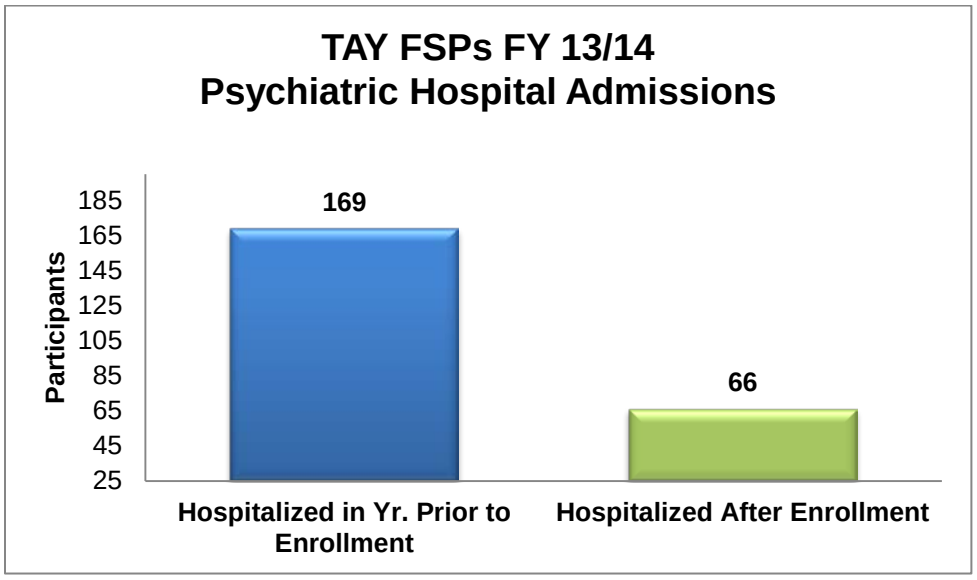
1. Program Description

The target group for these programs are youths who are 16-25 who are homeless or at risk of homelessness, who are culturally or linguistically isolated, and/or who are at risk of incarceration or psychiatric hospitalization because of mental illness, frequently complicated by substance use. There are four distinct programs within the Transitional Age Youth FSP category, which serve particular target populations. One serves a broad spectrum of youths in the community including youths experiencing a first psychotic break and former foster youth, almost all of whom are at some risk of homelessness. A second focuses on the unique needs of the Asian Pacific Islander community with particular focus on the Korean and Vietnamese populations. The third is a program designed to meet the needs of youths who have been exposed to significant rehabilitation attempts while in the custody of the Orange County Probation Department. This program focuses on maintaining the gains the youths have made and on 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 needs of a variety of youths 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 youths who are Dual status (i.e. both wards and dependents of the court). These are multi-problem youths 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 youths, this is the first time they come to the attention of the “helping system.”

Additional funds have been set aside for TAY FSPs. These dollars will be distributed among the existing programs based upon the history of program spending and the impact of shifting costs in the community. Programs will be able to serve more clients and more funds will be available to cover raising costs, especially housing.

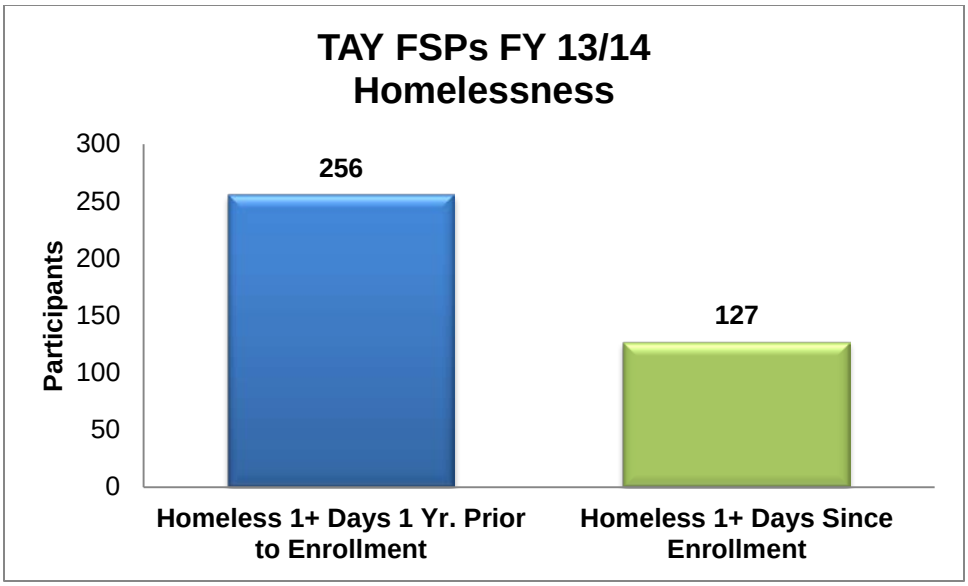
2. Outcomes

One of the primary goals of the FSPs is to reduce psychiatric hospital admissions among a group of young people who traditionally have high recidivism rates. As can be seen in the chart below, 169 out of 860 (20%) TAY were hospitalized during the year prior to enrolling in an FSP, whereas only 66 (8%) were hospitalized after enrolling in an FSP. This reflects a 61% decrease in the rate of psychiatric admissions during FY13/14.



In conjunction with the decreased hospitalization rate, there was also a 60% decrease in the total number of days TAY spent in a psychiatric hospital during FY13/14 (i.e., 4560 during the year prior to enrolling and 1395 after enrolling in an FSP).

In addition, 256 out of 860 (30%) TAY spent at least one night homeless in the year prior to enrolling in an FSP. After enrolling in an FSP, 127 (15%) TAY spent at least one day homeless, representing a 50% drop in homelessness (please see graph on next page).


TAY FSPs FY 13/14
Homelessness
Participants
300
250
200
150
100
50
0
256
127
Homeless 1+ Days 1 Yr. Prior to Enrollment
Homeless 1+ Days Since Enrollment

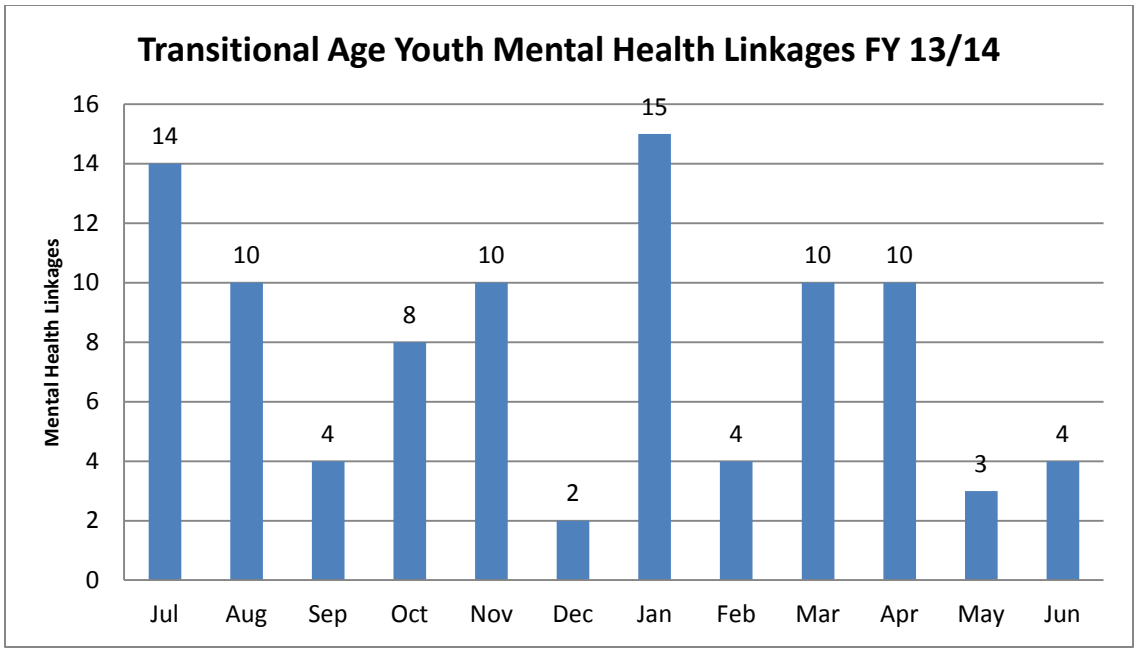
T2. Transitional Age Youth Outreach and Engagement	
Estimated annual number to be served in FY 15/16	**70**
Annual Budgeted funds for 15/16	**$128,638**
Estimated Annual Cost Per Client	**$1,838**

1. Program Description

This Outreach and Engagement program serves Seriously Mentally Ill (SMI) Transitional Age Youth 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 where a serious mental illness and homelessness (at risk) is involved. The team participates in activities throughout the county which provide greater access to the target population and increase community awareness of available services. The graph on the following page displays data on the number of successful linkages to service during FY 13/14. The number of linkages varies from two to 15 per month.


Transitional Age Youth Mental Health Linkages FY 13/14
Mental Health Linkages
16
14
12
10
8
6
4
2
0
14
10
4
8
10
2
15
4
10
10
3
4
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun

T3. Transitional Age Youth Crisis Residential Services	
Estimated annual number to be served in FY 15/16	**96**
Annual Budgeted funds for FY 15/16	**$1,198,950**
Estimated Annual Cost Per Client	**$12,489**

1. Program Description

The target population for this program is youths aged 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 and is located in a suburban community with 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 the community and more independent living.

2. Outcomes

The primary measure of program effectiveness is in keeping clients in the community and out of the hospital. The standard is no hospitalizations from admission until 60 days post discharge. In FY 13/14 this goal was achieved 86% of the time. Given the challenges of this population, this result is positive. The program also tracked the number of clients served. The Crisis program served 50 clients, considerably below the target of 78. There was significant difficulty providing safe housing for clients as they completed the Crisis phase of the program. Thus, many needed to stay longer until appropriate structured and supportive alternatives were located, thereby decreasing the total number of clients who could be served over the course of the year. In the longer term program, the target was exceeded, serving 27 clients when their goal had been 18.

T4. Transitional Age Youth Mentoring Program	
Estimated annual number to be served in FY 15/16	**80**
Annual Budgeted funds for FY 15/16	**$147,380**
Estimated Annual Cost Per Client	**$1,842**

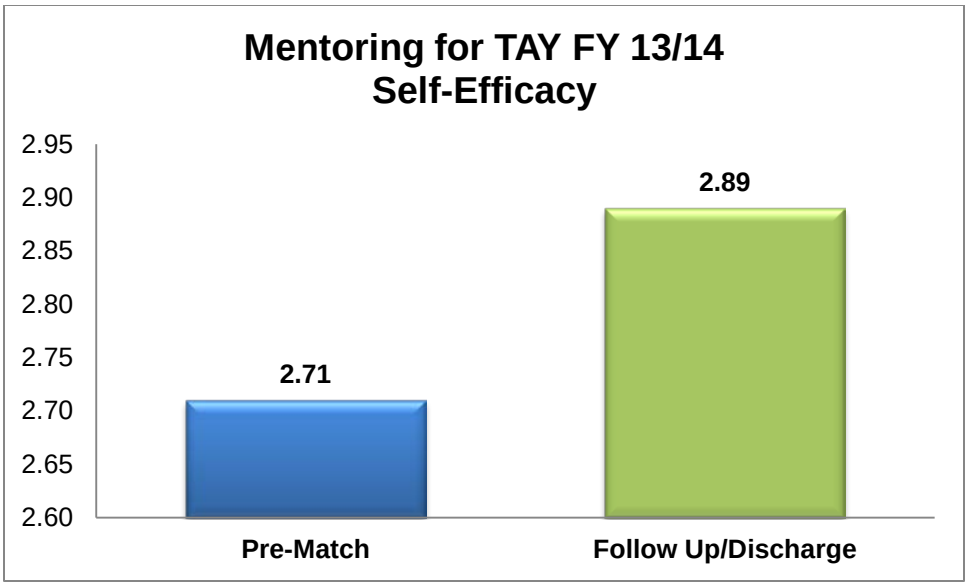
1. Program Description

This program provides mentoring services for Transitional Age Youth (TAY) between the ages of 16 and 25 who are receiving outpatient services through Children and Youth Behavioral Health (CYBH) 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.

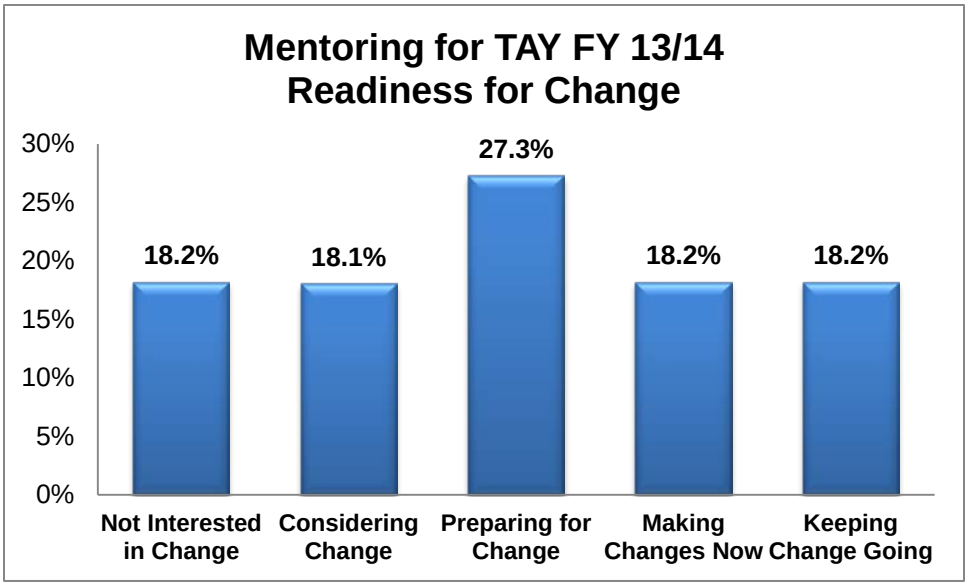
One-to-one mentoring has the potential to impact youth in a positive way. Strong relationships are formed and good mentoring practices are implemented. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youths 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. CYBH 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 youths with positive reinforcement and caring role models.

2. Outcomes

TAY in the Mentoring program complete a Resilience Scale prior to being matched with a mentor and once again after being in the program for six months (which typically coincides with discharge). As can be seen in the graph below, during FY13/14, TAY showed improvement in the self-efficacy subscale after being matched with a mentor. (Of note, over the course of FY13/14, a new version of the Resilience Survey was adopted. This new version is currently being tested for reliability, validity, and comparability to the original scale).



At discharge, therapists and/or mentors also rate TAY on their readiness for making positive changes in their behavior. At the conclusion of their matches, 36.4% of TAY were reported as currently making changes and/or keeping changes going. Another 27% were rated as preparing for positive changes and 18% were rated as considering change. Another 18% were uninterested in making changes. These findings suggest that involvement with a mentor corresponds to improvements in positive behavior.



T5. Transitional Age Youth Centralized Assessment Team	
Estimated number to be served in FY 15/16	**557**
Budgeted funds for FY 15/16	**$320,314**
Estimated Annual Cost Per Client	**$575**

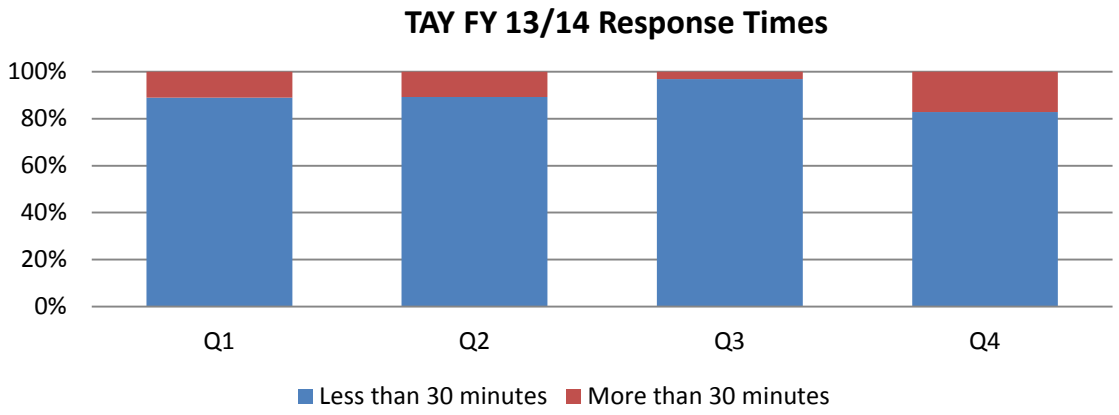
1. Program Description

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 provides crisis intervention, assessments for lower levels of care, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies. Bilingual/bi-cultural staff members 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

Transitional Age Youth CAT served 311 members during FY 13/14. The average response time was just under 20 minutes. An average 89% of the calls were responded to in less than 30 minutes. The data below is presented quarterly for FY 13/14.



T6. TAY Program of Assertive Community Treatment	
Estimated number to be served in FY 15/16	**150**
Budgeted funds for FY 15/16	**$896,092**
Estimated Annual Cost Per Client	**$5,974**

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, mentally ill adults and older adults. To qualify for PACT services, individuals have to have been psychiatrically hospitalized 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 maintain the person's stability.

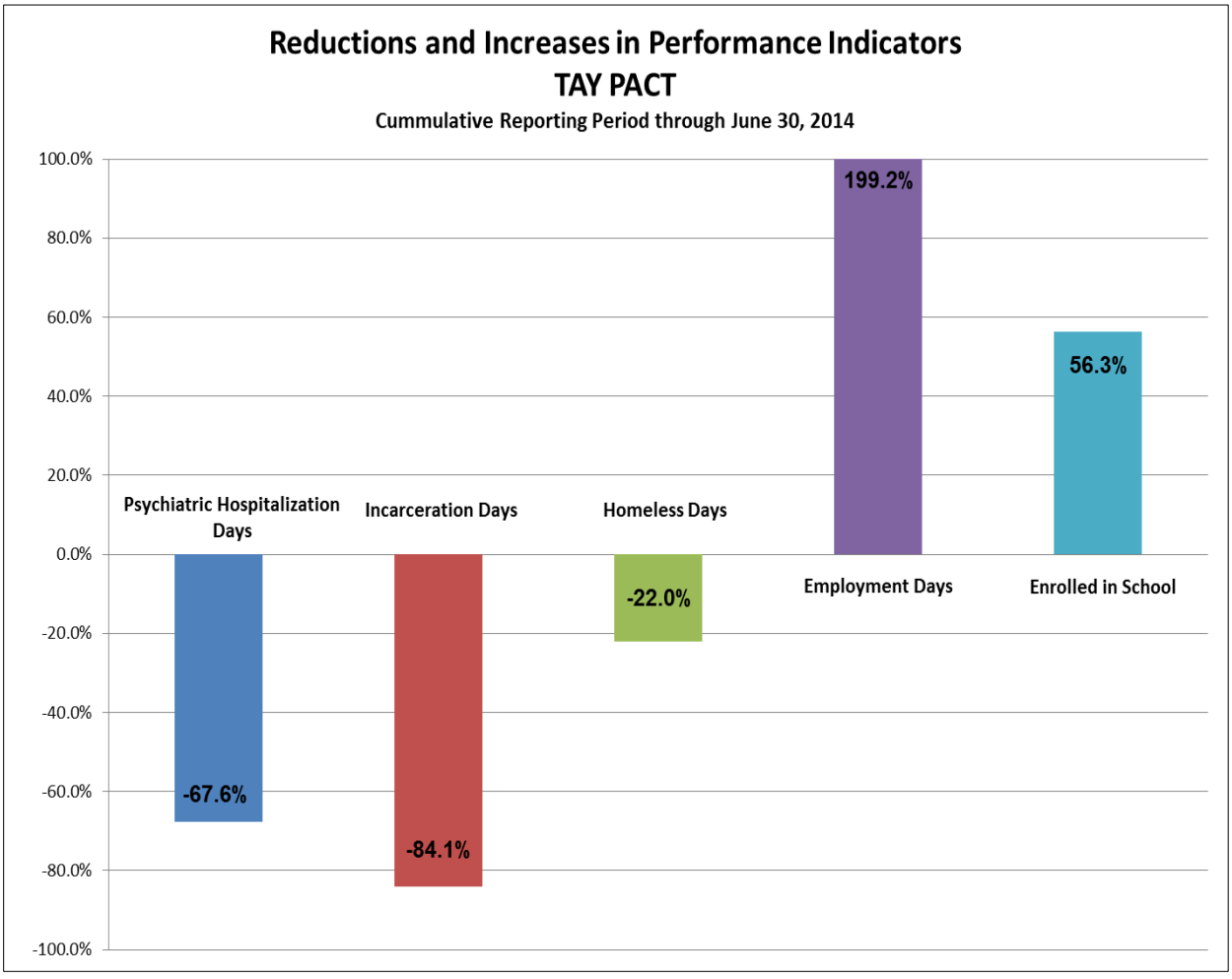
The target population for the Transitional Age Youth PACT program is diverse and includes chronically mentally ill TAY, ages 18 to 25. In particular, the program targets the underserved ethnic populations of Latinos, Vietnamese, Korean and Iranian, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing. Assertive Community Treatment is a best practices model and Orange County PACT teams work to improve 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 overcome barriers to access or engagement. 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.

The TAY population served in this program 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

TAY PACT programs served 146 clients during FY 13/14. The outcome measures for PACT remain consistent and include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness and increases in linkage to primary care. The graph below illustrates the reductions and increases of the outcome measures as of June 30, 2014.



A1. Adult Full Service Partnership	
Estimated number to be served in FY 15/16	**850**
Budgeted funds for FY 15/16	**$14,571,114**
Estimated Annual Cost Per Client	**$17,142**

1. Program Description

The MHSA Full Service Partnership (FSP) program serves adults ages 18-59. The target populations for the FSP programs are adults who are homeless or at risk of homeless; adults who have a mental illness and may also have co-occurring disorders; those being released from long-term care; those being released from jail; and those who are at risk of long jail sentences for minor crimes related to their mental illness. There are four distinct programs within the Adult FSP category, which serve particular target populations:

- The Opportunity Knocks (OK) program develops a collaborative relationship with clients who have current issues or a history with the criminal justice system, who are diagnosed with a severe mental illness, and who are homeless or at risk of homelessness.

- Telecare and Orange (TAO) is a program that serves adults who live with a persistent mental illness who are homeless or at risk of homelessness. These individuals typically have not been able to access or benefit from traditional models of treatment. TAO exists to help people living with chronic mental illness reach their full potential through a process of recovery. The mission is to deliver and manage excellent services and systems of care for people with serious mental illness. Additional funding is added for FY 14 / 15 to address the increase in referrals.

- Striving Towards Enhanced Partnerships (STEPS) is a program that serves adults with persistent mental illness coming out of residential or locked facilities and adults referred by the Mental Health Court. The program is committed to facilitating re-integration into the community, and helping clients develop the skills and supports needed to re-integrate successfully. STEPS is committed to a strengths-based approach which promotes recovery.

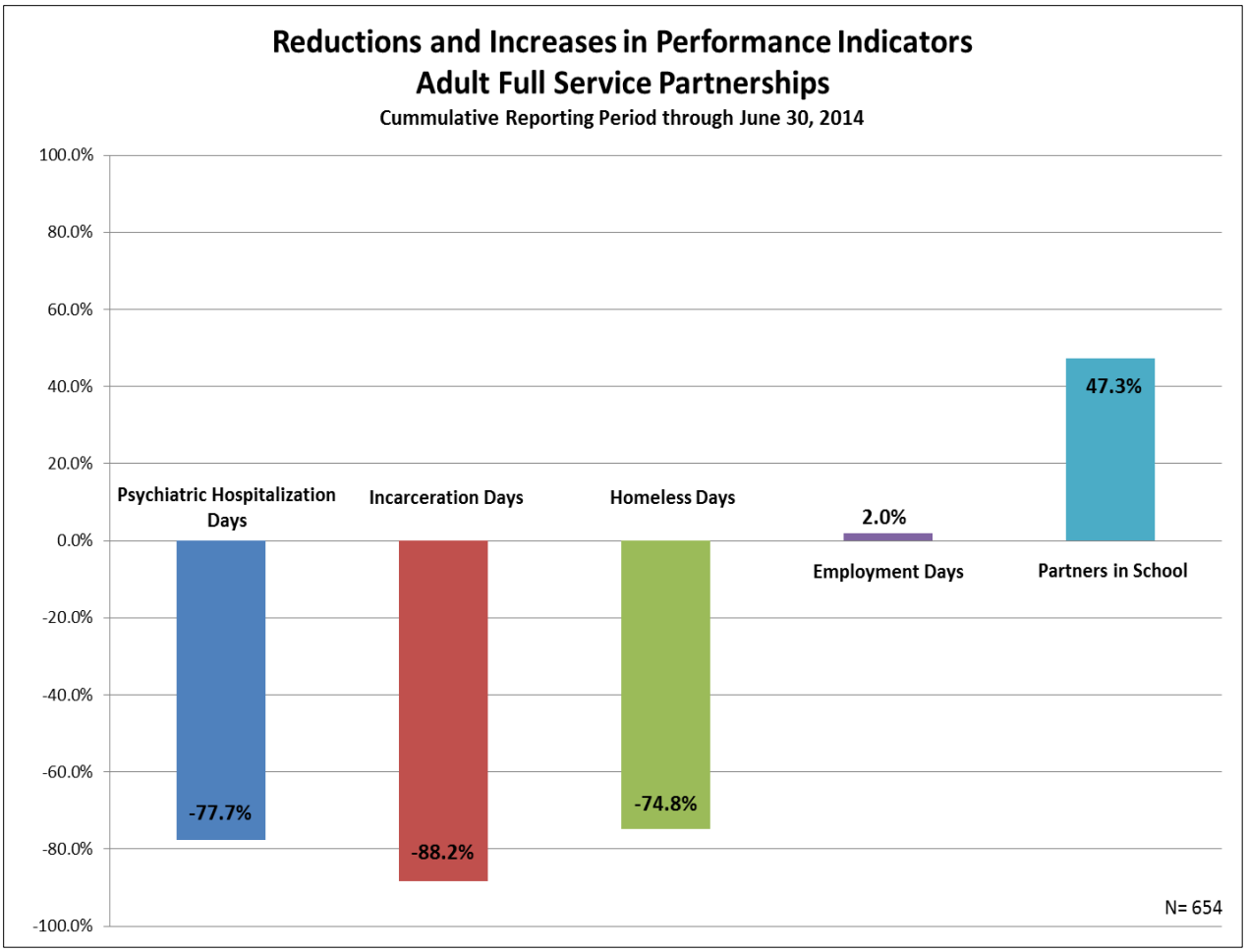
- "Whatever It Takes" Court (WIT) is a voluntary program for non-violent offenders who have been diagnosed as chronically and persistently mentally ill and who are homeless or at risk of homelessness. The participants must have a diagnosis of a mental illness and are provided with mental health counseling, psychiatric

services, drug and alcohol abuse counseling, residential treatment, safe housing, family counseling and peer mentoring. Clients are also assisted in accessing medical services, employment counseling, job training and placement, benefits and housing. The program involves frequent court appearances, regular drug and alcohol testing, meetings with the WIT Court support team and direct access to specialized services.

The adult FSP programs provide intensive case management/wrap-around-services, community-based outpatient services, peer mentoring, supportive education/employment services, transportation services, housing, benefit acquisition, and co-occurring disorder treatment. Personal Services Coordinators (PSCs) provide services to clients where they live and are available up to 24 hours a day, 7 days a week. 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 individuals who are deaf or hard-of-hearing.

2. Outcomes

The Adult FSP programs are evaluated by measuring outcomes to decrease incarcerations, hospitalizations, and homelessness and increase safe and adequate housing, employment, education and promote recovery wellness concepts. Cumulatively through June 30, 2014, clients in the Adult FSP programs had a 78% decrease in psychiatric hospitalization days and an 88% decrease in incarceration days. The graph below illustrates the reductions and increases of FSP performance indicators as of June 30, 2014.


Reductions and Increases in Performance Indicators
Adult Full Service Partnerships
Cummulative Reporting Period through June 30, 2014
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
-20.0%
-40.0%
-60.0%
-80.0%
-100.0%
Psychiatric Hospitalization Days
-77.7%
Incarceration Days
-88.2%
Homeless Days
-74.8%
2.0%
Employment Days
47.3%
Partners in School
N= 654

A2. Adult Centralized Assessment Team	
Estimated number to be served in FY 15/16	**2100**
Budgeted funds for FY 15/16	**$4,007,323**
Estimated Annual Cost Per Client	**$1,908**

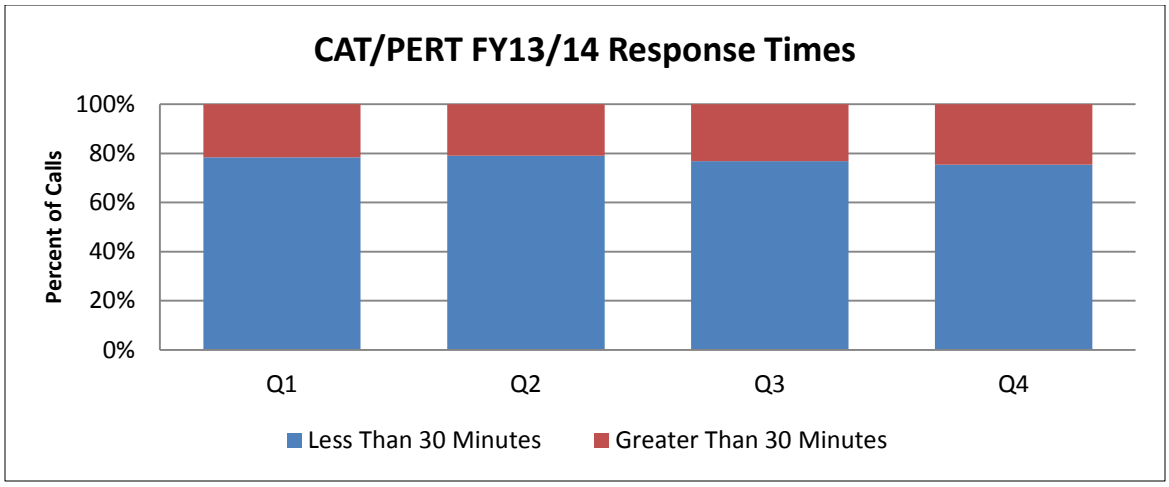
1. Program Description

The Centralized Assessment Team (CAT) provides 24-hour-mobile response services to any adult who has a psychiatric emergency. This program assists law enforcement, social service agencies and families in providing mental health crisis intervention services. CAT is a multi-disciplinary program that conducts risk assessments, initiates involuntary hospitalizations, provides resources and linkages and conducts follow up contacts for individuals evaluated. Bilingual/bi-cultural staff members work with family members to provide information, referrals and community support services.

The Psychiatric Evaluation and Response Team (PERT) is a specialized unit designed to create a mental health and law enforcement response team. While the primary purpose of the partnership is to assist mental health clients in accessing Behavioral Health Services, the PERT team also educates police on mental illness and provide them with the tools necessary to more effectively assist clients who are mentally ill. PERT provides a mental health clinician to ride along with a police officer to provide prompt response to mental health clients, assess the needs of individuals, and provide them with the appropriate care and linkages to other resources as needed in a dignified manner. During 2013, the PERT program significantly expanded, so 2014 represented the first full year operating a total of nine PERT teams in service to the County of Orange. During the year, PERT teams provided 15 trainings to various police and fire departments throughout Orange County.

2. Outcomes

CAT & PERT served 2,855 members during FY 13/14. The percent of total crisis response interventions from hospitalization continues to be monitored regularly. For FY 13/14 the average response time was just under 20 minutes, with 83% of calls responded to in less than 30 minutes. The graph below shows quarterly response time data for FY 13/14.


CAT/PERT FY13/14 Response Times
Percent of Calls
100%
80%
60%
40%
20%
0%
Q1
Q2
Q3
Q4
Less Than 30 Minutes
Greater Than 30 Minutes

A3. Adult Crisis Residential	
Estimated number to be served in FY 15/16	**325**
Budgeted funds for FY 15/16	**$2,251,229**
Estimated Annual Cost Per Client	**$6,927**

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 having clients take responsibility for their illness and reintegrate 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.

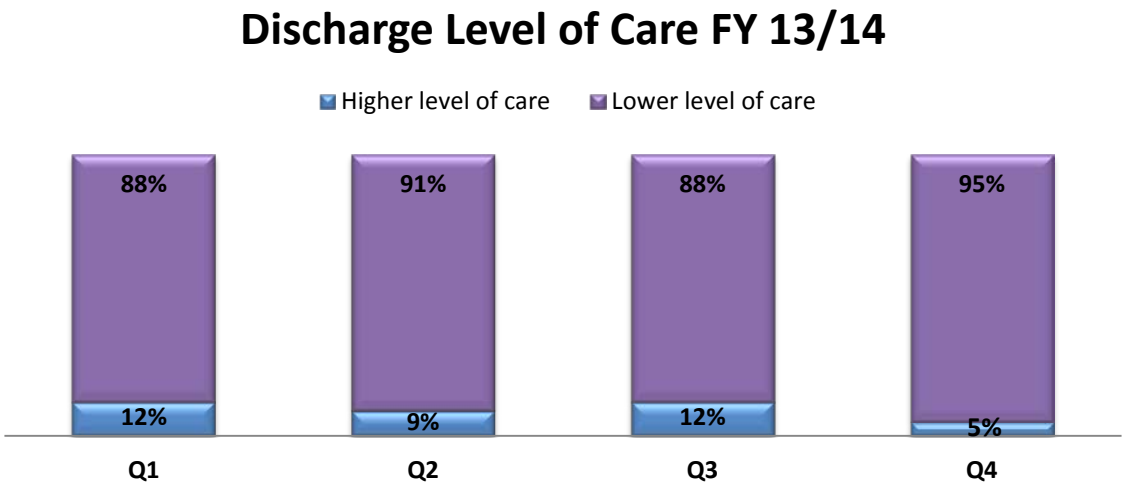
The Crisis Residential Program also provides assessment and treatment services that include individual and group counseling; monitoring psychiatric medications; substance abuse education and treatment; and family and significant-other involvement whenever possible. Each client admitted to the Crisis 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 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 who also have substance use or abuse issues. These are clients who otherwise may have been admitted to an emergency room or hospitalized.

The capacity of the program expanded from six adults to fifteen adults in FY 12/13.

2. Outcomes

The program served 379 (unduplicated) members during FY 13/14. Eighty-eight percent were discharges to a lower level of care and 98% did not require hospitalization within 48 hours of discharge. From total discharges, 84% of clients were linked to a provider. The occupancy rate for the program was an average of 83% for the fiscal year.



A4. Supported Employment	
Estimated number to be served in FY 15/16	**350**
Budgeted funds for FY 15/16	**$1,021,417**
Estimated Annual Cost Per Client	**$2,918**

1. Program Description

The Supported Employment program provides evidence-based services which include job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, 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, Korean, Farsi and American Sign Language.

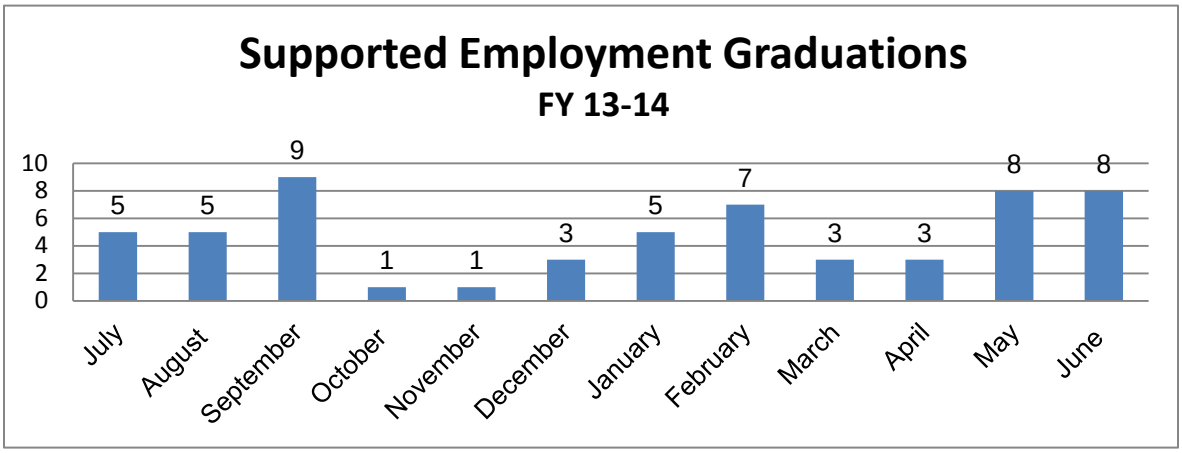
Each individual placed into competitive employment has the ongoing support of an Employment Specialist (ES). Program participants work with the ES to locate job leads using a variety of sources including in-the-field employer canvassing, newspaper publications, online job search engines, job fairs, business mixers, regional job developer conferences and recruitments. The ES 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 ES to help the employer understand mental illness and combat stigmatization. In addition to locating promising job leads and potential employers, the ES assists consumers with application submissions and assessments, interviewing, image consultation and transportation services.

The ES is responsible for providing the consumer with one-on-one job support to ensure successful job retention. Specifically, the ES 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 ES maintains ongoing, open communication with clinical care coordinators to promote positive work outcomes.

2. Outcomes

The Supported Employment Program served 371 participants in FY 13/14, which included 262 new enrollments. During FY 13/14, the program placed 145 program participants in employment. Additionally, 58 program participants

graduated from the program after successfully reaching the State of California's job retention benchmark which is greater than 90 days in paid employment.



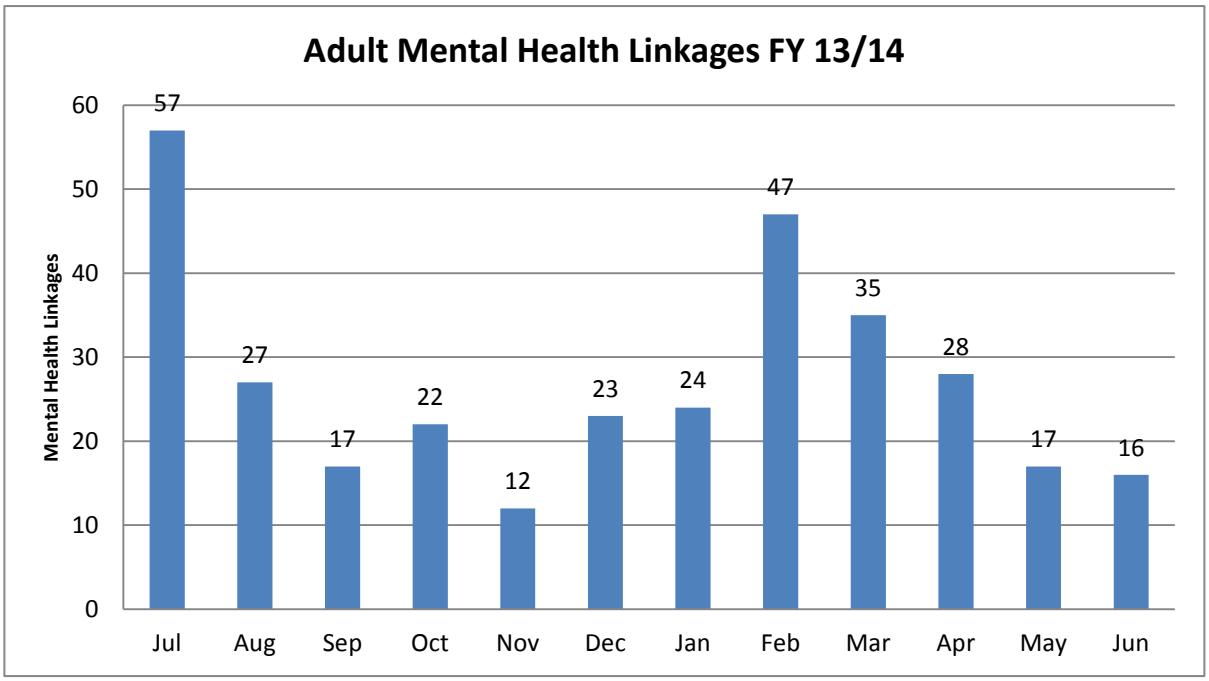
A5. Adult Outreach and Engagement	
Estimated annual number to be served in FY 15/16	**150**
Annual Budgeted funds for 15/16	**$517,701**
Estimated Annual Cost Per Client	**$3,451**

1. Program Description

This Outreach and Engagement (O & E) 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 behavioral health services which may include; full service partnerships, outpatient 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 where a serious mental illness and homelessness (at risk) is involved. The team participates in activities throughout the county which provide greater access to the target population and increase community awareness of available services. The graph on the following page displays data on the number of successful linkages to service during each month in FY 13/14. The number of linkages to any mental health or supportive service varies from 12 per month to 57 per month.


