WELLNESS • RECOVERY • RESILIENCE

Orange County MHSA Plan Update FY 16/17




OC health CARE AGENCY

Table of Contents

Table of Contents

Table of Contents

Message from the Deputy Agency Director for Behavioral Health Services

Since the Mental Health Services Act (MHSA) became law in January of 2005, the State has raised more than $13 billion, and created more than 1,600 new programs. Locally, we have received approximately $1.1 billion over the past 10 years and created more than 100 new programs that have had a significant impact on our community. We have seen thousands of clients successfully complete our Full Service Partnership programs; the successful completion of the 401 Tustin Campus; agreements for more than 194 new housing units for MHSA clients; implementation of Laura's Law (Assisted Outpatient Treatment); and countless other projects that have made MHSA the success that we all thought it could be. MHSA has transformed the mental health system in Orange County. In doing so, MHSA has supported the principles of community collaboration, cultural competency, wellness-focused services, recovery and resiliency, and reduction in disparities for unserved and underserved populations.

The progress made thus far would not have been possible without the support and guidance of groups and entities including: the Orange County Board of Supervisors; Mental Health Board; MHSA Steering Committee; Community Action Advisory Committee; advocates for unserved and underserved populations, and a multitude of others including County staff and volunteers who so graciously give of their time and expertise to create the successes achieved over the past ten years.

Nevertheless, there is always more work to be done, and ways to improve. We are trying innovative approaches to mental health issues and evaluating those projects for success. We are looking at our outcomes more closely than ever as well as opportunities to achieve better results in our programs. We are evaluating our MHSA-funded programs to assess our fidelity to the principles of MHSA. Finally, starting in FY 15/16, we will be performing a detailed review of the effectiveness of our Assisted Outpatient Treatment Program (Laura's Law). We will also be evaluating the cost benefits of our MHSA programs.

As I look at this year's MHSA Annual Plan Update FY 16/17, I am very pleased with the continued success of so many of our programs. I believe that we have put together a plan that reflects input from our stakeholders, and addresses the needs of the mental health community. This was truly a collaborative effort between our outstanding community partners and Behavioral Health Services staff. I believe this year's MHSA Plan is an illustration of the work we are doing to improve the lives of the individuals and family members affected by mental illness here in Orange County.

Sincerely,

Mary R. Hale

Mary R. Hale,
Deputy Agency Director for Behavioral Health Services

Overview and Executive Summary

California voters passed the Mental Health Services Act (MHSA) in November 2004 to expand and improve public mental health services. The intention of the Act is to provide state and local funding to reduce the long-term adverse impact on individuals and families resulting from untreated serious mental illness. Proposition 63 emphasizes transformation of the mental health system while improving the quality of life for Californians living with a mental illness. With more than ten years of funding, mental health programs and supports have been tailored to meet the individual needs of diverse clientele in each county in California. As a result, the community is experiencing the benefits of expanded and improved programs to assist individuals living with mental illness in becoming active members of society.

Orange County Behavioral Health Services has used a comprehensive stakeholder process to developlocal MHSA programs. MHSA funds a behavioral health system of care that ranges from prevention services to crisis residential care. The current array of services budgeted at $168,666,985 for FY 16/17 was created based on the planning efforts of stakeholders from 2005 to the current day.

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 serves as the basis for this plan update. The Three-Year Plan anticipated level funding for the three years covered by the plan, and the current Annual Plan Update has no change in funding for the majority of programs that were operational during FY 14/15. The principal exception to level funding occurred in Community Services and Supports.

Community Services and Supports

The Mental Health Services Act allocates 80% of the MHSA funds for Community Services and Supports (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.

As part of the fiscal review done in preparation for the FY 16/17 Annual Plan Update, the Orange County Health Care Agency's budget staff identified approximately $72.5 million dollars of unspent CSS funds that were available for allocation in FY 16/17 and on a sustainable basis. As a result, significant planning activities for this year's Plan centered on identifying programs for expansion consistent with CSS funding requirements.

Within the CSS component, the following programs were changed or enhanced in this current Plan Update. A full description of each of these programs is provided in the CSS section of the Annual Plan Update.

CSS Program Enhancements

Program Name	INCREASE IN 16/17
Housing for Homeless	$1,000,000
Dual Diagnosis (mental health and substance use disorder) Residential Treatment	$500,000
Full Service Partnership	$10,000,000
Adult Crisis Residential	$1,500,000
Supportive Employment	$300,000
Adult Outreach & Engagement	$1,000,000
Outpatient Clinics	$1,000,000
Crisis Stabilization Unit (Urgent Care)	$5,000,000
Co-Occurring (medical and mental health)	$2,000,000

Housing

In addition to the above enhancements, $5 million was allocated for housing projects. Initially, $33 million dollars were allocated to fund MHSA supportive housing projects through both stipend based vouchers as well as building/renovating units. Over the past 10 years, all of the initial housing funds have been spent or earmarked for future projects. The need for housing however continues to be the number one need according to stakeholders throughout the county.

Prevention and Early Intervention

Prevention and Early Intervention (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. Twenty percent of MHSA funding is dedicated to PEI programs. Within the PEI component, there was no change in funding between FY 15/16 and this current Plan for FY 16/17.

Overview and Executive Summary

Innovation

The Innovation component funds and evaluates new approaches that increase access to the unserved and/or underserved communities, promote interagency collaboration and increase 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. During FY 15/16, the funding for all Group 1 projects ended. Ongoing funding for three projects was approved in last year's Plan: Integrated Community Services (now funded by CSS), OC4Vets (now funded by PEI) and OC Accept (now funded by PEI). Final evaluation of all Round 1 projects is underway.

Workforce Education and Training (WET)

WET funding is intended to increase the number of qualified individuals who 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 programs continue through the use of Community Services and Supports funding. Within the WET component, the MHSA Steering Committee approved adding $200,000 for FY 16/17 to enhance the Recovery Education Institute and Crisis Intervention Training programs.

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). An EHR is a digital version of a patient's medical record that allows programs at different locations to better coordinate services and stay up-to-date on patients' treatment. The goals of implementing an EHR 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 toward 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. We look forward to continuing our partnership with our stakeholders as we implement MHSA in Orange County.

County Demographics

3 million
RESIDENTS

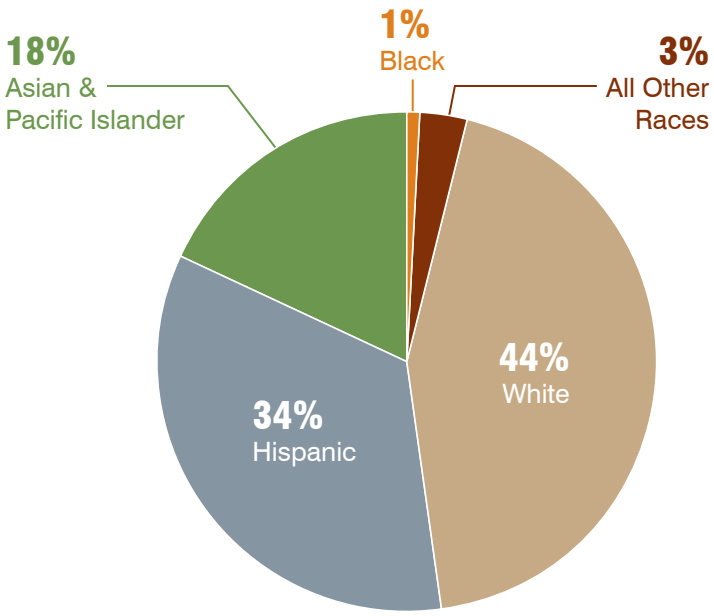
46%
OF RESIDENTS SPEAK ANOTHER LANGUAGE AT HOME

$79,000
INCOME NEEDED FOR A FAMILY WITH TWO ADULTS, ONE PRESCHOOLER AND ONE SCHOOL-AGED CHILD TO MEET BASIC NEEDS

12,000
HOMELESS

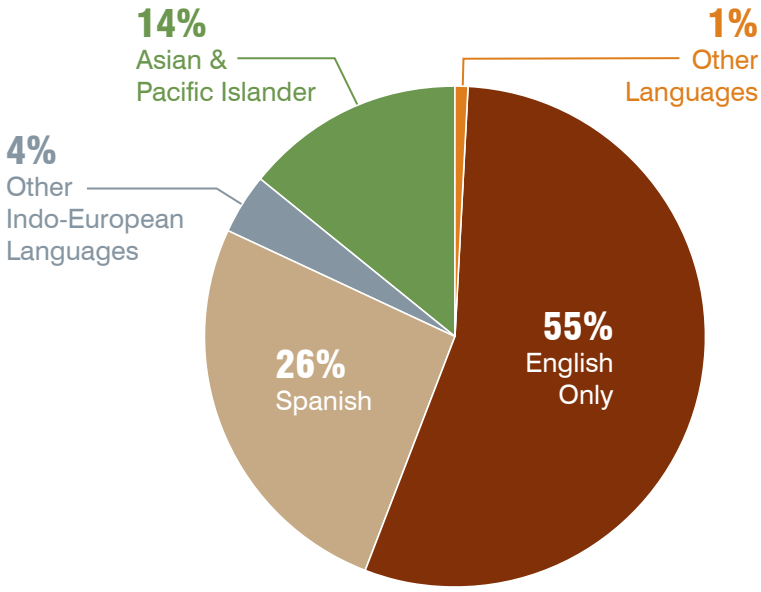
130,000
VETS

Race and Ethnicity Profile of Orange County



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

Language Spoken at Home



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

County Demographics

A Changing Demographic

- Orange County is the third-most populous county and second most densely populated county in California.
- It is home to a little over 3 million (3,114,363; 2013 Census estimate) people.
- Nearly half of residents over four years of age speak a language other than English at home (1.3 million compared to 1.5 million), with at least 108 different languages represented. 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%). Within the last 10 years, Orange County became a minority majority county, meaning the non-Hispanic white population no longer comprises more than 50% of the county population. By 2030, it is projected that Hispanics will become the majority (38.6%) ethnic group in the County, surpassing Whites (36.7%).

Living Here is Expensive

- 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.
- $52,337: Per Capita Income (DataQuick Information System, 2011/2012).
- $79,482: Income that a family of two adults with one preschooler and one school-age child needs to meet basic needs in Orange County.
    - $63,979: Income needed statewide (kidsdata.org, 2014).
- $610,000: Median House Price (Corelogic, 2015).
- 4.4%: Percentage of Orange County residents 16 years and older who did not have jobs (as of 12/15).
    - 7.0%: Unemployment rate statewide.
- 12.4%: Percentage of Orange County's population living under 100% of the federal poverty level (FPL), which is $10,890 annual income for a single-person household size (from 2009 to 2013). The FPL for a family of four is $24,250.

County Demographics

A Lot of Young Residents, But We're Getting Older

- 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 the County's 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.

Other Unique Characteristics

- Orange County is also home to 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% (130,000) of the civilian population over 18 years old are veterans. In one study of OC veterans (OC Veterans Initiative), half of post-9/11 veterans interviewed did not have full-time employment, 18% reported being homeless in the previous year, and nearly half screened positive for posttraumatic stress disorder (PTSD) and/or depression.
- The County has a well-educated population, with 83.8% of the population age 25 years and over being a high school graduate or higher and 36.8% having a bachelor's degree or higher. This is slightly higher than the state average of 81.2% for high school graduate and 30.7% for bachelor's degree or higher (quickfacts.census.gov, 2013).