Adult Mental Health Linkages FY 13/14
Mental Health Linkages
60
50
40
30
20
10
0
57
27
17
22
12
23
24
47
35
28
17
16
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun

A6. Adult Program of Assertive Community Treatment	
Estimated number to be served in FY 15/16	**850**
Budgeted funds for FY 15/16	**$9,731,926**
Estimated Annual Cost Per Client	**$11,449**

1. Program Description

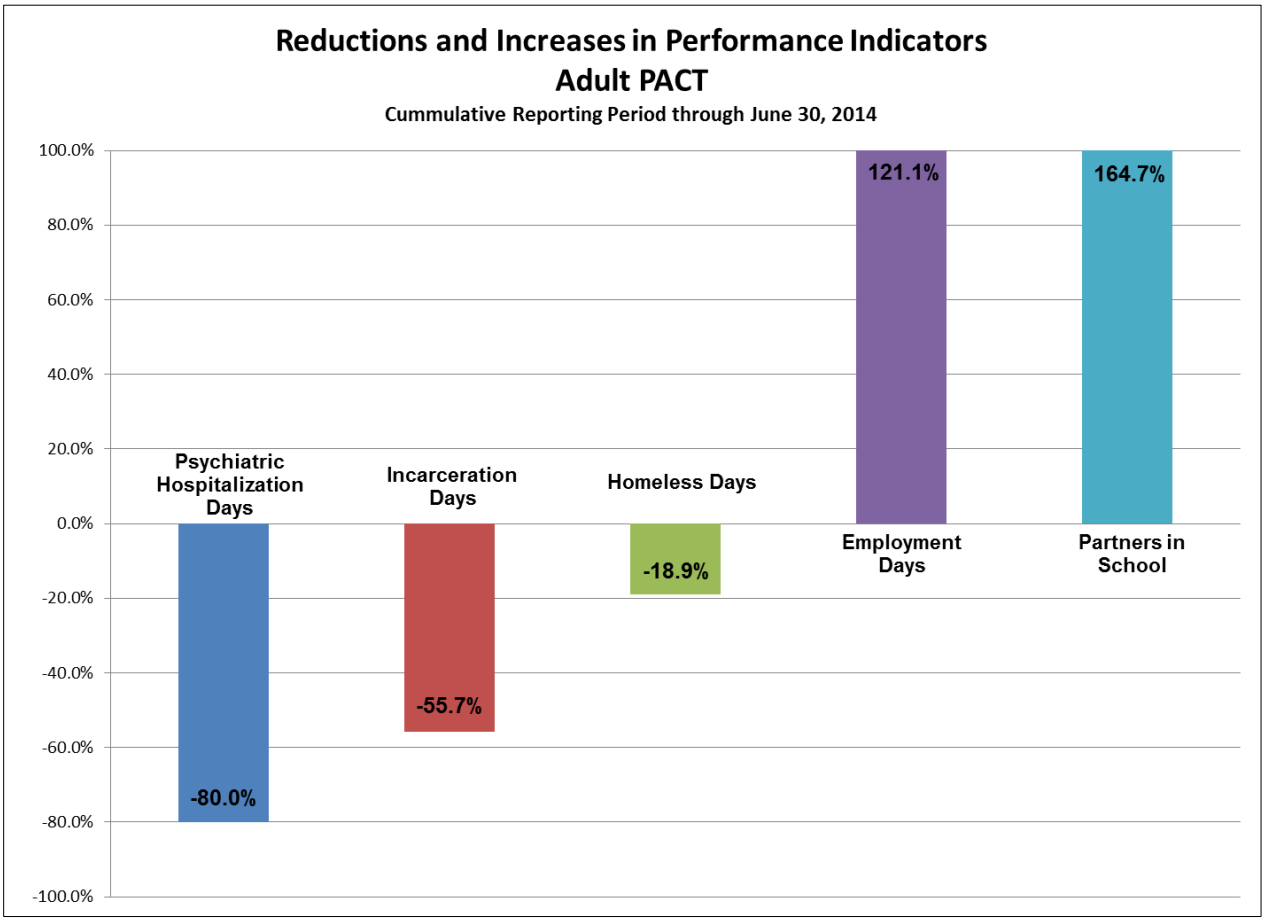
The Adult Program of Assertive Community Treatment (PACT) in Orange County targets high-risk or at-risk underserved populations, such as the monolingual Pacific Asian community and adults who have a chronic mental illness. Individuals qualifying for PACT services have been psychiatrically hospitalized multiple times in the last year. In addition, treatment at a lower level of care has failed to keep the person engaged in services. PACT teams serve consumers who are most in need of treatment 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 ensure 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, with 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.

This program was expanded in FY 14/15 to serve additional clients. The caseload ratios remain at 1:15 in order to effectively provide the high level of services consistent with the Assertive Community Treatment model.

2. Outcomes

Adult PACT programs served 525 clients during FY 13/14. The adult PACT program continues to focus on measuring outcomes, which include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness and increases in linkage to primary care. The graph below illustrates the reductions and increases of the outcome measures as of June 30, 2014.



A7. Wellness Center – North County	
Estimated number to be served in FY 15/16	**2,100**
Budgeted funds for FY 15/16	**$1,469,448**
Estimated Annual Cost Per Client	**$700**

1. Program Description

The Wellness Center's mission is to provide a safe and nurturing environment for each member 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 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 have a co-occurring disorder;

2. Relatively stable and actively working on their recovery

3. Require a support system to succeed in remaining stable while continuing to progress in their recovery.

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 will provide 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: peer supports, social outings, and recreational activities. Services are provided by clients or those with lived experience with mental illness. 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 or those with lived experience with mental illness. 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.

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

2. Outcomes

The Wellness Center had 1,908 members actively participate during fiscal year 13/14.

The following outcomes are newly established, and no data is available for reporting at this time. It is anticipated that data will be available to report for fiscal year 2014-2015.

1. Achieve monthly participation by 30 or more active members in community integration activities. Community integration activities include attending DBSA and Self-Empowerment groups in South county, NAMI walk, Getty Museum outing, Celebration Recovery picnic, bowling, movies and beach picnics.

2. Achieve monthly participation by active members in two or more groups or activities offered either at the Center of in the community.

3. Achieve annual member employment, paid or volunteer, of a minimum of 100 members as a result of skills learned in employability classes provided by the program as well as participation in the annual Job Fair sponsored by the program.

4. Achieve annual enrollment of a minimum of 50 members in education classes offered at local community colleges, the Education Center at Tustin Campus, or other education setting as a result of educational training groups/classes provided by the program

A7. Wellness Center – Expansion	
Estimated number to be served in FY 15/16	**TBD**
Budgeted funds for FY 15/16	**$1,500,000**
Estimated Annual Cost Per Client	**TBD**

1. Program Description

The county has had a Wellness Center operating in North Orange County for several years. Clients living in other parts of the county had difficulty accessing the services due to distance from residence and lack of transportation. During the planning process for FY 14/15, the need for an expansion of this program into other parts of the county was identified. This program expansion will become operational as a provider and site are established. The description below is based on the current model being used in North Orange County.

The Wellness Center's mission is to provide a safe and nurturing environment for each member 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 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 have a co-occurring disorder;

2. Relatively stable and actively working on their recovery;

3. Require a support system to succeed in remaining stable while continuing to progress in their recovery.

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 will provide 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: peer supports, social outings and recreational activities. Services are provided by clients or those with lived experience with mental illness. 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 or those with lived experience with mental illness. 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.

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

2. Outcomes

Proposed outcomes include the following:

1. Achieve monthly participation by 15 or more active members in community integration activities.

2. Achieve monthly participation by active members in 2 or more groups or activities offered either at the center or in the community.

3. Achieve annual member employment, paid or volunteer, of a minimum of 15 members as a result of skills learned in employability classes provided by the program as well as participation in the annual Job Fair sponsored by the program.

4. Achieve annual enrollment of a minimum of 15 members in education classes offered at local community colleges, the Education Center at Tustin Campus, or other education setting as a result of education training groups/classes provided by the program.

5. Achieve annual participate by a minimum of 30 members in facilitating all or portions of community meetings.

A8. Recovery Centers	
Estimated number to be served in FY 15/16	**3,000**
Budgeted funds for FY 15/16	**$8,658,531**
Estimated Annual Cost Per Client	**$2,886**

1. Program Description

The Recovery Center program provides a lower level of care for consumers who no longer need traditional outpatient treatment, but need to continue receiving medication and case management support. This program allows diverse consumers to receive distinct, mostly self-directed services that focus on 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 in which 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. 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

The Recovery Centers served 3,042 consumers during fiscal year 2013/2014. The programs have maintained a hospitalization rate of less than 1%. The program had a 0.6% hospitalization rate for FY 13/14. The Recovery Centers have shown consistent movement in graduations from their programs with 130 graduations during FY 13/14.

A9/O4. Adult and Older Adult Peer Mentoring	
Estimated number to be served in FY 15/16	**400**
Budgeted funds for FY 15/16	**$1,124,888**
Estimated Annual Cost Per Client	**$2,812**

1. Program Description

The Adult and Older Adult Peer Mentoring program was created to build community support services that bridge existing gaps in the recovery continuum. The Adult and Older Adult Peer Mentoring Program pairs qualified, culturally/linguistically competent peers, with individuals in psychiatric hospitals, who are preparing to be discharged, and assists them in successfully transitioning back to the community, and successfully linking with outpatient treatment providers. In addition, the peers work with individuals who are at risk of being hospitalized, and provide them with additional intensified support to assist them in gaining their independence at home. With the Older Adult population, individuals who frequent the emergency rooms or excessively call 911 due to behavioral health issues are also appropriate for peer mentoring.

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. Services are timely, and typically take place in the field: such as in the individual's home, a hospital, Dr.'s office, treatment facility, or community resource. The field work helps to engage individuals and reduce access barriers. Peer Mentors provide social support, assistance with basic household items, food, clothing, and transportation needs to facilitate successful reintegration into the community. This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian, as well as non-English-speaking monolingual individuals, and individuals who are deaf and hard of hearing.

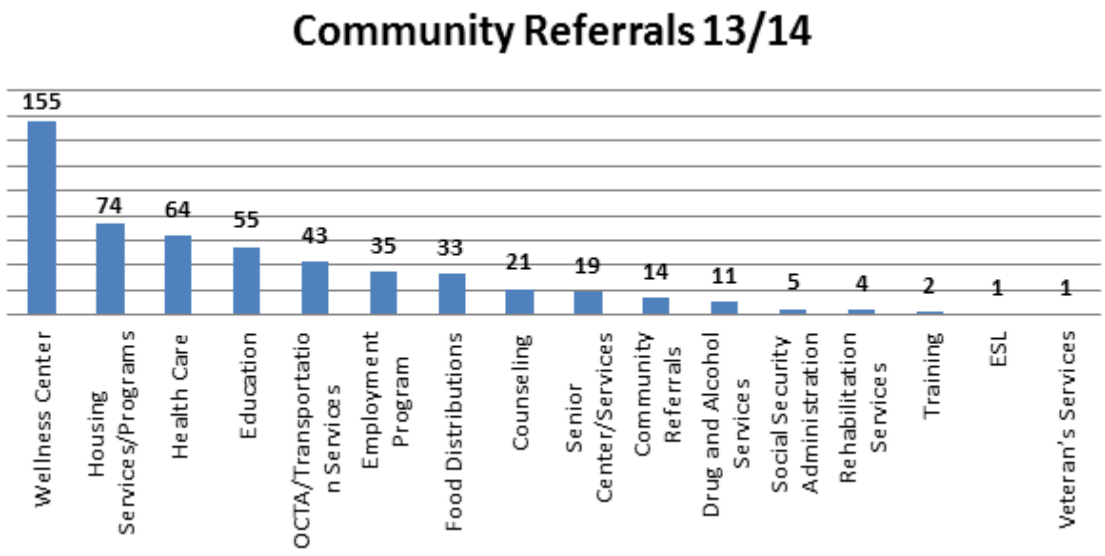
Peer Mentors support the individual's recovery goals and therapeutic needs. Examples of activities include: helping clients get to the first appointment; meeting with the individual's assigned care coordinator or psychiatrist; assisting clients in picking up prescribed medications at a local pharmacy; and encouraging (and at times participating) in their recovery activities. Peer Mentors 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

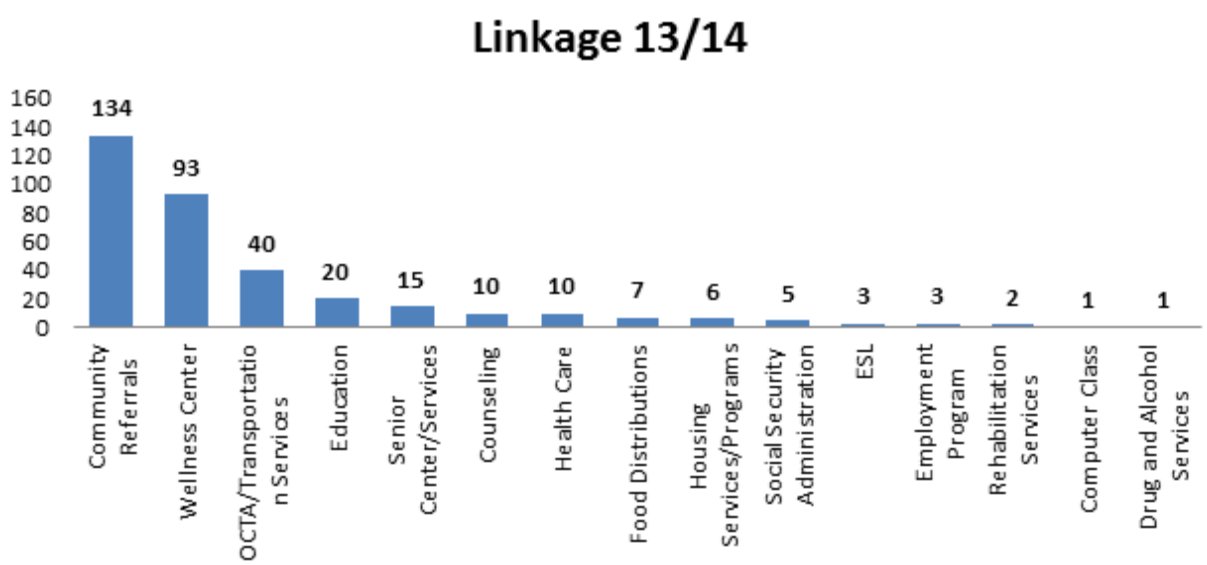
flexibility and rotational on-call in the evening and one weekend approximately every two months.

2. Outcomes

The Peer Mentoring program identified three primary outcomes which included reduction of hospitalizations, actively using community resources, and participation in self-sufficient activities. Outcome data for the reduction of hospitalizations, and participation in self-sufficient activities, was being collected and verified and would have been reportable beginning July 2014, however, the contract expired in June 2014, and only the outcome data for the utilization of community resources was available at that time.

During FY 13/14, Adult Peer Mentoring program served 244 clients.
The graphs below display the outcomes for consumers using community resources and identify the community referrals provided to those consumers, and the linkages actually made during fiscal year 13/14. These referrals and linkages are crucial in facilitating the consumer's re-integration into the community and participation in self-sufficient activities. Results displayed are for Adults and Older Adults combined.




Linkage 13/14
160
140
120
100
80
60
40
20
0
134
93
40
20
15
10
10
7
6
5
3
3
2
1
1
Community Referrals
Wellness Center
OCTA/Transportation Services
Education
Senior Center/Services
Counseling
Health Care
Food Distributions
Housing Services/Programs
Social Security Administration
ESL
Employment Program
Rehabilitation Services
Computer Class
Drug and Alcohol Services

A10. Assisted Outpatient Treatment	
Estimated number to be served in FY 15/16	**125**
Budgeted funds for FY 15/16	**$4,436,820**
Estimated Annual Cost Per Client	**$35,495**

1. Program Description

On May 13, 2014, the Board of Supervisors adopted the resolution to authorize implementation of Assisted Outpatient Treatment (AOT). The law creates an Assisted Outpatient Treatment program that provides court-ordered treatment for persons with severe mental illness who meet certain criteria. This program was operational as of October 1, 2014.

A person subject to AOT must live in the County and have a history of not participating in needed mental health treatment. The person must be unlikely to survive safely in the community without supervision, based on an investigation and resultant clinical determination. All persons placed on AOT must meet threshold criteria: the person's mental illness (1) has twice been a factor leading to psychiatric hospitalizations or incarcerations within the prior 36 months, or (2) has resulted in one or more actual or attempted serious acts of violence toward self or others within the prior 48 months.

If the criteria are satisfied, the County Mental Health Director or designee may file a certified petition with the court indicating that AOT is needed to help prevent relapse or deterioration that would likely result in grave disability or serious harm to self or others. Such a petition must establish that the person has been offered an opportunity to voluntarily participate in a treatment plan but continues not to engage in treatment and is deteriorating.

Legislation specifies that certain individuals can request an AOT evaluation. These include (1) immediate family members, (2) adults residing with the individual, (3) a hospital director or licensed mental health professional treating the individual, or (4) a peace officer, parole or probation officer supervising the individual. Once an AOT order has been issued, a treatment plan for the client is developed. The order is good for six months and can be renewed at that time if the criterion is still met.

2. Outcomes

As of March 26, 2015, there have been 228 referrals and 482 inquiries (request for information only) from the community. Of the referrals, only one client has gone through the AOT petition process which was resolved by settlement agreement where the client agreed to voluntarily enter services rather than having a court hearing. In addition, 51 clients have voluntarily accepted services of the 228 referred. The proposed outcome measures will be consistent with the Full Service Partnership and PACT programs and include reduction of hospitalizations, reduction of incarcerations, and reduction of homelessness.

Referrals Received: **228**
Continue to be outreached and assessed (active): **27**
Settlement Agreement: **1**

Accepted Voluntary Services	
FSP Services	46
County Behavioral Health Clinic	4
Community Services	1
Total	**51**

Other Referral Dispositions	
AOT Criteria Not Met and Referral Provided	47
Unable to Locate	50
Engaged in Services Prior to Referral	23
Extended Hospitalization	13
Extended Incarceration	13
Referral Withdrawn	2
Unable to Substantiate Petition	1
Total	**149**

A11. Mental Health Court – Probation Services

Estimated number to be served in FY 15/16	**216**
Budgeted funds for FY 15/16	**$696,000**
Estimated Annual Cost Per Client	**$3,222**

1. Program Description

The Collaborative Court Programs use a team approach to decision making, and include the participation of a variety of different agencies, such as Probation and mental health treatment providers. They involve active judicial monitoring and a high level of treatment.

This program provides support to the probation department for their participation in the mental health collaborative courts. It allows five probation officers to be dedicated to the mental health collaborative court members, and work in conjunction with the full service partnerships and county staff to support recidivism reduction efforts. The probation officers provide evaluations, drug testing, field visits and searches, participate in treatment meetings, and offer Cognitive Behavioral Training.

The target population for this program is individuals in the mental health collaborative court programs. These individuals have an identified chronic mental illness, have often times been homeless or at risk of homelessness, and have had at least one incarceration due to their mental illness. Many times the members have co-occurring substance abuse issues and are appropriate for the full service partnership or PACT level of care.

Below is a brief description of each of the Collaborative Court programs offered by the County of Orange:

Opportunity Court and Recovery Court

Opportunity Court and Recovery Court are voluntary programs for individuals who as a result of their chronic, persistent mental illness are unable to comply with the requirements of another program. Opportunity and Recovery Court program involves frequent court appearances, weekly meetings with the Probation Officer and Health Care Coordinator, mental health treatment, medication monitoring, drug and alcohol testing. Participants are also assisted in accessing medical services, employment counseling, job training and placement, benefits, and housing.

WIT Court

WIT "Whatever It Takes" Court is a voluntary program for non-violent offenders, who have a diagnosis of a mental illness and are provided with mental health counseling, psychiatric services, drug and alcohol abuse counseling, residential treatment, safe housing, family counseling and peer mentoring. Members are also assisted in accessing medical services, employment counseling, job training and placement, benefits, and housing. The program involves frequent court appearances, regular drug and alcohol testing, meetings with the WIT Court support team, and direct access to specialized services.

2. Outcomes

The probation-specific outcomes for these collaborative courts include monitoring jail days avoided, prison days avoided and monitoring results of drug and alcohol testing. All collaborative court clients are enrolled in either a PACT or Full Service Partnership. The information listed in the table below is for July1, 2014 through December 31, 2014.

Court	Jail Bed Days Saved	Prison Bed Days Saved	% Positive Drug Test
WIT Court	852	481	0.7%
Opportunity Court	180	0	0.4%
Recovery Court	517	0	0.2%

A12. Drop in Center – Civic Center

Estimated number to be served in FY 15/16	**300**
Budgeted funds for FY 15/16	**$500,000**
Estimated Annual Cost Per Client	**$1,667**

*In the table above, the annual estimated number to be served in FY 15/16 is identified. The actual number to be served will likely be less than this during this initial year of operation due to the program start-up process, including contract procurement and hiring staff . The exact numbers to be served will depend on the program implementation date.

1. Program Description

This is a new program. There is an overflow of homeless mentally ill individuals who congregate in the Civic Center area. Although there is another Drop-In Center in Santa Ana, it is difficult for homeless people to get there with all their possessions. An alternative Drop-In Center is needed to provide day time services and linkages to community supportive services for these individuals.

The alternative site in close proximity to the Civic Center area would provide the following services during the day:

a. Assessment of basic needs
b. Breakfast, lunch and snacks
c. Safe resting area
d. Secure location to keep belongings while there during the day
e. Showers
f. Clothing supply and laundry facilities
g. Personal hygiene items
h. Mailing address
i. Housing assistance
j. Employment assistance
k. Substance abuse assistance
l. Socialization opportunities and activities
m. Bus passes
n. Additional services as identified

2. Outcomes

This program is not yet implemented. The following outcome measures are proposed:

- Refer 100% of program participants to individually assessed community services.
- Successfully link 50% of participants to community behavioral health services.

A13. Housing for Homeless

Estimated number to be served in FY 15/16	**24 minimum**
Budgeted funds for FY 15/16	**$1,000,000**
Estimated Annual Cost Per Client	**$41,667**

*In the table above is the annual estimated number to be served in FY 15/16. The actual number to be served will likely be less than this during this initial year of operation due to the program start-up process, including contract procurement and hiring staff. The exact numbers to be served will depend on the program implementation date

1. Program Description

This program will provide interim housing (three to 18 months) for up to six individuals who are identified as severely and persistently mentally ill and homeless. Additionally, these individuals may have co-occurring medical issues that make them more fragile and at greater risk if left on the streets. County outreach teams working with the homeless will make referrals to the program.

Criteria will be developed similar to that used by Skid Row Housing Trust in Los Angeles, which was very successful at identifying the most fragile homeless individuals who were using the most public services while unhoused. This program surveyed the homeless people on the streets for the frequency of utilization of public services such as hospitals, jails, and shelters, and also assessed risk factors such as health indicators, length of time on the streets, and age. They then focused their efforts on permanently housing these homeless people first, working with them in targeted ways to accept the housing and begin their recoveries. It has been found that targeted outreach of this type coupled with housing results in significant savings of public resources such as emergency rooms, jails, and shelters.

Residents will have case management and psychiatric services provided by county or county-contracted programs attached to each participant. A nurse would visit the facility to ensure compliance with medication and other health regimens. The financing would be used to secure a residence and furnishings, hygiene and living necessities, and basic stocks of food. The treatment emphasis would be on medical and psychiatric stabilization and life skills/independent living.

There will be initial costs associated with leasing and furnishing the home. A replacement reserve will be maintained to replace furniture and other objects in

the house as needed. In addition some funding will be reserved for resident activities, transportation, food, supplies, etc. The assumption is that as people improve their independent living skills they will improve in the area of money management and require less assistance providing for basic needs.

A committee of community partners will be created to further develop this housing component.

2. Outcomes

The program is not yet implemented. The following outcome measures are proposed.

- Utilization of public services, such as jails, hospitals, etc. will decline significantly.
- Clients will be linked to permanent housing once they exit the program.

A14. Housing and Year-round Emergency Shelter

Estimated number to be served in FY 15/16 **100 unduplicated**

Budgeted funds for FY 15/16	**$1,367,180**
Estimated Annual Cost Per Client	**$13,672**

*In the chart above is the annual estimated number to be served in FY 15/16. The actual number to be served will likely be less than this during this initial year of operation due to the program start-up process, including contract procurement and hiring staff. The exact numbers to be served will depend on the program implementation date.

1. Program Description

The County of Orange is limited to seasonal sheltering capacity for the homeless population. The 2013 Point in Time study estimated a total annual homeless census in OC of 12,707 who spend at least one night either sheltered or unsheltered without having a permanent residence. This is an extrapolation from the 4,251 that were located during the one night physical count. Of these, 480 were determined to be severely mentally ill.

The community would like to have a year round program coupled with onsite services to provide shelter and the possibility of longer term solutions for those living on the streets, river beds, and other locations unfit for human habitation in OC. The task force for the Ten Year Plan to End Homelessness has been working to establish a year-round shelter. Recently, the MHSA Steering Committee voted to dedicate some new CSS funding to guarantee some of the planned shelter's capacity is reserved for the mentally ill homeless.

The County of Orange's Ten Year Plan to End Homelessness has been working to establish a year-round shelter for all homeless individuals. This funding will be folded into that effort in order to secure beds for the mentally ill homeless. This effort is consistent with HUD's plan to shorten shelter stays and move people more quickly into permanent housing.

The estimated length of stay per client for each episode of shelter housing is seven days. The cost estimates are based on 15 dedicated beds at any one time, with the option of more if needed.

2. Outcomes

The program is not yet implemented. The following outcome measures are proposed.

- Temporary housing and an evening meal for approximately 15 individuals with serious and persistent mental illness per night.
- A minimum of 50% of SPMI participants will be connected with permanent housing upon exiting the shelter program.

A15. Transportation	
Estimated number to be served in FY 15/16	**300**
Budgeted funds for FY 15/16	**$1,000,000**
Estimated Annual Cost Per Client	**$3,333**

*In the table above is the annual estimated number to be served in FY 15/16. The actual number to be served will likely be less than this during this initial year of operation due to the program start-up process, including contract procurement and hiring staff. The exact numbers to be served will depend on the program implementation date.

1. Program Description

This program will provide countywide transportation services for consumers who require assistance in transportation to get to medical appointments and other services available through Behavioral Health that may be otherwise difficult to access. Clients will be able to have transportation to and from the various programs that are needed to help them to manage their behavioral health treatment and enhance their progress in recovery. The programs where members could be transported to may include, but not necessarily be limited to, Outpatient Behavioral Health Clinics, Recovery Centers, Wellness Centers, Tustin Mental Health Campus, Older Adult Services, PACT Programs and other Behavioral Health Services. These services will be provided with vans.

2. Outcomes

The program is not yet implemented. The following outcome measures are proposed:

- Improved timeliness to appointments
- Reduction in “no shows”
- Increase consumer’s self-sufficiency in transportation

A16. Adult/TAY In-Home Crisis Stabilization	
Estimated number to be served in FY 15/16	**300**
Budgeted funds for FY 15/16	**$1,500,000**
Estimated Annual Cost Per Client	**$5,000**

*In the table above is the annual estimated number to be served in FY 15/16. The actual number to be served will likely be less than this during this initial year of operation due to the program start-up process, including contract procurement and hiring staff. The exact numbers to be served will depend on the program implementation date.

1. Program Description

This program will provide 24/7 in-home crisis response, short term in-home therapy, case management, and rehabilitation services, with a focus on maintaining family stabilization and preventing hospitalization and/or out-of-home placement. This innovative approach to addressing crisis situations has been very successful when children and adolescents are in crisis and will have considerable applicability for adults who are living at home. It is an option that is not presently available and a viable alternative to hospitalization.

The target population is adults aged 18 and older who are being considered for psychiatric hospitalization, but who don't meet criteria for admission. An evaluation will be provided by Adult services to determine if the individual meets the target population. The crisis stabilization team will 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. The team will target a brief intervention period usually three weeks, occasionally extending to six. The In-Home Crisis Stabilization Team will help the family and individual develop coping strategies and linkages to on-going support.

2. Outcomes

The anticipated program outcome is for clients and their families to adaptively function at a higher and more productive level in the community. This will be measured by the number of clients who are not psychiatrically hospitalized during their time in the program and for 60 days after discharge from the program.

A17. Volunteer to Work	
Estimated number to be served in FY 15/16	**100**
Budgeted funds for FY 15/16	**$541,510**
Estimated Annual Cost Per Client	**$5,415**

*This project was recommended by the MHSA Steering Committee for 1-year of additional funding under CSS.

1. Program Description

See description on page 190 in Innovation Group 1.

O1. Older Adult Mental Health Recovery Program	
Estimated number to be served in FY 15/16	**545**
Budgeted funds for FY 15/16	**$1,668,135**
Estimated Annual Cost Per Client	**$3,061**

1. Program Description

The Older Adult Recovery Program serves individuals 60 years of age or older who are living with persistent mental illness. At times, the program will take individuals under 60 years and of age due to medical conditions or the client being homebound. The Recovery Program provides the initial Mental Health Assessment in the consumer's home, hospital or location of clients' preference. As the program follows up with clients, they are seen at the location that is most convenient for the client. Participants have access to case management, crisis intervention, medication monitoring, and therapy (individual, group, and family) services.

This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian as well as non-English-speaking monolingual individuals and individuals who are deaf and hard of hearing. The target population struggles with acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. 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

In FY 13/14, the program refined the targeted goals and data gathering procedures, and developed a new database to track the outcomes. The three primary goals identified were: to decrease depression in older adults, increase access with primary care, and improve level of recovery. The program utilizes the PHQ-9 to measure depression, using nursing assessments to assess linkage to primary care and the Milestones of Recovery Scale (MORS) to assess level of recovery. MORS is a recovery based evaluation tool in which there are eight levels. The score reflects where an individual is in his or her process of recovery at the time of the assessment. The score is determined once a month and indicates how engaged that individual is in recovery, level of risk, and level of skills and supports. The MORS score for Older Adults is essentially the same as the Adult scale, but includes some unique elements in the area of skills and supports. The program served 598 clients in FY 13/14.

O2. Older Adult FSP Older Adult Support Intervention Systems (OASIS)	
Estimated number to be served in FY 15/16	**184**
Budgeted funds for FY 15/16	**$2,536,395**
Estimated Annual Cost Per Client	**$13,785**

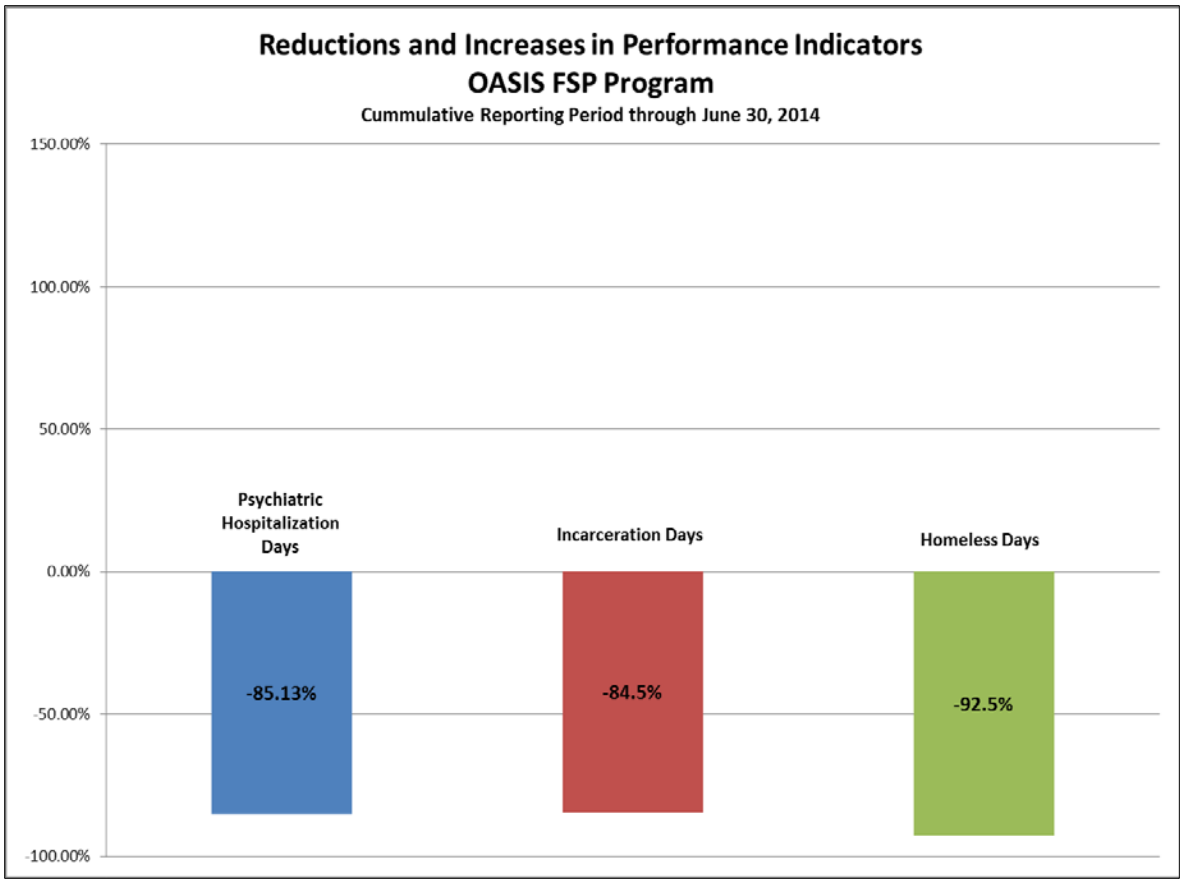
1. Program Description

The Mental Health Services Act Full Service Partnership (FSP) Older Adults Program serves the target population of 60 and over. These seniors are at risk of institutionalization, criminal justice involvement, homelessness or risk of homelessness. Services include; 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. Personal Services Coordinators (PSCs) are also available to clients where they live, 24 hours a day, 7 days a week.

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 delivered at the consumers' homes. The program works with families and significant others to ensure that clients are able to remain in the least restrictive level of placement. The Program is linguistically and culturally capable of providing services to the underserved ethnic populations in Orange County, including Vietnamese and Spanish-speaking consumers. Additional funding will be added starting in FY 14/15 to allow an increase in the number of clients served. It is anticipated that the average annual cost for each client enrolled will remain the same as before the expansion.

2. Outcomes

The Older Adult FSP program served 180 consumers during FY 13/14. The FSP goals are to: decrease incarcerations, hospitalizations, and homelessness; increase safe and adequate housing, employment, education; and promote recovery wellness concepts. The graph below illustrates the reductions and increases of FSP performance indicators as of June 30, 2013.


Reductions and Increases in Performance Indicators
OASIS FSP Program
Cummulative Reporting Period through June 30, 2014
150.00%
100.00%
50.00%
0.00%
-50.00%
-100.00%
Psychiatric Hospitalization Days
Incarceration Days
Homeless Days
-85.13%
-84.5%
-92.5%

O3. Older Adult Program of Assertive Community Treatment	
Estimated number to be served in FY 15/16	**74**
Budgeted funds for FY 15/16	**$521,632**
Estimated Annual Cost Per Client	**$7,050**

1. Program Description

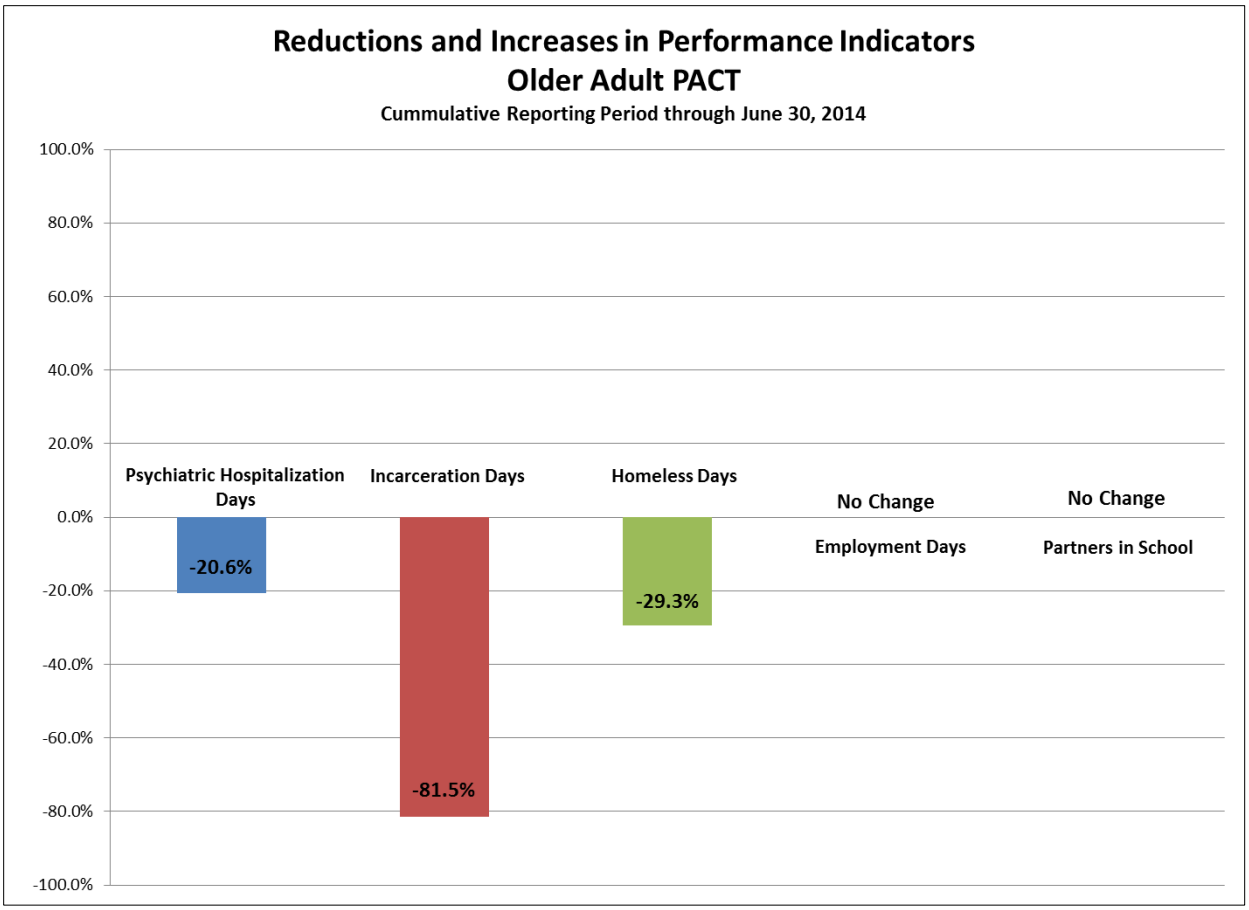
The Older Adult Program of Assertive Community Treatment (PACT) team in Orange County provides intensive community based services to adults over the age of 60. The target population includes individuals who have been psychiatrically hospitalized and/or incarcerated due to their symptoms of mental illness within the past year. In addition, older adults who have repeated emergency room visits or excessive 911 calls due to behavioral health issues are also appropriate for PACT. Individuals in PACT typically have not benefited from traditional programs. 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 individuals 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 a priority 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 Latino, Vietnamese, Korean and Iranian, and is disproportionately represented in the suicide statistics, as well as victimization statistics.

2. Outcomes

The Older Adult PACT program served 66 clients during FY 2013/2014. The older adult PACT program goals include reduction of hospitalizations, reduction of incarcerations, reductions in homelessness and increases in linkage to primary care.


Reductions and Increases in Performance Indicators
Older Adult PACT
Cummulative Reporting Period through June 30, 2014
100.0%
80.0%
60.0%
40.0%
20.0%
0.0%
-20.0%
-40.0%
-60.0%
-80.0%
-100.0%
Psychiatric Hospitalization Days
-20.6%
Incarceration Days
-81.5%
Homeless Days
-29.3%
No Change
Employment Days
No Change
Partners in School

WORKFORCE EDUCATION AND TRAINING

Workforce Education and Training

A. Component Information

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

Skills building and education are provided to prepare and encourage the employment of mental health consumers and family members within the behavioral health system. A primary focus is 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 Associate 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, however, the one-time fund for the WET component was exhausted in June 2012 and available dollars from Community Services and Supports (CSS) are being used to support the programs. In FY 13/14, WET Programs were maintained with CSS funding.

Estimated funds to be expended for the next fiscal years are as follows:

Table 1. Annual Funds Budgeted for FY 15/16

WET Programs	FY15/16 Budgeted Funds
1. Workforce Staffing Support	$375,324
2. Training and Technical Assistance	$899,657
3. Mental Health Career Pathways Programs	$867,000
4. Residencies and Internships	$199,876
5. Financial Incentives Programs	$1, 674,789
Total annual budgeted funds for all WET programs(1-5)	**$4,016,646**

B. Program Information

WET funds a wide range of programs/services. To provide a better picture of who is being served with WET funding, demographic information on participants in Trainings/Conferences is presented below. In FY 13/14, 5,951 attendees participated, and 5,219 (87.7 percent) filled out the training evaluation form. Presented in aggregate, the demographic data in Figure 1 represents 4,929 WET participants of total FY 13/14 WET participants who responded to the age survey question.

Figure 2 indicates the race and ethnicity of 5,162 attendees who answered that question. Figure 3 reports the primary language spoken at home for 5,138 participants. Special population status was also queried. However, the number of responses to this question was extremely low (1,375 or 23.1 percent of total attendees). Of those people answering this question, 11.3 percent indicated that they were lesbian, gay, bisexual, transgender intersex or questioning (LGBTIQ). While 14.3 percent indicated that they were veterans, 6.1 percent reported that they were Deaf and Hard of Hearing, and 39.4 percent stated that they were a member of some other special population.

Figure 1: Age Range of WET Participants in FY13-14
(n=4,929 Completed Questionnaire)

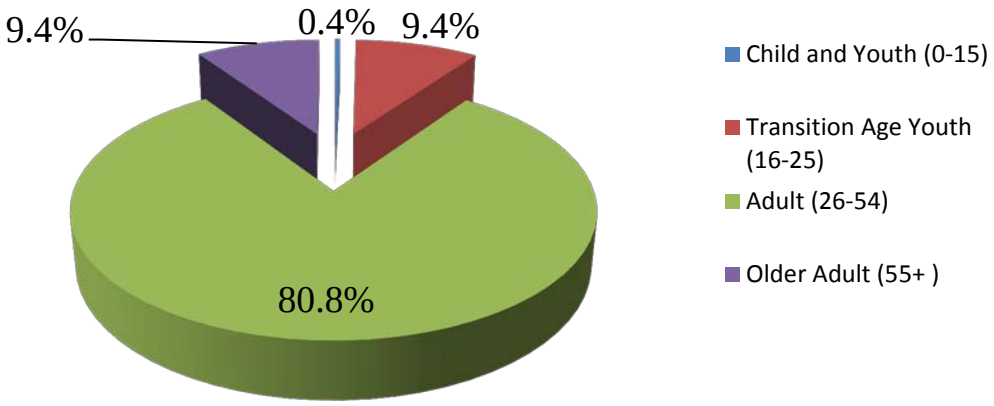


Figure 2. Race/Ethnicity of WET Participants in FY13/14
(n= 5,162 Completed Questionnaire)

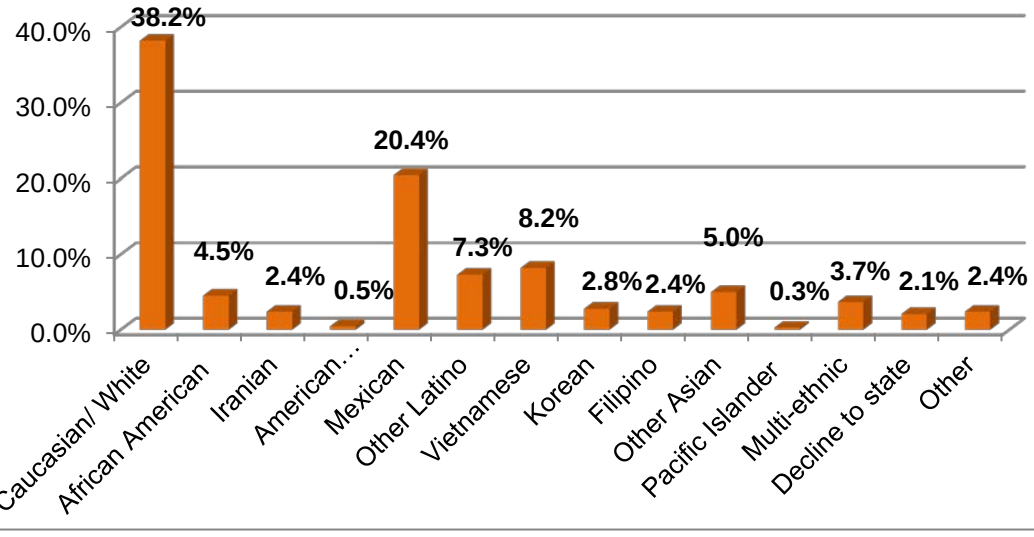
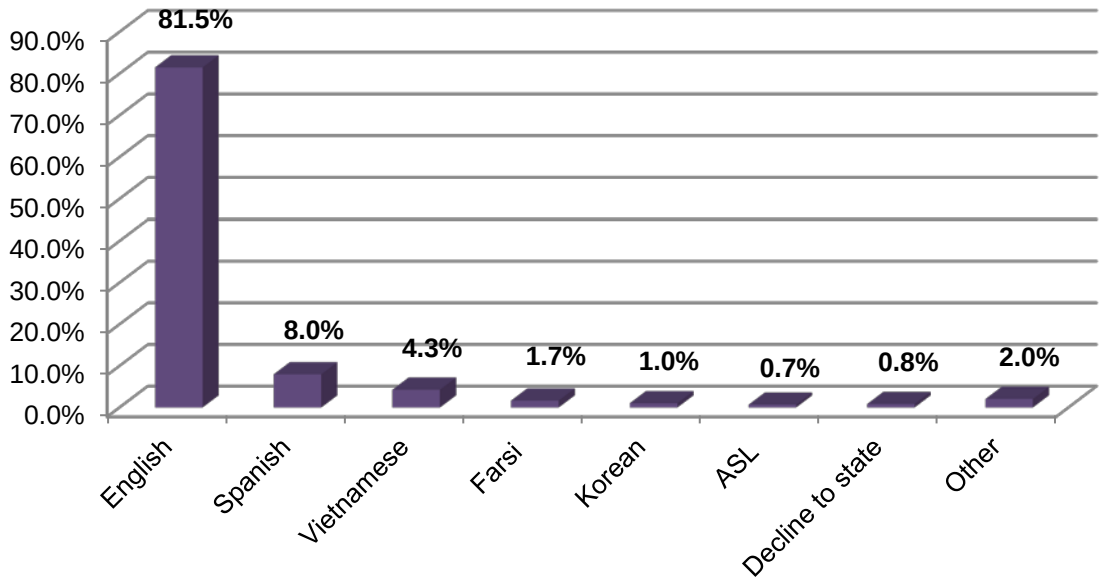


Figure 3. Primary Language of WET Participants in FY13/14
(n= 5,138 Completed Questionnaire)



1. Workforce Staffing Support

The Workforce Education and Training plan requires a training coordinator who also serves as a liaison to work collaboratively with the Southern Region and participates in regional conference calls to plan training activities and increase work force diversity/opportunities in the public mental health system.

The Orange County WET plan also requires continued coordination with County Behavioral Health, numerous contractors, consumers, family members, and the wider community to promote recovery, resiliency, and culturally competent services. Numerous multidisciplinary staff members with language proficiency and cultural responsive skills work to effectively coordinate, provide trainings, research, formulate, evaluate, and monitor WET programs. Staff time is also dedicated to interpretation and translation of materials into the threshold languages Spanish, Vietnamese, Korean and Farsi as well as providing linguistically appropriate behavioral health information and resources to the underserved monolingual consumers and family members. A Consumer Employment Support staff person is assigned to interface with Behavioral Health, its contract agencies and community partners to promote and support employment of consumers in the public mental health system.

2. Training and Technical Assistance

Trainings under this category include evidence-based practices, consumer employment support training and consultation, trainings provided by consumers and family members for staff and the community, development of multi-cultural competency for staff and the community, training for foster parents and others working with foster children and youth, and mental health training for law enforcement. Trainings, continuing education credits, developing program evaluations and tracking outcomes to training partners are part of providing technical assistance.

Forty-nine trainings on Ticket to Work and SSI/SSDI Work Incentives/ Employment Training were offered to 558 consumers and providers in FY 13/14 to raise awareness on work incentives. SSI/SSDI Work Incentive consultation was also provided to 134 consumers who requested more in-depth guidance sessions.

In FY 13/14, 54 trainings were provided on evidence-based best practices such as Trauma-Focused Cognitive Behavior Therapy (TF-CBT), Motivational Interview and Application, SAMHSA model of Anger Management for Behavioral Health, clinical-track Applied Suicide Intervention Skills Training (ASIST) and community-track safeTALK model of Living Works, Mental Health First Aid, and Non-Violent Crisis Intervention (NVCI). A total of 1,011 County and contracted staff, community partners, and consumers/family members attended these evidence-based trainings. In an effort to become more trauma-informed, 73 clinicians received TF-CBT trainings with coaching sessions, and 47 pursued additional training with TF-CBT Advanced Topics. Eighty-five clinicians also completed training and clinical supervision on how to conduct Anger Management groups and individual sessions using the SAMHSA Model. Seventy-six clinicians also received training and certificate of completion for suicide first-aid ASIST, and a total of 116 case managers and community members became safeTALK suicide-alert helpers. Twenty-three Mental Health First Aid classes were offered to 270 community partners and members.

Fifteen NAMI Provider Education courses were also offered. Trainings on recovery were implemented in FY 13/14 by and from the lived-experience perspectives of consumers/family members to reduce stigma among staff in the mental health system and to raise awareness of behavioral health conditions across communities.

Twenty-seven culturally responsive trainings were conducted to raise awareness and acceptance of cultural diversity among behavioral health providers and community partners in FY 13/14, and 920 people attended. Trainings on culturally responsive approach in working with the Deaf and Hard-of-Hearing, consumers and underserved populations, Client Culture, and Vietnamese American population were conducted. A collaborative interfaith community and behavioral health advisory board continues to guide topics and contents of a workshop series that integrates spirituality with behavioral health. Besides the Second Annual Spirituality Integration Conference that drew 189 attendees, the first training for Orange County religious leaders to introduce this concept was also implemented.

In FY 13/14, the biennial Transitional Age Youth conference was conducted in collaboration with the Orange County Social Services Agency and Probation. The conference drew 253 attendances and offered a variety of topics, including extended foster care and resources, substance use and suicide prevention.

Fourteen best-practice classes of the Crisis Intervention Training (CIT) curriculum were taught to a total of 368 Orange County law enforcement officers in FY 13/14. This 16-hour curriculum was conducted by a psychologist, subject matter experts, and contracted providers from a community college, along with the participation of behavioral health consumers and family members. Staff effort was also put forth to support coordination of the California statewide Crisis Intervention conference. In FY 15/16, an additional 8-hour curriculum—CIT II class- will be added to include trainings about Dementia, Developmental Disorders—including Autism Spectrum Disorders, and how to work with Deaf and Hard-of-Hearing individuals. An Interactive Video Simulator will also be utilized to provide more hands-on training and prepare law enforcement officers and public safety personnel (Officers) in identifying the different needs of individuals with mental health and substance use dual diagnosis, and homelessness.

The WET program also 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 2,116 attendees participated in 50 of these trainings that included Clinical Supervision, Laws and Ethics, 5150 & 5585.5 Voluntary Hospitalization, Pharmacology and Drug Interactions, Prescription Drugs Abuse Prevention, Strategic Approach to Tobacco Recovery, Assessment and Treatment Planning for Substance Use and Co-Occurring Disorders, Mental Health Patients' Rights, Healing Children from Trauma with Play Therapy, Human Trafficking and Clinical Interventions,

Behavioral Management and Challenges in Autism Spectrum Disorder, and Tools for Effective Customer Services. A Health Literacy conference and a series on Understanding Unhealthy Eating Patterns including Etiology, Neurobiology and Treatment of Eating Disorders were also implemented.

3. Mental Health Career Pathways

Included in this category is the Recovery Education Institute (REI) Program that prepares consumers and family members who aspire to a career in behavioral health. 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 13/14, a total of 519 trainings were offered. 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 8,807.

4. Residencies and Internships

To expand a culturally diverse, bilingual work force committed to working in the public behavioral health system, clinical supervision has been provided by county-licensed staff to graduate student interns 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 13/14, a total of 5,479 supervision hours were provided to 57 interns who contributed 64,092 clinical hours. In addition, 17 pre-doctorate California Psychology Internship Council (CAPIC) student interns were supervised by licensed psychologists and provided 32,640 clinical hours including neurobehavioral testing.

In order to overcome the shortage of child and community psychiatrists working in the public mental health system, supervision and multicultural and client-centered trainings are provided to psychiatry residents and fellows to recruit talented physicians, reduce stigma and enhance understanding from the consumer and family perspectives. In FY 13/14, WET funded seven residencies and three fellowships through the Psychiatry Department at the University of California Irvine (UCI) School of Medicine. The psychiatry residents and fellows provided a total of 3,648 clinical hours.

5. Financial Incentives Programs

In this category of the WET plan, financial incentive stipends are offered to county and contracting staff as well as graduates from consumer training programs at the Associate of Arts (AA), Bachelor of Arts (BA), and Masters of Arts (MA) levels to expand a diverse bilingual/bicultural workforce. The County of Orange collaborates with numerous colleges and universities to provide stipends to students who, upon graduation, are then required to work for county or county-contracted agencies in return.

In response to the shortage of Community Psychiatrists due to strong recruiting competition within the private sector organizations and other governmental agencies, an Orange County Mental Health Loan Assumption Program (OC-MHLAP) for Psychiatrists is being developed. A sum of $1.5 million will be added to the FY 15/16 Financial Incentive Program budget in order to recruit and retain qualified psychiatrists working within the Public Mental Health System (PMHS). An award recipient must work in the County PMHS in exchange for the Financial Incentive award, and an awardee may not receive payments for more than five consecutive twelve month periods. This additional OC-MHLAP program will help achieve staffing goals and enhance the quality of care to Orange County's population.

C. Outcomes

1. Workforce Staffing Support

In FY 13/14, WET staff devoted time, coordination and support to 196 behavioral health trainings (in addition to those conducted by REI and Golden West College), and provided training activities to 5,951 county and contracted providers, community partners, consumers and family members.

	Active WET Programs	Number of Trainings/ Conferences FY13/14	Number of Attendees FY13/14
Workforce Staffing Support	Workforce Education &Training Coordination	50	2,116
	Consumer Employment Specialist Services	49	558
	Liaison to Regional Workforce Education & Training Partnership	N/A	2
Training and Technical Assistance	Training on Evidence-Based Practices	54	1,011
	Training Provided by Consumers & Family Members for Staff, Consumers/Family Members and the Community	15	224
	Cultural Competence Training for Staff & the Community	27	920
	Training for Foster Parents & Others Working w/Foster Children & Youth	1	253
	Mental Health Training for Law Enforcement	14	368
Mental Health Career Pathways	Recovery Institute	519	396 new enrollees (8,807 total attendants)
Residency and Internship Programs	Graduate Student Interns	N/A	57 Interns (5,479.5 supervision hours provided to interns who in return contributed 64,092 clinical hours)
	Psychiatry Residents and Fellows	N/A	7 residents/3 fellows (provided 3,648 clinical hours)
Financial Incentive Programs	Financial Incentives: AA and BA stipends	N/A	10
	Financial Incentives: Graduate Degree Stipends	N/A	26
	Total	**729**	**5,951**

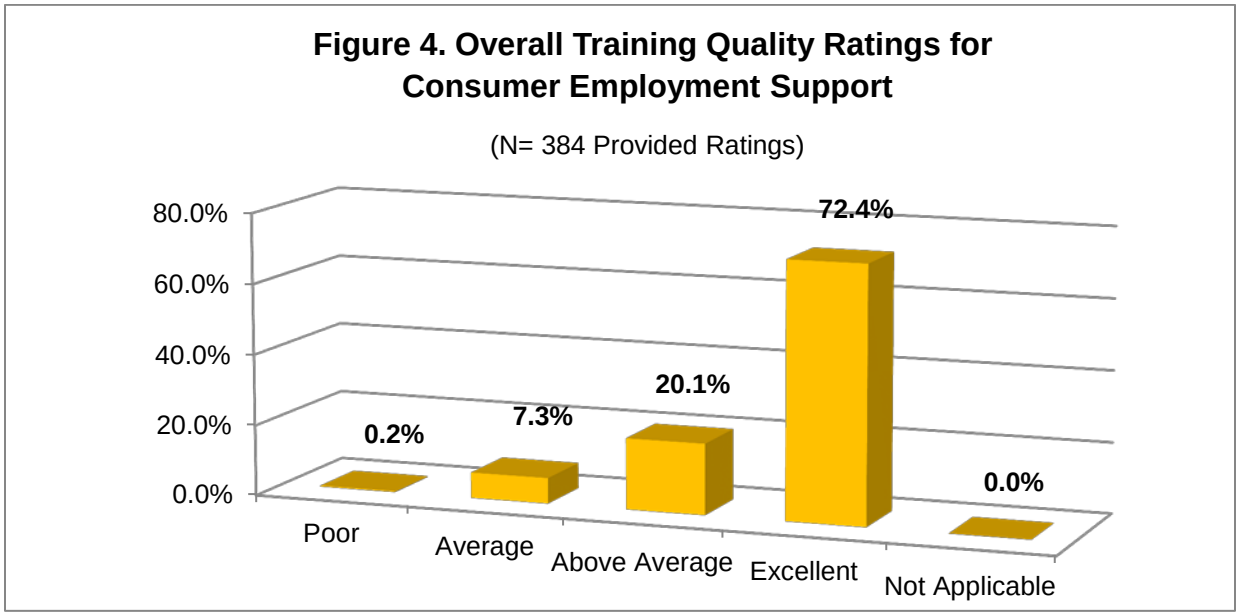
2. Training and Technical Assistance

- Overall Training Program Quality Rating:

Of the 558 total individuals who attended Ticket to Work (SSI/SSDI Work Incentives and Employment Trainings in FY 13/14, 384 (68.8%) provided ratings on the overall training quality. Presented in Figure 4 and in aggregate, 72.4

percent of 384 participants gave an “Excellent” rating, and 20.1 percent marked “Above Average.” The combined percentage for “Excellent” and “Above Average” ratings of these consumer employment support training activities equals 92.5 percent.

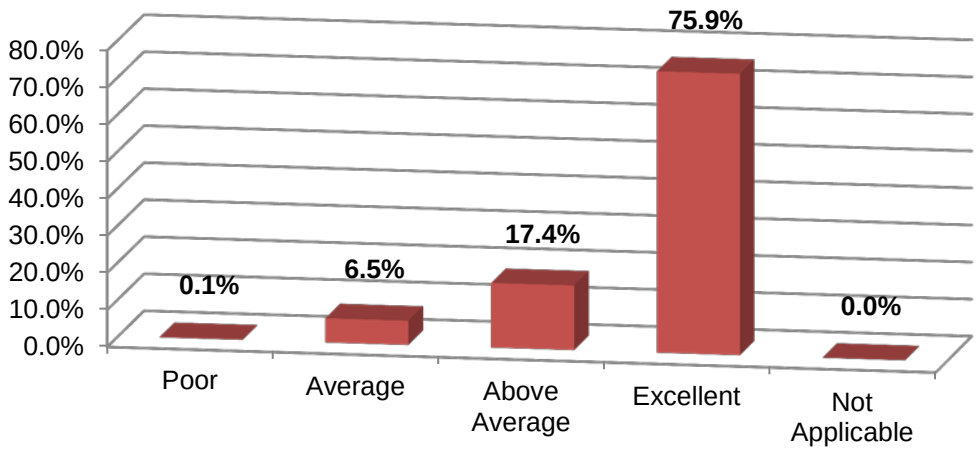
Figure 4. Overall Training Quality Ratings for Consumer Employment Support



Out of the 1,011 individuals who attended the evidence-based practices trainings, 829 participants (82.0%) completed the rating on the overall quality for these activities. While 17.4% gave an “Above Average” rating, 75.9% provided an “Excellent” rating as depicted in Figure 5. 93.3% of individuals who went to the training rated the program either “Excellent” or “Above Average” %.

Figure 5. Overall Quality Ratings for Trainings on Evidence-Based Practices

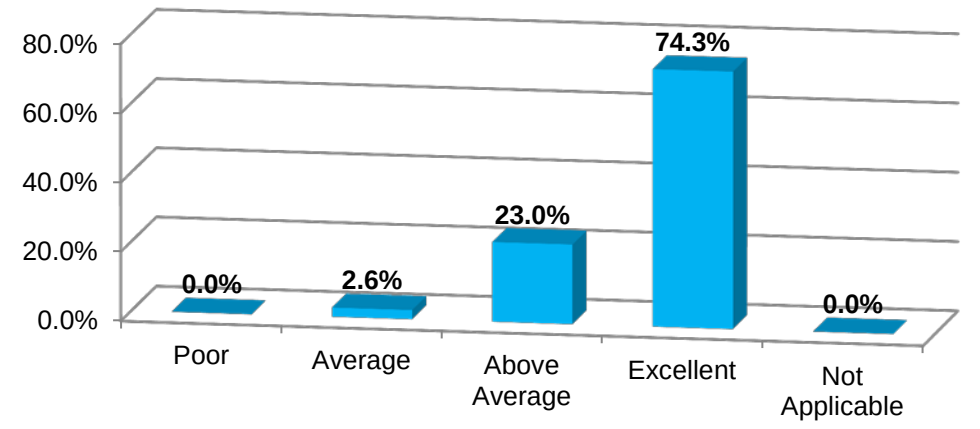
(N= 829 Provided Ratings)



Of the 224 individuals attended who trainings provided by consumers and family members, 207 participants (92.4%) gave ratings on the overall training quality. Figure 6 shows that 74.3% gave an "Excellent" rating while 23.0% provided an "Above Average" rating in aggregate. 97.3% of participants rated the training either "Excellent" or "Above Average"%.

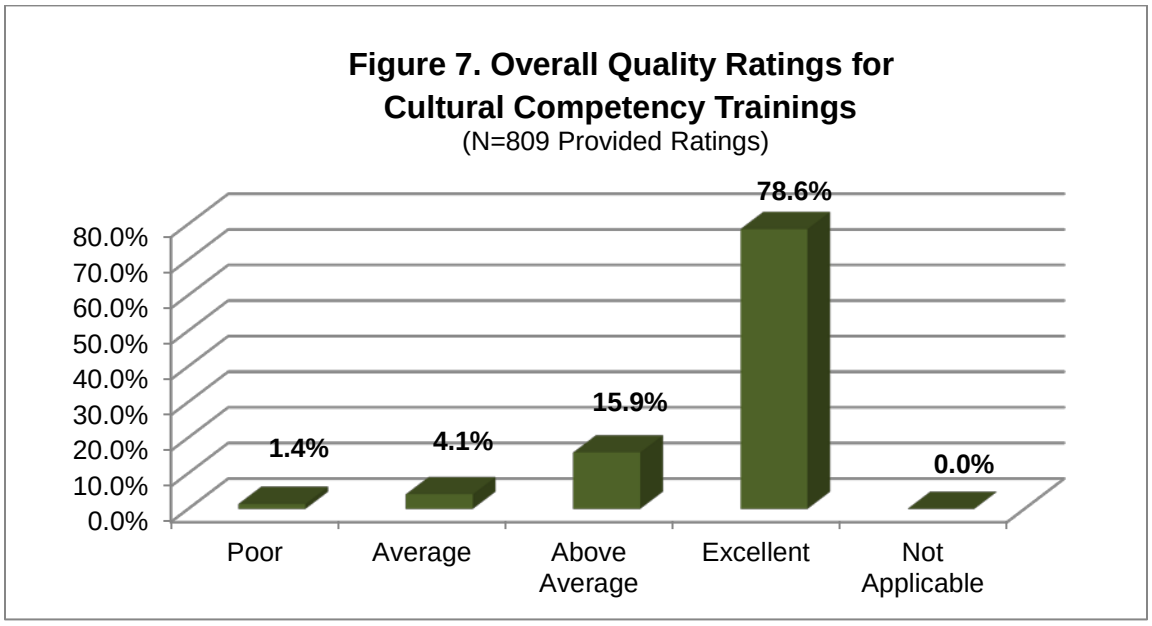
Figure 6. Overall Quality Ratings for Trainings Provided by Consumers and Family Members

(N= 207 Provided Ratings)

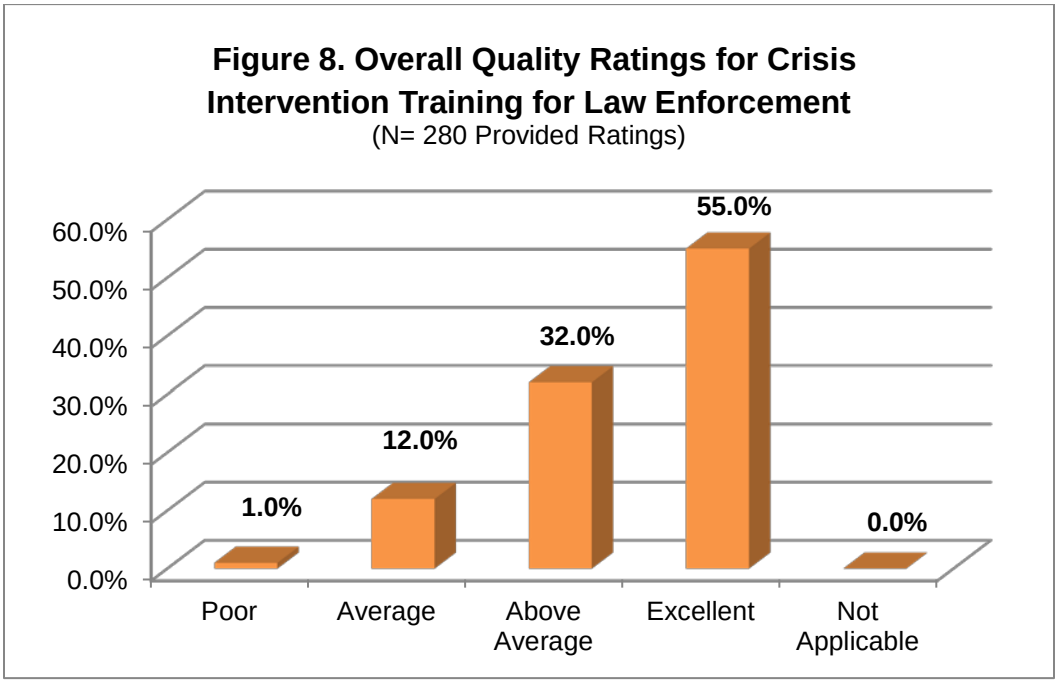


Of the 920 total individuals who attended cultural competence trainings in FY 13/14, 809 (87.9%) provided ratings on the overall training quality. Presented in Figure 7, 78.6% of 809 participants gave an "Excellent" rating and 15.9% marked

"Above Average." 94.5% of individuals who went to the training rated the program either "Excellent" or "Above Average".



Out of the 368 law enforcement officers who attended the CIT trainings, 280 (76.1%) completed the rating on the overall quality for these activities. While 32.0% gave an "Above Average" rating, 55.0% provided an "Excellent" rating as depicted in Figure 8. The combined percentage of "Excellent" and "Above Average" ratings equals 87.0%.



Overall Satisfaction Rating with Training Activities:

Mean ratings of participants for the overall satisfaction with the training and technical assistance category on a scale of 1 to 10 (1= least satisfactory, 10= most satisfactory) is depicted in Table 2.

For the consumer employment support training activities in FY 13/14, 384 participants (68.8%) out of 558 total who attended provided a mean rating of 8.6 for overall satisfaction on a 1 to 10 scale. 84% of participants reported a score of 8, 9, or 10.

In FY 13/14, out of the 1,011 total who attended, 829 participants (82.0%) provided a mean rating of 9.0 on a 1 to 10 scale for the overall satisfaction of the trainings in evidence-based practices. 90% of participants reported a score of 8, 9, or 10.

Of the 224 individuals who attended the trainings provided by consumers and family members in FY 13/14, 207 (92.4%) provided ratings on the overall training quality. A mean rating of 9.1 on a 1 to 10 scale was given for these training activities. 89% of participants reported a score of 8, 9, or 10.

For the cultural competence training activities in FY 13/14, 809 participants (87.9% out of 920 total) who attended provided a mean rating of 9.0 on a 1 to 10 scale for the overall satisfaction. 91% of participants reported a score of 8, 9, or 10.

For the Crisis Intervention training activities for Law Enforcement in FY 13/14, 280 participants (76.1% out of 368 who attended) provided a mean rating of 8.3 on a 1 to 10 scale for the overall satisfaction. 79% of participants reported a score of 8, 9, or 10.

Table 2. Overall Satisfaction Ratings by Participants for Training and Technical Assistance

(1= With the Least Satisfaction, 10= With the Most Satisfaction)

Satisfaction Level	1	2	3	4	5	6	7	8	9	10	Mean Rating
Consumer Employment Support Trainings	0%	0%	1%	2%	5%	3%	6%	18%	34%	32%	8.6
Evidence-Based Practices Trainings	0%	0%	0%	1%	1%	2%	6%	18%	26%	46%	9.0
Trainings Provided by Consumers/ Family Members	0%	0%	0%	0%	0%	4%	6%	18%	20%	51%	9.1
Cultural Competence Trainings	0%	0%	1%	1%	1%	2%	5%	19%	26%	46%	9.0
CIT Trainings for Law Enforcement	1%	0%	2%	1%	2%	4%	11%	28%	30%	21%	8.3

3. Mental Health Career Pathways

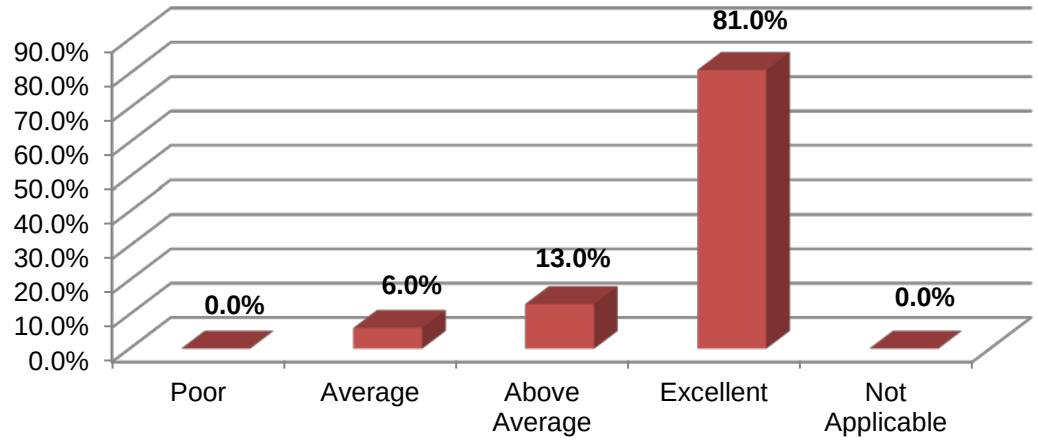
The Recovery Education Institute (REI) reported a high level of productivity in FY 13/14 both in the number of courses provided and the number of participants as depicted in Table 3. A total of 519 courses were offered, and the total (duplicated) number of students attended at REI was 8,807.

Table 3. Number of Courses REI Offered in FY 13/14 and The Total Number of Students Attended		
REI Courses/Advisement Sessions	**Total Number of Courses Offered**	**Total Number of Students Attended**
Workshop	**293**	**1,127**
Pre-Vocational Courses	**192**	**473**
Extended Education	**19**	**1,802**
College Credit Courses	**15**	**2,339**
Academic Advisement Sessions	**--**	**1,492**
Success Coach Contacts	**--**	**1,574**
Total	**519**	**8,807**

- Overall Training Program Quality Rating:

Of the total students who attended the REI programs in FY 13/14, 602 ratings were provided on the overall training quality. Presented in Figure 9 in aggregate, 81.0 percent of the total provided ratings chose “Excellent” rating, and 13.0 percent marked “Above Average.” The combined percentage for “Excellent” and “Above Average” ratings of these training activities equals 94.0 percent.

Figure 9. Overall Quality Ratings for the Recovery Education Institute
(N=602 Provided Ratings)



- Overall Satisfaction Rating with Training Activities:

Mean rating by participants on the scale of 1 to 10 (1= with the least satisfaction, 10= with the most satisfaction) for the overall satisfaction with the training and technical assistance category is depicted in Table 4.

For the REI training activities in FY 13/14, a total of 602 training evaluations were completed which provided a mean rating in aggregate of 9.0 on the 1 to 10 scale for the overall satisfaction. The combined percentage in aggregate for high scale 8, 9, and 10 ratings equals 89 percent.

Table 4. Overall Satisfaction Ratings by Participants for The Recovery Education Institute Training Activities
(1= With the Least Satisfaction, 10= With the Most Satisfaction)

Satisfaction Level	1	2	3	4	5	6	7	8	9	10	Mean Rating
Overall REI Training Activities	0%	0%	0%	0%	3%	1%	7%	10%	21%	58%	9.0

4. Residencies and Internships

The clinically supervised psychiatry residents and fellows provided a total of 3,648 clinical hours in FY 13/14 to Behavioral Health Services (BHS) as shown in Table 4.

Table 4. Total Hours Psychiatry Residents/Fellows Under Clinical Supervision Provided in FY 13/14 Behavioral Health Services			
Psychiatry Supervisees	**Total No.**	**Total Monthly Hours**	**Total FY12-13 (Monthly Hours X 12)**
Fellows	3	96	1,152
Residents	7	208	2,496
TOTAL	**10**	**304**	**3,648**

In FY 13/14, 57 supervised interns provided 64,092 clinical hours to BHS. Table 5 indicates 13,692 clinical hours provided by unlicensed staffs who are working toward various clinical licensures and certificates. Table 6 reports the total 50,400 clinical hours contributed by clinical supervised volunteers-including the 17 supervised pre-doctorate CAPIC students who provided 32,640 clinical and neurobehavioral testing service hours to BHS.

Table 5. Total Hours Provided to Behavioral Health Services in FY 13/14 by Unlicensed Staff Under Clinical Supervision			
Unlicensed Staff	**Total No.**	**Total Monthly Hours**	**Total FY 13/14 (Monthly Hours X 12)**
Supervisees working toward LCSW	3	148	1,776
Supervisees working toward LMFT	6	665	7,980
Supervisees working toward Psychologist Licensure	5	150	1,800
Supervisees on a non-licensure track (e.g. certificates)	2	178	2,136
TOTAL	**16**	**1,141**	**13,692**

Table 6. Total Hours Provided to Behavioral Health Services in FY 13/14 by Volunteers Under Clinical Supervision			
Supervisees as Volunteers	**Total No.**	**Total Monthly Hours**	**Total FY13-14 (Monthly Hours X 12)**
MSW Students (Pre-Master)*	2		
MFT Practicum Students (Pre-Master)	2	24	288
MFT Interns (Post-Master)	2	122	1464

Psychology Practicum Students	13	1,209	14,508
CAPIC Pre-Doctorate Students	17	2,720	32,640
Post-Doctorates	2	125	1,500
Consumer Interns/Peer Mentors*	3		
TOTAL	**41**	**4,200**	**50,400**

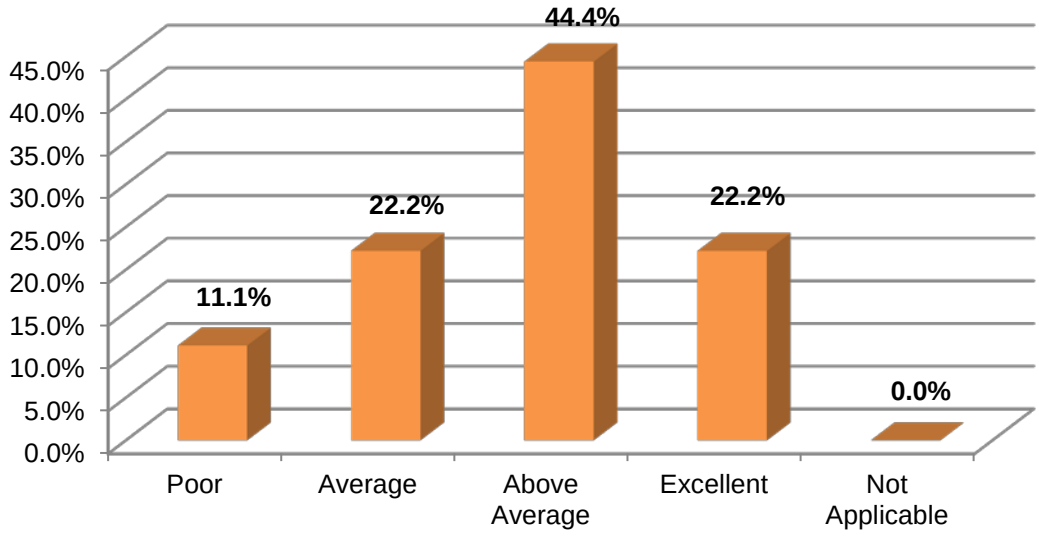
*Supervised volunteers not providing clinical hours

- Overall Training Program Quality Rating:

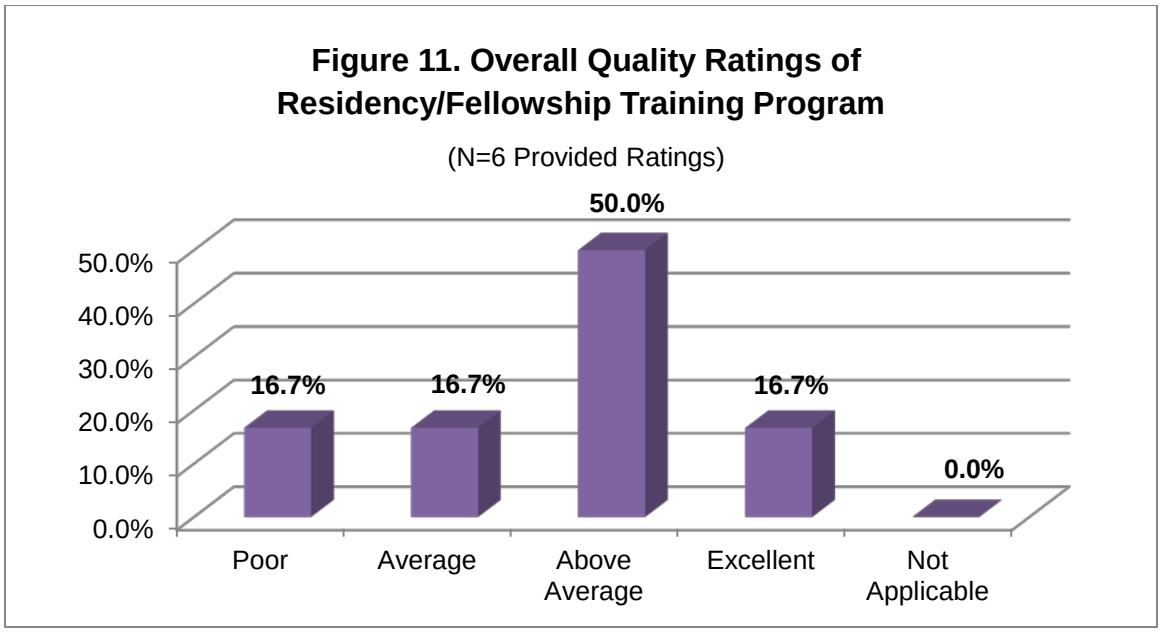
Out of the 17 pre-doctorate students who participated in the CAPIC program, nine (52.9 percent) completed the rating on the overall quality for their training activities. While 44.4 percent gave an "Above Average" rating, 22.2 percent provided an "Excellent" rating as depicted in Figure 10. The combined percentage of "Excellent" and "Above Average" ratings equals 66.6 percent.

Figure 10. Overall Quality Ratings of the CAPIC Program

(N= 9 Provided Ratings)



Six out of ten (60 percent) residents/fellows provided ratings on the overall quality of the FY 13/14 residency/fellowship training they received. As depicted in Figure 11, 16.7 percent gave an "Excellent" rating while another 50.0 percent marked "Above Average." The combined percentage for "Excellent" and "Above Average" ratings equals 66.7 percent.



- Overall Satisfaction Rating with Training Activities:

Mean rating by participants on the scale of 1 to 10 (1= with the least satisfaction, 10= with the most satisfaction) for the overall satisfaction with the training and technical assistance category is depicted in Table 7.

For the CAPIC training activities in FY 13/14, 9 out of 17 interns (52.9 percent) completed the training evaluation and provided a mean rating of 7.7 on the 1 to 10 scale for the overall satisfaction. The combined percentage for high scale 8, 9, and 10 ratings equals 66 percent.

For the psychiatry residency/fellowship training activities in FY 13/14, 6 (60 percent) out of 10 residents/fellows completed the training evaluations. A mean rating of 4.5 on the 1 to 10 scale for the overall satisfaction was provided, and the combined percentage for high scale 8, 9, and 10 ratings equals 67 percent.

Table 7. Overall Satisfaction Ratings for Residency and Internship Training Activities

(1= With the Least Satisfaction, 10= With the Most Satisfaction)

Satisfaction Level	1	2	3	4	5	6	7	8	9	10	Mean Rating
CAPIC Program	0%	0%	11%	0%	0%	11%	11%	22%	33%	11%	7.7
Psychiatry Residencies/ Fellowship	0%	0%	0%	17%	0%	17%	0%	17%	50%	0%	4.5

Financial Incentives Programs

In FY 13/14, tuition incentives were provided to 10 staff with the potential to obtain the necessary educational skills for their AA and BA degrees and to 26 staff to acquire the needed educational skills toward their Master of Arts.

Prevention and Early Intervention

Prevention and Early Intervention (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.

The Mental Health Services Act (MHSA) allocates 20% of the Mental Health Services Fund to counties for PEI as a key strategy to prevent mental illness from becoming severe and disabling and improve timely access for underserved populations. PEI Programs emphasize strategies to reduce negative outcomes that may result from untreated mental illness: suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and removal of children from their homes. PEI identifies individuals at risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources.

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” vs. “fail first” philosophy. Prevention and Early Intervention services involve reducing risk factors or stressors, building protective factors and skills, and increasing resiliency.

The goal of prevention and early intervention is to keep people healthy, or to provide treatment early on in an illness. The result is a dramatic reduction in negative consequences caused by leaving mental illness untreated until it reaches our emergency rooms, jails and streets. Through prevention and early intervention, we can reduce the human suffering caused by leaving mental illness untreated.

The Orange County Health Care Agency, Behavioral Health Services, Prevention and Intervention 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 a diverse population. 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.

Research shows that prevention and early intervention pays off. Treating mental illness early on can reduce lost work days and the need for costly treatments. In fact, more days of work are lost because of untreated mental illness than those lost to diabetes, asthma and arthritis combined. Prevention and early intervention services are cost effective. They help at-risk children, youth and adults avoid high-cost crisis services. And those who receive help early on are more likely to make long-term, positive social contributions.

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

After a multi-stage process that took nearly two years and involved extensive community involvement, the original PEI Plan was approved by the California Department of Mental Health (DMH) and the Oversight and Accountability Committee (OAC) in April 2009. The original Plan consisted of 8 project areas with a combined total of 33 programs. The PEI Plan covered a three-year period and was updated each year through the annual update report to the State.

A restructuring of the Plan was initiated in 2012 to address issues identified during the first three years of implementation. The restructuring addressed areas of overlap in services, inconsistencies, and unsuccessful solicitations due to a lack of community response. Existing programs in the plan were restructured in order to better meet the prevention and early intervention needs of the community and, whenever possible, take advantage of economies of scale. The re-packaged Plan maintained all services, but re-organized them into three Service Areas. These Areas are: Community Focused Services, School Focused Services, and System Enhancement Services.

FY 14/15 Changes to the Plan

During FY 14/15, because of the expanded efforts to increase access to all behavioral health services, the funding for Information and Referral Services was increased by $200,000. The funding for the Training, Assessment and Coordination Services program was decreased by $200,000. Besides these

approved changes, the recommendation for level funding for all other PEI programs was approved with available dollars to be utilized to sustain two Innovation Projects that were recommended for continuation. These two Innovation projects described below were determined to be effective, and Innovation funding for these projects will end. Shifting the funding to PEI allows for the continuation of these projects.

OC Accept: OC ACCEPT provides LGBTIQ specific behavioral health services to address behavioral health issues disproportionately faced by the LGBTIQ community. This program offers LGBTIQ specific behavioral health services and peer support services. In addition, LGBTIQ identified or allied peer specialists provide case management services, advocacy, and outreach and engagement activities. The goals of the program are to provide a safe environment to express feelings, build resilience, become empowered, and connect with others for support and to raise awareness and reduce stigma by providing education about the LGBTIQ population to the community at large.

OC4Vets: OC4Vets provides a participant-focused environment for veterans or families within the local military and veteran community to receive an integrated, holistic approach to address veteran behavioral health issues and facilitate a smooth transition back to civilian life. This program offers co-located veteran's services and peer support services, as well as peer navigators familiar with veteran and military culture who provide support and case management services.

Although the original PEI Plan has continued to evolve, the Plan addresses community mental health needs identified in the original PEI plan and targeted the same priority populations. Plan changes have been discussed and approved by the MHSA Sub-committee and the MHSA Steering Committee and presented to the Mental Health Advisory Board for review and feedback.

This 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

The PEI Plan is currently organized into the following programs:

Community Focused Services

- CF1: Early Intervention Services for Stress-free Families
- CF2: 1st Onset of Psychiatric Illness (OC CREW)
- CF3: Orange County Postpartum Wellness
- CF4: Early Intervention Services for Older Adults
- CF5: Youth as Parents
- CF6: Behavioral Health Counseling Program
- CF7: Crisis Prevention Hotline
- CF8: Survivor Support Services
- CF9: Parent Education and Support Services
- CF10: Family Support Services
- CF11: Children's Support and Parenting Program
- CF12: PEI Services for Parents and Siblings of Youth in the Juvenile Justice System (Stop the Cycle)
- CF13: Outreach and Engagement Collaborative
- CF14: WarmLine (NAMI)
- CF15: Professional Assessors

School Focused Services

- SF1: School-based Mental Health Services
- SF2: School-based Behavioral Health Intervention and Support Early Intervention
- SF3: School Readiness/Connect the Tots
- SF4: College Veterans Program (The Drop Zone)
- SF5: School-Based Behavioral Health Intervention and Support
- SF6: Violence Prevention
- SF7: Transition
- SF8: K-12 Coping Skills to Manage Stress

System Enhancement Services

- SE1: Information and Referral/OC Links
- SE2: Training, Assessment, & Coordination Services
- SE3: Training in Physical Fitness and Nutrition Services/Goodwill
- SE4: Community-based Stigma Reduction
- SE5: Statewide Projects

Example of Notable Community Impact

HCA manages over two hundred programs to assist those struggling with all levels of behavioral health issues. In an attempt to provide a service to better navigate the County's Behavioral Health Services, OCLinks was created. OCLinks is an information and referral phone and online chat service to help callers determine which program is the right fit for them. Callers are connected to clinical Navigators who are knowledgeable in all of the County's programs and provide warm handoffs to the behavioral health programs.

During the first year, there were a total of 7,787 combined calls/chats and an additional 9,701 webpage hits. During the first year, 9,145 referrals were given out and 43% of callers were linked to services. The top referral category was Substance Use Disorder Treatment with 5,349 referrals. 2,254 referrals were made for Mental Health Treatment, and 1,070 referrals were made to Prevention and Early Intervention services.