Orange County MHSA Stakeholder Process

A hallmark of the Mental Health Services Act is its reliance on a community stakeholder process for advising on community needs and making decisions related to the funding of MHSA programs. The community stakeholder process includes a planning process for each upcoming fiscal year that will recommend funding levels for each service category within the MHSA Plan. The planning process for the MHSA FY 16/17 Plan Update was built on the foundation of approved services from the MHSA Three-Year Plan Update FY 14/15-FY 16/17. Those services, in turn, were based on extensive stakeholder planning efforts dating back to when the Mental Health Services Act was enacted in 2005. Since the inception of MHSA, thousands of community stakeholders in Orange County have been engaged through surveys, focus groups, steering committee meetings, subcommittee meetings and mental health board meetings, all with the purpose of planning, implementing and evaluating MHSA in Orange County.

MHSA Steering Committee

While it is the MHSA Coordination Office that creates the framework for the community planning process, it is the mental health stakeholder community, and in particular the MHSA Steering Committee, that offers guidance on what MHSA services are needed in Orange County. The Orange County MHSA Steering Committee currently has a membership of 58 individuals who represent a variety of stakeholders throughout the community. The Steering Committee meets on a monthly basis, with members also given the choice to sit on up to 2 of 4 subcommittees that are based on the components of MHSA service delivery (i.e., Community Services and Supports (CSS) Adults; CSS Children; Prevention and Early Intervention (PEI); Innovations).

MHSA Steering Committee members meeting, January 11, 2016.

Orange County MHSA Stakeholder Process

Each county is required to partner with local constituents and stakeholders throughout the planning process, and because of their importance, certain stakeholder categories are specifically required by MHSA regulations. All categories that require representation on the Steering Committee are represented by at least two individuals. These categories include: adults and seniors living with a mental illness; families of children, adults, and seniors with a severe mental illness; mental health service providers; law enforcement agencies; education; social services agencies; veterans; representatives from veterans organizations; providers of alcohol and drug services; health care organization and other important interests.

There are seven key responsibilities of the Steering Committee:

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

A wide range of perspectives is critical to fostering inclusiveness and efforts are made to include underrepresented voices in the planning process. As the demographics of Orange County have shifted toward being a more diverse community, so too has the steering committee. In general, the MHSA Steering Committee reflects the demographics of Orange County. The details, based on a survey of the membership, are presented below.

The MHSA office provided a survey to the 58-member Steering Committee in August 2015 and received back 39 questionnaires (67% response rate). Of the 34 cities in Orange County, members of the steering committee identified 20 different cities they associated with. In addition, 15 members responded that they worked in an organization with countywide reach, or in other ways were associated with the county as a whole rather than with a specific city. The majority (56%) of the members responded as being between the ages 26-59; 41% of the member reported being older adults age 60 and over; only 3% of the membership responded as being younger than age 26. The gender breakdown results showed close to an even split, with 21 female and 18 male respondents. The stakeholder's race and ethnicity showed a majority of members identified as white/Caucasian (62%), followed by Hispanic and Asian (both at 15%) and then Blacks/African Americans (8%). Orange County is now a minority majority county, meaning the non-Hispanic white population no longer comprises more than 50% of the county population. The race/ethnic breakdown of the Steering Committee, while having a majority of members identifying as white/Caucasian, roughly follows the race/ethnic diversity of the county.

Orange County MHSA Stakeholder Process

MHSA Community Action Advisory Committee

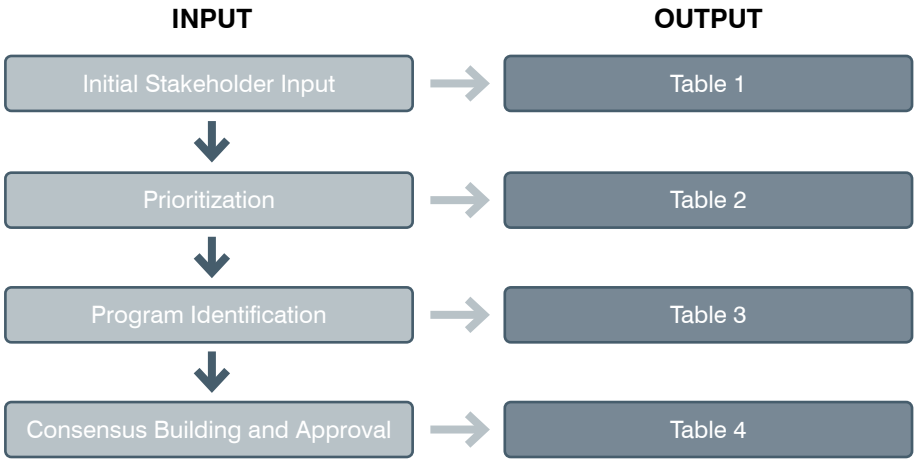
The MHSA Community Action Advisory Committee (CAAC) is a group of no more than 15 individuals who are living with a mental health condition, or who have a family member living with a mental health condition. This group advises the MHSA Coordination Office on issues related to MHSA funded services in Orange County. The goal of the group is to assist the Health Care Agency in ensuring that MHSA services are of high quality, accessible, culturally competent, client-driven, consumer and family focused, and recovery and resiliency-focused. CAAC meets monthly to discuss HCA policies concerning service delivery, learn about the various services offered by HCA, and to plan mental health advocacy-related projects such as evaluation projects, and learn about public conferences and community get-togethers. In collaboration with the MHSA Coordination Office, members of CAAC have started an evaluation of MHSA programs during the past year. This project evaluates Orange County's fidelity in implementing MHSA programs consistent with the standards contained in the Mental Health Services Act. This evaluation is expected to be completed during this next fiscal year, and preliminary results of the evaluation have already been shared with Behavioral Health Services managers and the MHSA Steering Committee.

CSS Expansion Community Planning Process

As part of the fiscal review done in preparation for the FY 16/17 Annual Plan Update, the County of Orange Health Care Agency's budget staff identified approximately $50 million of unspent Community Services and Supports (CSS) funds that were available over the next five years for allocation on a sustainable basis. As a result, significant planning activities for this year's Plan centered on identifying programs for expansion consistent with CSS funding requirements.

The CSS Planning Process consisted of four major steps: **(1) Initial Stakeholder Input** – gathering stakeholder input on gaps and needs in the CSS System of Care, **(2) Prioritization** – solicitation of broader community stakeholder input and prioritization of the identified gaps and needs, **(3) Program Identification** – identifying and aligning programs to address the gaps and needs, and **(4) Consensus Building and Approval** – building consensus and voting on recommended program enhancements. Each of these steps will be described in greater detail. See Figure A for a diagram of the process and outputs associated with each step.

Figure A. Outline of the CSS Planning Process



Orange County MHSA Stakeholder Process

Initial Stakeholder Input

In May 2015, the MHSA office began having initial discussions with the Steering Committee and the Mental Health Board to identify gaps (unserved) and needs (underserved) in the behavioral health system of care that potentially could be addressed with the additional sustainable CSS funding. At the May 2, 2015 MHSA Steering Committee Meeting, members generated an initial list of mental health system expansion needs. The initial discussion identified five guiding principles and three specific areas for allocating CSS funds:

- Expansion should focus on the targeted populations specified in the CSS component
- Expansion should address local priorities identified by Behavioral Health Services management and community stakeholders
- Expansion should address gaps and unmet needs in the current system of care
- The Steering Committee expressed a desire to have the flexibility to fund emerging issues by creating a pool of unallocated money that could be assigned during the Plan year for needs that arose after the planning document was finalized. This interest, however, is not consistent with regulations and was not supported, but was kept on as a guiding principle.
- Partner with or leverage resources of other cities and agencies (e.g. similar to the 10-year plan to end homelessness).
- The following three needs were identified:
    - Additional funding for FSP services
    - Additional funding for Housing
    - Additional funding for jobs and vocational training

Following the input from the Steering Committee, MHSA Coordination Office staff met with BHS managers to expand the list of gaps and needs. The following is the expanded list of gaps and needs:

Table 1: Initial Gaps and Needs Identified by the Community Stakeholders and BHS Managers

1	Additional funding for Full Service Partnerships
2	Housing for individuals with severe mental illness
3	Jobs and vocational training for individuals with severe mental illness
4	Residential treatment for Dual Diagnosis: Mental Health and Substance Use
5	Residential Care expansion
6	Transportation expansion
7	Dual Diagnosis: Mental Health and Dementia
8	Expansion of services for youth in foster care
9	Eating Disorders program expansion
10	Outreach and Engagement expansion

This expanded list formed the basis of a survey that was sent out to various community partners in the next step of the planning process for CSS expansion.

Orange County MHSA Stakeholder Process

Prioritization

During the month of July, the MHSA Coordination Office staff designed and distributed a brief survey to more than 1,000 community stakeholders that included MHSA Steering Committee members, the Mental Health Board, the Community Action Advisory Committee (CAAC), BHS staff, BHS contracted providers, and other community stakeholders interested in mental health services in Orange County. The survey listed the above 10 gaps and needs and then asked the following three questions:

1. Please describe any gaps or needs not included in the list above.
2. Please prioritize (rank order) the top five gaps and needs that have been identified or that you have identified in question 1.
3. Please identify any specific group or population that you believe are unserved or underserved within the Behavioral Health system of care.

Stakeholders were given 30 days to respond to the survey. In addition to the survey, a Public Forum was held on August 10th, 2015, to solicit additional public input, discuss survey results, and establish stakeholder-derived priorities. The MHSA office received 188 responses to the survey, including the input and surveys received at the Public Forum.

MHSA Coordination Office staff reviewed and categorized the survey responses into groupings based on service type and articulated need. For example, several surveys identified a general interest in increasing clinical staffing, even though the specific reason may have been different (e.g., smaller caseloads, more Veterans clinic services, more Foster Youth services). All similar responses were grouped into a single category in order to try to capture the broader intentions of the survey respondents. Once the different responses were organized, MHSA staff used weighted voting to prioritize the gaps and needs. Gaps and needs that were ranked as a #1 priority would be given five points; those ranked a #2 priority would be given four points; etc. The initial gaps and needs prioritization process identified eight different priorities. See Table #2 (below) for the results of the stakeholder prioritization process.

Table 2: Priority Rankings from CSS Survey by Community Stakeholders

Gaps and Needs	Rank #1 (n*5)	Rank #2 (n*4)	Rank #3 (n*3)	Rank #4 (n*2)	Rank #5 (n*1)	Total Points
Housing for individuals with severe mental illness	355	176	117	64	13	725
Residential Treatment for Dual Diagnosis: Mental Health and Substance Use	120	116	66	26	13	341
Jobs and vocational training for individuals with severe mental illness	35	88	75	60	23	281
Outreach and Engagement expansions	70	52	45	32	22	221
Increase staffing for smaller caseloads/clinic expansion/veterans based clinic services/foster youth services	95	44	27	22	12	200
Additional funding for Full Service Partnerships (FSP)	65	44	27	22	10	168
Transportation expansion	15	40	69	26	14	158
Eating Disorders program expansion	25	16	24	10	9	84

Program Identification

After reviewing the results of the survey's top-ranked priorities, the MHSA Office identified programs currently funded with MHSA dollars that a) matched the top-ranked priorities, and b) had room for expansion. Due to the extensive time needed to establish new services, which includes a lengthy procurement process and start up, where possible, priority was given to existing programs that had room for growth.