B. PEI Program Information & Outcomes : Community-Focused (CF) Programs

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS	
CF1 Early Intervention Services for Stress Free Families	
Estimated annual number to be served in FY 15/16	**160**
Annual Budgeted funds for FY 15/16	**$534,693**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,342**

1. Program Description

The Stress Free Families Program serves families that have been reported and/or investigated by Child Protective Services for allegations of child abuse and/or neglect. 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. Staff is co-located at a Social Services Agency (SSA) site to provide consultation and receive referrals from SSA staff.

2. Outcomes

During FY 13/14, 157 families were served by Stress Free Families, which is an increase of 52% from the previous fiscal year. In addition, the total number of home visits also increased by 64% from the previous fiscal year.

The Social and Occupational Functioning Assessment Scale (SOFAS) was used to assess participants' current level of social and occupational functioning, at the time of enrollment, every three months, and at program exit. Of the 118 participants with matched pre-test and post-test scores, there was an overall average improvement in scores of 15% with 82% of participants reporting improved social and occupational functioning scores over time.

The Protective Factors Survey was used to measure changes in a family's protective factors in the areas of family functioning/resiliency, social support, concrete support, and nurturing and attachment. This survey was completed by parents/caregivers at program intake and at program exit. Of the 112 participants with pre-test and post-test scores, 77% of participants improved in family functioning/resiliency, 66% improved in nurturing and attachment, 61% improved in social support, and 57% improved in concrete support.

The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being. A 10 percentage-point change in scores indicates a significant change in well-being. Among the 100 participants with matched pre-test and post-test scores, there was an average improvement of 39 percentage points.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS	
CF2 1st Onset of Psychiatric Illness (OC CREW)	
Estimated annual number to be served in FY 15/16*	**80**
Annual Budgeted funds for FY 15/16	**$1,500,000**
Estimated Annual Cost Per Client (for direct service programs only) *	**$18,750**

*Estimated number served does not take into account family members served in multi-family groups or participants receiving community trainings.

1. Program Description

The Orange County Center for Resiliency Education and Wellness (OC CREW) serves individuals 14 to 25 years of age who are experiencing the first onset of psychotic illness and provides services to their families. Services include: psychiatric care; psycho-education; cognitive-behavioral intervention; multi-family groups; peer mentoring; development of long-term economic and social support; opportunities for physical fitness activity; and services to address substance misuse and Wellness Recovery Action Plans.

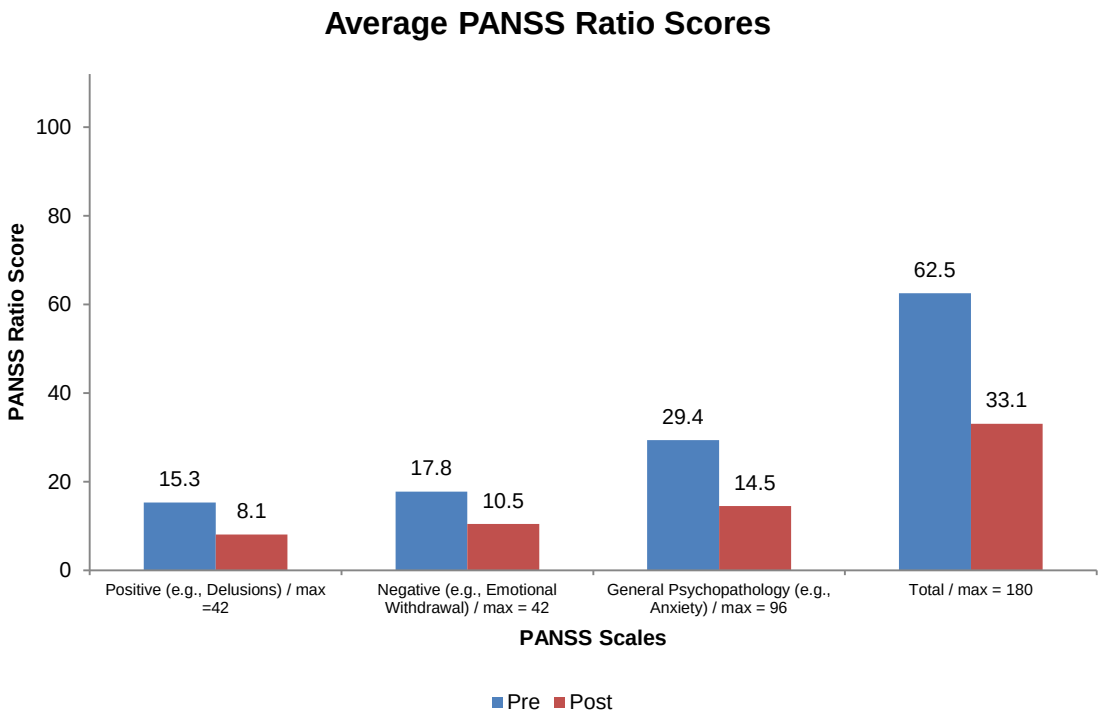
This program also provides trainings to persons and organizations most likely to encounter individuals presenting with early warning signs of mental illness. Training is provided on how to recognize these early warning signs, how to support these individuals/families and how to refer persons from diverse ethnic/ cultural groups.

2. Outcomes

During FY 13/14, 79 participants were served by the OC CREW program. In addition to the 79 enrolled, 75 of their family members/friends also participated in the services, and 316 individuals received community trainings on the early warning signs of mental illness.

The Positive and Negative Syndrome Scale (PANSS) was administered to assess the symptom severity of participants with schizophrenia. Positive symptoms refer to an excess or distortion of normal functions (e.g., hallucinations and delusions), and negative symptoms represent a diminution or loss of normal functions (e.g., blunted affect, emotional withdrawal, or poor rapport). The PANSS was administered to OC CREW participants upon enrollment, every six months following, and again at program exit. For participants who have taken the assessment more than once, their initial score and most recent post-test scores

were matched to identify changes over time. Of the 37 participants with matched pre-test and post-test scores, the overall average improvement was 7.2 points in the positive scale ratio scores and 7.3 points in the negative scale ratio scores. Overall, 92% of participants improved their total PANSS scores, positive scale scores, and psychopathology scale scores. Additionally, 82% of participants improved their negative scale scores. These results indicate a decrease in the severity of psychotic symptoms. The results for these tests are shown in the figure below.



The Milestones of Recovery Scale (MORS) is a clinician-reported rating of recovery designed to assess effectiveness of mental health programs in promoting recovery, with higher MORS score reflecting greater recovery. Clinicians rated OC CREW participants upon enrollment, every six months following, and again at program exit. For participants who have more than one rating, their initial score and most recent post-test scores were matched to identify changes over time. Nearly half (45%) of OC CREW participants showed improvement on their MORS recovery ratings between pretest and post-test, and 38% maintained their ratings over time.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores, which range

from 0 to 100, indicates a significant change in well-being. Among the 42 participants with matched pre-test and post-test scores, the average improvement in scores was 24 percentage score points.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS	
CF3 Orange County Postpartum Wellness (OCPPW)	
Estimated annual number to be served in FY 15/16 *	**600**
Annual Budgeted funds for FY 15/16	**$1,913,072**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,188**

*Growth funds were added mid FY 13/14 to expand program services. The estimated count of numbers to be served is based on program expansion/ full staffing for a 12 month period.

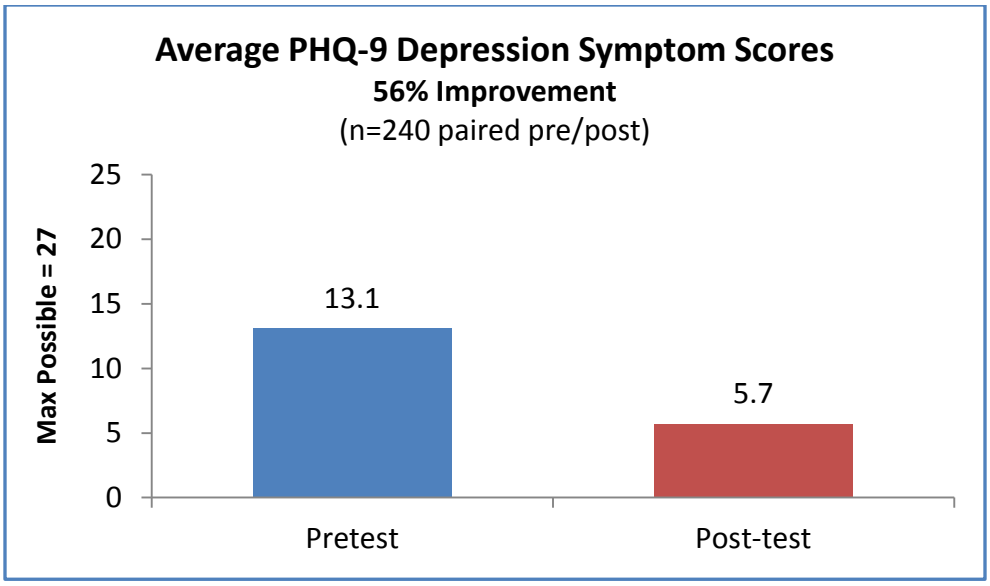
1. Program Description

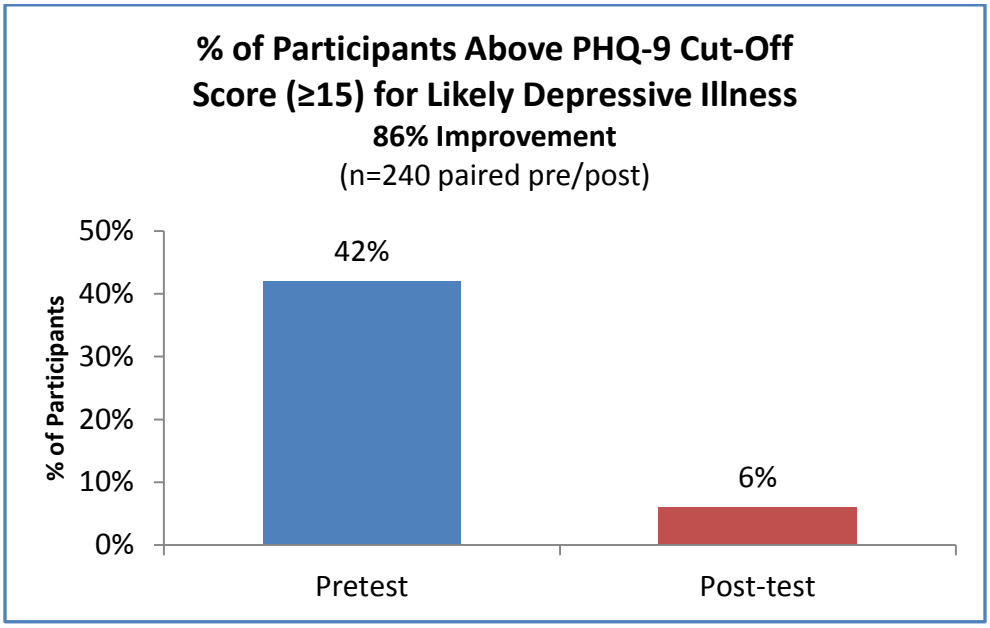
This program provides early intervention services to new mothers, up to one year postnatal, experiencing mild to moderate postpartum depression. Services include assessment, case management, individual, family and group counseling, educational groups, wellness activities and coordination and linkage to community resources and community education. In FY 13/14, this program expanded to maternal wellness to serve the many women who develop perinatal depression.

2. Outcomes

During FY 13/14, 345 participants were served by the OCPPW Program. The number of participants served reflects a 49% increase from the previous fiscal year.

The Patient Health Questionnaire (PHQ-9) measures depressive symptom severity among participants, with higher scores indicating more severe depressive symptoms. This was administered to participants at program intake, every three months, and at program exit. For participants who have more than one rating, their initial score and most recent post-test scores were matched to identify changes over time. As seen in the first figure below, among the 240 participants with matched pre-test and post-test scores, average scores decreased from 13.1 to 5.7. Additionally, at pre-test, 42% of participants were above the clinical cut-off (score ≥ 15) for depressive illness, and this decreased to only 6% of participants at post-test. This reflects an 86% reduction in number of participants above the clinical cut-off score for depressive illness.





The Generalized Anxiety Disorder (GAD-7) scale screens for generalized anxiety disorder, panic disorder, social anxiety disorder, and PTSD, with higher scores indicating more severe anxiety symptoms. Of the participants with matched pre-test and post-test scores, there was a decrease in the percentage of participants who scored above the PHQ-9 cut off score from 42% of participants at pretest to 6% at post-test. In other words, 42% of participants had scores indicating the likelihood of depressive illness on the pretest measure, whereas only 6% of participants had the same score on post-test. Overall, 85% of participants experiencing decreased anxiety symptoms.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 236 participants with matched pre-test and post-test scores, the average improvement in scores was 73 percentage score points.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF4 Early Intervention Services for Older Adults (previously known as the Socialization Program for Adults and Older Adults)	
Estimated annual number to be served in FY 15/16	**800**
Annual Budgeted funds for FY 15/16	**$1,419,500**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,774**

*Growth funds were added mid FY 13/14 to expand programs services. The estimated annual number to be served is based on program expansion/full staffing for a 12 month period.

1. Program Description

The Early Intervention Services for Older Adults provides behavioral health early intervention services to older adults who are experiencing the early onset of mental illness and/or those who are at greatest risk of developing behavioral health conditions due to isolation. The program conducts comprehensive in-home assessments and connects participants to trained Life Coaches and volunteers to develop individualized socialization plans and to facilitate involvement in support groups, educational training, physical activities, workshops, and other activities. Based on the needs of the participants, the program also links participants to outside resources and services. Tele-geropsychiatric services are also available to consult with primary care physicians, participants and families.

2. Outcomes

During FY 13/14, 613 participants were served by the Socialization Program for Isolated Adults and Older Adults.

The Participant Health Questionnaire (PHQ-9) measures depressive symptom severity among participants, with higher scores indicating more severe depressive symptoms. This was administered to participants at program intake, every three months, and at program exit. For participants who have more than one rating, their initial score and most recent post-test scores were matched to identify changes over time. Among the 256 participants with matched pre-test and post-test scores, there was an overall average improvement of 44%, with 77% of participants reporting decreased depression severity scores.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 249 participants with matched pre-test and post-test scores, the average improvement in scores was 47 Percentage score points.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF5 Youth as Parents	
Estimated annual number to be served in FY 15/16	**100**
Annual Budgeted funds for FY 15/16	**$500,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$5,000**

1. Program Description

The Youth as Parents Program serves pregnant and parenting youth who are at risk of behavioral health problems, and their children. The goal of the program is 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

During FY 13/14, 97 teen parents were served by the Youth as Parents Program which is an increase of 11% from the previous fiscal year. Additionally, the number served does not reflect the 1,782 individuals served in group parent trainings and the 408 individuals served in community outreach events.

The Parenting Tasks Checklist was used to measure changes in a parent's self-efficacy (confidence) in their ability to successfully handle their children's difficult behaviors in a variety of situations/settings. A higher score indicates a higher level of self-efficacy. This scale was administered to participants at program intake, every three months, and at program exit. For participants who have more than one rating, their initial score and most recent post-test scores were matched to identify changes over time. Among the 47 participants with matched pre-test and post-test scores, the overall average improvement in scores was 7%, with 66% of participants reporting improved self-efficacy.

The Protective Factors Survey was used to measure changes in a family's protective factors in the areas of family functioning/resiliency, social support, and concrete support. This was administered to parents/caregivers at program intake, at 3-month intervals, and again at program exit. Initial and most recent scores were compared to identify changes over time. Among the 56 participants with matched pre-test and post-test scores, 71% of parents improved in social support, 57% improved in family functioning/resiliency, and 16% in concrete support.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 53 participants with matched pre-test and post-test scores, the average improvement in scores was 29 Percentage score points.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS CF6 Behavioral Health Counseling Program	
Estimated annual number to be served in FY 15/16*	**600**
Annual Budgeted funds for FY 15/16	**$1,800,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,000**

*The annual estimated number to be served is for a 12-month period. The actual number to be served in the first year will be less due to the program start-up process, such as hiring staff and will depend on the program implementation date.

1. Program Description

The Behavioral Health Counseling Program will provide behavioral health treatment services for all age groups including short-term counseling and psychiatric services for those not meeting the criteria at the community mental health clinics. Staffing will include psychiatrists, behavioral health nurses and clinicians with the capacity of supervising a team of interns to further increase the program's capacity.

2. Outcomes

Services are anticipated to begin during the first half of 2015. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include the PHQ-9 (adult and adolescent versions), the GAD-7 for measuring decreases in symptom severity for depression and anxiety, as well as the WHO-5, for measuring general well-being.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS	
CF7 Crisis Prevention Hotline	
Estimated annual number of calls in FY 15/16	**6,500**
Annual Budgeted funds for FY 15/16	**$272,533**
Estimated Annual Cost Per Call (for direct service programs only)	**$42**

1. Program Description

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention service that is 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. Hotline counselors will also conduct follow-up calls for individuals who give their consent to ensure their continued safety. Callers who are not experiencing a crisis are triaged and offered access to a WarmLine or other appropriate resources.

2. Outcomes

During FY 13/14, a total of 7,334 calls were received and 6,094 callers were served by the Crisis Prevention Hotline. Of the total calls received, 73% were crisis calls and 27% were information/referral calls. The total number of calls increased by 12% from the previous fiscal year. In addition, the program conducted 48 staff initiated rescues and 262 outreach activities that reached 26,926 individuals.

The Suicidal Intent Assessment was administered to callers at the beginning and end of the call who expressed suicidal intentions. Among the 930 participants with matched pre-test and post-test scores, 54% of participants reporting decreased suicidal intent. Of all the callers who were categorized as medium risk at the beginning of the call, 79% exhibited lower risk by the end of the call. Additionally, of all the callers who were categorized as high risk at the beginning of the call, 66% showed lower risk by the end of the call.

COMMUNITY-FOCUSED EARLY INTERVENTION PROGRAMS	
CF8 Survivor Support Services	
Estimated annual number to be served in FY 15/16	**200**
Annual Budgeted funds for FY 15/16	**$270,693**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,353**

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. 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

During FY 13/14, 137 participants were served by Survivor Support Services. Additionally, these numbers do not take into account the 59 training activities conducted for 3,054 individuals, and the 203 outreach events which reached 26,926 individuals.

The Patient Health Questionnaire (PHQ-9) measures depressive symptom severity among participants, with higher scores indicating more severe depressive symptoms. This was administered to participants at program intake and at program exit. Among the 33 participants with matched pre-test and post-test scores, there was an overall average improvement of 44%, with 79% of participants reporting decreased depression severity scores.

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF9 Parent Education and Support Services	
Estimated annual number to be served in FY 15/16	**3,400**
Annual Budgeted funds for FY 15/16	**$507,590**
Estimated Annual Cost Per Client (for direct service programs only)	**$149**

1. Program Description

Parent Education and Support Services provides parent education to strengthen parenting skills and family communication. The program utilizes an evidence-based training model called COPE and provides parent education classes to parents and caregivers of children 0 to 12 years of age.

2. Outcomes

During FY 13/14, 3,302 participants were served by Parent Education and Support Services.

The Protective Factors Survey was used to measure changes in a family's protective factors in the area of nurturing and attachment. This was administered to parents/caregivers at program intake and at program exit. Of the 531 participants with pre-test and post-test scores, 54% of participants improved in nurturing and attachment scores.

The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 457 participants with matched pre-test and post-test scores, the overall average improvement in scores was 12 percentage score points.

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF10 Family Support Services	
Estimated annual number to be served in FY 15/16	**1,600**
Annual Budgeted funds for FY 15/16	**$718,424**
Estimated Annual Cost Per Client (for direct service programs only)	**$449**

1. Program Description

Family Support Services provides ongoing support for families struggling with behavioral health issues. The focus is on supporting and educating families about behavioral health and parenting issues to prevent the development of behavioral health problems in other members of the family. Services include group and individual support, weekly peer mentor support, educational workshops, a volunteer family mentor network, family matching and parenting classes. Family Support Services are available to family members/caregivers of individuals with behavioral health issues, and parenting classes are available to parents and caregivers of children 13 to 18 years of age.

2. Outcomes

During FY 13/14, 2,041 participants were served in Family Support Services, which is a 36% increase from the previous fiscal year.

The Protective Factors Survey was used to measure changes in a family's protective factors. For the Peer Mentoring Services, protective factors were assessed in the areas of family functioning/resiliency (n = 48), social support (n=47), concrete support (n=47), and nurturing and attachment (n = 47). Among the participants with matched pre-test and post-test scores, 100% of participants improved in concrete support, 96% improved in social support, 88% improved in family functioning and resiliency, and 81% improved in nurturing and attachment. For the Parenting Education Services, protective factors in the area of nurturing and attachment (n=965) were assessed. Among the participants with matched pre-test and post-test scores, 68% of participants improved in nurturing and attachment.

The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 898 participants with matched pre-test and post-test scores, the average improvement in scores was 24percentage score points.

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF11 Children's Support and Parenting Program	
Estimated annual number to be served in FY 15/16	**650**
Annual Budgeted funds for FY 15/16	**$1,400,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,154**

1. Program Description

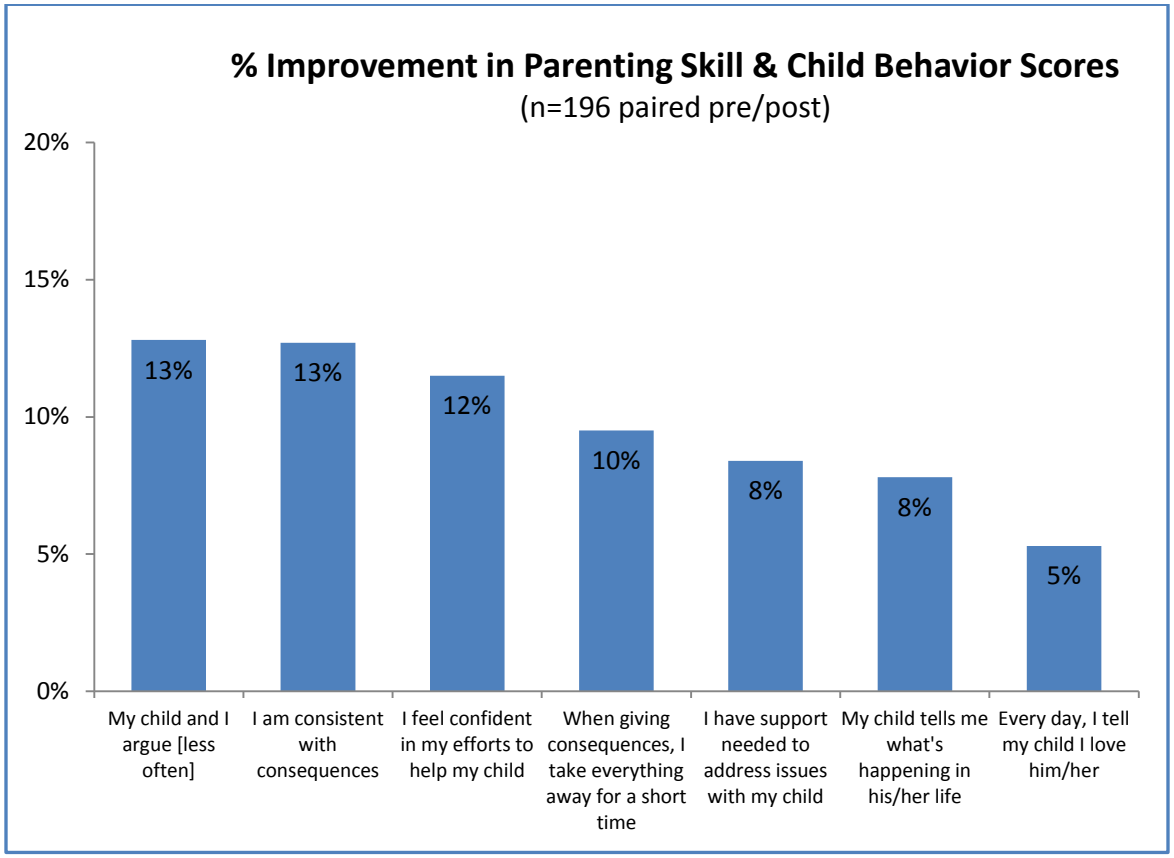
The Children's Support and Parenting Program (CSPP) serves a wide range of families from different backgrounds whose stressors make children more vulnerable to developing behavioral health problems. The program serves families that have a common parental history of serious substance abuse and/or mental 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.

2. Outcomes

During FY 13/14, 573 participants were served by the Children's Support and Parenting Program, which is a 20% increase from the previous fiscal year.

The Protective Factors Survey was used to measure changes in a family's protective factors in the areas of family functioning/resiliency, social support, concrete support, and nurturing and attachment. This was administered to parents/caregivers at program intake and at program exit. Of the 203 matched pairs with pre-test and post-test scores, 64% of participants improved in family functioning/resiliency, 55% of participants improved in nurturing and attachment, and 46% of participants improved in social and concrete support.

The Parent Survey is a self-report measure of parenting skills and child behaviors administered at program intake and exit, with higher scores indicating desirable parenting outcomes. Of the 196 matched pairs with pre-test and post-test scores, the largest improvements in scores were in the areas of parent-child communication (13%), consistent use of consequences (13%), and parenting confidence (12%).



The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 204 participants with matched pre-test and post-test scores, the average improvement in scores was 15 percentage score points, with 64% of participants reporting improved well-being.

COMMUNITY-FOCUSED PREVENTION PROGRAMS CF12 PEI Services for Parents and Siblings of Youth in the Juvenile Justice System (Stop the Cycle)	
Estimated annual number to be served in FY 15/16	**450**
Annual Budgeted funds for FY 15/16	**$1,000,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,222**

1. Program Description

The Stop the Cycle Program serves a broad range of families 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

During FY 13/14, 395 participants were served by the Stop the Cycle program, which is more than a 100% increase from the previous fiscal year.

The Protective Factors Survey was used to measure changes in a family's protective factors in the areas of family functioning/resiliency, social support, concrete support, and nurturing and attachment. Of the 135 matched pairs with pre-test and post-test scores, 58% of participants improved in nurturing and attachment, 56% in family functioning/resiliency, 52% improved in concrete support, and 47% improved in social support.

The Parent Survey is a self-report measure of parenting skills and child behaviors administered at program intake and exit, with higher scores indicating desirable parenting outcomes. Of the 133 matched pairs with pre-test and post-test scores, the largest improvements were in the areas of parenting confidence (17%), effective discipline strategies (14%), parenting support (14%), and less truant behavior of the child (14%).

The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being.

Among the 134 participants with matched pre-test and post-test scores, the average improvement in scores was 20 percentage score points.

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF13 Outreach and Engagement Collaborative	
Estimated annual number to be served in FY 15/16	**18,000**
Annual Budgeted funds for FY 15/16	**$3,819,044**
Estimated Annual Cost Per Client (for direct service programs only)	**$212**

1. Program Description

The Outreach and Engagement Collaborative provides mental health preventative services to unserved and underserved populations at risk of mental illness and behavioral health problems. 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 works with respected members of the community organization to connect them to those needing information and assistance and maintains 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.

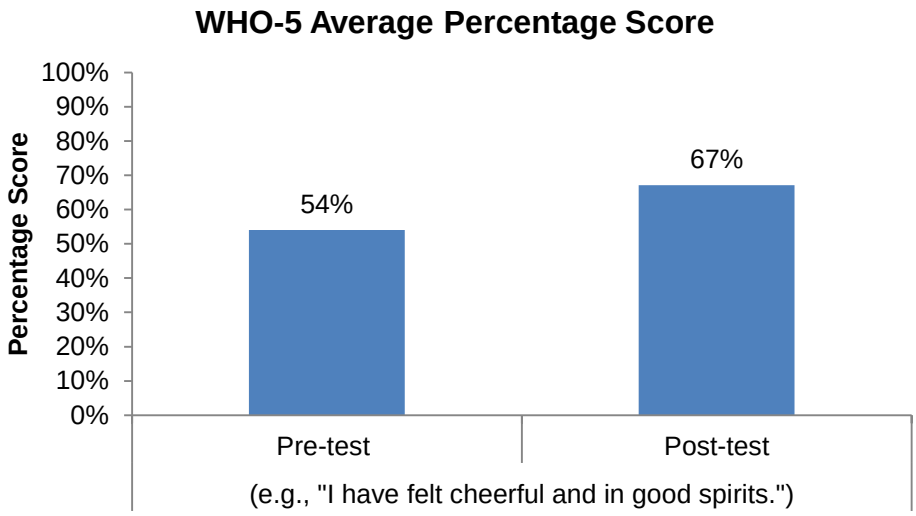
2. Outcomes

During the FY 13/14, a total of 24,441 participants were served by the Outreach and Engagement Collaborative. In addition, 115,553 were reached via outreach contacts, 1,921 group sessions were held, and 848 individuals received wellness screens. A total of 23,942 Outreach and Engagement referrals were made with 8,719 resulting in linkages. The top linkages in descending order are as follows: mental health care, family support services, adult education/literacy, food/nutrition services, employment services, legal services, financial assistance primary health care, and housing services.

For services targeting families with children, the Protective Factors Survey was used to measure changes in a family's protective factors in the areas of family

functioning/resiliency (*n* = 471), nurturing and attachment (*n* = 334), social support (*n* = 474), and concrete support (*n* = 460). This was administered to parents/caregivers at program intake and program exit. Of all participants with pre-test and post-test scores, 63% of participants improved in family functioning/resiliency, 55% improved in nurturing and attachment, 52% improved in social support, and 45% improved in concrete support.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 737 participants with matched pre-test and post-test scores, the average improvement in scores was 24 percentage score points.



COMMUNITY-FOCUSED PREVENTION PROGRAMS CF14 WarmLine	
Estimated annual number of calls in FY 15/16	**25,000**
Annual Budgeted funds for FY 15/16	**$441,566**
Estimated Annual Cost Per Call (for direct service programs only)	**$18**

1. Program Description

WarmLine 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. The WarmLine operates Monday through Friday 9am-3am and Saturday and Sunday 10am-3am.

2. Outcomes

During FY 13/14, a total of 24,605 calls were received and 10,790 callers were served by the WarmLine. The total number of calls received reflects a 50% increase from the previous fiscal year. Additionally, the total number of callers reflects a 67% increase from the previous fiscal year.

A modified version of the Profile of Mood States (POMS) was used. Callers were asked to report on one of ten mood states at the beginning and end of each call to track changes in their affective mood. Among the 19,602 callers with matched pre-test and post-test scores, 90% of participants reported feeling less overwhelmed, 90% reported feeling less anxious, 90% reported feeling less worried, and 85% reported feeling less depressed.

COMMUNITY-FOCUSED PREVENTION PROGRAMS	
CF15 Professional Assessors	
Estimated annual number to be served in FY 15/16	**3,550**
Annual Budgeted funds for FY 15/16	**$536,136**
Estimated Annual Cost Per Client (for direct service programs only)	**$151**

1. Program Description

Professional Assessors provide services to individuals who may be experiencing untreated depression and/or anxiety, or who may have been exposed to trauma to determine whether further evaluation and referrals to behavioral health services are needed. Services include screening, assessment, case-management and referral/linkages to community resources. Professional Assessors are currently placed at community sites including Veterans Treatment and Family Court, family health clinics and senior centers.

A new program was piloted integrating SBIRT (Screening Brief Intervention and Referral to Treatment) into the University of California, Irvine (UCI) Family Health Clinic in Santa Ana. The program developed a modified SBIRT screening tool to assess anxiety, depression, substance abuse problems, family violence exposure and exposure to trauma. Patients were offered screenings and re-screenings when visiting the clinic, by two licensed mental health clinicians. Patients who screened positive received a brief intervention and were referred to community or County services. Approximately one week after their screening, the clinicians made telephone follow-up calls to patients who screened positive to assess how the patients were doing and whether they had followed through on their referrals.

2. Outcomes

During F/Y 13/14, 36 enrolled Veterans were served at court locations. The Posttraumatic Stress Disorder (PTSD) Checklist – Military Version (PCL-M) was administered to participants to assess PTSD symptoms at program intake and program exit. Seventy-five percent of participants experienced a decrease in the severity of PTSD symptoms.

Between June 2013 and June 2014, a total of 4,313 patients were screened at the UCI Family Health Clinic using the modified SBIRT. Nearly one-third (29%, *n*=1,270) screened positive for a behavioral health issue. The majority of positive screens were for depression and/or anxiety, but some patients also showed

signs of problematic alcohol and/or drug abuse, violence exposure, or trauma. Approximately 50% of all positive screens identified an “untreated” issue (i.e., an issue that had not been treated/addressed in the previous month).

A total of 1,880 referrals were made for these patients, including referrals for some patients who screened negative, but whose scores indicated they were “at risk” for a behavioral health issue.

Finally, nearly four in ten patients (39%) were re-screened at least once after their initial screening (*n* = 1682). Based on daily aggregated data that were tracked, 60% of all patients who were re-screened showed no behavioral health issues at either time point. In contrast, 17% showed persistent symptoms over time, and 8% showed a worsening of symptoms over time (i.e., went from a negative initial screen to a positive re-screen).

Nurse Case Manager served 528 older adults in the community, providing 190 referrals and 114 confirmed linkages.

C. PEI Program Information & Outcomes: School-Focused (SF) Programs

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS	
SF1 School-Based Mental Health Services	
Estimated annual number to be served in FY 15/16*	**800**
Annual Budgeted funds for FY 15/16	**$2,000,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$2,500**

*The annual estimated number to be served is for a 12 month period. The actual number to be served in the first year will be less due to the program start-up process, such as hiring staff and will depend on the program implementation date.

1. Program Description

The School-Based Mental Health Services will provide a combination of prevention and intervention services to empower families, reduce risk factors, build resiliency, and strengthen culturally appropriate coping skills in students. These school-based services will also utilize peer-to-peer helping programs to play a role in reducing the alienation and disconnectedness many youth feel from their schools, families, and society.

Services will include parent education, individual/group counseling, crisis intervention, case management, community linkages, referrals, educational groups, screening and early intervention.

2. Outcomes

Services are anticipated to begin during the first half of 2015. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include brief pre/post measures of youth symptoms of depression and anxiety, past 30-day substance use, and general well-being, as well as participant feedback surveys to measure such things as increased knowledge of access to community resources and satisfaction with the peer-to-peer interactions and overall services.

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS SF2 School-Based Behavioral Health Intervention and Support-Early Intervention Services	
Estimated annual number to be served in FY 15/16	**16**
Annual Budgeted funds for FY 15/16	**$400,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$25,000**

1. Program Description

The School-Based Behavioral Health Intervention and Support - Early Intervention Services serves families with children, grades K-7, experiencing challenges in attention, behavior and learning and/or Attention Deficit/Hyperactivity Disorder (ADHD). The program provides a regular education school experience with modifications and skill development to meet the psychosocial and academic needs of children and families. Program services include academic support, social skills development, parent training and academic transitional support. The duration of the program is 12 to 24 months, after which the child is transitioned to the next academic setting.

2. Outcomes

During FY 13/14, 25 children were served. Clinical staff worked with participants to identify and correct problem behaviors by setting target behaviors. Of the students who worked on improving social-emotional regulation, 86% improved. Of the students working on verbal self-regulation and motor self-regulation, 67% improved.

The Dynamic Indicators of Basic Early Literacy Skills (DIBELS) was used to assess academic development in basic literacy skills among participants. Among the 12 participants with matched pre-test and post-test scores, 58% of participants demonstrated improved basic literacy skills scores.

The Disruptive Behavior Stress Inventory (DBSI) was administered to assess the occurrence and severity of specific behavior-related stressors that result from having a child with ADHD. Among the 10 parent/caregivers with matched pre-test and post-test scores, 90% of participants reporting decreased behavior-related stressors.

SCHOOL-FOCUSED EARLY INTERVENTION PROGRAMS	
SF3 School Readiness Program/Connect the Tots	
Estimated annual number to be served in FY 15/16	**1,500**
Annual Budgeted funds for FY 15/16	**$1,800,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,200**

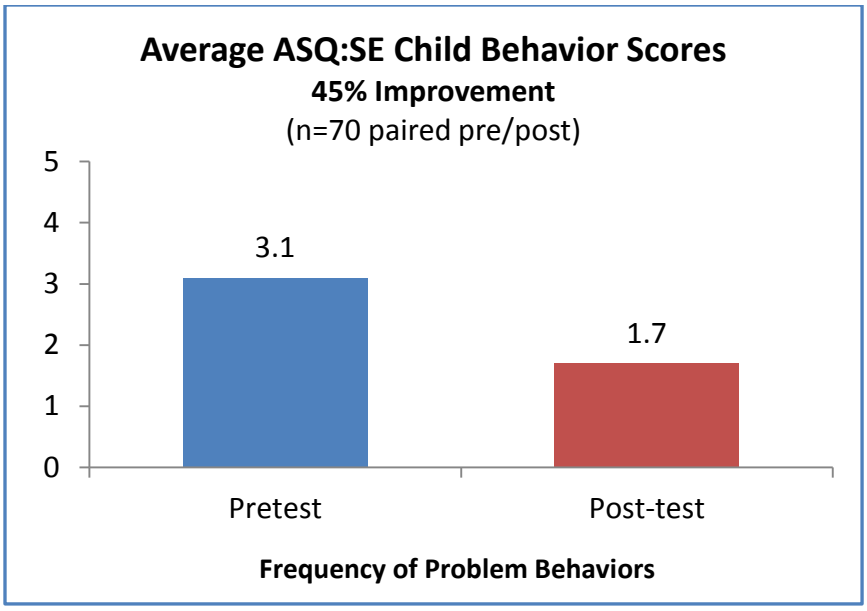
1. Program Description

School Readiness Program/Connect the Tots provides services to underserved families with children 0 to 6 years of age 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 School Readiness Program/Connect the Tots services include children's and family needs assessment, parent education and training, case management and referral and linkage to community resources. Connect The Tots and the School Readiness Program take a regional approach in covering the County. Initially, Connect the Tots was the only program in place. The implementation of the School Readiness Program in FY 13/14 has allowed the two programs to better serve the community in a geographical region of OC.

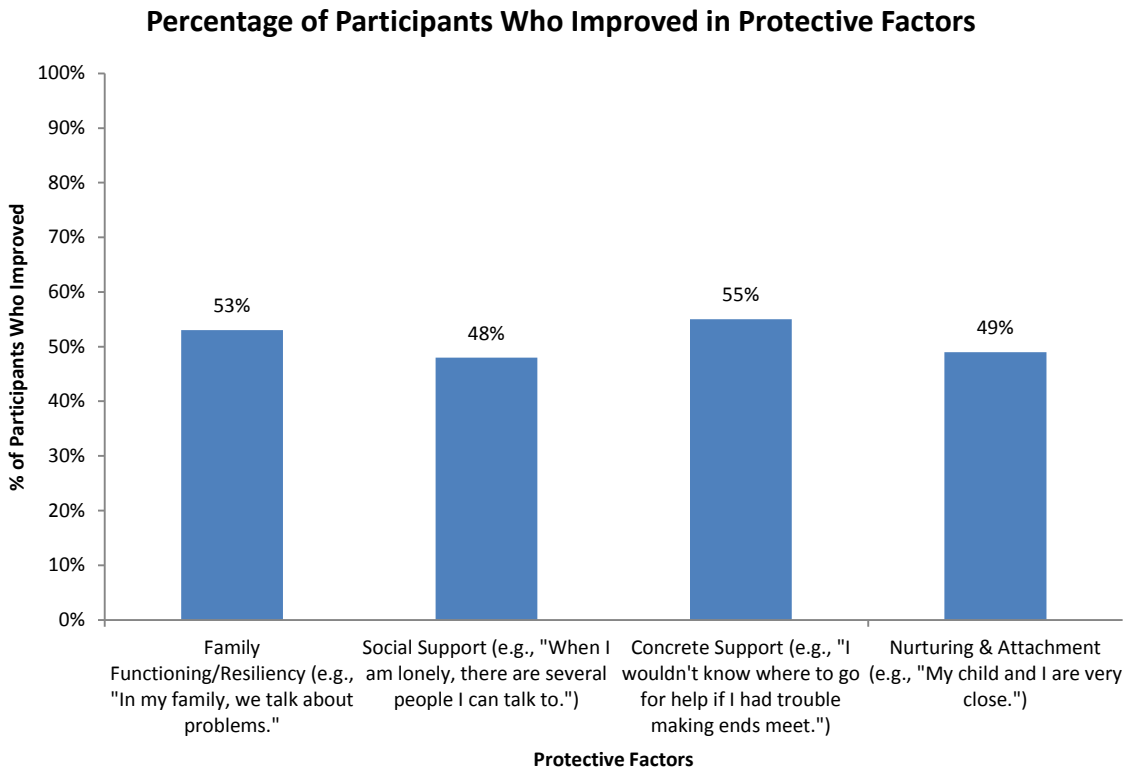
2. Outcomes

During FY 13/14, 1,361 children were served by the School Readiness/Connect the Tots programs. These numbers do not reflect the 66 outreach events reaching 881 participants and the 15 parenting workshops reaching 194 participants. For Connect the Tots, the number of participants served reflects an increase of 15% from the previous fiscal year.

The Connect the Tots program administered the Ages and Stages Questionnaire: Social Emotional (ASQ:SE) for parents of children 0 to 5 years of age, to assess the parents' ratings of frequency of specific child behaviors. Among the 70 participants with matched pre-test and post-test scores, on a 5-point scale, average scores of problem behaviors decreased from 3.1 to 1.7.



The Protective Factors Survey was used by both the School Readiness and Connect the Tots programs to measure changes in family protective factors in the areas of family functioning/resiliency (*n* = 282), social support (*n* = 280), concrete support (*n* = 278), and nurturing and attachment (*n* = 276). Among the participants with matched pre-test and post-test scores, 54% of participants had improved scores measuring family functioning/resiliency, 55% had improved scores measuring concrete support, 49% improved in nurturing and attachment, and 48% improved in social support.



The World Health Organization Well-being Index (WHO-5) was used to measure parent/caregiver participants' well-being in both programs. A 10-point change in percentage scores indicates a significant change in well-being. Among the 281 participants with matched pre-test and post-test scores, the average improvement was 15 percentage score points.

SCHOOL- FOCUSED PREVENTION PROGRAMS	
SF4 College Veterans Program (The Drop Zone)	
Estimated annual number to be served in FY 15/16	**50**
Annual Budgeted funds for FY 15/16	**$150,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,000**

1. Program Description

The College Veterans Program is a collaborative with local community colleges. The program provides services on-campus at the Veterans Resource Center for students who are military veterans. Veteran students have access to appointments with a Behavioral Health Services clinician who is also a veteran. Some of the direct interventions available include behavioral health screening and assessment, individualized case management, referrals and linkages to appropriate community resources. The clinician also provides outreach and engagement on Orange County campuses using veteran-specific events and support groups to encourage discussion of barriers to successful transition to college and civilian life.