In September 2015, the stakeholder-identified priorities in Table 2 were brought to a meeting with BHS Managers along with a list of existing MHSA funded programs that could address the identified priorities. Based on input from managers, additional needs were identified within the CSS system of care. Because costs to expand all of the identified programs exceeded the available funding, BHS managers refined their estimations and narrowed down the focus of each of the program expansions in order to identify a set of recommendations consistent with the available funding. See Table #3 below for the initial funding recommendations:

Table 3: 5-Year Program Budget for Expanded/New CSS Programs

Gaps and Needs	Total Points	Program Recommendation	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	
Housing for individuals with severe mental illness	725	Emergency (FSP Support) Short Term Supported Long Term Supported Housing	$1,000,000	$800,000	$800,000	$800,000	$800,000	
		Drop in Center (enhance $500K in plan)	$500,000	$500,000	$500,000	$500,000	$500,000	
Residential Treatment for Dual Diagnosis: Mental Health and Substance Use	341	Dual DX Mental Health (Adults/TAY/Children)	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	
Jobs and vocational training for individuals with severe mental illness	281	Ongoing funding for VTW	$550,000	$550,000	$550,000	$550,000	$550,000	
Outreach and Engagement expansions	221	Expansion of O&E (CSS only)	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	
Increase Staffing for smaller caseloads/clinic expansion/veterans based clinic services/foster youth services	200	Clinic Expansion	$1,000,000	$1,000,000	$1,000,000	$1,000,000	$1,000,000	
Additional funding for Full Service Partnerships (FSP)	168	New FSP Services	-	$3,750,000	$3,750,000	$3,750,000	$3,750,000	
Transportation expansion	158	Already in Plan ($1 million)	-	-	-	-	-	
Eating Disorders program expansion	84		-	-	-	-	-	
Crisis Beds		Increase the number of crisis beds by 15	$2,250,000	$2,250,000	$2,250,000	$2,250,000	$2,250,000	
Capital Facilities		Purchase/renovation of mental health facilities	$2,000,000	-	-	-	-	
CIT expansion		Expansion of hours for CIT training	$40,000	$40,000	$40,000	$40,000	$40,000	
TOTAL:			**$9,340,000**	**$10,890,000**	**$10,890,000**	**$10,890,000**	**$10,890,000**	**$52,900,000**

Orange County MHSA Stakeholder Process

Consensus Building and Approval

At the MHSA Steering Committee on October 5, 2015, the MHSA Office presented the set of recommendations (Table #3) that was guided by the priorities established through the survey and other stakeholder input, consistent with CSS funding requirements, and within the limit of the available funding identified. While there was a general consensus about the identified services, there was a thorough discussion about how much money to allocate to each of the identified programs.

Following the Steering Committee meeting, the MHSA Coordination Office scheduled a meeting with BHS Managers and the co-chairs from the two CSS subcommittees. The purpose of this October 27, 2015 meeting was to review each of the recommended programs and to come to a consensus on an approach to allocating the additional CSS funds. For the meeting, the co-chairs were given information sheets on each program that included:

1. Program description
2. The existing program budget (if program already exists) and recommended additional funding amount
3. Purpose of the additional funding
4. Basis for the need
5. Rationale for the approach
6. What the additional dollars would provide and who it would serve

In discussion with the co-chairs, it was decided that the next regularly scheduled Steering Committee Meeting on November 2, 2015 should be conducted as a joint (both Children and Adult) CSS subcommittee meeting in which each of the recommended programs would be discussed in detail. BHS managers and co-chairs from both subcommittees would be available to present and answer questions from the subcommittees.

The co-chairs for the CSS Subcommittees requested that MHSA staff assemble a document that provided a general summary of the CSS expansion process and clearly illustrated the amount that was being allocated to each program and for whom the program would be serving. The co-chairs also requested that the information in the table be organized to demonstrate what issue or problem was being addressed with the program enhancement. The following chart was distributed prior to the November 2015 Subcommittee and the December 2015 Steering Committee meetings (see Table #4 on page 18).

At the November combined CSS subcommittee meeting, after a lengthy discussion, the CSS Subcommittees voted to support the expansion of programs. The approval of the set of recommended CSS programs was placed on the agenda as an action item for the full MHSA Steering Committee in December.

At the December 2015 Steering Committee meeting, MHSA Subcommittee CSS Co-Chairs presented the programs recommended by both HCA and the respective CSS Subcommittees. The merits of funding each program was presented by the co-chairs and discussed at length. BHS managers were on hand to respond to any questions pertaining to the programs or new money that would be spent for those programs. At the conclusion of the presentations and after vigorous discussion, the expansion of CSS programs was approved by a majority of the Steering Committee.

Table 4: CSS Expansion Programs with Budgets and Targeted Age Groups

MHSA Community Services and Supports Expansion Recommendation

Problem	Solution	Recommended FY 16/17 Enhancement	Age Groups			
			Older Adult	Adult	TAY	Children
Homelessness	Housing	$1,000,000	X	X		
	Full Service Partnership Expansion	$3,000,000		X	X	
	Crisis Intervention Training	$150,000	X	X	X	X
	Outreach and Engagement Expansion	$1,000,000	X	X	X	X
Behavioral Health Crisis	Crisis Beds	$1,500,000	X	X	X	
	Crisis Stabilization Unit	$2,000,000	X	X	X	X
Access to Treatment and Vocational Services	Dual Diagnosis Treatment	$500,000	X	X	X	
	Supported Employment	$300,000	X	X	X	
	REI Expansion	$50,000	X	X	X	
	Outpatient Clinic Expansion	$1,000,000	X	X	X	X
TOTAL:		**$10,500,000**				

Full Budget Approval for MHSA Plan Update for FY 16/17

The MHSA Steering committee reconvened in January 2016 to discuss the total budget of programs approved at the onset of the Three-Year Plan (MHSA Three-Year Plan FY 14/15-16/17). The Steering Committee reaffirmed their support for the programs contained in the Three-Year Plan by approving the budget by consensus.

Additional CSS Expansion Approval

Following the full budget approval at the January 11, 2016 MHSA Steering Committee, HCA received revised revenue predictions from our State fiscal consultant that anticipated greater revenue than previously projected. In particular, the increases over previous revenue estimates were approximately $3.5 million and $11.7 million for FY 15/16 and FY 16/17 respectively. In order to adjust the plan based on these new revenue estimates, senior and executive management of Behavioral Health Services were able to revisit the set of recommended CSS enhancements and identify additional enhancements to the CSS system of care that were consistent with the gaps and needs survey results and the prioritization of the Steering Committee and other community stakeholders. The recommendations were to budget additional funds in the areas of greatest need already recommended for CSS Expansion (see Table 5).

Table 5: HCA Recommendations for CSS enhancements

	FY 15/16	FY 16/17
Housing	$3,500,000	
FSPs		$7,000,000
Crisis Stabilization Units		$3,000,000
Co-Occurring medical/mental health		$2,000,000
Total	**$3,500,000**	**$12,000,000**

After sending these recommendations to the CSS co-chairs and receiving their input and support, the above recommendations were presented to the MHSA Steering Committee at the February 1, 2016 meeting. The Steering Committee approved the recommended CSS enhancements by consensus.

Public Hearing and Approval by Board of Supervisors

The MHSA Annual Plan Update FY 16/17 was completed, reviewed and approved by the BHS Director and posted on the Orange County MHSA website on April 10, 2016 for a 30-day review period. At the conclusion of that time, the MHSA office responded to all substantive public comments and attached a summary with the entire Plan Update for the Mental Health Board. A Public Hearing notice was posted by the Clerk of the Board and an email notice was sent to the MHSA Steering Committee and other interested individuals and stakeholders, as well as being announced on the MHSA website. The Public Hearing was held in conjunction with the Mental Health Board's regularly scheduled study meeting on May 10, 2016 at the Hall of Administration in Santa Ana. At that meeting the Mental Health Board listened to a presentation from the BHS Director on this plan. In addition, the Mental Health Board heard testimonials from individuals served in Orange County's MHSA programs. After a brief discussion amongst the board members, the Plan was approved.

After the approval from the Mental Health Board, the MHSA Plan Update FY 16/17 was brought before and approved by the Orange County Board of Supervisors at the regularly scheduled meeting on May 24, 2016.

Community Services and Supports (CSS)

Community Services and Supports (CSS)

A. Component Information

Community Services and Supports (CSS) was the first 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 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, to increase the quality of services and to 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. (At least 50% of CSS funds must be spent on FSPs)
- 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 individuals living with the most severe mentally illness and their families, 24 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.

Community Services and Supports (CSS)

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 individuals with serious mental illness, who are homeless or at risk of homelessness.

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 MHSA Steering Committee.

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

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) – eight programs
2. Transitional Age Youth (ages 16-25) – six programs
3. Adults (ages 26-59) – 18 programs
4. Older Adults (ages 60 and above) – four programs

FY 14/15 Changes to the Plan

In the first half of FY 15/16, the MHSA Office held an extensive planning process to determine what the community stakeholders saw as the biggest needs or gaps in the system that could be addressed using available CSS funds totaling $50 million over a five-year span.

As reviewed earlier in the FY 16/17 Plan Update's Community Stakeholder Process Section, three different services areas (homelessness, behavioral health crisis, and access to treatment and vocational services) were identified and ten different program solutions were approved for expansion of existing services or new projects. The MHSA Steering Committee approved funding for all of the 10 projects in the table on page 23 on January 11, 2016.

Community Services and Supports (CSS)

MHSA Community Services and Supports Expansion Recommendation

Problem	Solution	Recommended FY 16/17 Enhancement	Age Groups			
			Older Adult	Adult	TAY	Children
Homelessness	Housing	$1,000,000	X	X		
	Full Service Partnership Expansion	$3,000,000		X	X	
	Crisis Intervention Training	$150,000	X	X	X	X
	Outreach and Engagement Expansion	$1,000,000	X	X	X	X
Behavioral Health Crisis	Crisis Beds	$1,500,000	X	X	X	
	Crisis Stabilization Unit	$2,000,000	X	X	X	X
Access to Treatment and Vocational Services	Dual Diagnosis Treatment	$500,000	X	X	X	
	Supported Employment	$300,000	X	X	X	
	REI Expansion	$50,000	X	X	X	
	Outpatient Clinic Expansion	$1,000,000	X	X	X	X
TOTAL:		**$10,500,000**				

Orange County's State Fiscal Consultant estimated that there would be higher revenue coming in than originally anticipated in the amount of $3.5 million for FY 15/16 and 11.7 million for FY 16/17. Because of this new information, the MHSA Steering Committee approved additional CSS funding for Housing ($3.5 million), FSPs ($7 million), the newly approved Crisis Stabilization Units ($2 million), and for Co-Occurring medical/mental health programs ($3 million).

The additional Housing money will be allocated with the recently approved $5 million to extend the MHSA housing program into another phase. The original $33 million assigned to CalHFA has all been spent or allotted to future projects. The new funding will continue to help create new units for the MHSA target populations. With the additional funding for the Crisis Stabilization Unit, HCA has the capacity to fund one or more sites based on community needs and the best model for implementation.