2. Outcomes

During FY 13/14, 28 veterans were served in case management services by the College Veterans Program. Additionally, 458 individuals were served in outreach events. The MOU was not in place at Orange Coast College until mid FY 13/14, accounting for fewer veterans being served.

The Posttraumatic Stress Disorder Checklist – Military Version (PCL-M) was administered to participants to assess PTSD symptoms. The recommendations indicate that a 5-point minimum threshold must be met in order to indicate a response to intervention, and a 10-point threshold must be met to indicate a clinically-meaningful improvement. The scale was administered at program intake and at program exit. Among the 23 participants with matched pre-test and post-test scores, the overall average decrease in PTSD symptoms was 10 points, with 78% of participants experiencing decreased scores on the PCL-M. Specifically, 10 participants (44%) showed clinically meaningful improvements between pre-test and post-test scores.

The World Health Organization Well-being Index (WHO-5) was used to measure participants' well-being. A 10-point change in percentage scores indicates a

significant change in well-being. Among the 23 participants with matched pre-test and post-test scores, the average improvement was 34 percentage score points.

SCHOOL-FOCUSED PREVENTION PROGRAMS	
SF5 School-Based Behavioral Health Intervention and Support	
Estimated annual number to be served in FY 15/16	**20,500**
Annual Budgeted funds for FY 15/16	**$1,749,589**
Estimated Annual Cost Per Client (for direct service programs only)	**$85**

1. Program Description

School-Based Behavioral Health Interventions and Supports (BHIS) provides services and curriculum for students and their families for the purpose of preventing and/or intervening early with behavioral health conditions. Services are provided in elementary, middle and high schools in school districts that have the highest indicators of behavioral issues, including dropout rates, expulsions, and suspensions. Curriculum is implemented at the classroom level for all students in these schools and more intensive curriculum is available for students and families with a higher level of need.

2. Outcomes

During FY 13/14, 16,907 participants were served by BHIS. This was the first year of this program implementation, and delays in program implementation resulted from the MOU approval process which was required by each school district accounting for reduced number served. Program services were provided in 5 school districts including Santa Ana Unified, Orange Unified, La Habra City, Huntington Beach City and Huntington Beach Joint Union High. Overall, 75% of school personnel who responded to the survey reported increased knowledge of local resources and support services. In addition, 100% of the schools exhibited improvements in students' social-emotional development, with 30% to 41% of student surveys demonstrating improvements in the areas of self-control, prosocial behaviors, honesty, and self-development.

SCHOOL-FOCUSED PREVENTION PROGRAMS	
SF6 Violence Prevention	
Estimated annual number to be served in FY 15/16	**12,775**
Annual Budgeted funds for FY 15/16	**$1,287,751**
Estimated Annual Cost Per Client (for direct service programs only)	**$101**

1. Program Description

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

Safe from the Start

The Safe from the Start program provides essential knowledge specific to the brain development of young children. This program disseminates scientific research based on how exposure to violence, whether through direct physical impact or witnessing violence, can impact the neurological development of young children. Such exposure can compromise learning and normal cognitive development, as well as social and emotional development.

Gang Reduction Intervention Partnership (GRIP)

The Gang Reduction Intervention Partnership (GRIP) provides case management services in schools across Orange County. GRIP provides services to 4th through 8th grade youth who display signs of being at risk for gang activity. Schools selected for service include sites with high levels of truancy, discipline issues and gang proximity. Case-managed youth are enrolled based on individual rates of truancy, disciplinary issues, and poor academic performance in comparison to other students at the school site.

Crisis Response Network/Behavioral Health Disaster Response

The Crisis Response Network/Behavioral Health Disaster Response coordinates, manages and mobilizes a roster of trained crisis responders who are ready and can assemble to assist the school and community in times of emergency or need. The Crisis Response Network/Behavioral Health Disaster Response is a resource for schools and the community for situations that may be a threat and/or crisis to student(s).

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

Media Literacy
The Media Literacy program provides training and support for students, parents and school staff on areas related to the use of digital media, bullying, and cyber-bullying. Programs are designed to decrease opportunities for digital harassment, bullying and exploitation at the student level.

Conflict Resolution
The Conflict Resolution program provides support to students and parents in the development of conflict resolution and peer mediation skills. Training and skill-building activities are available for students to learn and develop needed skills related to solving conflicts at the school level.

2. Outcomes

During FY 13/14, 14,858 participants were served across all Violence Prevention programs.

Satisfaction surveys were administered across all programs and participants expressed high satisfaction overall, with 89% indicating that they were satisfied with the trainings, and 85% indicating that they would recommend the trainings or presentations to a friend.

OC GRIP administered the World Health Organization Well-being Index (WHO-5) to measure participants' well-being. A 10-point change in percentage scores indicates a significant change in well-being. Among the 273 with matched pre-test and post-test scores, the average improvement in scores was 10 percentage score points.

SCHOOL-FOCUSED PREVENTION PROGRAMS	
SF7 Transitions	
Estimated annual number to be served in FY 15/16	**2,000**
Annual Budgeted funds for FY 15/16	**$915,236**
Estimated Annual Cost Per Client (for direct service programs only)	**$458**

1. Program Description

Transitions is a prevention program serving youth making a transition in their lives, such as transitioning from elementary to middle school and middle to high school. The goal of the program is to develop protective factors and create resilience in youth to better meet the new academic and social challenges and educate parents about these challenges and how they can assist their transitioning youth. Services include curriculum provided in the classroom and workshops for parents and caregivers.

2. Outcomes

During FY 13/14, 1,713 participants were served by the Transitions program, which is an 11% increase from the previous fiscal year. A total of 658 student sessions and 25 parent education sessions were held.

The Youth Survey was administered to participants to assess students' knowledge based on the curriculum. Among the 547 participants with matched pre- and post-test scores, 57% of students improved their knowledge score, with an average improvement of 12%. Most notably, at post-test, 28% more students knew the signs of withdrawal from substance use, 20% more knew that assertive is the most successful form of communication, and 17% more demonstrated knowledge of what is not a healthy way to handle academic stress. Additionally, students showed a 19% increase in frequency of trying to work out problems by talking and/or writing.

The School Climate Survey was administered before and after the Transitions program to assess changes in school-related domains such as relationships between students and staff, student learning engagement and motivation, safety, violence, and victimization (bullying). The survey items assess school staff perceptions of physical and emotional safety at the school as well as the frequency of positive and negative behaviors among students at the school. Surveyed school staff reported perceived improvements in school climate such as decreases in gang activity (7.1%), threats of violence towards teachers

(5.5%), and student disrespect of teachers (5.3%), as well as increases in students resisting peer pressure (5.3%).

SCHOOL-FOCUSED PREVENTION PROGRAMS	
SF8 K-12 Coping Skills to Manage Stress	
Estimated annual number to be served in FY 15/16*	**4,720**
Annual Budgeted funds for FY 15/16	**$120,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$26**

*The annual estimated number to be served is for a 12 month period. The actual number to be served in the first year will be less due to the program start-up process, such as hiring staff and will depend on the program implementation date.

1. Program Description

This program will serve students in grades K-12. Services include utilizing evidence-based mindfulness practices to reduce stress and increase coping skills. A similar program has been piloted in Orange County schools and shown to promote resiliency and increase students' ability to manage their stress through learned stress-reduction techniques.

2. Outcomes

This program will go out for RFP in FY 15/16. Outcome measures will be determined as part of the program evaluation plan which will include the completion of a program logic model. Proposed outcome measures may include the Child & Youth Questionnaire, for measuring improvements in youth resilience and coping skills, as well as program-specific survey items to assess satisfaction with the program and increased knowledge, self-efficacy (confidence) and/or skills in the area of mindfulness-based stress management.

D. PEI Program Information & Outcomes: System Enhancement (SE) Programs

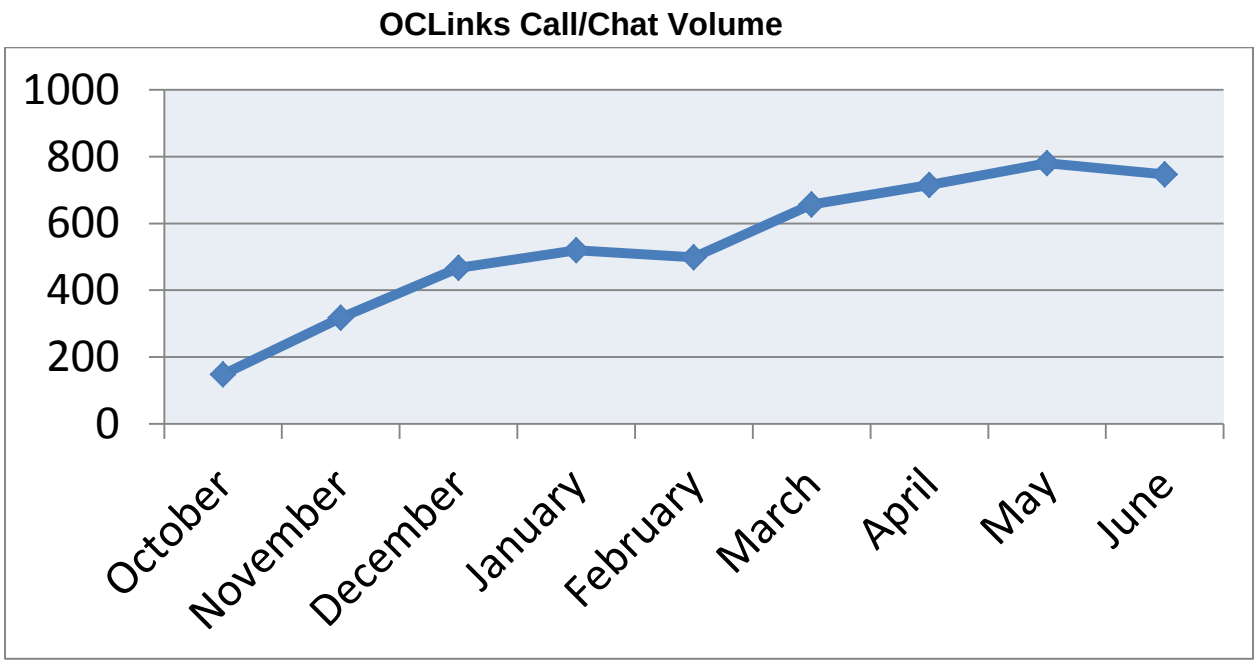
SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE1 Information and Referral/OCLinks	
Estimated annual number to be served in FY 15/16	**8,760**
Annual Budgeted funds for FY 15/16	**$1,000,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$114**

1. Program Description

OCLinks is a telephone and internet chat-based information and referral line that serves as a single access point for any community member seeking behavioral health services through the County of Orange's Health Care Agency/Behavioral Health Services department. Clinical Navigators have been extensively trained on all of the Child/Adult Mental Health, Alcohol and Drug inpatient and outpatient, and Prevention/Early Intervention programs provided through County and County contracted operations. Program services include callers' needs assessment and direct linkage to appropriate program. A clinical staff position has also been added at Emergency Treatment Services (ETS) to provide resource linkage for families in need of assistance with navigation and accessing services.

2. Outcomes

During FY 13/14, 4,867 participants were served by OCLinks during the first 8 months of the program. There were 5,583 referrals and 3,324 linkages provided to callers. Additionally, staff at ETS served a total of 269 participants, with 252 referrals to services. The total number of follow-ups and linkages will be tracked in FY 14/15 data reports.


OCLinks Call/Chat Volume
1000
800
600
400
200
0
October
November
December
January
February
March
April
May
June

SYSTEM ENHANCEMENT PREVENTION PROGRAMS SE2 Training, Assessment and Coordination Services	
Estimated annual number to be served in FY 15/16	*****
Annual Budgeted funds for FY 15/16	**$984,777**
Estimated Annual Cost Per Client (for direct service programs only)	**Not a direct service program**

*Cannot estimate annual number to be served. There are currently no agreements and we cannot anticipate what agreements may be approved.

1. Program Description

The goal of the Training Assessment Program is to provide a variety of relevant behavioral health-related trainings for the many communities in Orange County. Included in this program, is funding specifically for Crisis Response Network/ Behavioral Health Disaster Response Services for increasing the County's capacity for responding to the mental health needs of the community during disasters and crises.

Since many things have changed in the economy and environment since the original PEI Plan was created, a more up-to-date needs assessment is needed before the training plans can be developed and implemented. To obtain this information, a countywide needs assessment will be completed to determine the current training needs of caregivers and service providers.

Once the needs assessment is completed and the program is implemented, ongoing services will include the development and coordination of countywide training plans.

2. Outcomes

During FY 13/14, a total of 300 participants were served by the Crisis Response Network/Behavioral Health Disaster Response Services. Services included debriefings to 116 individuals, Psychological First Aid trainings to 52 individuals, crisis management briefings to 108 individuals, and supportive consultations to 24 individuals.

Contract for the training needs assessment was executed in March 2015, and the final assessment will be completed in September 2015

SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE3 Training in Physical Fitness and Nutrition Services/Goodwill	
Estimated annual number to be served in FY 15/16	**100**
Annual Budgeted funds for FY 15/16	**$50,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$500**

1. Program Description

The Goodwill Fitness Center is a 12,000-square-foot facility specifically designed for people living with physical disabilities or chronic illness. The Fitness Center offers accessible exercise equipment, knowledgeable, trained staff, a personalized fitness program as well as group support and nutrition education classes. This program makes this service available for individuals receiving Behavioral Health Services.

2. Outcomes

During FY 13/14, 80 new participants used the Goodwill Fitness Center. On average, a total of 26 participants used the facilities per month.

Overall, all participants who completed the satisfaction survey (*n* = 9) reported that the staff treated them with courtesy and respect, and that they would recommend the services to someone they know.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE4 Community-Based Stigma Reduction	
Estimated annual number to be served in FY 15/16	*
Annual Budgeted funds for FY 15/16	**$214,333**
Estimated Annual Cost Per Client (for direct service programs only)	

*Cannot estimate annual number to be served. There are currently no agreements and we cannot anticipate what agreements may be approved.

1. Program Description

Community-Based Stigma Reduction services provide artistic events and activities that support self-confidence and hope to consumers and their family members and educate the general public about the abilities and experiences of those living with a behavioral health issue. Activities include art workshops and exhibits, musical and dance performances representing many cultures, and other activities as approved. These events provide a creative outlet and entertainment with consistent messages aimed at ending the silence of mental illness.

2. Outcomes

During FY 13/14, there were no new projects. However, for FY 14/15, several stigma and arts projects are currently underway.

SYSTEM ENHANCEMENT PREVENTION PROGRAMS	
SE5 Statewide Projects	
Estimated annual number to be reached in FY 15/16	**35,946**
Annual Budgeted funds for FY 15/16	**$900,000**
Estimated Annual Cost Per Client (for direct service programs only)	**$25**

1. Program Description

Statewide Prevention and Early Intervention (PEI) Projects include the Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health initiatives. Suicide Prevention activities include social marketing and training to support helpers and gatekeepers identify and respond to suicide risk and work with local suicide prevention partners to respond to individuals in crisis through hotlines. Stigma and Discrimination Reduction activities include implementation of best practices to support help-seeking behavior, build knowledge and change attitudes through development of policies, protocols, and procedures; informational/online resources; training and educational programs; and media and social marketing campaigns, including cultural adaptations to engage and inform underserved racial and ethnic communities. Student Mental Health activities include partnerships from Kindergarten through Higher Education to change school climate and campus environments by promoting mental health, engaging peers, providing student screening and providing technical assistance and social media campaigns to support efforts, increase awareness and engage community locally.

2. Outcomes

A 2015 RAND report, entitled “Evaluation of California’s Statewide Mental Health Prevention and Early Intervention Programs,” reviewed the evaluation findings from the summer of 2013 through the fall of 2014. Based on the report, the CalMHSA PEI initiatives are already showing positive outcomes in stigma and discrimination reduction, suicide prevention, and improvement of student mental health. For example, the Each Mind Matters campaign has shown signs of promise, with a modest number of adults (11%) having already been exposed to the campaign within the first month of its launch. The report highlights several key findings informing future program planning and evaluation currently underway.

Innovation

Innovation

A. Component Information

An Innovative project is defined as one that contributes to learning rather than one with 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 project contributes to learning in one or more of the following three ways.

1. Introduces new mental health practices/approaches including prevention and early intervention that have never been done;
2. Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community;
3. 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) programs can be conceived of as research projects to evaluate the effectiveness of new approaches and practices. By their very nature, not all INN projects will be successful. Innovation projects are expected to be operational about one to three years - although in some instances the length of the project may be extended. A thorough evaluation of each project will be conducted. Findings will be shared with the MHSA Steering Committee. Those projects deemed "unsuccessful" will be discontinued. To continue, those projects showing positive outcomes, another funding source must be identified.

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

The initial nine Group 1 Innovation projects all shared a common theme, which was the involvement of consumers and family members (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. A major objective of these Group 1 innovation projects, is to increase paid employment opportunities for trained consumers and family members and to assess the impact of having peers involved in service delivery and support.

The overarching question from the 9 Group 1 projects is: “Can a well-trained consumer/family member be an effective paraprofessional in all clinical settings?”

The nine initial Group 1 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. Project Life Coach
8. Training to Meet the Mental Health needs of the Deaf Community
9. Brighter Futures (formerly Consumer Early Childhood Mental Health)

All of the nine projects have been implemented. In the FY 13/14 Annual Update, an additional eight programs were approved locally. Of these three were deemed not to be innovative by the MHSOAC. The five remaining programs were approved by the MHSOAC on April 24, 2014.

These five Innovation Group 2 projects are:

1. Proactive On-site Engagement Collaborative Courts
2. Religious Leaders Trained in Mental Health First Aid
3. Access to Mobile Cellular/Internet Devices for Improving Quality of Life
4. Veterans Services for Military/Veteran Families and Caregivers
5. Skill Sets for Independent Living Project

In FY 14/15, three of these projects were bid out by the Health Care Agency. The evaluation panels are currently reviewing received bids and will be recommending providers based on their review of the bids. Projects will commence in FY 15/16. The remaining two projects are in the development phase.

As detailed earlier in the Community Program Planning section of this document, the Health Care Agency conducted a robust community stakeholder process for identifying new Innovation Group 3 projects. Technological Assistance meetings were held to help those with ideas work on program description, innovation language and budget writing. After being presented with the different Innovation Group 3 Project Ideas, the Mental Health Act Steering Committee recommended 11 projects to move forward for approval and funding.

1. Continuum of Care for Veteran and Military Children and Families
2. Community Employment Services Project
3. Employment and Mental Health Services Impact
4. Veteran Student Needs Assessment and Treatment
5. Shared Housing Program
6. Child Focused Mental Health Training for Religious Leaders
7. Job Training and On-Site Support for TAY
8. Developing and Testing Effective EBPs for Children
9. LGBTIQ Homeless Project
10. Immigrant Screening and Referrals
11. Whole Person Healing Initiative

Group 1 INN 1. Integrated Community Services (ICS)	
Estimated annual number to be served in FY 15/16	**600**
Annual budgeted funds for FY 15/16	**$1,666,432***
Estimated Annual Cost Per Client (for direct service programs only)	**$2,777**

*Innovation funding for this project will be fully expended in FY 15/16. Ongoing funding for this project will be assumed by Community Services and Supports (CSS)

1. Program Description

The Integrated Community Services (ICS) project is a collaboration between County Behavioral Health services and contracted community medical clinics that provide access to integrated medical and mental health services to County and community participants. The ICS model creates one health home for participants, bringing culturally and linguistically competent providers together to meet the needs of a diverse population. Mental health therapists, peer specialists (i.e., consumers or family members), psychiatrists, primary care physicians, and registered nurses work as an integrated team to provide coordinated care. 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 overall health outcomes for the participants involved.

There are two components to the ICS project: ICS County Home and ICS Community Home. On the County side, primary care physicians, registered nurses, and peer specialists are placed in three behavioral health clinics: Santa Ana, Westminster, and Anaheim. The ICS County home provides primary medical care services to transitional age youth (TAY), adults and older adults. Participants must be residents of Orange County, Medi-Cal eligible or enrolled, or have third party coverage. Project participants must also have a chronic health condition and be currently enrolled in behavioral health services at an Orange County Behavioral Health Clinic in Santa Ana, Westminster or Anaheim. Within the community side, County therapists and psychiatrists work within contracted and subcontracted primary care sites: Southland Health Center and Korean Community Services. The community side also contracts with Central City Community Health Center, which includes a psychiatrist and peer specialists. The ICS community home provides services to adults who are Medi-Cal enrolled

or eligible, or have third party coverage and have both a chronic primary care and a mental health care need.

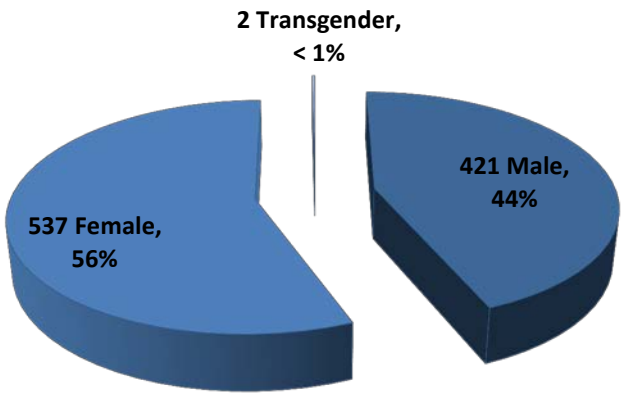
All ICS participants are assigned to either a nurse case manager or peer case manager. Services include assessment and treatment planning, case management, individual, family and group therapy, crisis intervention, care collaboration within a treatment team, in-service training, psychiatric evaluation and consultation, medication monitoring and support, outreach and engagement, assistance with healthcare enrollment, referrals and linkages, advocacy and mentoring, health education, and psychoeducation groups. Services available to participants enrolled in the Central City Community Health Center include psychiatric medication and case management. The program provides services in English, Spanish, Vietnamese, and Korean.

2. Outcomes

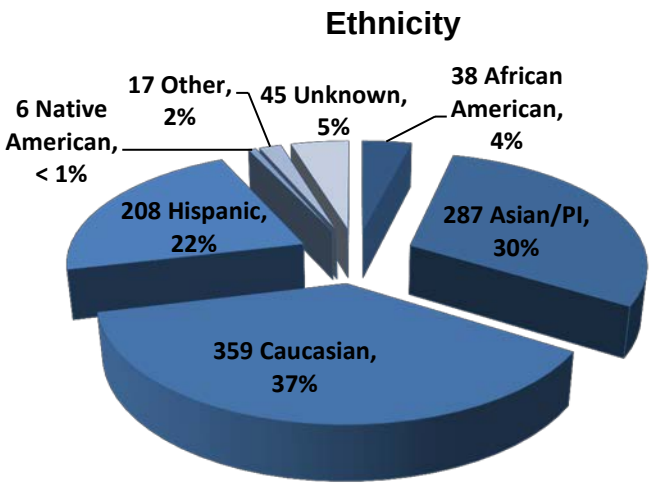
Data outcomes were analyzed from project launch date (September 1, 2011) to FY13/14. During this time frame, ICS served 960 participants. The participant demographics were as follows:

Participant Demographics
September 1, 2011 – June 30, 2014

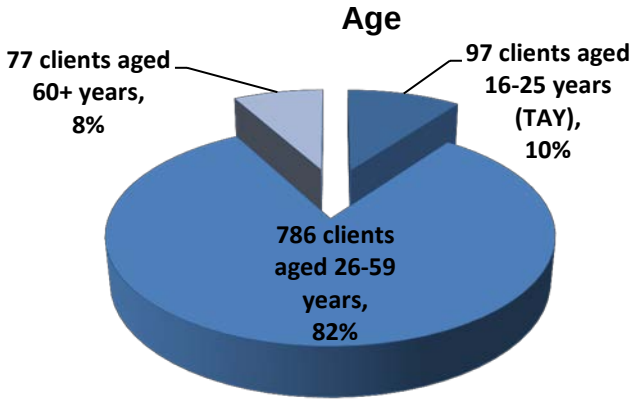
Gender



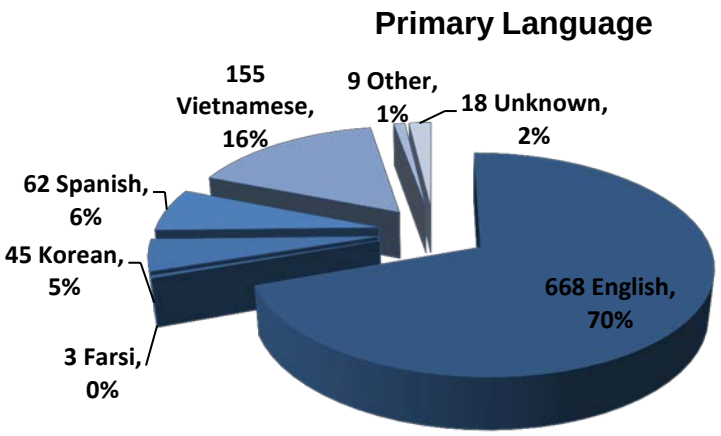
Gender	Gender	County	Community
Male	421	190	231
Female	537	171	366
Transgender	2	0	2
Total	960		



Ethnicity	Ethnicity	County	Community
African American	38	23	15
Asian/PI	287	33	254
Caucasian	359	192	167
Hispanic	208	85	123
Native American	6	2	4
Other	17	6	11
Unknown	45	20	25
Total	960		



Age	Age	County	Community
16-25 years (TAY)	97	43	54
26-59 years	786	316	470
60+ years	77	2	75
Total	960		



Primary Language	Primary Language	County	Community
English	668	326	342
Farsi	3	2	1
Korean	45	2	43
Spanish	62	19	43
Vietnamese	155	8	147
Other	9	2	7
Unknown	18	2	16
Total	960		

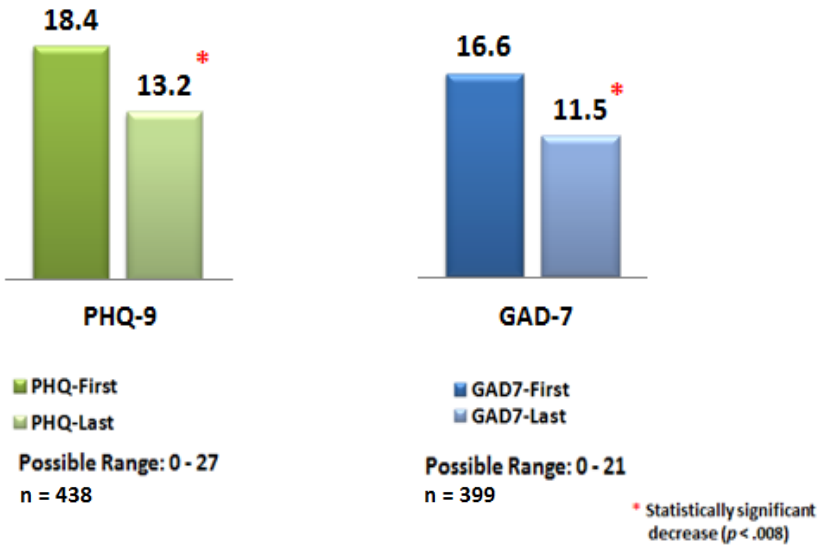
ICS served more females (56%) than males (44%). Ethnicity of participants varied, with 37% Caucasian, 30% Asian, and 22% Hispanic. Of the participants, 82% were between the ages of 26 and 59 years old, 10% were transitional age youth between the ages of 16 and 25 years old, and 10% were adults ages 60 years and older. In terms of primary language, 70% spoke English, 16% Vietnamese, 6% Spanish, and 5% Korean.

From project launch date to FY 13/14, ICS staff provided 1,488 referrals and made 565 successful linkages to various types of resources, including: transportation, specialty health care, primary health care, mental health care, and recreation to name a few of the many provided.

ICS utilizes a combination of behavioral health assessment tools, physical health measures, and laboratory measures to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale

(GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants complete the PHQ-9 and GAD-7 at enrollment and every six months until program exit. A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p < .008$) in symptoms of moderate or severe depression and anxiety. On average, participants experienced a reduction in their depression scores by 5.2 points and a reduction in their anxiety scores by 5.1 points.

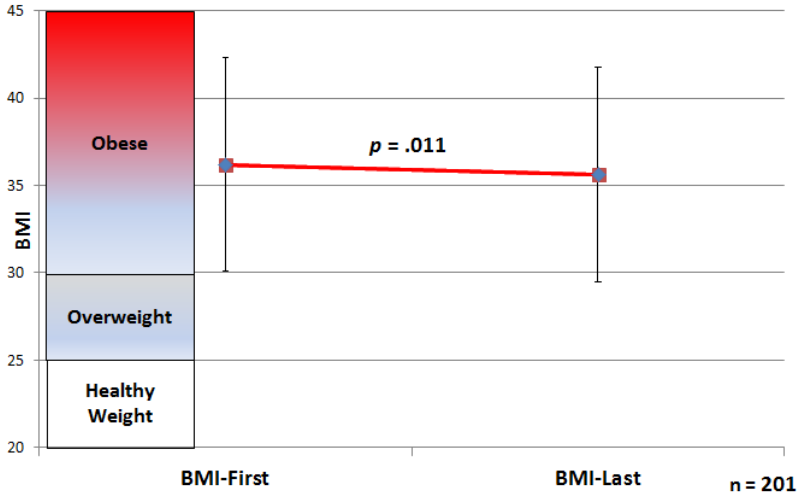
Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Scores
Initial Score = Moderate or Severe
Launch – June 30, 2014



In addition to behavioral health assessments, ICS maintains continuous tracking and comparison of lab measures to evaluate participants' progress in health outcomes. Physical health measures, such as blood pressure (BP), weight, height, Body Mass Index (BMI), and waist circumference, etc. are taken at every medical visit. Laboratory measures, such as cholesterol, A1C levels for diabetics, triglycerides, fasting blood sugar, etc. are taken as needed. A paired samples t-test was also used to test whether there was a significant pre/post change in BMI

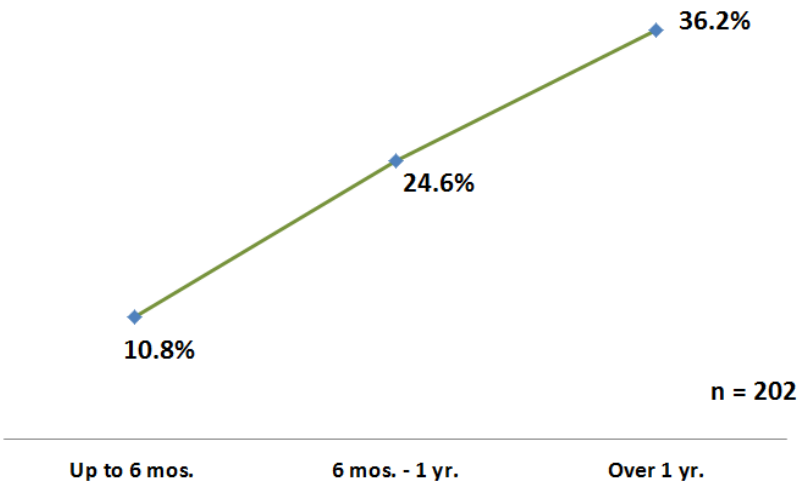
for those participants whose initial BMI measurement classified them in the obese range (BMI >=30). The graph below demonstrates on average participants lost about ½ a BMI point from initial measurement ($\overline{x}$ = 36.2) to last measurement ($\overline{x}$ = 35.6).

Change in Mean BMI for Initially Obese ICS Participants (BMI >=30)
First to Last Measurement
Launch – June 30, 2014



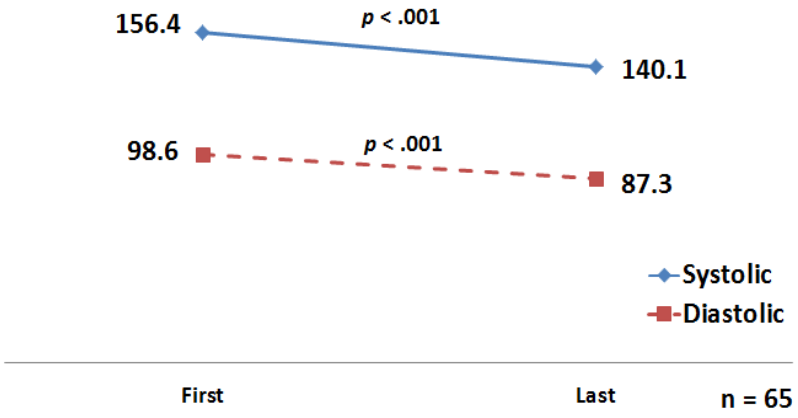
Results were also reported for the percent of initially obese ICS participants who showed significant weight loss (i.e., > 5%) between their first and last measurement based on the amount of time between measurement (i.e., up to 6 months, 6 months – 1 year, and over 1 year between first and last measurement). As indicated in the graph below, within 6 months of initial measurement, 10.8% of participants lost at least 5% of initial weight; within 6 months to 1 year, 24.6% lost at least 5% of initial weight; and within over a year, 36.2% lost at least 5% of initial weight. Overall, 22.3% of participants lost weight. This is particularly impressive, considering that the use of psychotropic medication often leads to weight gain.

Significant Weight Loss (>5%) Among Initially Obese ICS Participants
First to Last Measurement
Launch – June 30, 2014



In addition, a paired samples t-test was used to test whether there was a significant pre/post change in blood pressure (systolic and diastolic separately) for those participants whose initial BP classified them as hypertensive (> 140/90; p <.05). As indicated on the graph below, on average, participants experienced about 16-point drop in systolic and 10.5-point drop in diastolic BP.

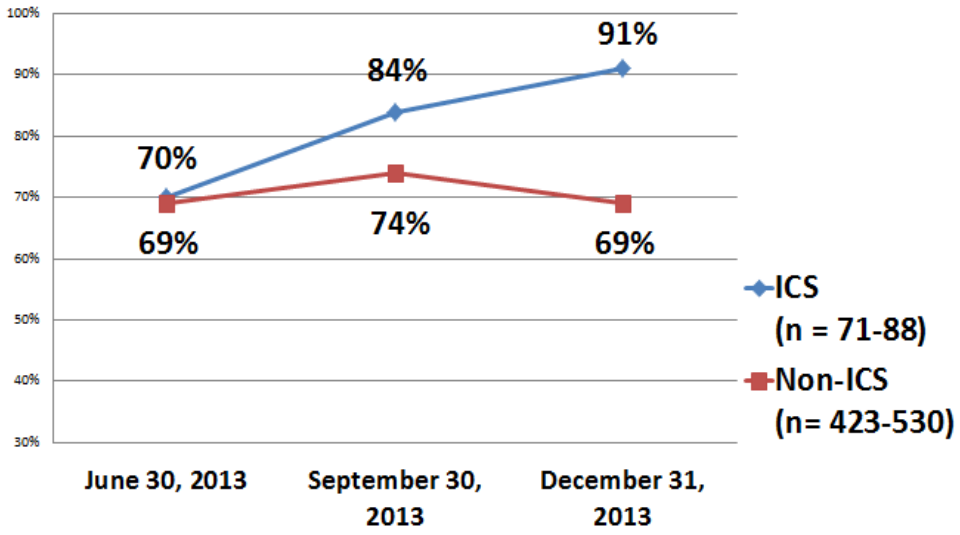
Change in Mean Blood Pressure for Initially Hypertensive ICS Participants (BP > 140/90)
First to Last Measurement
Launch – June 30, 2014



A separate report included the percent of ICS hypertensive participants and non-ICS participants being seen at the same clinic who showed blood pressure management over time (BP < 140/90; no statistical test computed). This comparison was done to determine whether the health improvements were

attributable to ICS specifically or to the care received in these clinics generally. At the last time-point of analysis (Dec 31, 2013), 91% ICS hypertensive participants were managing their BP as opposed to 69% of non-ICS participants. Compared to non-ICS participants, a greater proportion of hypertensive ICS participants showed a drop in BP so that their BP no longer classified as hypertensive (>140/90). Compared to non-ICS participants, a greater proportion of hypertensive ICS participants showed a drop in BP so that their BP no longer classified as hypertensive (>140/90).

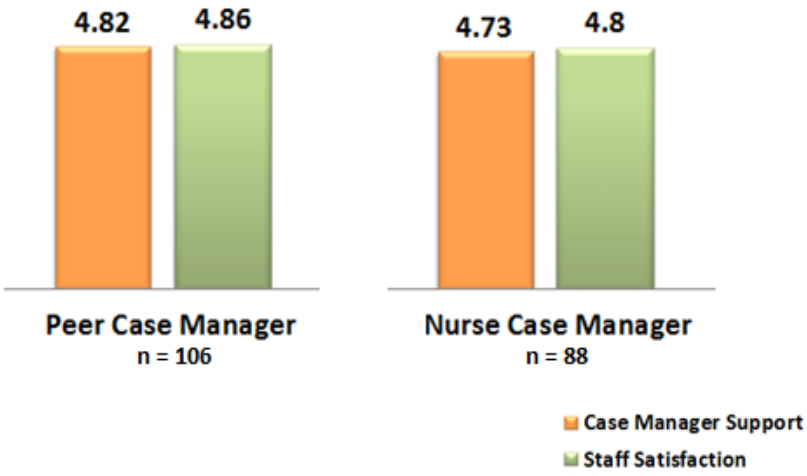
ICS Chronic Health Condition Management:
Hypertensive Patients* with BP > 140/90



* with and without diabetes

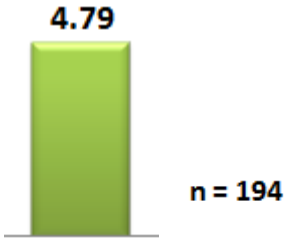
Data analysis also included results of satisfaction surveys completed by ICS participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction indicated participants were equally satisfied with services provided by peer and nurse case managers.

Comparison of Peer and Staff Satisfaction
By Case Manager Assignment
Participant Survey FY 13/14
Possible range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.79 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13 –14
Possible Range: 1 – 5



ICS data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of ICS program services, innovative components, assessment measures, and participant outcomes to committee and community members. Based on the project's successful outcomes and positive impact, Health Care Agency staff recommended the continuation of project services through alternative funding. The MHSA Steering Committee approved the continuation of project services for an additional two years through the Community Services and Supports (CSS) component of MHSA.

Group 1 INN 2. Collective Solutions	
Estimated annual number to be served in FY 15/16	**150**
Annual budgeted funds for FY 15/16	**$216,370***
Estimated Annual Cost Per Client (for direct service programs only)	**$1,442**

*Innovation funding for this project will be fully expended in FY 15/16.

1. Program Description

Collective Solutions (formerly Family-Focused Crisis Management and Community Outreach) provides community-based services to family members struggling to cope with or manage a loved one's diagnosis or symptoms of mental illness. While many programs offer direct services to individuals suffering from mental illness, Collective Solutions focuses on the impact and recovery process of family members. The primary purpose of this project is to promote interagency collaboration that will reduce stigma related to mental illness and assist family members in creating a community-based support network. This project includes an innovative approach of utilizing peer specialists to empower families, instill hope, and model recovery for participants and their loved ones.

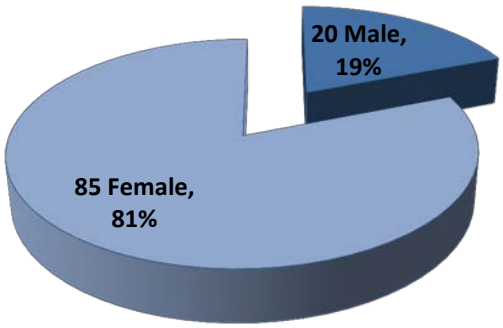
Through a combination of counseling and peer support services, the project assists family members in strengthening family communication and functioning; reducing stigma regarding mental illness; navigating the mental health system; practicing self-care; and increasing the ability to effectively manage, cope and respond to crisis situations. Project services include peer support; short-term individual, couple, and family counseling; case management; referral and linkage to mental health services within Orange County; and education about mental illness. This project provides services in English and Spanish.

2. Outcomes

Data outcomes were analyzed from project launch date (April 4, 2012) through FY13/14. During this time frame, Collective Solutions served 105 unduplicated participants and 81 additional family members. The participant demographics were as follows:

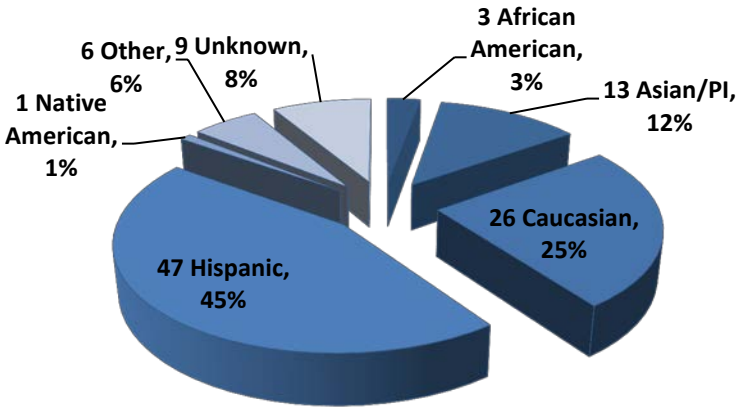
Participant Demographics
Launch – June 30, 2014

Gender



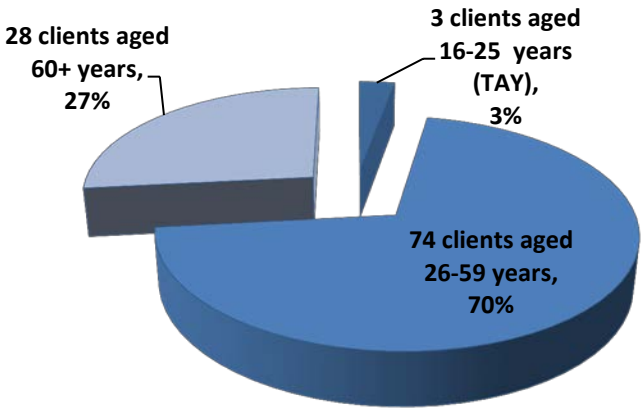
Gender	#
Male	20
Female	85
Total	105

Ethnicity



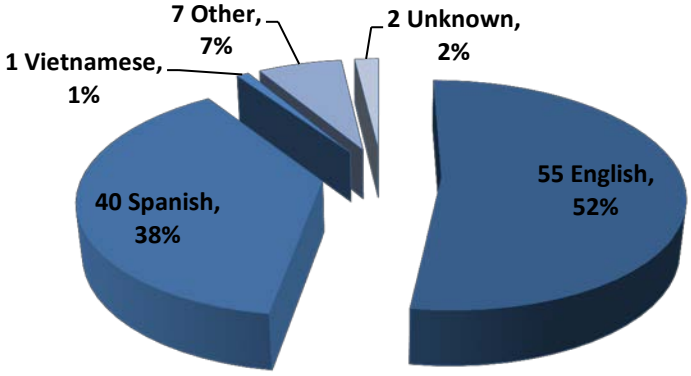
Ethnicity	#
African American	3
Asian/PI	13
Caucasian	26
Hispanic	47
Native American	1
Other	6
Unknown	9
Total	105

Age



Age	#
16-25 years (TAY)	3
26-59 years	74
60+ years	28
Total	105

Primary Language



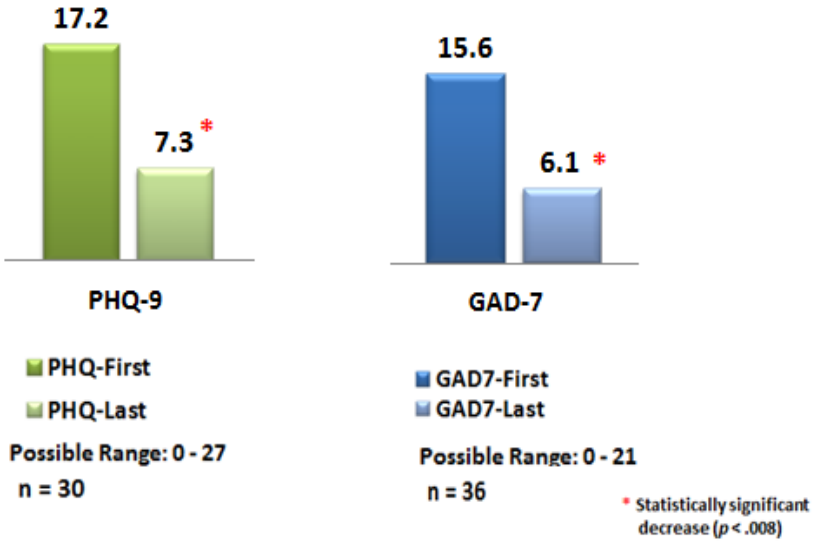
Primary Language	#
English	55
Spanish	40
Vietnamese	1
Other	7
Unknown	2
Total	105

Collective Solutions served more females (81%) than males (19%). Ethnicity of participants varied, with 45% Hispanic, 25% Caucasian, and 12% Asian. Of the participants, 70% were between the ages of 26 and 59 years old, 27% were adults ages 60 years and older, and 3% were transitional age youth between the ages of 16 and 25 years. In terms of primary language, a majority of participants indicated English as their primary language (52%), followed by Spanish (38%).

From project launch date to FY 13/14, Collective Solutions staff provided 404 referrals and made 157 successful linkages to various types of resources, including mental health care, adult education/literacy, recreation, employment, public safety, etc.

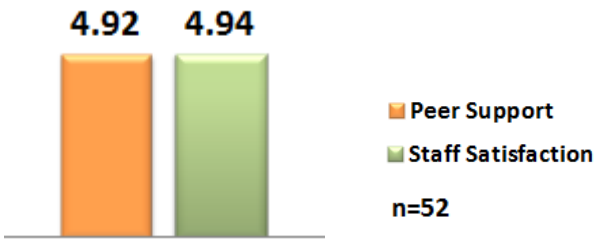
Collective Solutions utilizes various behavioral health assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants complete the PHQ-9 and GAD-7 at enrollment and every four months until program exit. A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p<.008$) in symptoms of moderate or severe depression and anxiety. As shown on the graph below, on average, participants experienced a reduction in their depression scores by 9.9 points and a reduction in their anxiety scores by 9.5 points.

Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Scores
Initial Score = Moderate or Severe
Launch – June 30, 2014



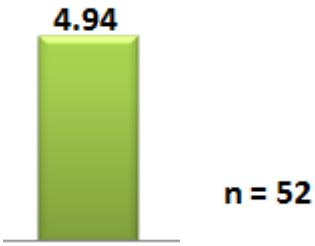
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were equally satisfied with services provided by peer specialists ($\overline{x}$ = 4.92) and clinical staff ($\overline{x}$ 4.94).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction. As indicated in the graph below, participants rated the project a score of 4.94 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Collective Solutions data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. Collective Solutions will discontinue services on December 31, 2015; however, data analysis, evaluation, and reporting will continue through March 2016.

Group 1 INN 3. Volunteer to Work (VTW)	
Estimated annual number to be served in FY 15/16	**N/A**
Annual budgeted funds for FY 15/16	**No new INN funds***
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

*This project was initially contracted for two years. Innovation funding will end on June 30, 2015. As of July 2015, funding will be assumed by Community Services and Supports as reflected in the CSS budget and also in the CSS summary (see page 34).

1. Program Description

Volunteer to Work (VTW) is an innovation project contracted with Goodwill Industries Orange County. It is a peer-to-peer, participant-driven project for adults 18 and older living with a mental health diagnosis and seeking successful entry or re-entry into employment. This “stepping stone” to employment aims to increase the quality of services, including better outcomes for the participants involved.

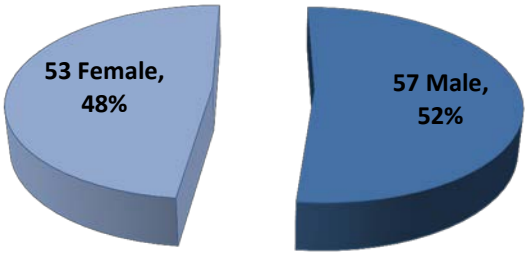
Led by a staff of peer specialists, VTW assists participants in finding volunteer opportunities tailored to each participant’s unique interests, goals, and needs. Project services include peer support, skills development trainings, and connections to volunteer opportunities in the community. Participants are provided with support and encouragement throughout their 90-day commitment to volunteer work. The project provides services in English, Spanish, Vietnamese, and Farsi.

2. Outcomes

Data outcomes were analyzed from project launch date (July 1, 2013) to FY13/14. During this time period, VTW served 110 unduplicated participants, which exceeded their annual target goal. The participant demographics were as follows:

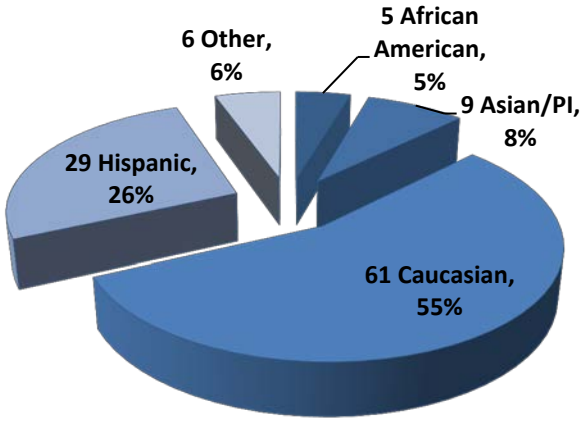
Participant Demographics
Launch – June 30, 2014

Gender



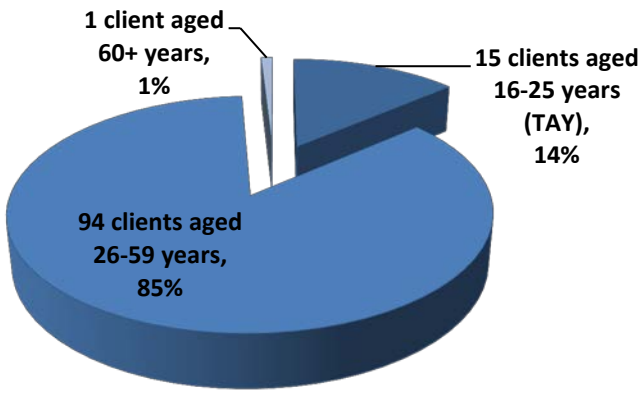
Gender	#
Male	57
Female	53
Total	110

Ethnicity



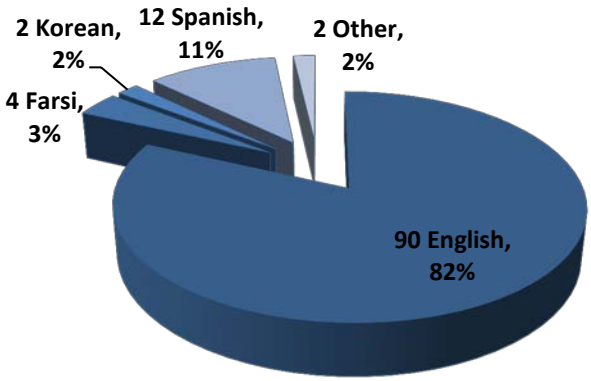
Ethnicity	#
African American	5
Asian/PI	9
Caucasian	61
Hispanic	29
Other	6
Total	110

Age



Age	#
16-25 years (TAY)	15
26-59 years	94
60+ years	1
Total	110

Primary Language



Primary Language	#
English	90
Farsi	4
Korean	2
Spanish	12
Other	2
Total	110

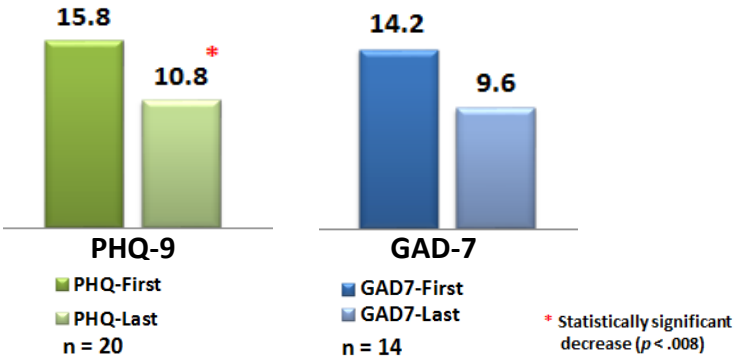
VTW served slightly more males (52%) than females (48%). Ethnicity of participants varied, with 55% Caucasian, 26% Hispanic, and 8% Asian. Of the participants, 85% were between the ages of 26 and 59 years, 14% were transitional age youth between the ages of 16 and 25 years, and 1% were adults ages 60 years and older. In terms of primary language, a majority of participants indicated English as their primary language (82%), followed by Spanish (11%), Farsi (3%), and Korean (2%).

From project launch date to FY 13/14, VTW staff provided 41 referrals and made 26 successful linkages to various types of resources, including job placement, adult education/literacy, clothing, and mental health care.

VTW utilizes various behavioral assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants complete the PHQ-9 and GAD-7 at enrollment, placement at host site, and 3 months after program exit.

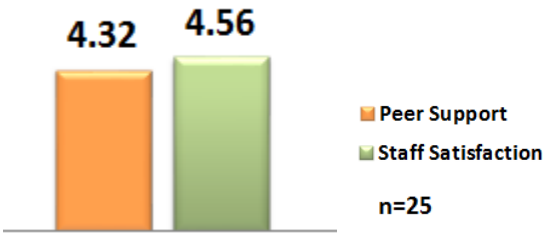
A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p<.008$) in symptoms of moderate or severe depression and a decrease in symptoms of anxiety. As indicated below, on average, participants experienced a reduction in their depression scores by 5 points and a reduction in their anxiety scores by 4.6 points.

Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Score
Initial Score = Moderate or Severe
Launch – June 30, 2014



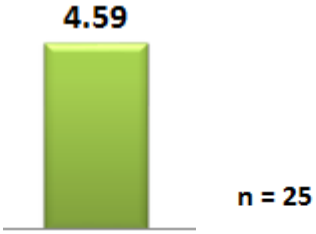
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were equally satisfied with services provided by peer specialists ($\overline{x}$ 4.32) and VTW staff ($\overline{x}$ 4.56).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.59 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



VTW data outcomes for FY13/14 were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of VTW program services, innovative components, assessment measures, and participant outcomes to committee and community members. Innovation funding for this project will end on June 30, 2015; however, based on successful outcomes and positive feedback from the community, Health Care Agency staff requested approval for a 1-yr extension of project services with available funds. The MHSA Steering Committee approved the extension of VTW for an additional year with level funding through the Community Services and Supports (CSS) component of MHSA.

Group 1 INN 4. OC ACCEPT	
Estimated annual number to be served in FY 15/16	**150**
Annual budgeted funds for FY 15/16	**$518,256***
Estimated Annual Cost Per Client (for direct service programs only)	**$3,455**

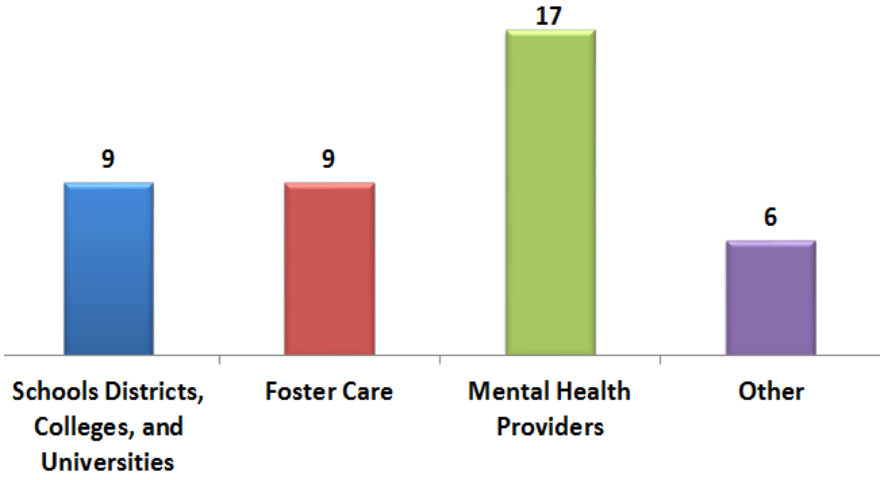
*Innovations funding for this project will be fully expended in FY 15/16. Ongoing funding for this project will be assumed by Prevention and Early Intervention (PEI)

1. Program Description

OC ACCEPT (formerly OK to BE Me) provides community-based mental health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and the important people in their lives. The program 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 increase access to underserved groups and provide a safe environment with acceptance and compassion for individuals to express their feelings, build resilience, become empowered, and connect with others for support. Services are provided in English and Spanish.

The program also raises awareness and reduces stigma by providing education about the LGBTIQ population to the community at large. Since beginning services, OC ACCEPT has provided 73 ongoing cultural competency trainings to various agencies and locations within the community, including schools, foster care, mental health organizations and agencies, etc.

OC ACCEPT Trainings
Launch – June 30, 2014

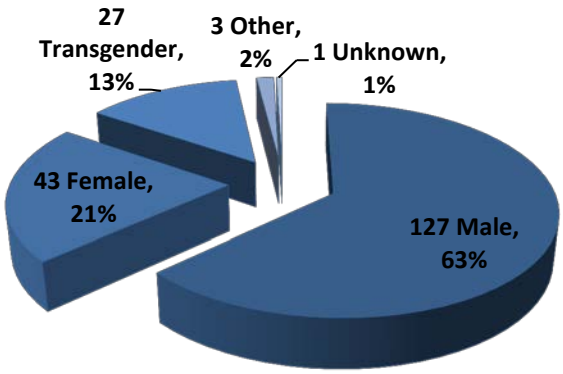


2. Outcomes

Data outcomes were analyzed from project launch date (July 11, 2011) to FY13/14. During this time frame, OC ACCEPT served 201 unduplicated participants. The participant demographics were as follows:

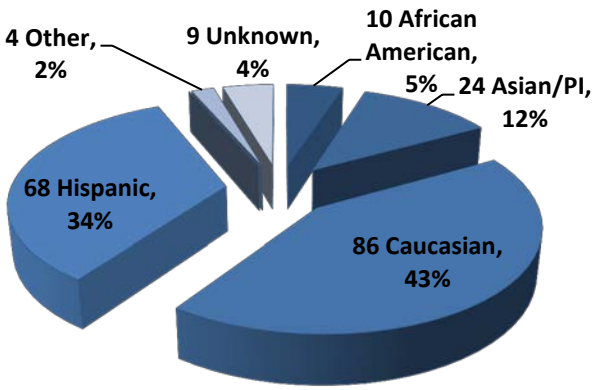
Participant Demographics
Launch – June 30, 2014

Gender



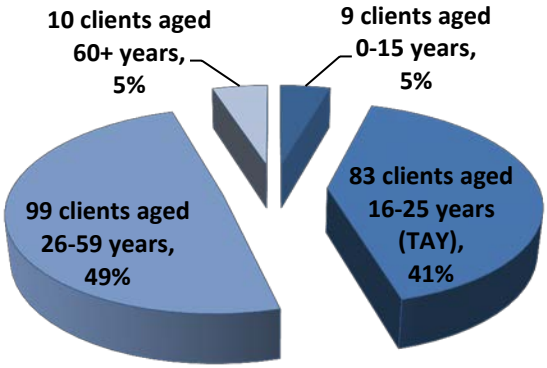
Gender	#
Male	127
Female	43
Transgender	27
Other	3
Unknown	1
Total	201

Ethnicity

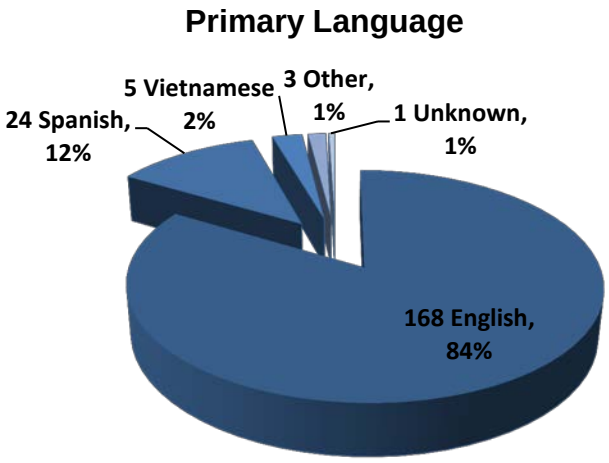


Ethnicity	#
African American	10
Asian/PI	24
Caucasian	86
Hispanic	68
Other	4
Unknown	9
Total	201

Age



Age	#
0-15 years	9
16-25 years (TAY)	83
26-59 years	99
60+ years	10
Total	201



Primary Language	#
English	168
Spanish	24
Vietnamese	5
Other	3
Unknown	1
Total	201

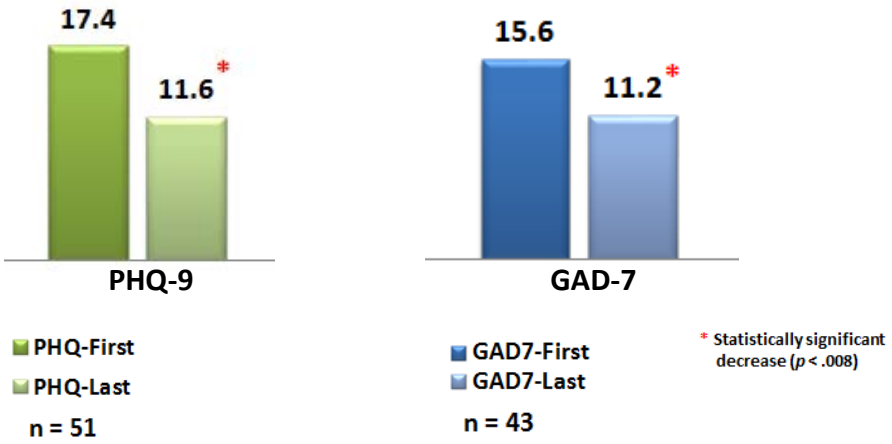
As indicated, 63% of participants served were male, 21% female, 13% transgender, and 2% other. Ethnicity varied, with 43% Caucasian, 34% Hispanic, 12% Asian, and 5% African American. Of the participants, 49% were between the ages of 26 and 59 years old, 41% were transitional age youth between the ages 16 and 25 years, 5% were adults ages 60 years and older, and 5% were ages 0 to 15 years. In terms of primary language, a majority of participants indicated English as their primary language (84%), followed by Spanish (12%), and Vietnamese (2%).

From project launch date to FY 13/14, OC ACCEPT staff provided 344 referrals and made 80 successful linkages to various types of resources, including specialty health care, primary health care, substance abuse services, employment and mental health care.

OC ACCEPT utilizes various behavioral assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health

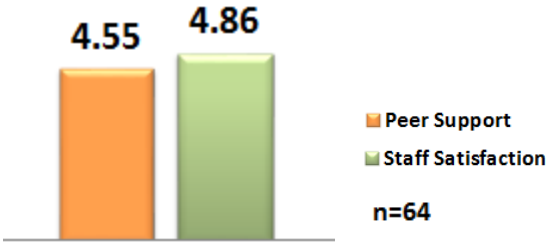
screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants complete the PHQ-9 and GAD-7 at enrollment and every four months until program exit. A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p<.008$) in symptoms of moderate or severe depression and anxiety. On average, participants experienced a reduction in their depression scores by 5.8 points and a reduction in their anxiety scores by 4.4 points.

Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Score
Initial Score = Moderate or Severe
Launch – June 30, 2014



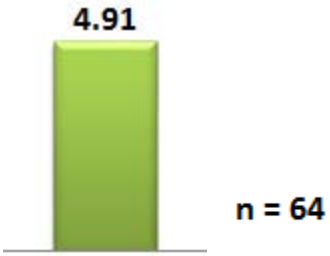
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were as equally satisfied with services provided by peer specialists ($\bar{x}$ = 4.55) and clinical staff ($\bar{x}$ = 4.86).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/ 14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.91 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/ 14
Possible Range: 1 – 5



OC ACCEPT data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. Based on successful outcomes and positive feedback from the community, Health Care Agency staff recommended the continuation of OC ACCEPT services through alternative funding. The MHSA Steering Committee approved the continuation of project services for an additional two years through the Prevention and Intervention (P&I) component of MHSA.

Group 1 INN 5. OC4Vets	
Estimated annual number to be served in FY 15/16	**100**
Annual budgeted funds for FY 15/16	**$662,135***
Estimated Annual Cost Per Client (for direct service programs only)	**$6,621**

*Innovations funding for this project will be fully expended in FY 15/16. Ongoing funding for this project will be assumed by Prevention and Early Intervention (PEI)

1. Program Description

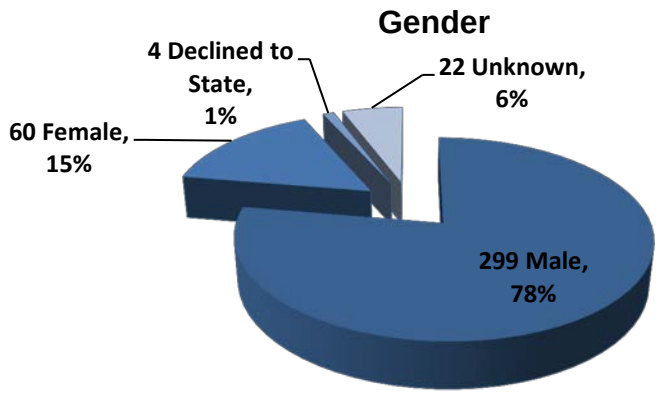
OC4VETS serves Orange County residents who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service. Hosted by the Orange County Veterans Service Office (VSO), this collaborative project aims to increase access to underserved groups, providing a participant-focused environment for veterans or families within the local military and veteran community.

OC4Vets is staffed with a diverse and versatile multi-disciplinary team comprised of trained clinicians, peer specialists (i.e., peer navigators), and supportive services staff with expertise in housing and employment resources. Specifically reaching out to veterans not yet integrated into the Department of Veterans Affairs (VA) system or unaware of their need for behavioral health services, OC4Vets offers a fluid and clinically-informed setting for case management, behavioral health screening and assessment, employment and housing supportive services, referral and linkage to community resources, outreach and engagement activities, and community trainings. This project provides services in English and Spanish.

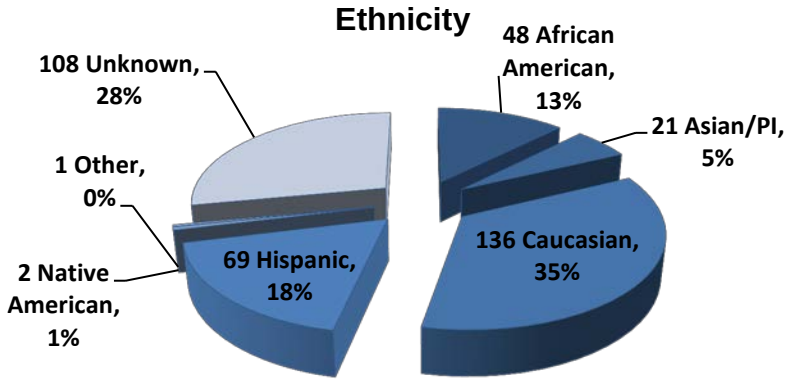
2. Outcomes

Data outcomes were analyzed from project launch date (July 1, 2012) to FY13/14. During this time frame, OC4Vets served 385 unduplicated participants. The participant demographics were as follows:

Participant Demographics
Launch – June 30, 2014

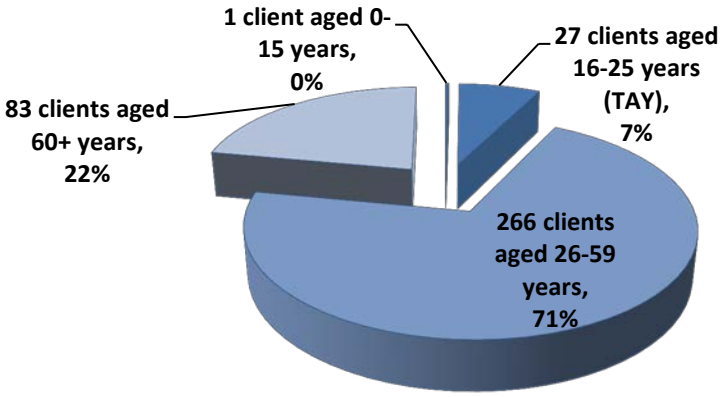


Gender	#
Male	299
Female	60
Declined to State	4
Unknown	22
Total	385



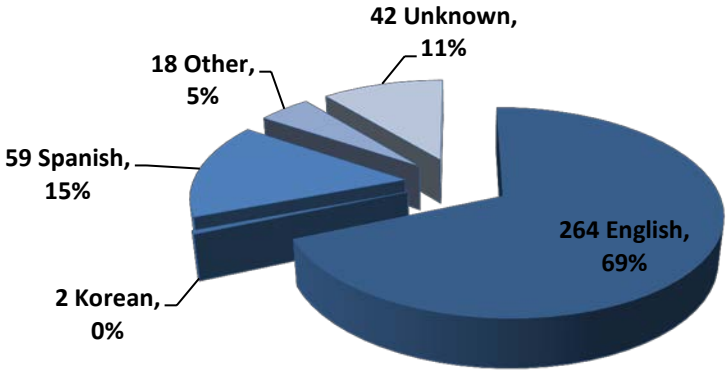
Ethnicity	#
African American	48
Asian/PI	21
Caucasian	136
Hispanic	69
Native American	2
Other	1
Unknown	108
Total	385

Age



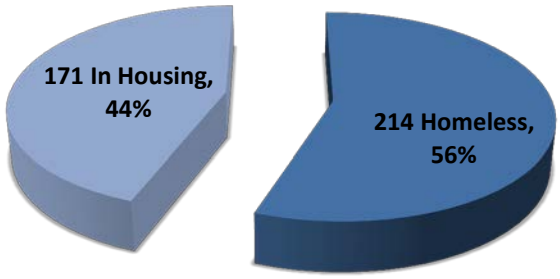
Age	#
0-15 years	1
16-25 years (TAY)	27
26-59 years	266
60+ years	83
Total	377

Primary Language



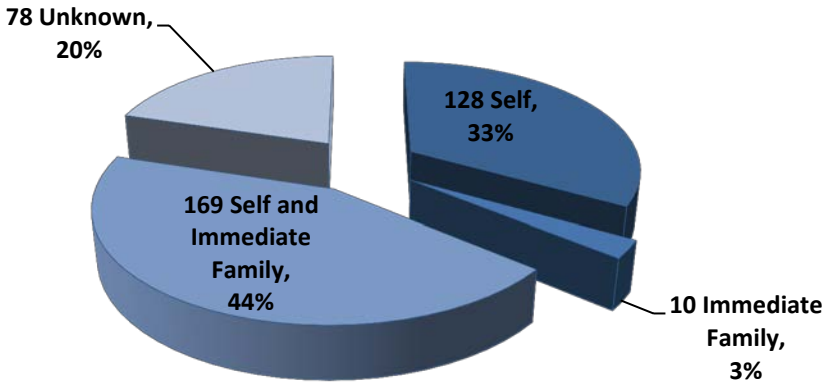
Primary Language	#
English	264
Korean	2
Spanish	59
Other	18
Unknown	42
Total	385

Homelessness



Homeless	#
Homeless	214
In Housing	171
Unknown	0
Total	385

Military Status

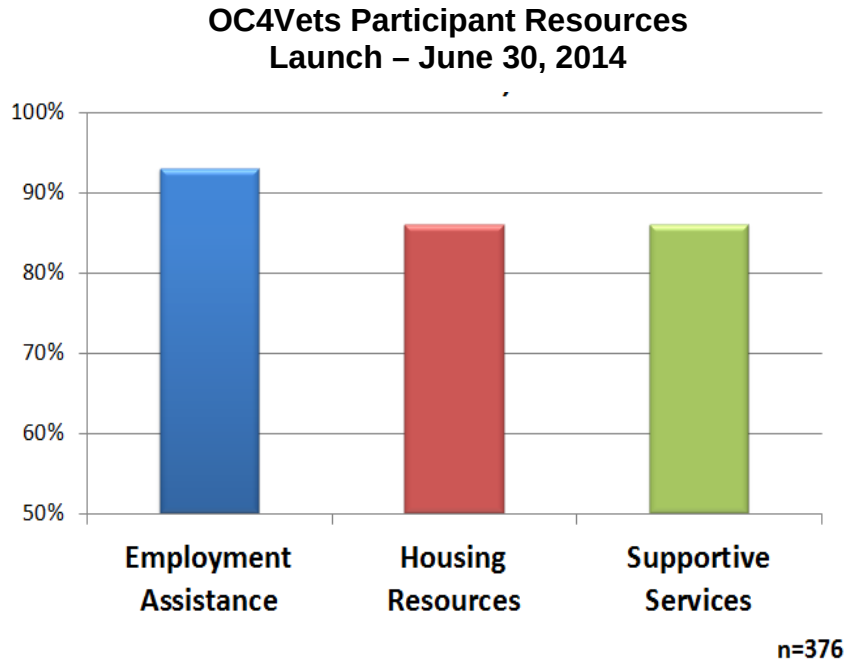


Ever Served in US Military	#
Self	128
Immediate Family	10
Self and Immediate Family	169
Unknown	78
Total	385

As indicated in the graphs, 78% of participants served were male and 15% were female. Of the participants, 44% indicated their military status as self and immediate family, 33% indicated self, and 3% indicated immediate family.

Ethnicity varied, with 35% Caucasian, 18% Hispanic, 13% African American, 5% Asian, and 1% Native American. Of the participants, 71% were between the ages of 26 and 59 years old, 22% were adults ages 60 years and older, and 7% were transitional age youth between the ages 16 and 25 years. In terms of primary language, a majority of participants indicated English as their primary language (69%), followed by Spanish (15%). More than half of participants reported being homeless (56%).

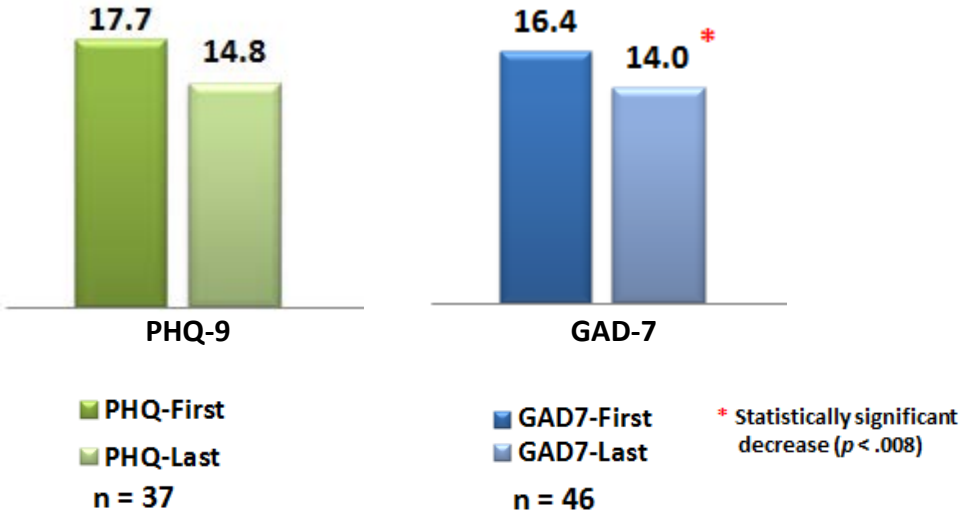
From project launch date to FY 13/14, OC4Vets staff provided 1,944 referrals and made 1,331 successful linkages to various types of resources, including housing, food and nutrition, employment, transportation, mental health, etc. The project also exceeded target goals, which included providing employment assistance to 85% of enrolled participants and providing housing resources to 70% of enrolled participants. As indicated below, 350 of 376 participants (93%) received employment assistance, 323 of the 376 (86%) received housing resources, and 325 of the 376 (86%) received supportive services.



OC4Vets utilizes various behavioral assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores

range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants complete the PHQ-9 and GAD-7 at enrollment and every three months until program exit. A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a decrease in symptoms of moderate or severe depression and a statistically significant decrease in symptoms of anxiety ($p < .008$). On average, participants experienced a reduction in their depression scores by 2.9 points and a reduction in their anxiety scores by 2.4 points.

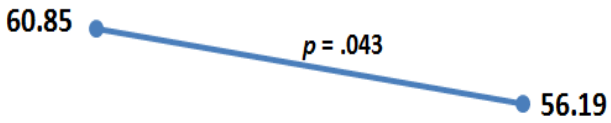
Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Scores
Initial Score = Moderate or Severe
Launch – June 30, 2014



At enrollment, participants also completed the PTSD Checklist–Military version (PCL-M), a measure utilized to assess symptoms of posttraumatic stress disorder (PTSD). PCL-M outcome scores range from 17-85, with higher scores indicating increasingly severe symptoms of PTSD. A paired samples *t*-test was also used to test whether there was a significant pre/post change in total score for those subjects whose initial score was above the recommended cutoff for a military population seen in specialty VA clinic (i.e., 45; $p < .05$). Results indicated a statistically significant change in average PTSD scores from initial to last administration. Participants experienced a 4.66 point decrease in scores from

first to last assessment among those who initially scored above the cut-off point of 45.

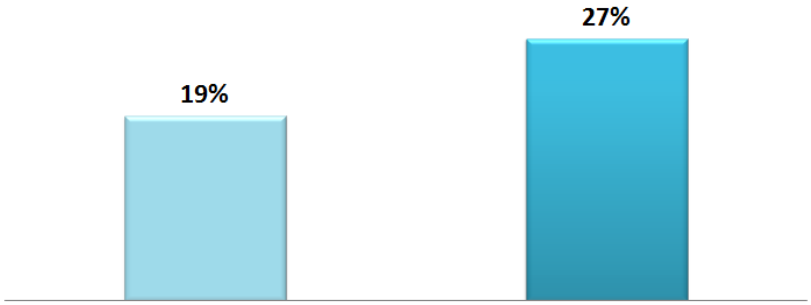
Change in Average OC4Vets PTSD Score
Initial Score >=45
Launch – June 30, 2014



PCL-M: First PCL-M: Last n = 37

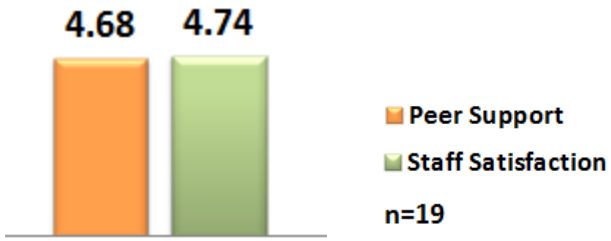
Moreover, 19% of participants who initially scored at or above the PCL-M cut-off point showed a reliable improvement of 5-9 points, suggesting improvement and progress. An additional 27% showed a clinically meaningful improvement of 10 or more points.

Degree of Change in OC4Vets PTSD Score
Initial PCL-M Score >= 45
Launch – June 30, 2014



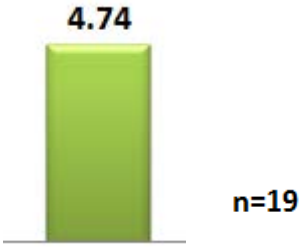
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were about equally as satisfied with services provided by peer specialists ($\overline{x}$ = 4.68) and clinical staff ($\overline{x}$ = 4.74).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.74 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



OC4Vets data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. Based on successful outcomes and positive impact, Health Care Agency staff recommended the continuation of OC4Vets services through alternative funding. The MHSA Steering Committee approved the continuation of project services for an additional two years through the Prevention and Intervention (P&I) component of MHSA.

Group 1 INN 6. Orange County Community Cares Project (OC CCP)	
Estimated annual number to be served in FY 15/16	**N/A**
Annual budgeted funds for FY 15/16	**No new funds***
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

*Innovation funding for this project will be fully expended in FY 15/16

1. Program Description

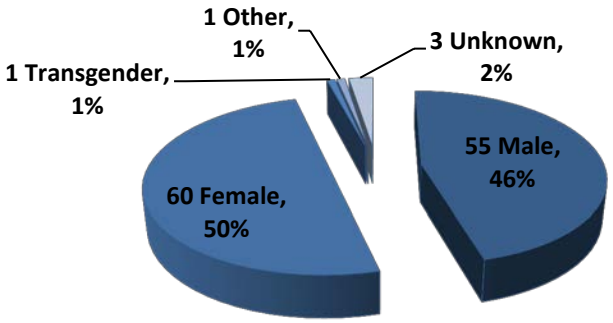
The Orange County Community Cares Project (OC CCP) served as a referral and linkage-based system that established working relationships with local mental health providers and connected them to Orange County residents unable to access mental health care. OC CCP staff assessed participant eligibility based on mild to moderate symptoms of depression or anxiety and experienced difficulty accessing mental health care due to financial means and lack of insurance. Eligible participants were linked to culturally and linguistically sensitive mental health providers who offered short-term, pro-bono psychotherapy (i.e., 12 sessions). OC CCP was also staffed with two peer specialists who provided ongoing outreach efforts to recruit mental health providers and potential participants, and offered case management services to ensure participants' access to their mental health provider, program effectiveness and overall satisfaction of services.

2. Outcomes

Data outcomes were analyzed from project launch date (November 21, 2011) through FY13/14. During this time frame, OC CCP served 120 unduplicated participants. The participant demographics were as follows:

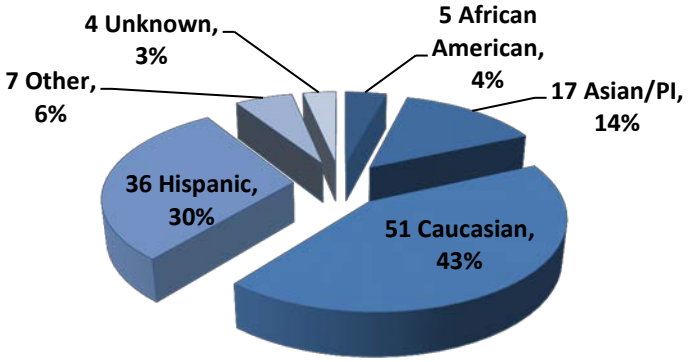
Participant Demographics
Launch – June 30, 2014

Gender



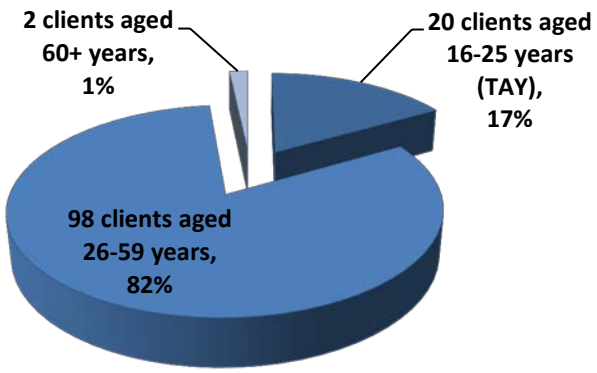
Gender	#
Male	55
Female	60
Transgender	1
Other	1
Unknown	3
Total	120

Ethnicity



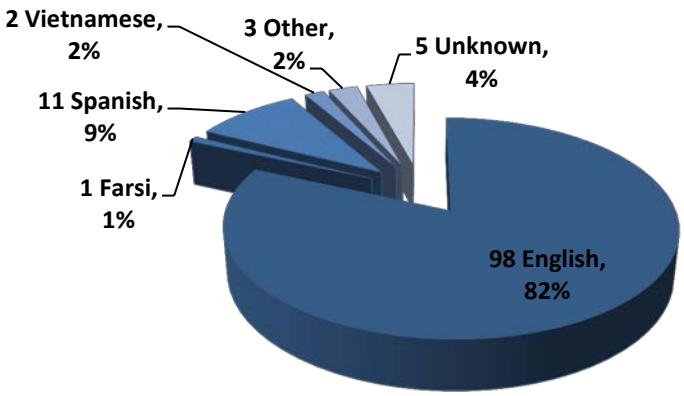
Ethnicity	#
African American	5
Asian/PI	17
Caucasian	51
Hispanic	36
Other	7
Unknown	4
Total	120

Age



Age	#
16-25 years (TAY)	20
26-59 years	98
60+ years	2
Total	120

Primary Language



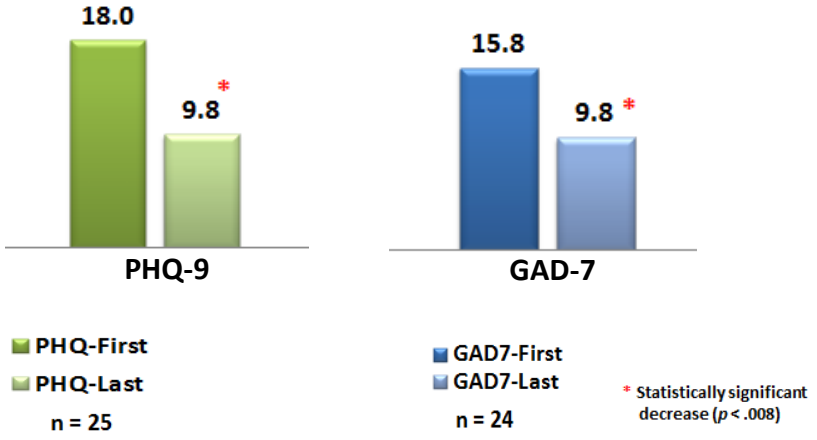
Primary Language	#
English	98
Farsi	1
Spanish	11
Vietnamese	2
Other	3
Unknown	5
Total	120

As indicated in the graphs, 50% of participants were female, 46% male, and 1% transgender. Ethnicity of participants varied, with 43% Caucasian, 30% Hispanic, and 14% Asian, and 4% African American. Of the participants, 82% were between the ages of 26 and 59 years old, 17% were transitional age youth between the ages of 16 and 25 years old and 1% were adults ages 60 years and older. In terms of primary language, 82% spoke English, 9% Spanish, 2% Vietnamese and 1% Farsi.