Community Services and Supports (CSS)

C1. Children's Full Service Partnership	
Estimated number to be served FY 16/17	400
Annual Budgeted funds for FY 16/17	$6,654,575
Estimated Annual Cost Per Person Served	$16,636

Program Description

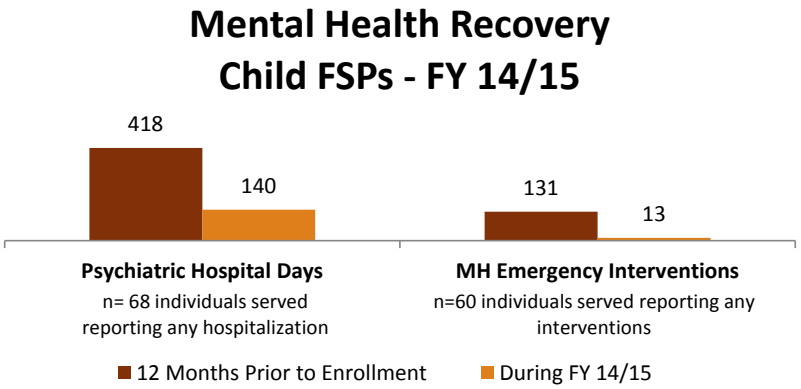
There are five distinct programs within the Children's FSP category with each program serving a particular target population. One FSP focuses on seriously emotionally disturbed (SED) children and youth in the general community by taking referrals from the Outreach and Engagement teams, Centralized Assessment Team, and County and contracted clinics. Prominent among the referrals are individuals who are homeless, or who are at risk of homelessness. In addition to the direct treatment of the children and youths, the parents frequently need job assistance, especially when the needs of their Seriously Emotionally Disturbed (SED) child or youth impact their ability to maintain employment. Another FSP program focuses on the culturally and linguistically isolated, particularly those in the Vietnamese and Korean Communities. A third FSP serves a small number of children and youth who entered the juvenile justice system at a younger age and, after in-custody rehabilitation, need support reintegrating into the community. The fourth and fifth children's FSPs offer programs for young people who come to the attention of the Juvenile Court, especially those who require the services of specialized collaborative courts and who have behavioral health needs that may be present after the court is no longer involved.

Outcomes

A total of 340 children and youth were served during FY14/15 in the Children's FSP programs. Their success was evaluated by measuring a number of outcomes related to mental health recovery, housing, legal involvement, and educational performance.

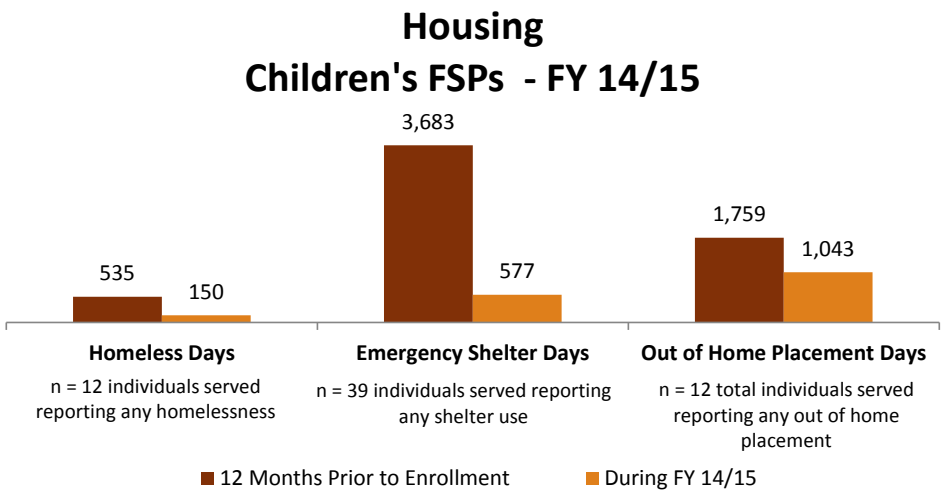
Mental health recovery was evaluated through changes in two measures: (1) number of days psychiatrically hospitalized, and (2) the number of times a child or youth experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room visit, crisis assessment/WIC 5585 evaluation, or police response due to a mental health and/or substance use crisis). Support for the FSP programs' effectiveness in promoting recovery was observed through a 67% decrease in the number of days spent psychiatrically hospitalized during FY14/15, as well as a substantial 90% decrease in the total number of mental health-related emergency interventions, when compared to the 12 months prior to enrollment (see graph on page 25). The average decrease for both of these measures was statistically significant.[1]

Community Services and Supports (CSS)



[1] *Psychiatric Hospitalization Days: Prior M=6.2, SD= 8.8; Since M=2.1,SD=5.8; t(67) = 3.23, p=.002, Cohen's d=.55 / Mental Health Emergency Interventions: Prior M=2.2, SD= 3.4; Since M=0.2, SD=0.7;t(59) =4.35, p<.001, Cohen's d=.80*

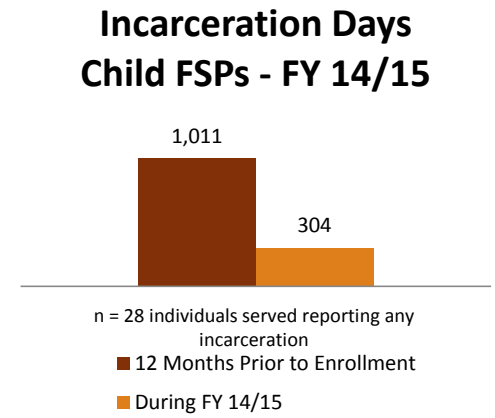
Another goal of the FSP programs is to prevent and reduce homelessness and reduce out-of-home placements, which are defined as a group home or residential treatment facility placement. Consistent with prior years, the FSP programs continued to improve the housing circumstances of the children and youth served. This success was seen in a dramatic 84% reduction in the total number of days spent in an emergency shelter during FY14/15 (see center graph below). There was also a 72% reduction in total days homeless and a 41% decrease in the total number of days spent in an out of home placement when compared to the year prior to enrollment (see graph below). Statistical analyses revealed that the average decrease in emergency shelter days was statistically significant, whereas the average decreases in homeless and out-of-home placement days were not. Only 12 children and youth served reported having been affected by homelessness or out-of-home placements, thus limiting the ability to detect statistical significance.[1] The magnitude of homeless and out-of-home placement decreases were notable, despite not being statistically significant.

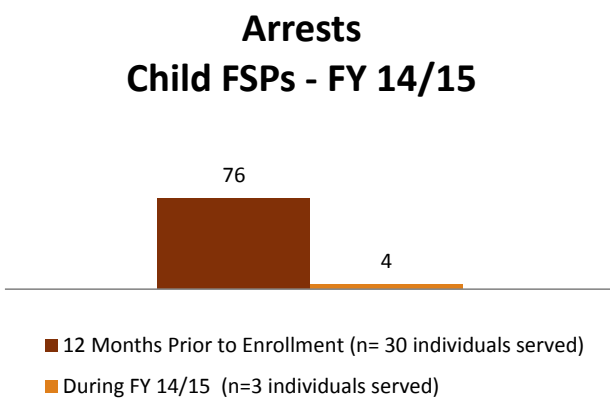


[1] *Homeless Days: Prior M=44.6, SD=59.5;Since M=12.5, SD=32.1; t(11) = 1.47, p=0.17, Cohen's d=.67 / Emergency Shelter Days: Prior M=94.4, SD=118.0; Since M=14.8, SD=55.1; t(38) =3.63, p=.001, Cohen's d=.86 / Out of Home Placement Days: Prior M=146.6, SD=139.2; Since M=86.9, SD=137.4; t(11) =-1.69, p=0.12, Cohen's d=.43*

Community Services and Supports (CSS)

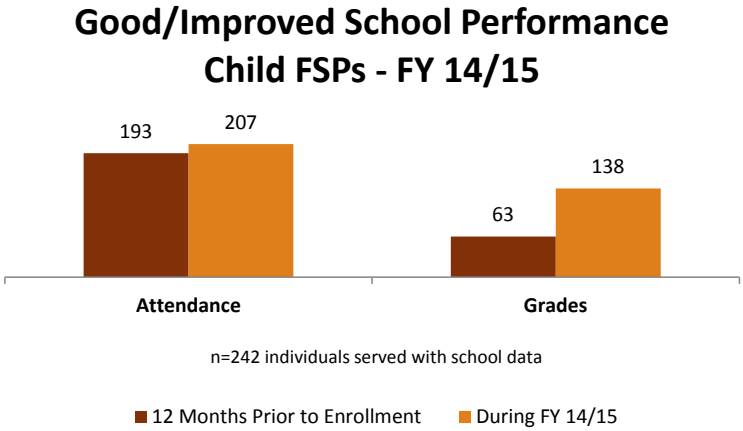
Outcomes related to decreasing involvement with the legal system were tracked using two measures: days incarcerated in jail or prison and number of arrests. The FSP programs continued to make statistically significant improvements in this area[1], and also reported a 70% reduction in total incarceration days during FY 14/15 compared to the year prior to FSP enrollment (see left graph below). Children and youth involved with an FSP also reported a 95% decrease in the total number of times they were arrested during the same timeframe (see right graph below).





[1] *Incarceration Days: Prior M=36.1, SD=47.4;Since M=10.9, SD=35.0;t(27) = 2.13, p=.04, Cohen's d=.61 / Arrest data not available for statistical testing*

The last set of outcomes examined maintenance of good/very good school attendance and grades, or improvement in attendance and grades while enrolled in the FSP program. School-aged children and youth served experienced a 7% improvement in attendance during FY14/15 when compared to the year prior to enrollment. This minimal change in attendance is due to the fact that a large proportion of school-aged children and youth with attendance data were already attending school all or most of the time in the year prior to enrolling in the FSP program (see left graph below).[1] There was also a statistically significant improvement in maintenance of grades at the good/very good level, during FY 14/15 (see right graph below).[1]



[1] *Attendance: $\chi^2(1, n = 242) = 20.33, p < .001, v = .004$ / Grades: $\chi^2(1, n = 242) = 5.5, p = .019, v = .004$*

Community Services and Supports (CSS)

Community Impact

These programs have been successful in meeting the goals of decreased homelessness, fewer and shorter psychiatric hospitalizations, increased school attendance and employment with less involvement with law enforcement. The programs have adopted a strategy in assisting with housing needs where the family becomes more responsible with meeting costs so that when clinical goals are met, the family is able to independently meet housing costs. This strategy creates stability so that clinical advances can be maintained. Another notable outcome is the significant reduction of recidivism rates in a population with historically high rates of continued involvement with law enforcement.

Changes/Challenges/Barriers

The primary challenges are in obtaining adequate housing in areas where families have support systems. Housing costs continue to rise and every attempt is made so that the client can remain in their neighborhood school. Along with the housing challenge, is the difficulty finding adequate parental employment. It is difficult for the FSP programs to assist parents in finding employment, especially finding employers who are flexible enough to employ a parent of an SED child or youth who may require time away from work to address their child's needs.

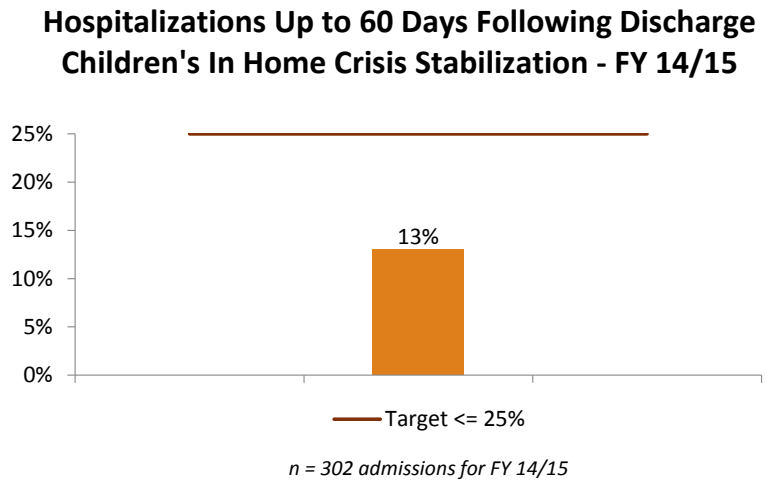
C3. Children's In-Home Crisis Stabilization	
Estimated number to be served FY 16/17	400
Annual Budgeted funds for FY 16/17	$1,085,480
Estimated Annual Cost Per Person Served	$2,714

Program Description

The program's target population is children and youth up to their 18th birthday who are being considered for psychiatric hospitalization, but who do not 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 member is asked to evaluate a youth for possible hospitalization. Once it is determined that the child or youth does not meet criteria for hospitalization and the family clearly needs assistance, the evaluator calls the crisis stabilization team to the site of the evaluation. The crisis stabilization team helps develop a treatment plan that identifies the causes of the current crisis and identifies healthy ways of avoiding future crises. When families are exhausted from the crisis and the evaluation process, in-home appointments to begin the stabilization process can be made for the next day. 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 establish a safety plan, develop coping strategies and transition to on-going support.