In addition to referring and linking participants to mental health providers, OC CCP staff also assisted participants in navigating local resources. From project launch date through FY 13/14, the project provided 10 referrals and made 7 successful linkages to employment, family welfare, and mental health care.

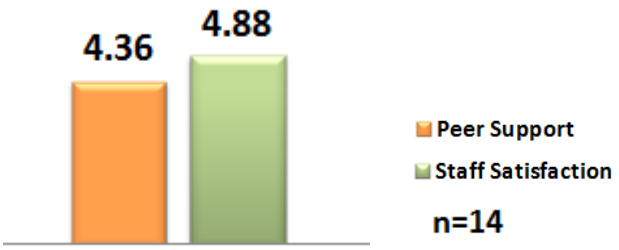
OC CCP utilized various behavioral assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19) and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14) and severe (15-21) symptoms of anxiety. Participants completed the PHQ-9 and GAD-7 at enrollment and program exit. A paired sample *t*-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p<.008$) in symptoms of moderate or severe depression and anxiety. On average, participants experienced a reduction in their depression scores by 8.2 points and a reduction in their anxiety scores by 6 points.

Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Score
Initial Score = Moderate or Severe
Launch – June 30, 2014



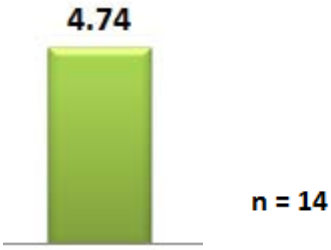
Data analysis also included results of satisfaction surveys completed by OC CCP participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were about as equally satisfied with services provided by peer specialists ($\overline{x} =$ 4.36) and clinical staff ($\overline{x}$ = 4.88).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.74 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/ 14
Possible Range: 1 – 5



OC CCP data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. Although OC CCP discontinued services at the end of FY 13/14, project activities will be limited to data analysis and evaluation through FY 15/16.

Group 1 INN 7. Project Life Coach (PLC)	
Estimated annual number to be served in FY 15/16	**250**
Annual budgeted funds for FY 15/16	**$428,666***
Estimated Annual Cost Per Client (for direct service programs only)	**$1,714**

*Innovation funding for this project will be fully expended in FY 15/16.

1. Program Description

Project Life Coach (PLC) provides comprehensive life-coaching and supportive employment services to individuals with mental illness struggling to obtain employment. This project seeks to increase access to underserved groups, specifically individuals within the unserved and underserved monolingual or limited English proficiency communities in Orange County.

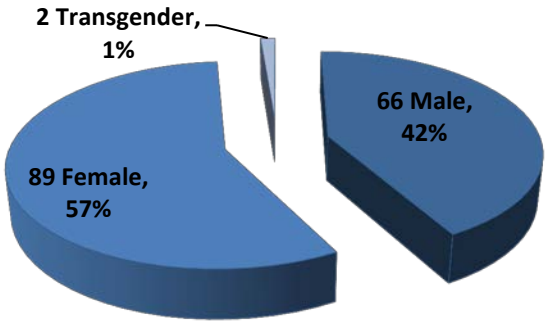
Staffed with clinicians and peer specialists, PLC utilizes a participant-driven approach that enables participants to work at their own pace and personalize goals. Project services include comprehensive life-coaching, peer support services, psychoeducation, outreach and engagement, case management, brief individual therapy, support groups, and referrals and linkages to Orange County community resources. Working alongside clinicians, PLC peer specialists provide support, case management, and employment readiness skills to assist participants in reaching desired goals. Services are provided in English, Farsi, Korean, Spanish, and Vietnamese.

2. Outcomes

Data outcomes were analyzed from project launch date (July 27, 2012) to FY13/14. During this time frame, PLC served 157 unduplicated participants. The participant demographics were as follows:

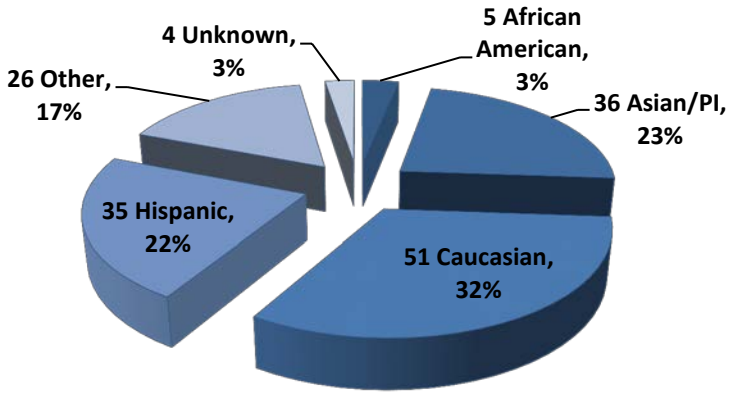
Participant Demographics
Launch – June 30, 2014

Gender



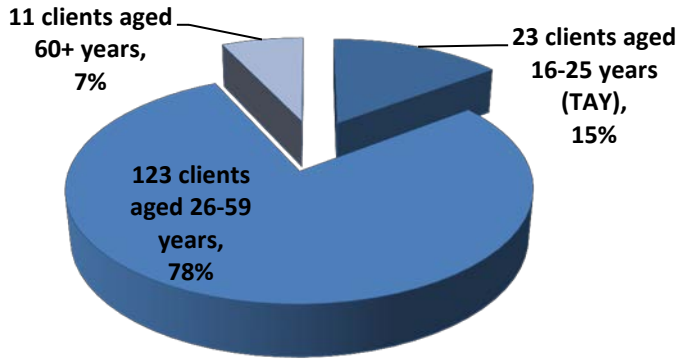
Gender	#
Male	66
Female	89
Transgender	2
Total	157

Ethnicity



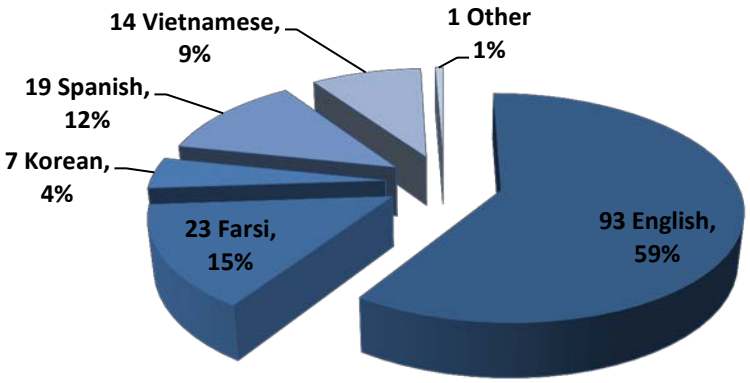
Ethnicity	#
African American	5
Asian/PI	36
Caucasian	51
Hispanic	35
Other	26
Unknown	4
Total	157

Age



Age	#
16-25 years (TAY)	23
26-59 years	123
60+ years	11
Total	157

Primary Language



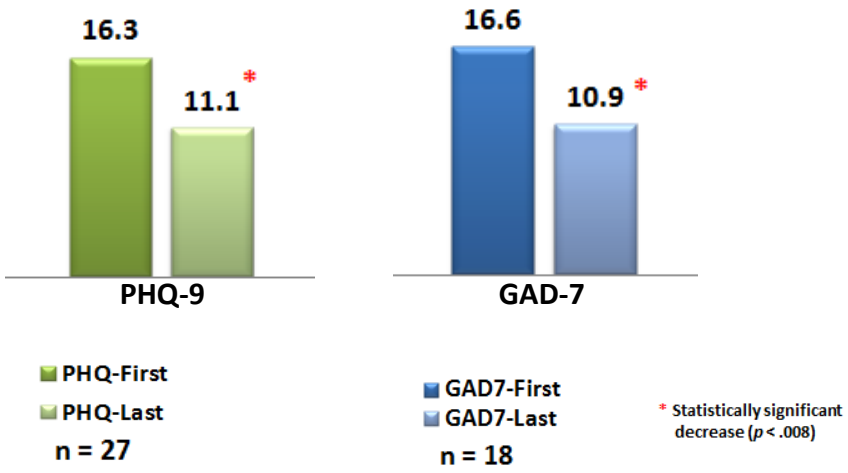
Primary Language	#
English	93
Farsi	23
Korean	7
Spanish	19
Vietnamese	14
Other	1
Total	157

As indicated in the graphs, 57% of participants served were female, 42% male and 1% transgender. Ethnicity varied, with 32% Caucasian, 23% Asian, 22% Hispanic and 3% African American. Of the participants, 78% were between the ages of 26 and 59 years old, 15% were transitional age youth between the ages of 16 and 25 years, and 7% were adults ages 60 years and older. In terms of primary language, a majority of participants indicated English as their primary language (59%), followed by Farsi (15%), Spanish (12%), Vietnamese (9%) and Korean (4%).

From project launch date through FY 13/14, PLC staff provided 233 referrals and made 113 successful linkages to various types of resources, including employment, adult education/literacy, mental health care, food and nutrition and housing.

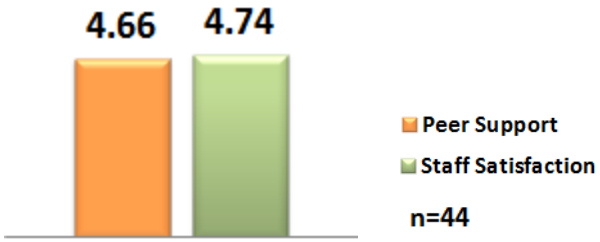
PLC utilized various behavioral assessment tools to evaluate participant outcomes. The Patient Health Questionnaire-9 (PHQ-9) is a validated and widely used behavioral health screening tool that measures symptoms of depression. PHQ-9 outcome scores range between minimal (0-4), mild (5-9), moderate (10-19), and severe (20-27) symptoms of depression. The Generalized Anxiety Disorder scale (GAD-7) is also a validated and widely used behavioral health screening tool that measures symptoms of anxiety. GAD-7 outcome scores range between minimal (0-4), mild (5-9), moderate (10-14), and severe (15-21) symptoms of anxiety. Participants completed the PHQ-9 and GAD-7 at enrollment and every six months until program exit. A paired sample t-test was used to test whether there was a significant change in pre- and post-test depression and anxiety scores for those participants whose initial score placed them in the moderate to severe range. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .008$ and .0125, respectively). Results of participants' change in average depression and anxiety from project launch date to FY 13/14 indicated a statistically significant decrease ($p<.008$) in symptoms of moderate or severe depression and anxiety. On average, participants experienced a reduction in their depression scores by 5.2 points and a reduction in their anxiety scores by 5.7 points.

Change in Average Depression (PHQ-9) and Anxiety (GAD-7) Scores
Initial Score = Moderate or Severe
Launch – June 30, 2014



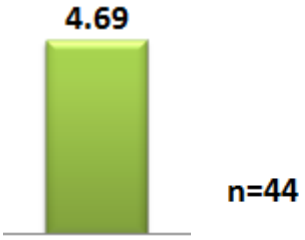
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were as equally satisfied with services provided by peer specialists ($\overline{x}$ = 4.66) and clinical staff ($\overline{x}$ = 4.74).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.69 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/ 14
Possible Range: 1 – 5



PLC data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. PLC will discontinue services on December 31, 2015; however, data analysis and evaluation will continue through March 2016.

Group 1 INN 8. Training Services to Meet the Mental Health Needs of the Deaf Community	
Estimated annual number to be served in FY 15/16	**N/A**
Annual budgeted funds for FY 15/16	**No new funds***
Estimated Annual Cost Per Client (for direct service programs only)	**N/A**

*Innovation funding for this project will be fully expended in FY 15/16

1. Program Description

This project was designed to prepare deaf and hard-of-hearing individuals with the necessary skills to become Mental Health Workers and Peer Specialists through participation in a Mental Health Worker Certificate Program.

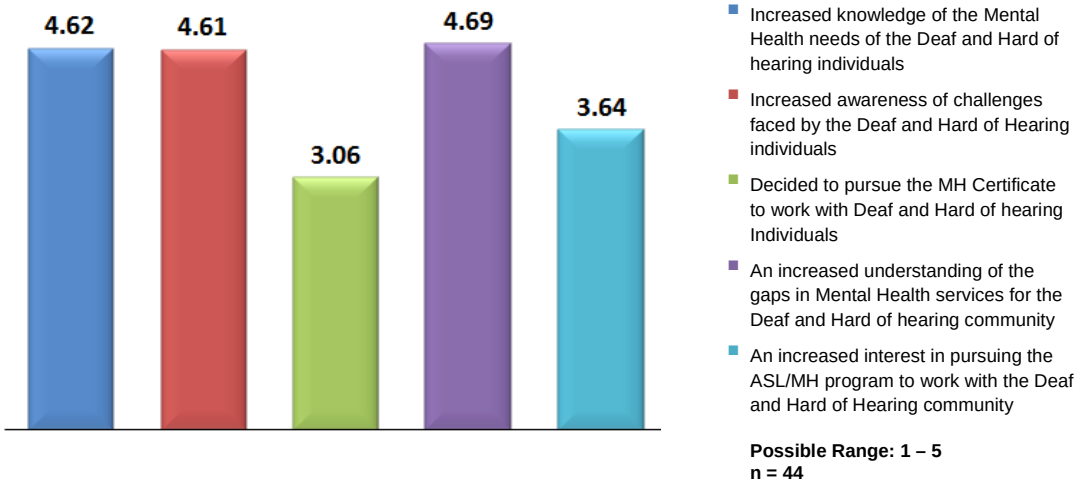
Contracted with Saddleback College, this project offered eight courses to increase knowledge and awareness of the mental health needs of the Deaf and Hard of Hearing community, with the primary goal of training individuals to help meet the needs of this highly underserved community.

2. Outcomes

Data outcomes were analyzed from project launch date (July 1, 2012) through FY13/14. During this time period, the project enrolled 428 duplicated participants.

Students enrolled in two of the eight courses offered, completed a survey regarding their level of education, awareness of challenges faced by the deaf and hard of hearing community, and interest in pursuing certification to serve the deaf and hard of hearing population. Results of students' feedback are presented on the following page.

Training Services to Meet the Mental Health Needs of the Deaf Community
Student Feedback
HS 100 and HS 176 Fall 2013



Based on a 5-point scale, results indicated increased awareness and interest in pursuing certification to work with the Deaf and Hard of Hearing community.

This project was initially intended as a two-year innovation project and discontinued services at the end of FY 13/14. However, this course may be integrated into the current curriculum at Saddleback College.

Group 1 INN 9. Brighter Futures	
Estimated annual number to be served in FY 15/16	**150**
Annual budgeted funds for FY 15/16	**$359,676***
Estimated Annual Cost Per Client (for direct service programs only)	**$2,397**

*Innovation funding for this project will be fully expended in FY 15/16.

1. Program Description

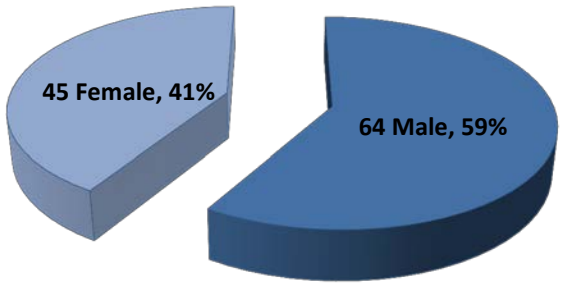
Brighter Futures (formerly Consumer Early Childhood Mental Health) is a 16-week program that provides community-based counseling and peer supportive services to families with children ages 6 to 13 who experience social, emotional, and behavioral health problems. Aimed at building healthy relationships, Brighter Futures utilizes play therapy techniques to provide brief behavioral interventions, build self-esteem, increase resiliency, and recognize personal strengths. In addition, services have been extended to family members and caregivers. Project services also include peer support, education about mental illness, and referrals and linkages to services in the community. This project aims to increase the quality of services, including better outcomes. Services are provided in English and Spanish.

2. Outcomes

Data outcomes were analyzed from project launch date (April 4, 2012) to FY13/14. During this time frame, Brighter Futures served 109 unduplicated participants and 125 additional family members. Participant demographics were as follows:

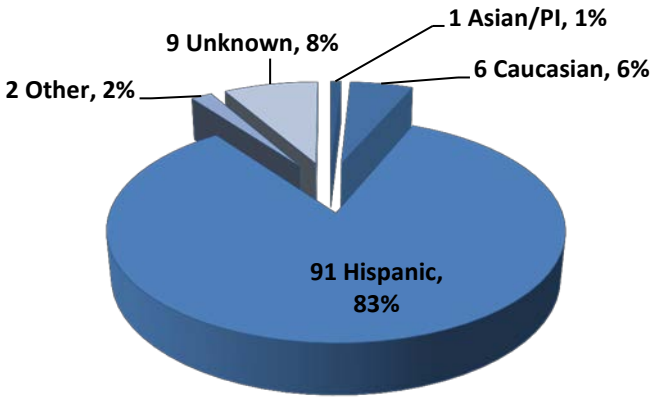
Participant Demographics
Launch – June 30, 2014

Gender



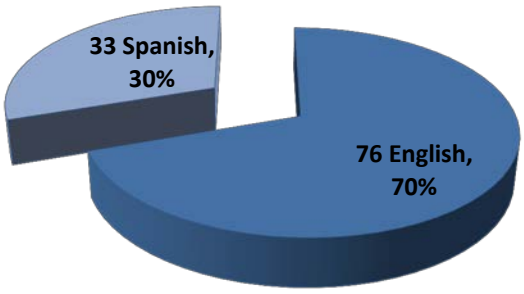
Gender	#
Male	64
Female	45
Total	109

Ethnicity



Ethnicity	#
African American	0
Native American	0
Asian/Pacific Islander	1
Caucasian/European/White	6
Latino/Hispanic	91
Other	2
Unknown	9
Total	109

Primary Language



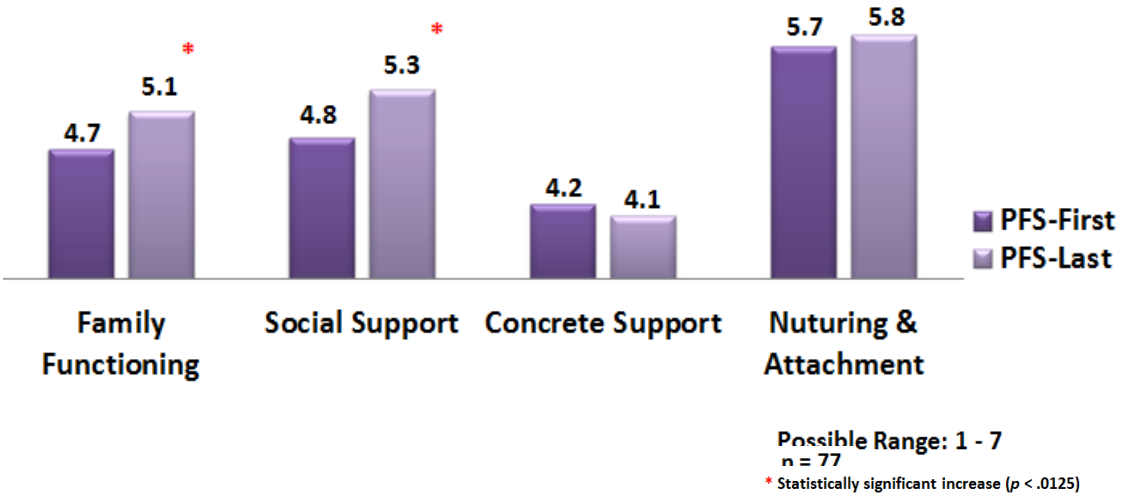
Primary Language	#
English	76
Spanish	33
Total	109

As indicated in the graphs, 59% of participants served were male and 41% were female. A majority of participants were Hispanic (83%), followed by Caucasian (6%) and Asian (1%). All participants were between the ages of 0 to 15 years. In terms of primary language, a majority of participants indicated English as their primary language (70%), followed by Spanish (30%).

From project launch date to FY 13/14, Brighter Futures staff provided 255 referrals and made 69 successful linkages to various types of resources, including mental health care, food and nutrition mentoring, housing and family welfare.

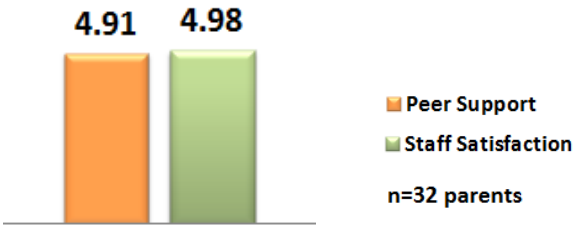
Brighter Futures utilizes the Protective Factors Survey to evaluate participant outcomes. The Protective Factors Survey is a validated and widely used behavioral health screening tool that measures family resiliency in various domains, including family functioning, social support, concrete support, and nutrition and attachment. Protective Factor outcome scores range from 1 to 7, with higher scores indicating higher resiliency and coping. Participants completed the measure at enrollment and program exit. A paired sample *t*-test was used to test whether there was a significant pre- to post-test change in the Protective Factors Survey subscale scores within each domain. In addition, the alpha level was calculated using Bonferroni correction to control for Type I error (i.e., $p < .0125$). Results of participants' change in protective factors subscale scores from project launch date to FY 13/14 indicated a statistically significant increase in family functioning and social support and slight increase in nurturing and attachment.

Change in Average Protective Factors Scores
Launch – June 30, 2014



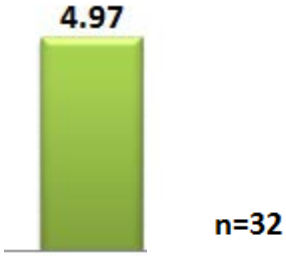
Data analysis also included results of satisfaction surveys completed by participants. Satisfaction surveys did not require statistical analyses and were reported based on the average subscale score and overall program rating. A comparison of peer and staff satisfaction on a 5-point scale indicated participants were as equally satisfied with services provided by peer specialists ($\overline{x}$ = 4.91) and clinical staff ($\overline{x}$ = 4.98).

Comparison of Peer and Staff Satisfaction
Participant Survey FY 13/ 14
Possible Range: 1 – 5



Participants also indicated high levels of overall program satisfaction, rating the project a score of 4.97 on a 5-point scale.

Overall Program Satisfaction
Participant Survey FY 13/14
Possible Range: 1 – 5



Brighter Futures data outcomes were presented to the Orange County Mental Health Services Act (MHSA) Steering Committee in December 2014. Innovations program staff and research analysts provided an overview of project services, innovative components, assessment measures, and participant outcomes to committee and community members. Brighter Futures will discontinue services on December 31, 2015; however, data analysis and evaluation will continue through March 2016.

Group 2 INN 1. Proactive On-site Engagement in the Collaborative Courts	
Estimated annual number to be served in FY 15/16	**300**
Annual budgeted funds for FY 15/16	**$416,622**
Estimated Annual Cost Per Client (for direct service programs only)	**$1,388**

*This project is currently in the process of development.

1. Program Description

A wealth of resources and referrals are available to probation clients through the Collaborative Court system, but there is a lack of advocacy and access for probation clients and their families to seek basic mental health education. Basic mental health education could teach probation clients and their families about their diagnosis, symptoms and how to manage their serious persistent mental illness and live well on a daily basis. There is a need for integration of mental health education with mental health system navigation services to truly help make a change in these probations clients functioning and lives. Also, there is an increased rate of criminalization of the mentally ill within our community. This suggests that there is a growing need to integrate education and services between the criminal justice system and the mental health community. The belief is that this integration will reduce recidivism and hospitalization rates, as well as increase participants' quality of life.

This project is designed to increase the quality of mental health services by bringing access to mental health education programs to both the probation client and their families – onsite at the collaborative courts, which will thereby:

1. Increase participant engagement, enrollment and completion of mental health education programs.
2. Increase consistent exposure and access to mental health education programs on site at the collaborative courts.
3. Provide mental health education to participants to increase their understanding of mental health issues as well as the tools and skills to independently self- manage their mental health.
4. Engage family members in mental health education.
5. Refer and link participants to resources and services that promote successful independent living.

The intent of this project is to teach and help probation clients and their families to better understand their serious persistent mental health diagnosis and how to live well and thrive outside of the criminal justice system. Probation clients and families will also learn how to navigate the mental health system and manage their mental health independently on a daily basis. This combination of on-site mental health education, structured mental health education courses, family engagement and peer driven supportive services will create a safety net that we believe will result in better outcomes such as: increased mental health awareness, ability to navigate the mental health system, reduced recidivism, and decrease in hospitalization rates of probation client participants involved in this project.

At minimum, this project will serve 300 participants and their family members annually. Basic services will include training, case management, supportive counseling, mental health support, crisis intervention, mental health education, etc.

2. Outcomes

Performance outcomes will be measured by intake, enrollment and mental health education completion statistics, referrals and linkages, and pre- and post-tests measuring mental health awareness. Program outcomes will measure the effectiveness of the mental health and service system navigation education by analyzing court records and self-reported hospitalization history. Other information from intake and quarterly status reports from the Peer Specialist, (e.g. employment status, housing, medication compliance, hospitalization, probation status, etc.) will also be tracked in a narrative monthly report for additional information related to each participant's level of functioning. The expected program outcomes include, but are not limited to the following:

1. Providing mental health education courses to participants and their families, which will increase understanding of serious persistent mental illness (to be measured by pre- and post-test mental health awareness surveys related to the specific course topics).
2. Teaching participants and their families how to navigate the mental health system will increase participants' engagement and access to mental health services (to be measured by tracking referrals and linkages to County and community mental health resources and services).
3. As a result of mental health education and learning how to navigate the mental health system, the participants will learn to manage and live well

with serious persistent mental illness (to be measured by court records and participant self-reports).

4. As a result of the project services, participants will experience reduced recidivism and hospitalization rates (to be measured by court records and participant self-reports).
5. To examine the overall benefits of mental health education, this project will collect and compare data from the 4 years of the Collaborative Court project to 5 years of court records and participant self-reports of jail time and hospitalization prior to the implementation of the project.

Group 2 INN 2. Religious Leaders	
Estimated annual number to be served in FY 15/16	**30**
Annual budgeted funds for FY 15/16	**$315,106**
Estimated Annual Cost Per Client (for direct service programs only)	**$10,503**

*This project is currently in the process of development.

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 mental health professionals are ranked last. 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 use a train-the-trainer technique in which those in the mental health field, along with peer specialists, will help to train religious leaders in Orange County 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 and, in turn, train other congregants with behavioral health skill sets.

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

1. Increase the number of lay persons trained in mental health issues.
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 to recruit their leaders to receive basic behavioral health training. It is proposed that one leader from each of the recruited organizations will be trained in basic behavioral health interventions and practices to become certified trainers themselves. These 30 leaders will in turn each hold three trainings per year (with up to 20 people per training) to utilize and maintain his/her certification. Potentially, up to 1,800 lay people in various religious organizations will be trained in basic mental health interventions and serve as a gateway to refer those in need to professional services as appropriate.

Having this type of training available in the religious community creates 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 professional help is available. The physical presence of a trained leader 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 these services.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys and interviews. This project will collect data that will help evaluate the utilization and effectiveness of the training program. Enrollment and completion of train-the-trainer and general training numbers will be tracked. Each religious leader and subsequent trainees will be given a survey and a pre- and post-test mental health awareness survey to gauge their increase in knowledge about mental health compared to those religious leaders who did not participate in the project. Each religious leader and those trained will be asked to keep track of mental health referrals and linkages provided and the number of congregants trained by each religious leader.

It is expected that participants of the project who enrolled and completed behavioral health training would show improvement in the following areas:

1. Religious leader participants will show an increase in understanding/awareness of mental health (to be measured by self-assessment surveys, interviews).
2. Trainees (those trained by the religious leaders) will show an increase in understanding/awareness of mental health (to be measured by self-assessment surveys, interviews).
3. Participants and trainees will report increased referral/linkage to County/community mental health services and resources (to be measured by interviews and self-report).

Group 2 INN 3. Mobile Applications	
Estimated annual number to be served in FY 15/16	**50**
Annual budgeted funds for FY 15/16	**$271,946**
Estimated Annual Cost Per Client (for direct service programs only)	**$5,438**

*This project is currently in the process of development.

1. Program Description

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 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. This project will imbed the proposed innovation into its existing programming and community partnerships, using the following methodology:

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

2. Outcomes

Performance outcomes will be measured by intake data, quality of life self-assessment surveys, and weekly one-on-one sessions with the Peer Specialists.

Other information from intake and quarterly status reports from the Peer Specialist, (such as mental health management, employment status, housing, medication compliance, hospitalization, social networks, etc.) will also be considered in the measurement of performance outcomes.

It is expected that participants of the project who receive access to technology/mobile smart phones would show improvement in the following areas:

1. Increased access to mental health services (to be measured by self-reports, intake and enrollment information about habits and access before receiving the mobile smartphone, and weekly data about mobile smartphone usage, frequency, and purpose after receipt of the phone).
2. Reduced social isolation and increased support networks (to be measured by self-reports, intake and enrollment information about habits and existing social activities, and activities and networks after receipt of the mobile smartphones).
3. Increased self-reliance and management of mental health treatment (to be measured by data on usage, frequency and purpose of mobile smartphone use that might reveal ability to make and keep appointments, medication reminders, etc.).
4. Improved overall quality of life and well-being (to be measured by self-assessment surveys).

The data from participants who enroll and receive access to technology/mobile devices will be compared to those not enrolled in the project that are in the same housing or FSP programs as our project participants. Data from participants who received the phones in project year one may also be compared to those who received phones in project year two. Comparing these two data sets may contribute additional information to the evaluation, showing those that had use of the phones for two years versus one year had better outcomes, or the results may show that access of any duration has the same benefit for participants.

Group 2 INN 4. Veterans Services for Military Families	
Estimated annual number to be served in FY 15/16	**25**
Annual budgeted funds for FY 15/16	**$616,245**
Estimated Annual Cost Per Client (for direct service programs only)	**$24,649**

*This project is currently in the process of development.

1. **Program Description**

Orange County has the third largest population of recently deployed veterans in the state. There are an estimated 150,000 veterans in the county, many who struggle with posttraumatic stress disorder (PTSD) and/or traumatic brain injury (TBI). An evaluation of current Behavioral Health Veterans programs suggests family members are often affected by secondary trauma symptoms (i.e., anxiety, depression, communication issues) due to the veteran's behavior. However, family members lack the understanding and awareness to effectively cope on a day to day basis and do not have skills to effectively communicate in a non-confrontational manner. Additionally, the family member is often intimidated by the physical presentation (perceived intimidation) of the veteran. Compounding the issue is the fact that the Department of Veteran Affairs is tasked with serving the veteran not the veteran's Family and without another agency with the knowledge, ability, or funding to assist the family members, these families are left with little to no resources. The impact of this gap in services threatens family stability, further contributing to symptoms of trauma. There are currently Behavioral Health programs established for the veteran in venues like the Veteran Service Office, non-criminal domestic violence court, Veteran Treatment court, and outpatient counseling centers; however, a program that targets family members of veterans currently enrolled in County Veteran's Behavioral Health programs is not yet established.

This project will serve military family members of veterans involved in a behavioral health program, such as court, OC4Vets, or outpatient counseling. The Veteran Services for Military Families program will seek to address the family component of the issues facing veterans, such as PTSD, TBI, substance use, and other mental health issues. By addressing these issues, the goal is to prevent or provide early intervention by training family members to communicate using non-confrontational techniques, with improving knowledge of PTSD symptoms and developing resiliency and copings skills that will facilitate resolution of family issues. The program seeks to enhance the veterans' support

system through strengthening the family unit, which will in turn decrease the trauma symptoms that affect the veterans. Family members will become more resilient and have improved coping skills which will enable them to recover from their traumas. Providing services to the family unit will reinforce the protective factors that families provide in recovering from PTSD and other Behavioral Health issues. These services will include:

1. Screening and assessment of family members (spouses and partners), as needed.
2. Case management and brief counseling at minimum of 1 time per month per participant.
3. Referral and linkages to appropriate community resources for housing, employment, counseling, legal aid, etc.
4. Coordination and communication with court, as needed.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, and participant interviews.

It is expected that by addressing the family component, participants of the project will show improvement in the following areas:

1. Increased communication using non-confrontational techniques (to be measured by self-assessment surveys, interviews).
2. Increased education of PTSD symptoms (to be measured by self-assessment surveys, interviews).
3. Increased family resiliency and coping skills (to be measured by self-assessment surveys, interviews).
4. Veterans will report decreased symptoms of trauma (to be measured by interviews and self-report).

Group 2 INN 5. Developing Independent Living Skills	
Estimated annual number to be served in FY 15/16	**100**
Annual budgeted funds for FY 15/16	**$389,526**
Estimated Annual Cost Per Client (for direct service programs only)	**$3,895**

*This project is currently in the process of development.

1. Program Description

The Substance Abuse and Mental Health Services Administration (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 provide a foundation for independent living skill sets to empower participants with the confidence for a successful transition to independent living 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.

The target population will include 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 chronically ill, adult participants who have been homeless or are at risk of homelessness.

This project will teach participants independent living skills, which includes: 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. Overall, it is expected that these skills and resources will reduce participants tendency to return to homelessness or transient lifestyles.

This project is expected to 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. Working with trained peers (consumers and family members) will engage the participants and serve as a model of competency that participants may achieve. The program increases and eases access to independent living with the expectation that increased independent living skills and an understanding of their mental illness will

empower participants to retain stable housing for longer periods of time. This project highlights participants' strengths and the development of resilience in the promotion of recovery and total wellness.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests and participant interviews. Additionally, all participants will be tracked for completion of independent living skill set courses and follow through on any referrals and linkages given.

It is expected that project participants would show improvement in the following areas:

1. Increased independent living skill sets (to be measured by intake and enrollment data, self-assessment surveys, and participant interviews).
2. Increased understanding of their own mental health diagnosis and the tools and skills necessary to manage mental health independently (to be measured by self-assessment surveys, participant interviews).
3. Increased access to resources and services that promote independent living (to be measured by referral and linkage data collection, self-report and interviews).
4. Increase participants' quality of life through learning independent living skills (to be measured and compared to periodic self-assessment).

Group 3 INN 1. Continuum of Care for Veteran & Military Children and Families	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$405,160***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.
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1. Program Description

Historically, veteran/military children and families have been underserved and may become isolated in their communities. The socio-emotional and mental health challenges brought by the pre-, mid-, and post-deployment often affect the children and family of veterans as much as it does the veteran/service member. However, there is a lack of coordinated, community-based services for veteran/military families. A comprehensive approach is needed to identify, engage, and address this gap. This project proposes to serve Orange County veteran and military-connected children, spouses/partners, and family members, while also including the veteran(s) or active service member(s).

The Continuum of Care for Veteran & Military Children and Families project seeks to identify, screen, and treat veterans and their families. Using a family resource model, peer navigators and clinicians will help identify barriers and unmet needs of veterans and their families and direct participants to mental health and substance abuse services.

The project will collaborate with community partners who specialize in community-based support, basic needs and homeless prevention, domestic violence prevention, mental health and trauma treatment, and research and evaluation. Services will include outreach, support and guidance, community resource information, referrals and linkages, basic needs, financial and career coaching, Tele-therapy, domestic violence prevention and education, and mental health and trauma treatment.

2. Outcomes

Performance outcomes will be measured by surveys, screening tools, self-assessment surveys, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

It is expected the project will improve mental health services for veteran/military children and families in the following areas:

1. Identification and screening of veteran/military children (to be measured by Census analysis, surveys of veteran/military and child/family agencies).
2. Identification of outreach and engagement strategies for veteran/military families and veterans/service members (to be measured by drop off analysis, participant and peer navigator interviews).
3. Increased strengths and resiliency of veteran/military families (to be measured by North Carolina Family Assessment Scale (NCFAS) assessment tool).
4. Identification of co-occurring substance use disorders and family violence among veteran/military family population (to be measured by NCFAS, surveys of agency practices in screening and serving the target population).
5. To examine how fragmented public and private insurance coverage and VA services could undergird a continuum of services for veteran/military families and the veteran/service member(s) that does not yet exist (to be measured by surveys, structured participant and agency interviews, review of County and statewide Covered California databases).

Group 3 INN 2. Community Employment Services Project	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$671,426***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Individuals struggling with severe and persistent mental illness are not prepared for the demands of supported employment programs and would benefit from a "stepping stone" to the current existing supported employment programs. This project will prove to increase the quality of services, including better outcomes.

The Community Employment Services Project seeks to provide a paid, supported employment program for adults with severe and persistent mental illness who are receiving mental health treatment and are unemployed. The project will offer a 6-12 month paid training program during which participants will work alongside peer support specialists for 100% on-site job training, case management and coaching. The goal of the project is to empower participants in reaching their vocational goals.

2. Outcomes

Performance outcomes will be measured using self-assessment surveys and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The expected program outcomes include, but are not limited to the following:

1. Improved quality of life and well-being (to be measured by self-assessment surveys, participant interviews)
2. Decreased symptoms of anxiety (to be measured by self-assessment surveys, participant interviews)

3. Employment and retention (to be measured by percentage of participants employed; hours per week duration of employment and/or unemployment)

Group 3 INN 3. Employment and Mental Health Services Impact	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$445,161***
Estimated Annual Cost Per Client (for direct service programs only)	*****

* The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Currently there are no employment focused centers that have co-located mental health support to provide services to unemployed jobseekers.

The Employment and Mental Health Services Impact project seeks to provide mental health, education and counseling services within local employment centers to support job seekers' emotional and mental health needs. This project proposes that the co-location and integration of mental health clinicians at existing local employment centers will positively impact unemployed job seekers' emotional and mental health thereby leading to more success in gaining and retaining employment. The clinicians will have the capacity to address mental health issues associated with unemployment as part of the One-Stop environment and integrated case management team.

This project will provide mental health counseling, education, support, and referrals/linkages to appropriate community resources. Services will be available to individuals seeking employment assistance at the One-Stop Employment Centers located in Orange County. This project will aim to serve high priority populations which include: individuals who are unemployed or at risk of unemployment, adults, transitional age youth, foster youth, seniors, veterans, and TANF recipients. (The Temporary Assistance for Needy Families (TANF) program is designed to help needy families achieve self-sufficiency). Potential participants will be screened and assessed during enrollment and intake at employment centers. Project clinicians will reach out to participants who show signs of emotional and mental health problems to offer supportive counseling, brief therapy and mental health workshops. Individuals who decline support will be utilized as a comparison group during data analysis of project outcomes.

This project is innovative in that it introduces a new entry point into the mental health system. Our research supports a link between unemployment and mental health, but there are no federally funded employment centers with co-located mental health support and services. The co-location of mental health and employment services would increase access to mental health services that unemployed clients may not have considered or desired previous to exposure through this project. Access to on-site mental health services will reach participants who are at risk of developing a mental illness or displaying early signs of emotional, behavioral, or mental instability or co-occurring substance abuse disorders that coincide with their unemployment.

The goals of this project are to prevent the development of mental health conditions and intervene early in their manifestation to reduce risk factors/stressors and prevent conditions from getting worse.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, and participant interviews. A pre-test will be given to One-Stop clients at intake to establish a baseline to be used for data analysis. The post-test will be given to One-Stop clients at exit, whether the exit occurs because employment has been obtained or the client voluntarily discharges from One-Stop services. Measurement tools to be used for this project are under consideration and include: PHQ-2; PHQ-9; GAD-7; WHO-5; Becks Depression Inventory; Worry and mood scales; Negative and Positive mood states checklists. The exact tools to be used would be determined upon program design and implementation.

This project is expected to address learning objectives in the following areas:

1. Will access to mental health support and counseling at local employment centers decrease negative emotional and mental health symptoms during job search? (to be measured by pre- and post-tests of emotional and mental health symptoms and stressors. Pre-tests to be included in intake packets. Post-tests to be given at each participant's exit from the employment center).
2. Will access to mental health education and workshops decrease negative emotional and mental health symptoms during job search? (to be measured by pre- and post-tests of emotional and mental health symptoms and stressors. Pre-tests to be included in intake packets.

Post-tests to be given at each participant's exit from the employment center).

3. Will the co-location and integration of a mental health clinician at existing local employment centers, positively impact the unemployed job seeker's emotional and mental health thereby leading to greater success in gaining and retaining employment? (to be measured by number of participants in the project who (with access and/use of clinical support and/or the mental health education/workshops) successfully obtain unsubsidized employment – compared to the employment numbers of participants who do not access/use project services).

Group 3 INN 4. Veteran Student Needs Assessment and Treatment	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$571,827***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

There are more than 10,000 veteran students in Orange County with little to no access to mental health services. Veterans typically do not self-identify or seek medical services. However, social support from peers produces significant improvement in academic adjustment and fewer posttraumatic stress disorder (PTSD) symptoms.

Operation Enduring Success seeks to utilize trained PTSD mental health providers to offer mental health support for veterans through an activity-oriented, educational, and social environment. The primary purpose of this innovative project is to increase access to services. During the initial phase of the project, services will focus on designing, distributing, and tabulating surveys to identify needs, problems and potential solutions for veterans. Based on these findings, a series of workshops will be offered to provide behavioral modification and address PTSD symptoms. Mental health providers will work with veterans on group projects, arrange volunteer work, provide outside interactions and visit with veteran students on a social basis to create an open and relaxing environment.

The project is new and unique, as support programs vary in that they are generally a medical intervention with a stigma attached. This educational intervention will provide veteran students with the tools and methods to replace persistent negative thoughts and the skills to create positive interactions. Mental Health Providers will instruct and/or work side-by-side with veterans in a social and applied learning environment. Activities, such as house painting, will provide a foundation and support structure for therapists and veterans to interact in an innovative method of therapy. Therapists will be able to view first hand, in an applied context, the issues that veterans face and will present approaches to

address and resolve the situation in real time. The program will serve veterans who are experiencing difficulties in the educational system and allow them to begin building a sense of purpose in their educational pursuits. Participation will increase through the desire to attend class and belong to a group that is positive and supportive while working to help others.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, grade assessments, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

This project is expected to address learning objectives in the following areas:

1. What is triggering depression among veterans? (to be measured by initial surveys, intake, grade assessments, query of veteran triggers)
2. What relationship does social support and peer support have with suicide? (Initial PTSD survey overall general survey, PHQ-9 and other developed data collection with outings, rating of support post outings, grade assessments)
3. Can college persistence rates increase if mental health support is provided, and if so, what increments of time frame? (to be measured by assessment of educational data pre-intervention, at 3 months, 6 months and 12 months)
4. Does building support communities assist the veteran student in success with college and transition? (to be measured by data collection college every semester and yearly, pre-/post-surveys, intake information, grade queries, research department data collection at college to compare and evaluate yearly and at final project end)

Group 3 INN 5. Shared Housing Program	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$376,361***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

People with lived experience of mental illness and limited income in Orange County experience a significant system gap in trying to identify a place to live where they can share housing costs. There is no reliable housing available to Health Care Agency clients that they can afford. This underserved group regularly struggles to identify viable living options where they can pursue their recovery goals. The primary purpose of this project is to increase access to underserved groups.

The Shared Housing Program seeks to offer a database of shared housing for consumers searching for affordable housing. The project will create a committee of consumers and providers to help establish voluntary standards of key elements of shared housing and a process to review homes to ensure that they meet these basic standards. The Way Home will partner with currently existing Orange County mental health databases to provide resources to consumers and family members. A listing of homes that have completed the process would be available through currently existing behavioral and mental health databases.

This project would create significant new opportunities to expand access to shared housing in Orange County to consumers and family members, as well as behavioral health/healthcare providers, while offering important learnings that can be replicated in other parts of California.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, grade assessments, and participant interviews.

The project is expected to address learning objectives in the following areas:

1. What is the connection between housing and recovery? (to be measured by MORS scores tracked at entry to housing and 6-month intervals)
2. How does providing access to quality shared housing help behavioral health providers achieve their goals? (to be measured by recording goals at entry and 6-month intervals)
3. What is the need for shared housing that meets established standards? (to be measured by tracking number of inquiries to local resource databases)

Group 3 INN 6. Child Focused Mental Health Training for Religious Leaders	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$550,104***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Faith communities are an underutilized resource to identify and support families dealing with mental and behavioral issues with their children (0-18). Families tend to bring concerns to pastors more frequently than other professionals; however, pastors are often unprepared to address these issues.

LEAP of Faith will provide increased access to services through the following:

1. Training and education of pastors (ministers of all faiths)
2. Educational resources and workshops for families in an environment where there is comfort and trust
3. Outreach during congregational events
4. An established referral network that enables pastors and/or their designees (e.g., trained Family Navigators) to link families to services that are timely and effective

2. Outcomes

Performance outcomes will be measured by tracking referral data, self-assessment surveys, focus groups, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The project is expected to address learning objectives in the following areas:

1. Can a well-trained pastor be an effective educator and resource for parents of children who have mental health issues? (to be measured by program satisfaction surveys)
2. Do congregation-based workshops and other services lead to an increase in access to mental health services? (to be measured by

focus groups; pastor interviews; number of referrals provided by pastors, trained Family navigators, and workshop providers)

Group 3 INN 7. Job Training and On-site Support for TAY	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$2,095,407***
Estimated Annual Cost Per Client (for direct service programs only)	*****

* The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Rates of unemployment and underemployment are high among those diagnosed with serious mental illness, specifically transitional age youth (TAY). Increasing employment rates would decrease the impact on SSI, and improve mental health, self-esteem, and social connectedness. However, the single most commonly reported obstacle to employment among TAY, is lack of confidence.

The **Job Training and On-site Support for TAY project** proposes to utilize a food service business that provides hands-on job training and experience combined with on-site support staff who builds participants' confidence in the workplace and help manage mental health symptoms and behaviors while on the job.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, between group comparisons, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The project is expected to contribute to improvements in the following areas:

1. Increased confidence/motivation in seeking employment (to be measured by Casey Life Skills Assessment).
2. Improved employment outcomes (to be measured by length of time between job search and employment, average length of employment, and number of missed days; comparison of the program's employment rates to national employment rates for those on public assistance).

3. Improved mental health outcomes (to be measured by Outcome Questionnaire, number of psychiatric hospitalizations).
4. Decreased levels of stigma and shame over having been diagnosed with a mental illness (to be measured by the Consumer Experience Survey).
5. Increased levels of resilience (to be measured by the Orange County Youth Resilience Survey).

Group 3 INN 8. Developing and Testing Effective EBP's for Children	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$260,011***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Children and teens suffering from trauma typically drop out of treatment or do not respond to traditional methods. Services are needed to engage youth into treatment. This project seeks to combine Trauma-Focused Cognitive Behavioral Therapy (TFCBT) and Integrative Treatment of Complex Trauma (ITCT) into a single manual for the treatment of trauma among children and teens for the primary purpose of increasing the quality of services, including better outcomes.

The target population will include participants in general clinic populations who have a history of trauma. All participants will be full scope Medi-Cal eligible clients, ages 5-18, who have an included diagnosis and who are willing to participate in one of the three treatments offered.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, and participant interviews.

The project is expected to address learning objectives in the following areas:

1. Can TFCBT and ITCT be combined? (to be measured by development of user-friendly manual)
2. Is the combined treatment better received by participants than traditional approaches? (to be measured by comparison of drop-out rates for participants with combined treatment to historical drop-out rates)

3. Is the combined treatment more effective than either TFCBT and ITCT alone? (to be measured by comparison of drop out and symptoms reduction rates for TFCBT, ITCT, and combined treatment)
4. Is the combined treatment useful in the community? (to be measured by other agencies solicited to try out combined method)

Group 3 INN 9. LGBTIQ Housing Project	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$1,071,827***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

There is a lack of resources for lesbian, gay, bisexual, and transgender (LGBT) youth who are homeless or at-risk of homelessness. Currently, there are no LGBTIQ specific beds to house the homeless or they are not safely housed, placing them at risk for harassment and physical assault. As a result, there is a need for housing and mental health services, particularly services aimed at prevention or family reunification.

The LGBTIQ Homeless Project would serve as an expansion of services to the existing programs serving the LBGT community in Orange County. This expansion of services would address the needs of the homeless and at-risk of homelessness population within the LGBTIQ community and increase access to underserved groups. Homelessness would be addressed through a combination of individual and family mental health services aimed at family reunification, behavioral health, and successful placement in LGBTIQ safe housing. The project would contract with community emergency shelters and room and boards to create at least 30 LGBTIQ specific transitional living beds, as well as at least 5 LGBTIQ specific emergency shelter beds in Orange County, allowing for the safe and humane housing of the LGBTIQ community who are not safely housed in traditional housing services. The program will hire peer mentors to serve as outreach and engagement workers within homeless communities to engage LGBTIQ individuals who often have a distrust of traditional homelessness services. Professional staff would also serve as housing specialists to help participants engage in housing search, negotiation with landlords to maintain housing for those at risk of homelessness, stabilization once housing is found (including employment, educational, and substance abuse treatment and support) and homelessness prevention services.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The project is expected to address learning objectives in the following areas:

a. Can LGBTIQ culturally competent mental health services and case management utilizing a family reunification focus help reduce or prevent homelessness in LGBTIQ individuals? (to be measured by participant satisfaction survey)
b. Can placement in LGBTIQ specific transitional housing and emergency shelter beds provide safe and humane housing for the LGBTIQ homeless community, resulting in increased mental health outcomes? (to be measured by GAD-7, PHQ-9, WHOQOL-BREF, Participant satisfaction survey)
c. Can placement in LGBTIQ specific transitional housing provide a stable environment for work on employment/educational goals that can move participants into stable, long-term housing and improve mental health outcomes? (to be measured by GAD-7, PHQ-9, WHOQOL-BREF, Participant satisfaction survey, referral and linkage tracking, participant progress tracking)

Group 3 INN 10. Immigrant Screening and Referrals	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$432,479***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

The often traumatic reasons for leaving one's country, as well as the long and hazardous journey and process of resettlement, increase the risk for refugees to suffer from a variety of mental health issues. The identification and treatment of mental health problems among immigrants, however, has lagged behind.

Project Embrace seeks to combine various support services for newly arrived immigrants and offer a 12-week program that will provide home visits, family support, mental health screenings, and referrals for services, as needed.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The project is expected to address learning objectives in the following areas:

1. Does the initial family meeting impact attitudes towards mental health? (to be measured by initial assessment and intake of the family, enrollment into program and retention in the program)
2. Does assigning a Mentor Family Member with the refugee family decrease isolation? (to be measured by pre- and post-test of PHQ-9 and RHS-15 measures)
3. Is there an improvement in self-efficacy and coping skills after the completion of the program? (to be measured by General Self-Efficacy Scale (GSE Scale) and enrollment in other programs offered by Access California Services, such as job search, English as a Second

Language, Senior Computer classes and Refugee Social Services Program)

4. Is there an improvement in depressive symptoms after attending the groups? (to be measured by PHQ-9).
5. Is the program successful in its implementation? (to be measured by Refugee Health Screener-15 (RHS-15) and program satisfaction survey).

Group 3 INN 11. Whole Person Initiative	
Estimated annual number to be served in FY 15/16	*****
Annual budgeted funds for FY 15/16	**$928,427***
Estimated Annual Cost Per Client (for direct service programs only)	*****

*The Mental Health Services Act Steering Committee recommended this project to move forward with the approval process. If approved by the MHSOAC, this project is not expected to be implemented until FY 16/17. The number to be served and cost per client cannot be determined at this point, as final approval and subsequent service procurement and program development are still pending.

1. Program Description

Unmet spiritual needs can have a negative impact on health, increase healthcare costs, and may result in overuse of health care system (e.g., 70% of visits to a Primary Care Physician are related to psychosocial and emotional problems). Religion and spirituality have been shown to make a positive impact on health, which suggests a more holistic approach is needed in mental health treatment.

The Whole Person Healing Initiative project proposes to incorporate a whole person healing model in an integrative care system. The project will utilize a multidisciplinary team of professionals (i.e., medical doctor, physician assistants, spiritual leaders, mental health workers, licensed clinicians) to address the whole person in mind, body, and spirit in the treatment of mild to severe mental illness. Services will include counseling, psychoeducation, peer support, prayer support groups, and teachings of exercises in spirituality.

This project is designed to increase the quality of services by incorporating the component of spirituality into mental health services. This innovative treatment approach seeks to contribute to learning in Orange County by answering questions related to the effectiveness of spirituality-integrated mental health services, benefits of an integrative health care system, as well as their effects on utilization of medical resources, health outcomes, overall cost of care, quality of patient care, and knowledge of mental health services.

2. Outcomes

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys, pre- and post-tests, and participant interviews. The exact tools to be used would be determined upon program design and implementation.

The project is expected to address learning objectives in the following areas:

1. Can integrating spirituality into mental health services increase the quality of services? (to be measured by frequency and number of mental health treatment sessions, length of treatment, patient satisfaction and feedback survey)
2. Can integrative health care services (physical, mental and spiritual) reduce overutilization of health care services and overall health care costs? (to be measured by frequency of office visits for physical, mental, and spiritual health care; overall cost of care)
3. Can integrative health services result in better outcomes? (to be measured by physical health stability, chart-based quality indicators for different disease conditions, cardiovascular risk index, appropriate medical laboratory values changes, frequency and number of hospitalization/ER visits, length of recovery time; mental health stability, PHQ-9, GAD-7; screening for somatoform disorders, spiritual competency assessment)
4. Can integrative health care services improve overall quality of patient care? (to be measured by quality of life measures for each patient, patient satisfaction survey, World Health Organization Quality of Life (WHOQOL-BREF).
5. Can integrating spirituality into mental health treatment help this underserved population learn more about mental health and mental health services? (to be measured by Mental Health Literacy Questionnaire)

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 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 a 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 the:

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.

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

Health Care Agency Behavioral Health Services (BHS) has begun to implement a fully integrated EHR system that supports the goals of MHSA to promote wellness, recovery and resiliency. It is also our intent to comply with the federal requirements for Meaningful Use, which is designed to benefit the clients we serve. This is a large project and will be accomplished in three phases that will span several years, and includes acquisition and implementation of software, technology infrastructure upgrades and services to develop and implement the overall system.

We have completed the first phase of the project plan that culminated in the completion of the build to deliver enhanced functionality to our EHR, IRIS, and to successfully implement it at our pilot clinic. Enhancements we implemented include the core clinical documentation management system with clinical decision support and medication and prescription management including electronic prescribing. Additional technical improvements to our EHR include document imaging (which includes such functionality as electronic signature pads and the ability to scan documents), compliance monitoring, auditing and reporting for privacy and security, and enhanced disaster recovery. We were also able to successfully implement kiosks to afford increased consumer/family access to computers and the internet at several BHS outpatient County operated clinics.

We have begun the second phase of our project this year. This will include continued progress at implementing at additional BHS County operated outpatient clinics, consumer access via an online portal, voice activated documentation for staff with physical challenges, support for mobile device access, and further enhancements to our technology infrastructure to support additional staff use of the EHR.

The final phase will address the ability to securely interface with our contract providers and to participate in consent-based Health Information Exchanges outside County BHS as appropriate, including the continued compliance with the federal EHR Meaningful Use program.

Housing

MHSA Housing Program Update

1. Program Description

The MHSA Housing Program's funding is used to develop new housing for enrolled or eligible tenants. MHSA Housing Program eligibility requires a person be diagnosed with serious and persistent mental illness and are homeless or at risk of homelessness. MHSA Housing Program funding is limited to 30% of total development costs for each MHSA unit. Eligibility requirements can vary at each project due to the restrictions of the various funding partners.

To date, funding for MHSA Housing has created 106 new housing units, including two projects which were built with CSS One-Time Funds. Those 34 units are not included in the table below. Eleven units that are currently under construction will be completed by spring, 2015 and an additional 15 units will begin construction in March 2015 with anticipated completion in the summer of 2016. An additional 42 units (within three projects, including one shared housing project) are engaged in pre-development activities, and if successful will leased-up by or before 2017. Seven more units are proceeding towards formal application. When all construction and projects are completed the MHSA Housing program is anticipated to have created at least 191 units of permanent housing for eligible tenants and their families.

Since it is unclear when or if some of these projects are going to be completed, it is difficult to determine annual spending or per/resident costs. The following is a current accounting of the original $33 million allocation which is assigned to CalHFA.

	MHSA Units	Total Units	Capital	COSR	Total
Beginning Balances			$22,105,500	$11,052,800	$33,158,300
CalHFA 1% Administrative Fee			-$331,583		-$331,583
Interest Earned			$2,988,356		$2,988,356
Revised Balances with Discretionary Funds			-$5,797,124	$5,797,124	$0
Avenida Villas	28	29	$3,259,600	$3,259,600	$6,519,200
Cerritos Family Apartments	19	60	$2,222,734	$2,222,734	$4,445,468
Cotton's Point	15	76	$1,622,400	$400,000	$2,022,400
Doria II	10	74	$1,169,850	$850,000	$2,019,850
Alegre Apartments	11	104	$1,286,835	$1,286,835	$2,573,670
Lincoln Family Apartments	15	70	$1,897,974	$1,325,000	$3,222,974

	MHSA Units	Total Units	Capital	COSR	Total
Total Committed at CalHFA	98	413	$11,459,393	$9,344,169	$20,803,562
Balance Remaining			$7,505,756	$7,505,755	$15,011,511
Planned Units					
Henderson House (Shared)	14	32	$1,771,442	$1,771,442	$3,542,884
Depot at Santiago	10	78	$1,265,320	$1,265,320	$2,530,640
Fullerton Heights	18	36	$1,800,000	$1,800,000	$3,600,000
Savi Ranch II	7	51	$ 851,655	$ 851,655	$1,703,310
Santa Ines Senior Villas	10	42	$1,216,650	$1,216,650	$2,433,300
Total Pipeline	63	239	$7,408,109	$7,408,109	$14,960,218
Total Committed/Planned	157	652			
TBD	4	TBD	$526,372	$526,372	$1,052,744
Balance Remaining			**$25,647**	**$25,646**	**$51,293**

One Time Projects	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Diamond Apartments	15	9	1	25
Doria Apts., Phase I	10	0	1	60
Totals	**25**	**9**	**2**	**85**

Completed MHSA Projects (CalHFA)	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Avenida Villas	24	4	1	29
Cotton's Point Seniors	15 (*)	0	1	76
Capestone Apts.	19	0	1	60
Doria Apts., Phase 2	8	2	1	74
Totals	**66**	**6**	**4**	**239**

MHSA Project in Construction	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Alegre Family Apts./Totals	**11**	**0**	**1**	**104**

MHSA Projects near construction start	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Henderson House, Rehab	14 Bedrooms, shared condos	0	0	32
Lincoln Ave. Apts.	15	0	1	70
Totals:	**29**	**0**	**1**	**102**

MHSA Projects in the "Pipeline"	One Bedroom MHSA Units	Manager's Unit	Total Units including MHSA	Comments
Depot at Santiago	10	1	78	Posted, awaiting Cal HFA approval, additional funding
Fullerton Heights	18	1	36	Posted, awaiting Cal HFA approval, additional funding
Santa Ines Seniors	10	1	42	MHSA funding awarded, seeking additional funds
Savi Ranch, Phase II	7	1	51	Posting next 30 days
Totals	**45**	**4**	**207**	

*Excludes 9 MHSA occupied units not financed through MHSA funding

2. Outcomes

1. 90% of referred, eligible tenants to remain housed in permanent housing for a minimum of one year. Of the MHSA Housing Projects that have been leased for more than one year, 90.5% of the current formerly homeless, or at risk of homelessness, residents have remained housed for over one year.
2. The program will complete and lease 57 additional new units during years 2015-17.

Budget Exhibit

FY 15/16 Annual Update- Mental Health Services Act Expenditure Plan
Funding Summary

County: Orange Date: 3/23/15

		MHSA Funding					
		A	B	C	D	E	F
		Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
C. Estimated FY 2014/15 Funding							
1.	Estimated Unspent Funds from Prior Fiscal Years	78,213,683	42,063,794	19,880,011	0	9,067,951	
2.	Estimated New FY 15/16 Funding	91,475,074	24,393,353	6,098,338			
3.	Transfer in FY 15/16[a/]	(4,739,642)			4,739,642		
4.	Access Local Prudent Reserve in FY 15/16						0
5.	Estimated Available Funding for FY 15/16	164,949,115	66,457,147	25,978,349	4,739,642	9,067,951	
D. Estimated FY 15/16 MHSA Expenditures		100,918,754	34,952,761	18,973,760	4,739,642	4,164,475	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2015	70,921,582
2. Contributions to the Local Prudent Reserve in FY 2015/16	0
3. Distributions from the Local Prudent Reserve in FY 2015/16	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	70,921,582
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	70,921,582

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 15/16 Annual Update – Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/23/15

		Fiscal Year 15/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs							
1.	C1 - Children's Full Service Wraparound	6,364,297	5,954,575	409,722	0	0	0
2.	T1 - TAY Full Service Wraparound	6,924,067	6,334,468	589,599	0	0	0
3.	A1 - Adult Full Service Partnership	17,641,223	14,571,114	2,782,906	0	0	287,203
4.	O2 - Older Adult FSP & Support & Intervention Systems	3,389,981	2,536,395	838,422	0	0	15,164
5.	FSP Percent of Non Admin Programs Below	17,601,298	15,383,235	2,164,468	0	0	53,595
Non-FSP Programs							
1.	C2 - Children's Outreach & Engagement	12,359	12,359	0	0	0	0
2.	C3 - Children's In-Home Crisis Stabilization	1,100,344	759,836	340,508	0	0	0
3.	C4 - Children's Crisis Residential Services	2,528,726	2,302,976	225,750	0	0	0
4.	C5 - Mentoring for Children	352,620	352,620	0	0	0	0
5.	C6 - Children's CAT	1,275,028	956,942	318,085	0	0	0
6.	C7 - OC Children with Co-Occurring MH Services for Children	400,000	400,000	0	0	0	0

7.	C8 - Outpatient Mental Health Services Expansion: Children and Youth	650,000	325,000	325,000	0	0	0
8.	C9 - Dual Diagnosis Residential Treatment	300,000	300,000	0	0	0	0
9.	C10 - Medi-cal Match: Mental Health Services	127,500	127,500	0	0	0	0
10.	T2 - TAY Outreach & Engagement	12,864	12,864	0	0	0	0
11.	T3 - TAY Crisis Residential Services	127,395	119,895	7,500	0	0	0
12.	T4 - TAY Mentoring Program	147,380	147,380	0	0	0	0
13.	T5 - TAY- CAT	272,267	272,267	0	0	0	0
14.	T6 - TAY PACT	568,680	448,046	114,410	0	0	6,225
15.	A2 - Adult CAT	3,609,743	3,005,492	588,251	0	0	16,001
16.	A3 - Adult Crisis Residential	2,865,594	1,800,983	972,010	0	0	92,600
17.	A4 - Supportive Employment	919,275	919,275	0	0	0	0
18.	A5 - Adult Outreach & Engagement	51,770	51,770	0	0	0	0
19.	A6 - Adult PACT	5,549,038	4,865,963	668,852	0	0	14,223
20.	A7 - Wellness Center	2,672,503	2,672,503	0	0	0	0
21.	A8 - Recovery Center Program	11,544,885	8,571,946	2,959,293	0	0	13,646
22.	A9 - Adult Peer Monitoring	253,817	249,134	0	0	0	4,683
24.	A10 - Assisted Outpatient Treatment	1,841,125	1,730,360	110,765	0	0	0
25.	A11 - Mental Health Court - Probation Services	696,000	696,000	0	0	0	0
26.	A12 - Drop in Center	425,000	425,000	0	0	0	0
27.	A13 - Housing for Homeless	950,000	950,000	0	0	0	0
28.	A14 - Housing and Year-Round Emergency Shelter	683,590	683,590	0	0	0	0

23.	A15 - Transportation Program	800,000	800,000	0	0	0	0
29.	A16 - In-Home Stabilization Services	1,496,250	1,425,000	71,250	0	0	0
30.	O1 - Older Adult Recovery Services	2,266,857	1,584,728	679,590	0	0	2,538
31.	O3 - Older Adult PACT	649,400	511,199	108,978	0	0	29,223
32.	O4 - Older Adult Peer Mentoring	686,469	673,803	0	0	0	12,666
33.	H1 - CSS MHSA Housing Program Assigned Funds	200,638	200,638	0	0	0	0
34	Integrated Community Services	1,848,000	1,848,000				
35	Volunteer to Work	541,510	541,510				
CSS Administration		15,492,984	15,394,386	0	0	0	98,598
Total CSS Program Estimated Expenditures		115,840,477	100,918,754	14,275,359	0	0	646,364
FSP Programs as Percent of Total		51.4%					

FY 15/16 Annual Update – Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Orange Date: 3/23/15

		Fiscal Year 2015/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs							
1.	Workforce Staffing Support	375,324	375,324				
2.	Training and Technical Assistance	899,657	899,657				
3.	Mental Health Career pathways Programs	867,000	867,000				
4.	Residencies and Internships	199,876	199,876				
5.	Financial Incentives Programs	1,674,789	1,674,789				
6.		0					
7.		0					
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
WET Administration		722,996	722,996				
Total WET Program Estimated Expenditures		4,739,642	4,739,642	0	0	0	0

Prevention and Early Intervention (PEI) Component Worksheet

County: Orange Date: 3/23/15

		Fiscal Year 15/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs – Early Intervention							
1.	CF1 – Early Intervention Services for Stress Free Families	534,693	534,693				
2.	CF2 – 1st Onset of Psychiatric Illness (OC CREW)	1,500,000	1,500,000				
3.	CF3 – Orange County Postpartum Wellness (OCPPW)	1,913,072	1,913,072				
4.	CF4 – Socialization Program for Adults and Older Adults	1,419,500	1,419,500				
5.	CF5 – Youth as Parents	500,000	500,000				
6.	CF6 – Behavioral Health Counseling Program	1,800,000	1,800,000				
7.	CF7 – Crisis Prevention Services	272,533	272,533				
8.	CF8 – Survivor Support Services	270,693	270,693				
9.	CF16 – OC4VETS	996,047	996,047				
10.	CF17 - OCACCEPT	420,000	420,000				

PEI Programs - Prevention							
11.	CF9 – Parent Education for Youth	507,590	507,590				
12.	CF10 – Family Support Services	718,424	718,424				
13.	CF11 – Children's Support and Parenting Program (CSPP)	1,400,000	1,400,000				
14.	CF12 – PEI Services for Parents and Siblings of Youth in the Juvenile Justice System – Stop the Cycle	1,000,000	1,000,000				
15.	CF13 – Outreach and Engagement Collaborative	3,819,044	3,819,044				
16.	CF14 - WarmLine	441,566	441,566				
17.	CF15 – Professional Assessors	536,136	536,136				
18.	SF1 – School Based Mental Health Services	2,000,000	2,000,000				
19.	SF2 – School Based Behavioral Health Intervention and Support-Early Intervention Services	400,000	400,000				
20.	SF3 – School Readiness Programs/Connect the Tots	1,800,000	1,800,000				
21.	SF4 – College Veterans' Program	150,000	150,000				
22.	SF5 – School Based Behavioral Health Intervention and Support	1,749,589	1,749,589				

23.	SF6 – Violence Prevention	1,287,751	1,287,751				
24.	SF7 – Transitions	915,236	915,236				
25.	SF8 – K-12 Coping Skills to Manage Stress	120,000	120,000				
26.	SE1 – Information and Referral/OCLINKS	1,000,000	1,000,000				
27.	SE2 – Training, Assessment and Coordination Services	984,777	984,777				
28.	SE3 – Training in Physical Fitness and Nutrition Services	50,000	50,000				
29.	SE4 – Community Based Stigma Reduction	214,333	214,333				
30.	SE5 – Cal MHSA Statewide Projects	900,000	900,000				
PEI Administration		5,331,777	5,331,777				
PEI Assigned Funds							
Total PEI Program Estimated Expenditures		34,952,761	34,952,761	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Orange Date: 3/23/15

		Fiscal Year 15/16					
		A	B	C	D	E	F
		Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
GROUP 1 INN Programs							
1.	INN1- Integrated Community Services	1,191,686	1,191,686				
2.	INN2-Collective Solutions	160,518	160,518				
3.	INN3-Volunteer to Work	285,890	285,890				
4.	INN4-OC Accept	791,815	791,815				
5.	INN5-OC4VETS	489,652	489,652				
6.	INN7-Project Life Coach	338,181	338,181				
7.	INN9-Brighter Futures	516,616	516,616				
8.	Program Monitoring	359,300	359,300				
	Group 1 Administration Cost	744,058	744,058				

GROUP 2 INN Programs							
1.	INN1 – Proactive On-Site Engagement in the Collaborative Courts to Offer Access to Mental Health Education Programs to Reduce Recidivism	416,622	416,622				
2.	INN2 – Religious Leaders Mental Health First Aid	315,106	315,106				
3.	INN3 – Access to Mobile, Cellular, Internet, Devices in Improving Quality of Life	271,946	271,946				
4.	INN4 – Veterans Services for Military Families and Caregivers	616,245	616,245				
5.	INN5 – Skill Sets for Independent Living Project	389,526	389,526				
	Group 2 Administration Cost	361,700	361,700				

GROUP 3 INN Programs							
1.	INN1 – Continuum of Care for Veteran & Military Children and Families	405,160	405,160				
2.	INN2 – Community Employment Services Project	671,426	671,426				
3.	INN3 – Employment and Mental Health Services Impact	445,161	445,161				
4.	INN4 – Veteran Student Needs Assessment and Treatment	571,827	571,827				
5.	INN5 – Shared Housing Program	376,361	376,371				
6.	INN6 – Child Focused Mental Health Training for Religious Leaders	550,104	550,104				
7.	INN7 – Job Training and On-Site Support for TAY	2,095,407	2,095,407				
8.	INN8 – Developing and Testing Effective EBPs for Children	260,011	260,011				
9.	INN9 – LGBTIQ Homeless Project	1,071,827	1,071,827				
10.	INN10 – Immigrant Screening and Referrals	432,479	432,479-				
11.	INN11 – Whole Person Healing Initiative	928,427	928,427				
	Group 3 Administration Cost	1,405,474	1,405,474				
INN Administration		2,511,233	2,511,233				
Total INN Program Estimated Expenditures		18,973,760	18,973,760	0	0	0	0

FY 15/16 Annual Update – Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Orange Date: 3/23/15

	Fiscal Year 15/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Electronic Health Record (E.H.R)	4,000,000	4,000,000				
12.	0					
13.	0					
14.	0					
15.	0					
20.	0					
CFTN Administration	164,475	164,475				
Total CFTN Program Estimated Expenditures	4,164,475	4,164,475	0	0	0	0

APPENDIX I: Minutes from the Mental Health Public Hearing

County of Orange
Mental Health Board

TEL: (714) 834-5481 / Email: ddaniels@ochca.com

Tuesday, May 12, 2015
9:00 a.m. – 11:00 a.m.

Meeting Location
Neighborhood Community Center
Victoria Room
1845 Park Ave
Costa Mesa, CA 92627

MINUTES

Members Present: Alisa Chatprapachai, April Guajardo, Brian Jacobs, Judith Lewis, Richard McConaughy, Karyn Mendoza, Carolyn Nguyen, Michell Rose, Gregory Swift

Members Absent: Supervisor Andrew Do, Jeffrey Davis, Ehsan Gharadjedaghi, Frances M. Williams

Call to Order at 9:06 a.m. by Richard McConaughy.

Welcome and Introductions

- Each member and attendee introduced themselves and their respective affiliation.

Open Public Hearing

- Opening Remarks: Jeff Nagel, MHSA Coordinator
  - In recognition of May being Mental Health Awareness month, Jeff shared information about California's Statewide Movement – Each Mind Matters (http://www.eachmindmatters.org/). Jeff also thanked the guest in attendance, members of the Mental Health Services Act (MHSA) Steering Committee, and the members of the Mental Health Board. Furthermore, Jeff also acknowledged the guest speakers who were invited to speak during the Public Hearing. Finally, Jeff shared information about the process to compose the MHSA Plan and the collaboration between the MHSA Steering Committee and Behavioral Health Services.
- Guest Speakers
  - A total of seven (7) individuals spoke in support of the MHSA Annual Plan Update Fiscal Year 2015-2016. These individuals represented a consumer, family member, professional, and public interest point of view.
- Public Comment
  - One (1) public comment was received during the Public Hearing. Keith Torkelson shared his support of the MHSA Plan and the continuity of new services and programs available in Orange County.

County of Orange
Mental Health Board

TEL: (714) 834-5481 / Email: ddaniels@ochca.com

Tuesday, May 12, 2015
9:00 a.m. – 11:00 a.m.

MINUTES

Close Public Hearing and MHB Vote: Action Item – Approved

- Richard McConaughy called for a motion to approve the MHSA Annual Plan Update Fiscal Year 2015-2016. Judith Lewis made a motion to approve the plan and Carolyn Nguyen seconded the motion. The MHSA Annual Plan Update Fiscal Year 2015-2016 was unanimously approved with a 9 yes/0 no vote.

Approval of Minutes: Action Item – Approved

- Richard McConaughy called for a motion to approve the meeting minutes from the MHB General Meeting on April 22, 2015. Michaell Rose made a motion to approve the minutes and Carolyn Nguyen seconded the motion. The minutes were unanimously approved with a 9 yes/0 no vote.

New Business: Action Item – Approved

- MHB Meeting Schedule – MHB General Meeting, May 27, 2015
  - Richard McConaughy called for a motion to cancel the MHB General Meeting on May 27, 2015. Brian Jacobs made a motion to cancel the meeting and Michaell Rose seconded the motion. The meeting cancelation was unanimously approved with a 9 yes/0 no vote.

Public Comment

- None

Adjournment: Action Item – Approved

- Richard McConaughy called for a motion to adjourn the meeting. Judith Lewis made a motion to adjourn and Michaell Rose seconded the motion. The meeting was adjourned at 10:45 a.m.

Officially submitted by:

Danielle A. Daniels
***Note: Copies of all writings pertaining to items in these MHB minutes are available for public review in the Behavioral Health Services Advisory Board Office, 405 W. 5th Street, Santa Ana, CA 92701, 714.834.5481 or Email: ddaniels@ochca.com ***

APPENDIX II: Minute Order from the Board of Supervisors

ORANGE COUNTY BOARD OF SUPERVISORS

MINUTE ORDER

June 02, 2015

Submitting Agency/Department: HEALTH CARE AGENCY

Approve Plan Update for Mental Health Services Act, Proposition 63 programs and services, 7/1/15 - 6/30/16 ($163,749,392); and authorize Director or designee to execute plan update - All Districts

The following is action taken by the Board of Supervisors:

APPROVED AS RECOMMENDED ☒ OTHER ☐

Unanimous ☒ (1) DO: **Y** (2) STEEL: **Y** (3) SPITZER: **Y** (4) NELSON: **Y** (5) BARTLETT: **Y**
Vote Key: Y=Yes; N=No; A=Abstain; X=Excused; B.O.=Board Order

Documents accompanying this matter:

- ☐ Resolution(s)
- ☐ Ordinances(s)
- ☐ Contract(s)

Item No. 33

Special Notes:

Copies sent to:

HCA – Jenny Qian

6/9/15

I certify that the foregoing is a true and correct copy of the Minute Order adopted by the Board of Supervisors, Orange County, State of California.
Robin Stieler, Interim Clerk of the Board

By: _____
Deputy

Agenda Item

AGENDA STAFF REPORT

2015 MAY 21 AM 7:40

ASR Control 15-000613

MEETING DATE:	06/02/15
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):	Jenny Qian (714) 834-7024
	Mary Hale (714) 834-6032

1SA2

SUBJECT: Mental Health Services Act Annual Plan Update FY 2015-16

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

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** FY 2015-16 $163,749,392

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

Current Fiscal Year Revenue: N/A

Funding Source: State: 100% (Mental Health Services Act/Prop 63) **County Audit in last 3 years:** No

Prior Board Action: 5/13/2014 #29

RECOMMENDED ACTION(S):

1. Approve the Plan Update for the provision of the Mental Health Services Act, Proposition 63 programs and services for the period of July 1, 2015 through June 30, 2016 in the amount of $163,749,392.

2. Authorize the Health Care Agency Director, or designee, to execute the Plan Update as referenced in the Recommended Action above.

SUMMARY:

The Health Care Agency requests approval of the FY 2015-16 Plan Update which will support expanded and enhanced mental health and supportive services consistent with the 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 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 the MHSA include Community Services and Supports, Workforce Education and Training, Capital Facilities and Technology, Prevention and Early Intervention, and Innovation.

On May 13, 2014, your Honorable Board approved the MHSA Three-Year Program and Expenditure Plan FY 2014-15, FY 2015-16, and FY 2016-17. The Mental Health Services Act statutes require that all plans and plan updates be approved at the local level. Welfare and Institutions Code § 5847 states that the County mental health program shall prepare and submit Annual Updates adopted by the County Board of Supervisors. This year's FY 2015-16 MHSA Plan Update is consistent with the Three-Year Plan already approved by the Board of Supervisors, and was developed with a significant community planning process. The MHSA Steering Committee approved the FY 2015-16 MHSA Plan Update after review and recommendation from the relevant subcommittees.

FY 2015-16 MHSA Plan Update was posted and distributed throughout the community on April 1, 2015 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 12, 2015 and the Plan Update was approved.

The FY 2015-16 MHSA Plan Update will provide revenue to support expanded and enhanced mental health and supportive services consistent with the Mental Health Services Act.

The Health Care Agency requests your Board approve the FY 2015-16 MHSA Plan Update as referenced in the Recommended Action.

FINANCIAL IMPACT:

Appropriations and revenues are included in the Health Care Agency's FY 2015-16 Recommended Budget.

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - FY 2015-16 MHSA Plan Update
Attachment B - Welfare and Institutions Code Section 5847

APPENDIX III: Public Comments

Public Comments

The Orange County MHSA Annual Plan Update and Expenditure Plan for FY 15/16 was available for Public Comment from April 1, 2015 through April 30, 2015. During that time a total of 4 comments were received. Some of the comments were requests for further information and others dealt with substantive issues related to the Plan. The MHSA Office would like to express our appreciation to the many stakeholders and staff that provided feedback or information that contributed to this document. This Plan would not be possible without the significant input of many individuals. Below is a summary of the substantive comments and the County's responses.

Comment 1

This comment addressed a variety of issues related to the Innovation component of the Plan. Specifically, the comment advocated for a research approach – using control groups for Innovation Projects – and selecting Best Practices models for Innovation Projects that receive funding beyond the initial Innovation funding.

Response to Comment 1:

The Mental Health Services Act is codified in the Welfare and Institutions Code. Division 5, Part 3.2 specifically addresses Innovative Programs. The information contained here and in the Innovative Project Regulations specify the rules that HCA must adhere to in the implementation of the Innovative Programs component of MHSA.

An Innovative project is defined as one that contributes to learning rather than one with 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 project contributes to learning in one or more of the following three ways:

1. Introduces new mental health practices/approaches, including prevention and early intervention that have never been done;
2. Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community;
3. 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.

Unlike other components of MHSA, Innovation funds can only be expended after the Mental Health Oversight and Accountability Commission (MHSOAC) approves the Innovation Project. Innovative projects are legislatively intended to assess a new or

changed application of a promising approach to solving persistent mental health challenges, so approved and funded projects may or may not be successful. If the outcomes determine an innovative project to be successful and a county chooses to continue it, the funding would have to be transitioned to another category (component).

In the current Plan Update, two Group 1 Innovation projects were transferred into both the Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) components. This transition of the funding into the different components is reflected in the budget summary documents contained in the Plan Update.

Comment 2

This comment asked about three distinct areas of the report, and a response will be provided for each separate area. The comment addressed the following: (1) outcome data for the AOT program, (2) statistical and clinical significance of the reported outcome data, and (3) the modest gains in employment for FSP participants.

Response to Comment 2:

1. A table will be added to the final version of the Annual Plan Update on page 84 that provides the disposition of all AOT referrals.

2. The reporting of outcomes in this Annual Report is similar to previous MHSA Three Year Plans and Annual Plan Updates. Clinical and statistical significance, however, are not discussed consistently across all programs. An effort has been initiated by the MHSA Office to standardize the use of outcome measures and the psychometrics to be used for the evaluation of MHSA programs through the development of a shared program performance evaluation framework. This will hopefully result in the use of common language and common set of tools and visual displays (e.g., charts and graphs) that will be incorporated into future Annual Plan Updates. This will allow stakeholders and interested readers to more easily gauge the impact of the individual MHSA programs.

3. Consumers in the FSP programs are individuals who have frequently experienced homelessness, incarceration as well as chronic mental illness, all factors which are barriers to re-enter the labor force. Emphasis has often been on achieving housing and providing stabilization prior to any efforts to obtain employment. There is, however, considerable variability in the outcome measures for employment. For example, in the previous MHSA Plan (Three Year Plan Update), the Adult FSPs reported a 38% increase in employment days – compared to the 2% increase in employment days reported in the current plan.

Statewide, there are significant challenges in obtaining employment for FSP participants. Orange County FSPs and BHS management are aware of the challenges of finding employment for FSP participants and have developed a workgroup to look at various models related to employment. As a partial result of this effort, an Employment Specialist position has been added to address the barriers our members face in seeking employment. In addition, FSPs are exploring how best to utilize community resources.

Comment 3

This comment asked about four distinct areas of the report, and a response is provided for each separate area. The comment addressed the following: (1) adding summary level information about budget and number served in the Executive Summary, (2) questions about the number served in the Dual Diagnosis Residential Treatment Program, (3) a request for better outcome data for Centralized Assessment Team, TAY and Adult, and (4) A request to clarify the costs per client for the Assisted Outpatient Treatment program.

Response to Comment 3:

1. The total dollars budgeted for Fiscal Year 15/16 has been added to the Executive Summary. Currently the Health Care Agency does not track unduplicated clients that may utilize services across different MHSA programs, so providing a single number of clients served derived by summarizing the total number of clients being served in each program could be misleading. The Annual Plan does provide the number of clients served and the cost per client for each MHSA program as that gives the most accurate representation of who is being served.

2. The Dual Diagnosis program is a 180 day residential treatment program. This program is licensed for clients under the age of 18 and serves 40-60 clients per year. MHSA funds are used to secure additional services beyond the program's core funding. No referral source is disqualified, but a commitment to change on the part of the client is expected and many adolescents find this difficult.

3. The tracking of Referrals and Linkages for the Centralized Assessment Team was implemented in January 2014. After gathering initial data, it was necessary to refine the outcome measure to accurately capture the desired information. There was insufficient data available for reporting the disposition of all clients in this Annual Plan Update. For Fiscal Year 13/14, 47% of the evaluations resulted in a hospitalization. The remaining 53% were able to be maintained in the community without hospitalization. Next year's Plan Update will be able to report

the disposition of those that were not hospitalized consistent with this comment/recommendation.

4. As this is the first full year of operation for the Assisted Outpatient Treatment program, the Health Care Agency is determining how much budget for the program. The current budget allocation is greater than expenditures and any unexpended funds will be maintained in the Health Care Agency as MHSA funds. Future budgets will be adjusted based on utilization and expenditures.

Comment 4

This comment offered several recommendations for consideration and asked about various areas of the report, and a response is provided for each separate area of inquiry/comment. The comment addressed the following: (1) seeking clarification on the percentage of Behavioral Health Services staff that are administrative, (2) a request for a graph to represent the outcomes for the Information and Referral/OCLinks program, (3) seeking clarification on the clients being served in the Integrated Community Services program and (4) seeking clarification on what was meant when by "referrals" in the Volunteer to Work program.

Response to Comment 4:

1. The Workforce Needs Assessment is based on a count of budgeted staff in Behavioral Health Services, employees in the county contract agencies, and individual county contractors. For the purposes of the needs assessment, the Program Director or Service Chief category included Managers (above direct supervisor or licensed clinician) – 20.24FTE, Service Chiefs – 34.33 FTE, licensed supervising clinicians – 12.65 FTE, and other managers and supervisors – 33.64 FTE. Both licensed supervising clinicians and Service Chiefs may have clinical caseloads. Non-direct services staff consist of analysts, tech support, quality assurance; clerical, secretary, administrative assistants; and other support staff. Of the 2089 budgeted FTE at the time of the Workforce Needs Assessment, 285 were categorized as program directors or Service Chief, which represents 13.4% of the total budgeted positions.

2. A graph representing the outcomes of the Information and Referral/OCLinks program was added to page 167 of the document.

3. There are two components to the ICS project: ICS County Home and ICS Community Home. On the County side, primary care physicians, registered nurses and peer specialists are placed in one of three County behavioral health clinics in Santa Ana, Westminster, or Anaheim. All clients served in the County

Home Integrated Community Services project must have a chronic health condition and be currently enrolled in behavioral health services at an Orange County Behavioral Health Clinic. All clients would need to meet medical necessity criteria in order to be enrolled in behavioral health services at one of the above clinics. Therefore, all 361 participants served in this component of the project would be considered to have severe and persistent mental illness (SPMI). The ICS community home component of this project provides services to adults who are being seen in a community health clinic and who have a mental health care need. Many of those participants served in this second component were provided referrals and or linkages to mental health services. The severity of mental health condition was not reported in this second component of this project.

4. The Volunteer to Work Innovation project assisted participants in finding volunteer opportunities in an area of interest to the particular participant with the hope that these volunteer activities would lead to job skills that could serve as a "stepping stone" to employment. Individuals who participated in this project were adults 18 and older who are living with a mental health diagnosis and seeking successful entry or re-entry into employment. The distinction between a referral and linkage as reported in the outcome data reflects how much assistance was offered to get the participant to the requested or needed service. If the project staff took an active role in ensuring the participant received a given service and followed up to ensure that a connection was made, it was considered a linkage (26 successful linkages provided). If the participant was just provided contact information, directions, pamphlet, etc. without active follow up by staff, the service was considered a referral (41 referrals reported).