Outcomes

During FY 14/15, 302 children and youth received in-home crisis stabilization services. The program goal is to maintain a psychiatric hospitalization rate of less than 25% during the time the child or youth is enrolled in the program through 60 days post-discharge. As can be seen in the graph below, this target was met for FY 14/15.



n = 302 admissions for FY 14/15

Community Services and Supports (CSS)

Community Impact

In-home services have proved to be effective in keeping children and youth out of institutional care. They focus on helping the children and youth and family learn coping skills and finding alternatives solutions in future crises. By providing services in the home, the team frequently encounters realities different than might be presented in a clinic setting and this perspective can, in turn, help with more effective interventions.

Changes/Challenges/Barriers

One major challenge is receiving referrals in a timely manner so that interventions can avoid more restrictive settings (e.g., hospitalization). This requires effective and timely communication between the referral source and the in-home team.

C4. Children's Crisis Residential Program	
Estimated number to be served FY 16/17	275
Annual Budgeted funds for FY 16/17	$3,289,966
Estimated Annual Cost Per Person Served	$11,964

Program Description

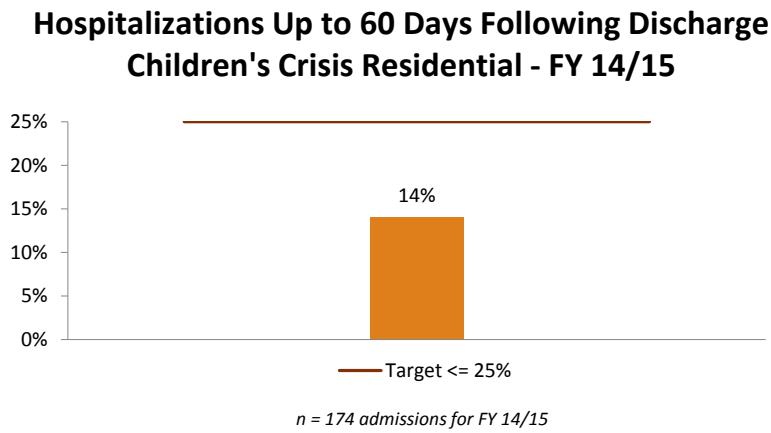
The Children's Crisis Residential Program was developed to address a system gap. A highly structured alternative to in-patient services and in-home crisis services was needed. The target population is children and youth up to 18 years old who are at risk of psychiatric hospitalization. This need arises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

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

Referrals are accepted on a 24/7 basis. The child or youth may stay three weeks, or up to six weeks, if the clinical situation warrants. They are provided a structured setting in which they maintain their school work and are introduced to problem solving techniques that they practice in family therapy. Parent education and skill building are important components of the program. The child or youth interact in structured groups and participate in activities like meal preparation, clean-up and supervised recreation.

Outcomes

During FY 14/15, 174 children and youth received crisis residential services. Similar to the Children's In Home Crisis Residential program, the Crisis Residential goal is to maintain a psychiatric hospitalization rate of less than or equal to 25% during the time the child or youth is enrolled in the program through 60 days post-discharge. As seen in the graph below, this target was met for FY 14/15.



Community Services and Supports (CSS)

Community Impact

The program provides timely interventions to children and youth and their families who are experiencing crisis. The program provides an alternative to hospitalizations by helping children and youth stay living in the community. The program reduces admittances to local emergency departments and inpatient psychiatric facilities.

Changes/Challenges/Barriers

In FY13/14, the program was expanded from 6 to 12 beds. Even with the addition of new beds, the beds are frequently filled creating a backlog. Additional beds were authorized and planning is under way to make new beds available at a mid-County location. The addition of new beds in a central location will better serve families, especially those with limited transportation options.

C5. Mentoring for Children	
Estimated number to be served FY 16/17	146
Annual Budgeted funds for FY 16/17	$352,620
Estimated Annual Cost Per Person Served	$2,415

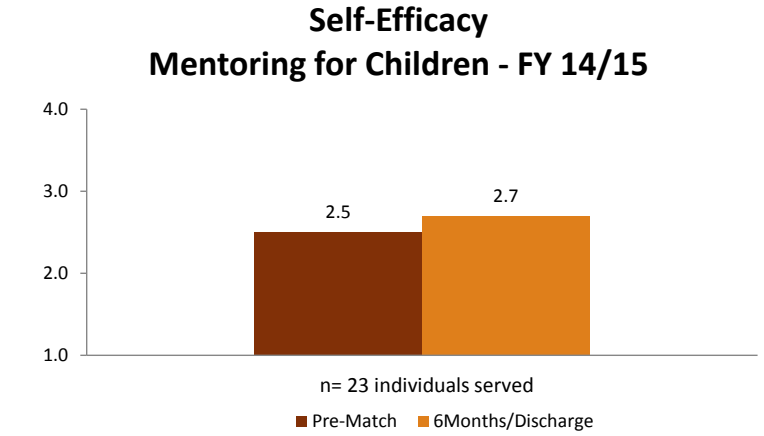
Program Description

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 children and 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 children and youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide children and youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal children and youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills and resiliency. Working with mentors also provides the child or 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 children and youth with positive reinforcement and caring role models.

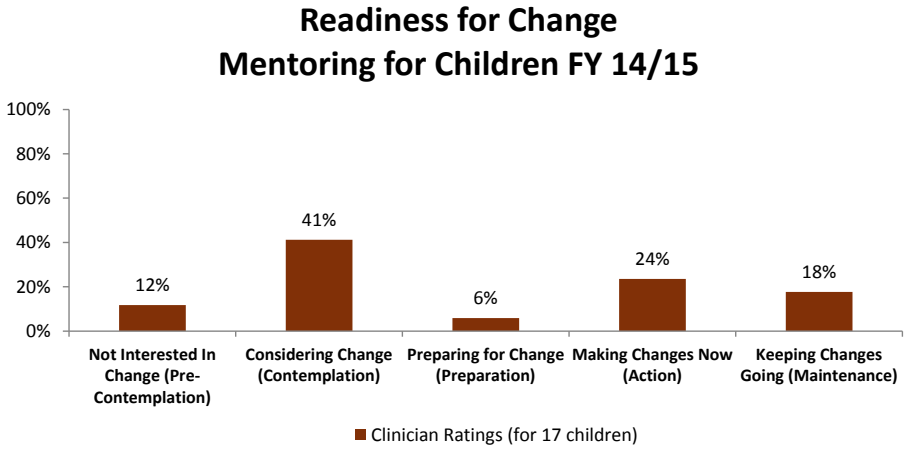
Outcomes

Children and youth in the mentoring program are asked to complete the County of Orange Health Care Agency Resilience Questionnaire prior to being matched with a mentor and once again after being in the program for six months (which typically coincides with discharge). During FY14/15, children and youth served did not demonstrate any gains in self-efficacy[1], one of the measure's primary subscales, after being matched with a mentor. Of note, the Resilience Questionnaire was in the process of being refined during FY 14/15 and some of the statistical comparisons were across different versions of the scale, which may have affected the analyses. The most recent version is currently being tested for reliability, validity and comparability to the original scale.



[1] *Self-Efficacy: t(22) = 1.96, p=.06, Cohen's d=.37*

The referring clinicians completed a Readiness for Change measure at discharge from the mentoring program, which reflects the extent to which they believe the child or youth is ready to make positive changes in his/her behavior (see graph below). Clinicians reported that 42% of the children and youth were making or keeping positive changes going and another 6% were rated as preparing for change, suggesting that a large proportion of children and youth were mobilized to make and/or maintain positive changes in their lives following their involvement with the mentor program.



Community Impact

The program provides children and youth with the laboratory to practice skills learned in treatment in a safe and controlled environment. Children and youth are provided non-judgmental feedback in a supportive setting especially when trying on new behaviors.

Changes/Challenges/Barriers

The program succeeds despite two complicated but necessary processes. It is a challenge identifying volunteer mentors, getting background checks and providing training and guidelines as to "how to be a mentor." At the same time, CYBH clinicians must identify children and youth who might benefit from the program. The program must then match a child or youth to an appropriate mentor in areas like gender, interests and language.

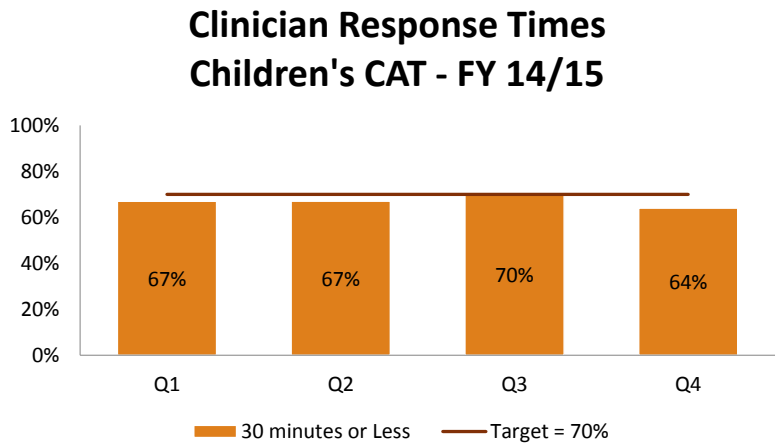
C6. Children's Centralized Assessment Team	
Estimated number to be served FY 16/17	2,140
Annual Budgeted funds for FY 16/17	$1,594,904
Estimated Annual Cost Per Person Served	$745

Program Description

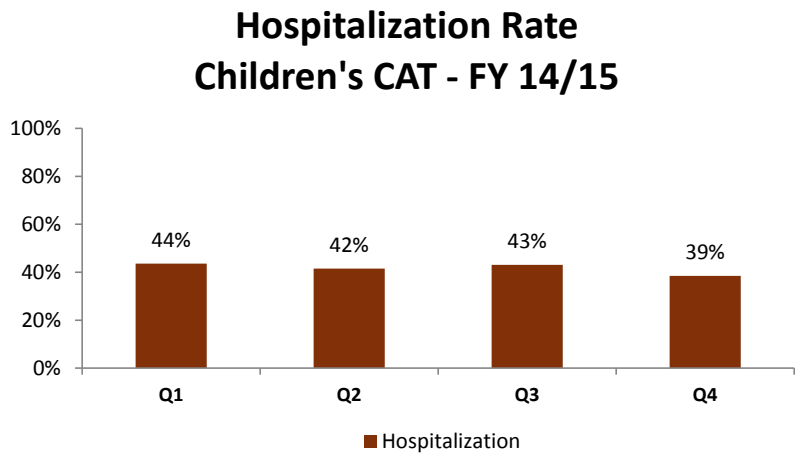
The Children and Youth Behavioral Health – Centralized Assessment Team (CAT) responds to psychiatric emergencies for any children and youth under 18 years of age, anywhere in the county. The team operates 24 hours a day, 365 days per year. The purpose of the team is to intervene in crisis situations. In addition to the traditional target groups of unfunded and Medi-Cal clients, the team responds to home-based assessments (with police accompaniment) and to any child or youth regardless of insurance coverage (if requested to assist). Evaluations occur in emergency rooms, police stations, schools and group homes. If safety cannot be assured, the CAT member will write a 72-hour hold and facilitate the child or youth's placement in a psychiatric hospital. If the child or youth 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.

Outcomes

The program's outcome is the efficiency with which CAT is able to respond to calls. This is measured by the number of minutes between the time a clinician dispatches for an evaluation and the time they arrive at the evaluation location. The goal is for the dispatch-to-arrival time to be 30 minutes or less 70% of the time. As can be seen in the graph below, the target rate was missed in three of the four quarters of FY14/15. This may be attributable to the high call volume (i.e., over 2270 total evaluations), as well as the fact that Children's CAT tends to see a spike in calls during the late afternoon/early evening rush hour time frame.



In addition, Children's CAT examines the psychiatric hospitalization rate as a way of monitoring the severity of children's presenting problems and availability of safe alternatives to inpatient services. Consistent with prior years, children evaluated by CAT continue to be hospitalized at a rate of 40-45%.



Community Impact

Inpatient hospitalization, while sometimes necessary for safety reasons, can have a devastating impact on a child or youth and their family. The CAT attempts to strike a balance between safety and the least restrictive environment necessary to address a crisis in every evaluation performed. No matter how long or short a hospitalization may be, the impact on a family is significant. MHSA has provided an array of alternatives that was not previously available and lessened the adverse effects for many families.

Changes/Challenges/Barriers

Since the team functions 24 hours per day, seven days per week, filling and keeping positions is difficult. Staff are assigned to a specific shift to provide some level of stability and predictability rather than rotating around the clock. Many prospective candidates are unwilling or unable to work an afternoon-to-midnight or midnight-to-morning shift, which shrinks the pool of available candidates, making vacancies harder to fill.

C7. OC Children with Co-occurring Mental Health and Chronic Acute Severe Physical Illness, Special Needs, or Eating Disorders	
Estimated number to be served FY 16/17	475 (up to 1000)
Annual Budgeted funds for FY 16/17	$2,500,000
Estimated Annual Cost Per Person Served	$5,263

Program Description

During the MHSA public planning process, children and youth with physical illness 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 children and youth's 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 children and youth with severe eating disorders who are at risk of physical deterioration to the extent of life-threatening risk. It is anticipated that many of these children and youth will have Medi-Cal and the MHSA funds will serve as match to drawdown of federal funds. The first children and youth were served in the 1st quarter of FY15/16.

Outcomes

Because the program did not start until the 1st quarter of FY 15/16, the program does not have outcomes to report for FY 14/15.

Community Impact

This program is a first step in the integration of behavioral and physical health services. The potential target population is large and this program is developing paradigms to use with children and youth whose recovery from physical illness is compromised by behavioral health issues.

Changes/Challenges/Barriers

Among the challenges in this start-up program is the integration of two cultures: A County Behavioral Health system largely built on an outpatient model and a private provider of general medical/surgical services new to integrating behavioral interventions into more comprehensive treatment plans. Communication has been key to collaboration so that issues concerning the delivery of services can be addressed.

C8. Children and Youth Outpatient Services Expansion	
Estimated number to be served FY 16/17	300
Annual Budgeted funds for FY 16/17	$1,000,000
Estimated Annual Cost Per Person Served	$3,333

Program Description

This program expanded behavioral health services to Medi-Cal beneficiaries (ages birth through 20) throughout Orange County. Children and youth who suffer from a wide variety of behavioral health disorders were provided services that include individual, collateral, group and family therapy, medication management, therapeutic behavioral services, in-home behavioral services, intensive case consultation, and case management. These funds were "match" to allow for drawdown of Federal Financial Participation funds, which essentially doubles the number of children and youth served for the MHSA funds spent.

The MHSA Steering Committee has identified the need to add additional expansion dollars, although the exact amount will be determined at a later time.

Services are needed for the following reasons:

1. Increased need for psychiatric medication management for children and youth due to expanded benefits under the Affordable Care Act.
2. Expanded services to foster children and youth under "Katie A" services (now referred to Children and Family's Integrated Practices).

Outcomes

Funding allocation for the six contracted providers was distributed to budgets during the first quarter of FY 14/15. Hiring and program adjustments took some time before any direct impact on client care occurred. By the end of FY 14/15, about eight FTE had been added to the contract provider staffs. Additionally, tracking of units of services could not be completed as no tracking mechanism was developed in the electronic health record that operationalized outcomes of services provided. Children and Youth Behavioral Health is nearing the selection of a universal tool that can be used to track client progress.

Community Services and Supports (CSS)

Community Impact

Children and youth who have permanency and stability in their living situation, are engaged with significant others in the community in which they live, and establish lasting relationships based on love and respect, bring stability to the community in which they live as well. This means fewer school changes, fewer hospitalizations, less police involvement, and reduced substance use.

Changes/Challenges/Barriers

As noted above, tracking of services provided remains the primary challenge for determining the impact of these funds. A system is now in place in the electronic health record to allow tracking of service by "Facility" where the service was provided.

Community Services and Supports (CSS)

C10. Medi-Cal Match: Mental Health Services	
Estimated number to be served FY 16/17	140
Annual Budgeted funds for FY 16/17	$427,500
Estimated Annual Cost Per Person Served	$3,054

Program Description

In reviewing service gaps, a need to provide additional services to youth who were experiencing both SED and Substance Use Disorder was identified. These youth were participating in residential substance abuse programs but their SED was interfering with their treatment. These funds purchase additional group, family and individual treatment that supplement their residential services.

Outcomes

Forty-nine youth were served (one less than the target) with over 295 hours of behavioral health services. State reported outcome data is still being processed at the time of this report.

Community Impact

Substance use and mental health issues are intertwined for many youth. Addressing both issues simultaneously is the preferred intervention for many youth. In the past, categorical funding, or funding restricted to a particular treatment, was a barrier to this approach. These MHSA funds now provide an opportunity for integrated care.

Changes/Challenges/Barriers

Staff recruitment was a barrier for this small program. When staff leave abruptly there are significant gaps in services provided. Back-up plans have been instituted to ensure that the impact of such gaps will be lessened in the future.

Community Services and Supports (CSS)

T1. Transitional Age Youth Full Service Partnership	
Estimated number to be served FY 16/17	925
Annual Budgeted funds for FY 16/17	$8,434,468
Estimated Annual Cost Per Person Served	$9,118

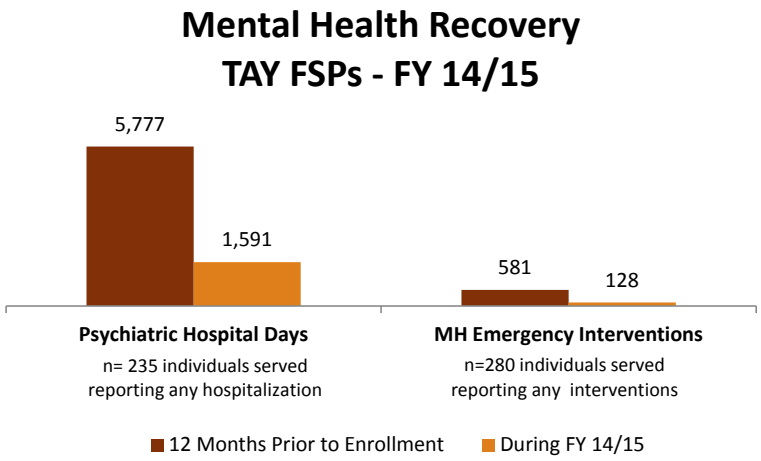
Program Description

The target group for these programs are youth aged 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 five distinct programs within the Transitional Age Youth FSP category, which serve particular target populations. One serves a broad spectrum of youth in the community including those 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 of the county. The third is a program designed to meet the needs of youth 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 youth have made and integrating back into the community. Learning how to obtain and maintain employment despite significant mental health issues is a particular focus. The fourth and fifth programs were designed to meet the needs of a variety of youth involved with the Juvenile Court. The fourth program supports groups of youth who are in the foster care system and have experienced multiple placement failures. These are multi-problem youth who may require services well into early adulthood. The fifth FSP program works primarily with the Juvenile Drug Court, particularly, to provide services to youth once they graduate from the Court's authority and are released into the community. This FSP also works with youth and families who come to the attention of the Truancy Response Program. For many multi-problem youth, this is the first time they come to the attention of the "helping system."

Outcomes

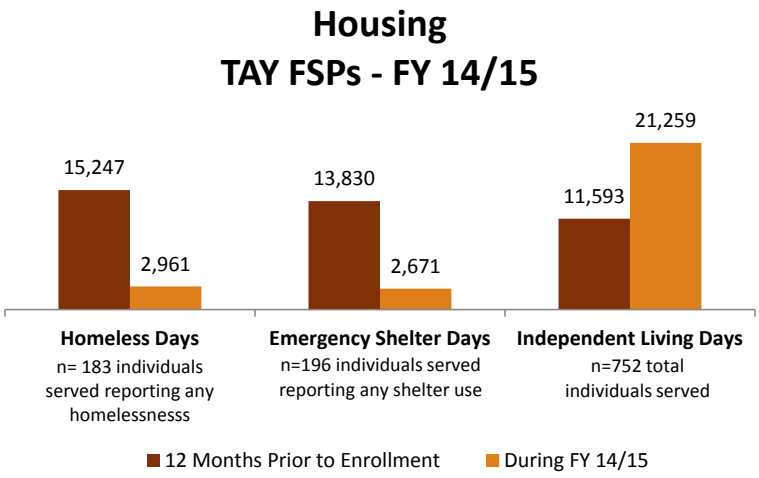
A total of 752 youth were served during FY14/15 in the TAY FSP programs. Their success was evaluated by measuring a number of outcomes related to mental health recovery, housing, legal involvement, and employment.

Mental health recovery was evaluated through changes in two measures: (1) number of days psychiatrically hospitalized, and (2) the number of times a youth served experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room visit, crisis assessment/WIC 5150/5585 evaluation, or police response due to a mental health and/or substance use crisis). Support for the FSP programs' effectiveness in promoting recovery was observed through a 72% decrease in the total number of days youth served spent psychiatrically hospitalized during FY14/15, as well as a substantial 78% decrease in the total number of mental health-related emergency interventions, when compared to the 12 months prior to enrollment in the program (see graph on page 41). The average decrease for both of these measures was statistically significant.[1]



[1] *Psychiatric Hospitalization Days: Prior M=24.6, SD=44.2;Since M=6.8, SD=19.1; t(234) = 5.52, p<.001, Cohen's d=.52 / Mental Health Emergency Interventions: Prior M=2.1, SD=2.6;Since M=0.5, SD=1.0; t(279) =9.29, p<.001, Cohen's d=.82*

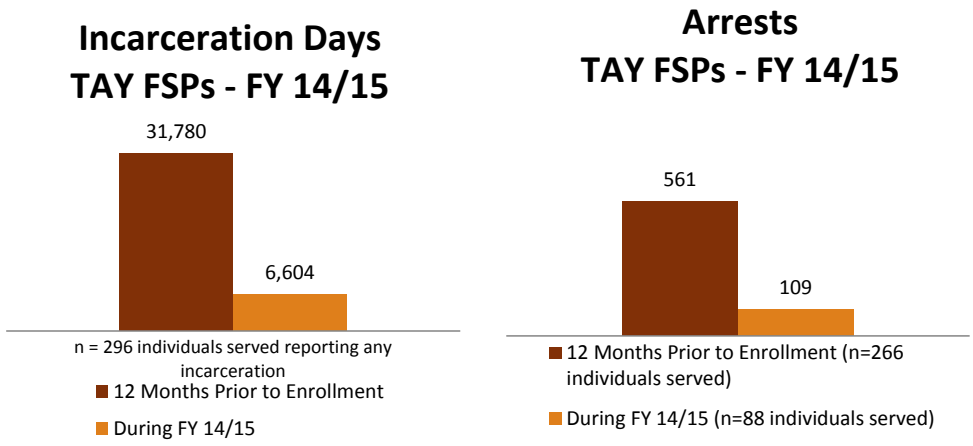
Another goal of the FSP programs is to prevent and reduce homelessness and to promote independent living. Consistent with prior years, the FSP programs continued to improve the housing circumstances of the youth served. This success was seen in the dramatic 81% reduction both in total days homeless and total days spent in an emergency shelter during FY14/15 compared to the year prior to enrolling in the FSP (see graph below). In addition, youth served experienced an 83% increase in the total number of days they spent in independent living, which is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement (see graph below). These average change for each of these three measures was statistically significant.[1]



[1] *Homeless Days: Prior M=83.3, SD=108.5;Since M=16.2, SD=37.8; t(182) = 7.58, p<.001, Cohen's d=0.83 / Emergency Shelter Days: Prior M=70.6, SD=98.7;Since M=13.6, SD=31.4; t(195) =7.53, p<.001, Cohen's d=.78 / Independent Living Days: Prior M=15.4, SD=59.5;Since M=28.3, SD=79.6;t(751) =-3.83, p<.001, Cohen's d=.18*

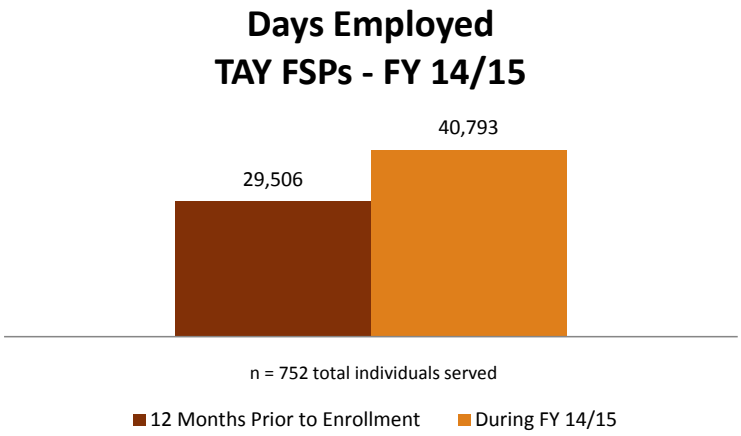
Community Services and Supports (CSS)

Outcomes related to decreasing youth's involvement with the legal system were tracked using two measures: days incarcerated in jail or prison and number of arrests. The FSP programs continued to make substantial improvements in this area as evidenced by the 79% reduction in total incarceration days during FY 14/15 compared to the year prior to FSP enrollment (see left graph below). The youth involved with an FSP program also reported an 81% decrease in the number of times they were arrested during FY 14/15 (see right graph below). The decrease in average days incarcerated was statistically significant.[1]



[1] *Incarceration Days: Prior M=107.4, SD=110.4 ; Since M=22.3, SD=38.9; t(295) = 12.59, p<.001, Cohen's d=1.03 / Arrest data not available for statistical testing*

The last set of outcomes examined days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, homelessness and/or a legal history. Youth enrolled in an FSP program experienced a 38% gain in total days employed during FY14/15 (see left graph below). The average increase was statistically significant.[1]



[1] *Employment Days: Prior M=39.2, SD=88.9; Since M=54.2,SD=99.1; t(751) = 3.53, p<.001, Cohen's d=.16*

Community Services and Supports (CSS)

Community Impact

These programs provide hope to youth who are having extreme difficulty transitioning to adulthood. They address the major developmental tasks of this age group starting with education and job training moving toward the ability to be independent with a satisfactory quality of life.

Changes/Challenges/Barriers

Despite a recovering job market, the major challenge for TAY FSP programs is assisting these youth in finding sustainable employment. Many have had little or no success in the job market. They are reluctant to use skills which they have rehearsed for fear of failure. Supported employment with job coaches has been successful in some instances; however, many youth remain reluctant to pursue employment or engage in self-defeating behavior once they are hired. For many of these youth, SSI becomes an attractive alternative to the struggle of establishing themselves in the work place.

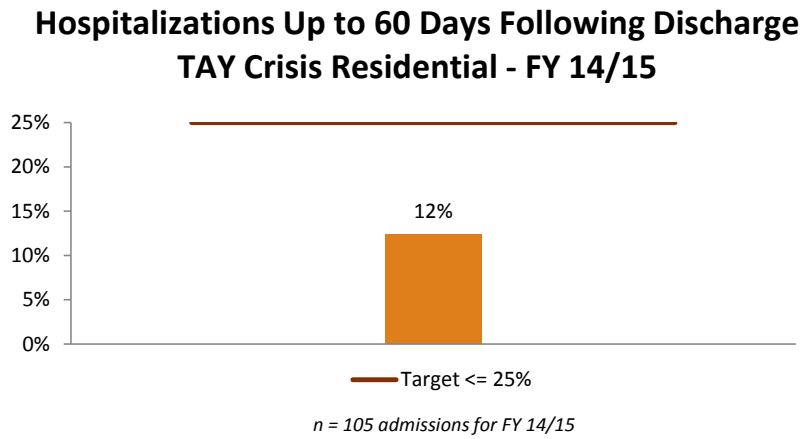
T3. Transitional Age Youth Crisis Residential Services	
Estimated number to be served FY 16/17	96
Annual Budgeted funds for FY 16/17	$1,198,950
Estimated Annual Cost Per Person Served	$12,489

Program Description

The target population for this program is youth 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. The program places an emphasis on growth and not on crisis, and should be viewed as a learning step toward returning to the community and more independent living.

Outcomes

During FY 14/15, 105 youth received crisis residential services. Similar to the children's crisis treatment programs, the goal of TAY Crisis Residential Services is to maintain a psychiatric hospitalization rate of less than or equal to 25% during the time the youth is enrolled in the program through 60 days post-discharge. As can be seen in the graph below, this target was met for FY 14/15.



Community Services and Supports (CSS)

Community Impact

The program provides an alternative to hospitalizations by helping youth stay living in the community. The program reduces admittances to local emergency departments and inpatient psychiatric facilities.

Changes/Challenges/Barriers

Many of the program participants have spent time as children and youth in group home settings. It is difficult to design a structured program that supports and encourages independence at the same time. The program has little control over the youth when they are away from the program. Substance use/misuse can be problematic even in a flexible harm reduction model.

T4. Transitional Age Youth Mentoring Program	
Estimated number to be served FY 16/17	80
Annual Budgeted funds for FY 16/17	$147,380
Estimated Annual Cost Per Person Served	$1,842

Program Description

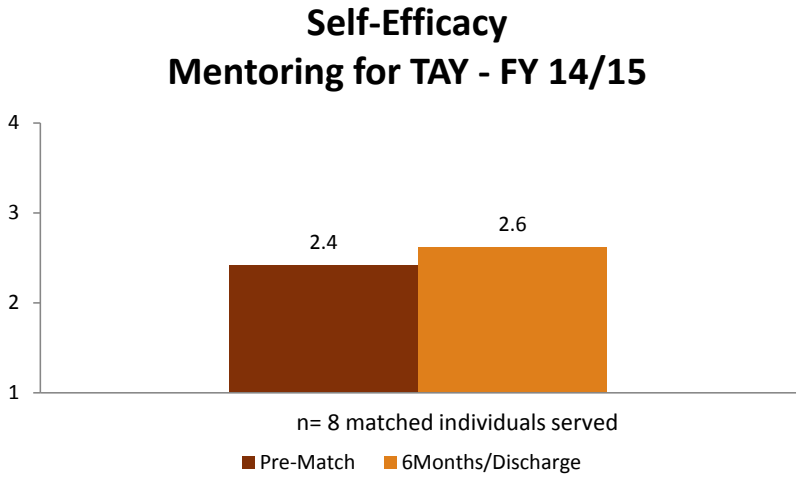
This program provides mentoring services for Transitional Age Youth (TAY) between the ages of 16 and 25 who are receiving outpatient services through Children and Youth Behavioral Health (CYBH) and its contractors. The Mentoring Program is a community-based, individual and family-centered program that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

One-to-one mentoring has the potential to impact youth in a positive way. Research conducted by the National Mentoring Partnership indicates that youth mentoring holds great promise in helping young people succeed in life. Studies of programs that provide youth with formal one-to-one mentoring relationships have provided strong evidence of reducing the incidence of delinquency, substance use and academic failure. Formal youth mentoring programs promote positive outcomes, such as improved self-esteem, enhanced social skills, resiliency, and for TAYs, enhanced life skills. Working with mentors also 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.

Outcomes

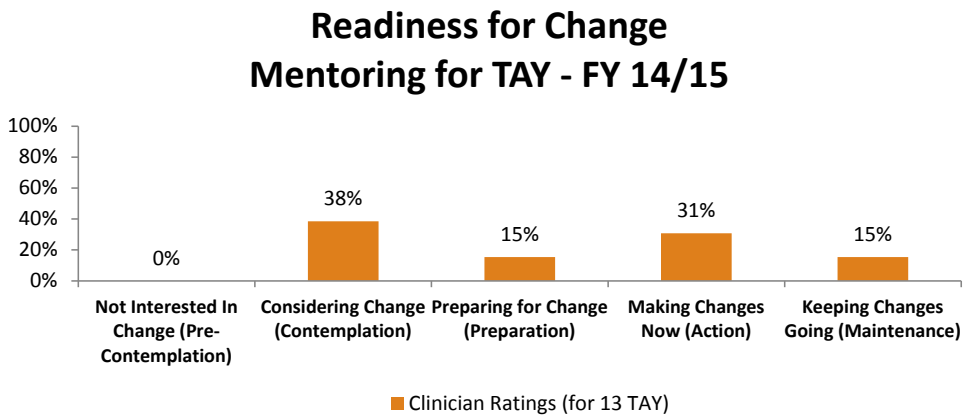
Youth in the Mentoring program are asked to complete the County of Orange Health Care Agency Resilience Questionnaire prior to being matched with a mentor and once again after being in the program for six months (which typically coincides with discharge). During FY14/15, youth served did not demonstrate any gains in self-efficacy[1], one of the measure's subscales, after being matched with a mentor. Of note, the Resilience Questionnaire was in the process of being refined during FY 14/15 and some of the statistical comparisons were across different versions of the scale, which may have affected the analyses. The most recent version is currently being tested for reliability, validity and comparability to the original scale. In addition, pre-match/discharge data were only available for eight youth served at the time of analysis, thus reducing the ability to detect a statistically significant change, if present.

Community Services and Supports (CSS)



[1] *Self-Efficacy: t(7) = 1.6, p=.16, Cohen's d=.40*

At discharge, clinicians rate youth served on their readiness for making positive changes in their behavior (see graph below). At the conclusion of their matches, 46% of youth served were reported as currently making changes and/or keeping changes going. Another 15% were rated as preparing for positive changes and 38% were rated as considering change. No youth served was rated as being uninterested in making changes. These findings suggest that involvement with a mentor corresponds to improved motivation to engage in positive behavior.



Community Impact

The program provides youths with the laboratory to practice skills learned in treatment in a safe and controlled environment. Youths are provided non-judgmental feedback in a supportive setting especially when trying on new behaviors.

Changes/Challenges/Barriers

The program succeeds despite two complicated but necessary processes. It is a challenge identifying volunteer mentors, getting background checks and providing training. At the same time, CYBH clinicians must identify youth who might benefit from the program. The program must then match youth to an appropriate mentor in areas like gender, interests and language.

T5. Transitional Age Youth Centralized Assessment Team	
Estimated number to be served FY 16/17	557
Annual Budgeted funds for FY 16/17	$320,314
Estimated Annual Cost Per Person Served	$575

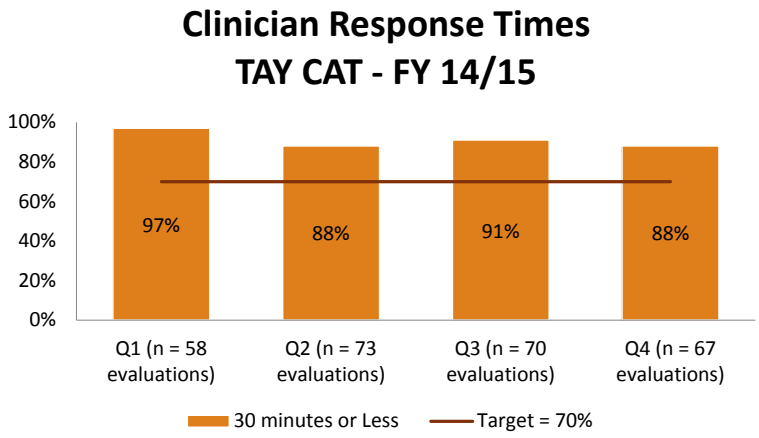
Program Description

The Centralized Assessment Team (CAT) provides mobile response, including mental health evaluations/assessment, 24 hours per day, 7 days per week, for those who are experiencing a mental health crisis. In response to psychiatric emergencies, staff provide crisis intervention, assessments for lower levels of care, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies.

The Centralized Assessment Team has a Transitional Age Youth (TAY) component that provides specialized services to young adults between the ages of 18 and 25 years of age. This program currently has three staff members that have expertise and additional training in working with the TAY population. The target population is young adults who are experiencing a mental health crisis.

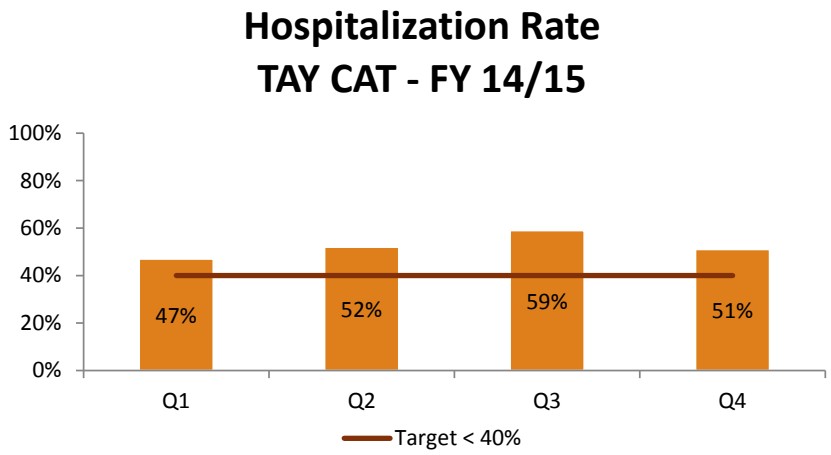
Outcomes

Transitional Age Youth CAT conducted 268 evaluations during FY 14/15. The program's outcome is the efficiency with which CAT is able to respond to calls. This is measured by the number of minutes between the time a clinician dispatches for an evaluation and the time s/he arrives at the evaluation location. The goal is for the dispatch-to-arrival time to be 30 minutes or less 70% of the time. As can be seen in the graph below, the target rate was exceeded by TAY CAT all four quarters of FY14/15. In addition, the average clinician response time for the fiscal year was 14 minutes.



Community Services and Supports (CSS)

In addition, TAY CAT examines the psychiatric hospitalization rate as a way of monitoring the severity of individuals' presenting problems and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals evaluated by CAT generally continued to be hospitalized at a rate of approximately 50%. The program has noted a growing number diagnosed with co-occurring disorders who are under the influence of alcohol or other substances at the time of evaluation, which increases their risk and can increase level of care needs, thereby limiting their placement options.



T6. Transitional Age Youth Program for Assertive Community Treatment	
Estimated number to be served FY 16/17	150
Annual Budgeted funds for FY 16/17	$896,092
Estimated Annual Cost Per Person Served	$5,974

Program Description

The Program for Assertive Community Treatment (PACT) is an individualized treatment approach that offers intensive services in the community. PACT assists individuals in their recovery from mental illness. The program helps individuals remain out of the hospital and the criminal justice system and to develop fulfilling lives. PACT teams are made up of a variety of service providers which include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, and Life Coaches. The program provides intervention services primarily in the home or community that are person-centered and recovery-based, in order to overcome barriers to access or engagement. Collaboration with family participants and other community supports are stressed in this multidisciplinary model of treatment. The team provides medication services, individual and group therapy, substance use and family therapy. In addition, supportive services such as money management and linkages are offered.

The Transitional Age Youth 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 youth in attaining independence and skills needed to be successful throughout their adult lives. Youth 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.

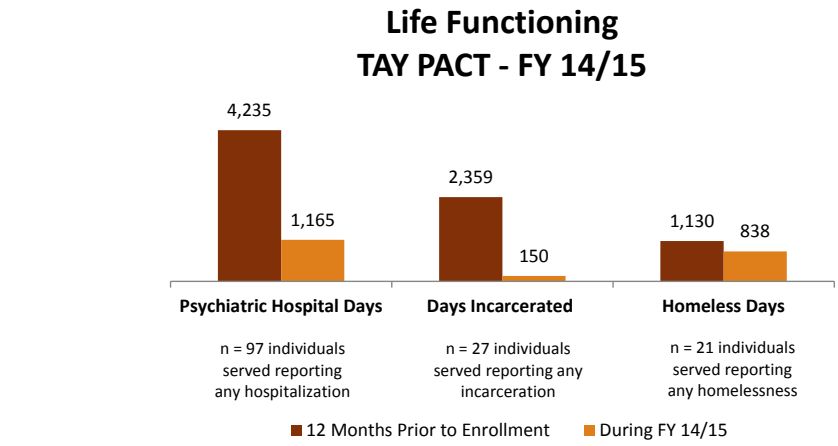
The target population is youth (18-25 years of age) with a severe and persistent mental illness, who have had multiple hospitalizations or incarcerations and are not engaged with treatment.

Outcomes

A total of 150 youth were served in the TAY PACT program during FY14/15. Similar to Adult PACT, the program evaluates its performance through several recovery-based outcome measures related to life functioning (i.e., psychiatric hospitalizations, homelessness, incarcerations) and independence/reintegration (i.e., employment).

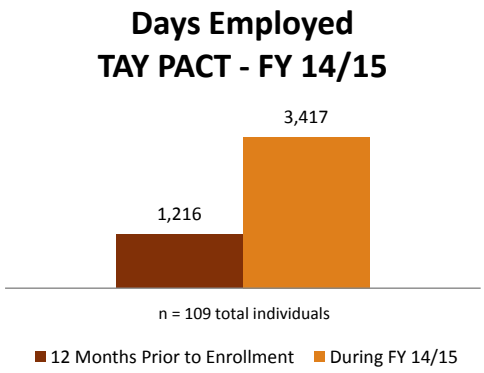
TAY PACT continued to be effective in helping youth improve their life functioning. There were statistically significant decreases in the average number of days youth served were psychiatrically hospitalized and incarcerated during FY 14/15 compared to the year prior to enrolling in PACT[1]. These changes corresponded with a 72% decrease in total days hospitalized and 94% decrease in total days incarcerated (see graph on page 51). The 26% decrease in the total number of days youth served spent homeless was not significant[1] (see graph on page 51).

Community Services and Supports (CSS)



[1] *Psychiatric Hospitalization Days: Prior M=43.7, SD=65.8; Since M=12.0 SD=32.5;t (96) = 4.42, p<.001, Cohen's d=.61 / Incarceration Days: Prior M=87.4, SD=82.1; Since M=5.6 SD=19.3; t (26) =4.94, p<.001, Cohen's d=.1.37 / Homeless Days: Prior M=53.8, SD=62.0; Since M=39.9 SD=54.1; t (20) =0.77, p=.45, Cohen's d=.24*

Youth enrolled in TAY PACT also achieved gains in independence as reflected by a 181% increase in total days employed during FY 14/15 compared to the year prior to enrolling in PACT (see graph below). The average improvement in employment was also statistically significant.[1]



[1] *Employment Days: Prior M=11.2, SD=42.6; Since M=31.4 SD=84.2;t(108) = -2.60, p=.01, Cohen's d=.30*

Community Impact

PACT teams in Orange County target high-risk underserved populations such as the monolingual Pacific Asian community, Transitional Age Youth (TAY), adults and older adults with behavioral health problems. This program has shown to reduce hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

Changes/Challenges/Barriers

To reach vulnerable youth who may face problems similar to TAY but are at a younger life stage, the TAY PACT program is being expanded to include youth aged 12 to 17. The success of TAY PACT with 18-25 year olds has led us to believe that all youth would benefit from this service. Another challenge is TAY PACT often experiences difficulty reaching certain populations and is working to improve outreach to these populations. TAY PACT has made the referral and linkage process more streamlined and has implemented follow-up procedures. Now when youth are referred, they are linked to services more quickly and they feel supported through the process.

Community Services and Supports (CSS)

A1. Adult Full Service Partnership	
Estimated number to be served FY 16/17	1,150
Annual Budgeted funds for FY 16/17	$21,771,114
Estimated Annual Cost Per Person Served	$18,931

Program Description

The Adult FSP programs provide intensive community-based outpatient services which include: peer support, supportive education/employment services, transportation services, housing, benefit acquisition, counseling and therapy, integration and linkage with primary care, intensive case management, 24/7 on call response, crisis intervention, and co-occurring disorder treatment. These programs strive to reduce barriers to accessing treatment by bringing treatment out into the community. Adult FSP programs provide services in a linguistically and culturally competent manner to culturally diverse underserved populations in Orange County, including individuals who may have co-occurring substance use disorders.

The target population for the Full Service Partnership (FSP) programs include adults who have a mental illness and who are unserved, and who may be: homeless or at risk of homelessness, involved in the criminal justice system or frequent users of inpatient psychiatric treatment.

The FSP programs in operation in Orange County each target unique populations:

- The Opportunity Knocks (OK) program serves adults who have current legal issues or a history with the criminal justice system.
- Telecare and Orange (TAO) has two programs that serve adults who live with a serious mental illness and who are homeless or at risk of homelessness. These individuals typically have not been able to access or benefit from traditional models of treatment.
- Striving Towards Enhanced Partnerships (STEPS) is a program that targets adults who are returning to the community from long-term care placements and adults referred by the Public Defender to the Mental Health Collaborative Court (Assisted Intervention court).
- "Whatever It Takes" Court (WIT) is a voluntary program for non-violent offenders who are referred through the collaborative court. The program works in collaboration with probation, the collaborative court judge, and the Public Defender's office to provide treatment that re-integrates members into the community and reduces recidivism.

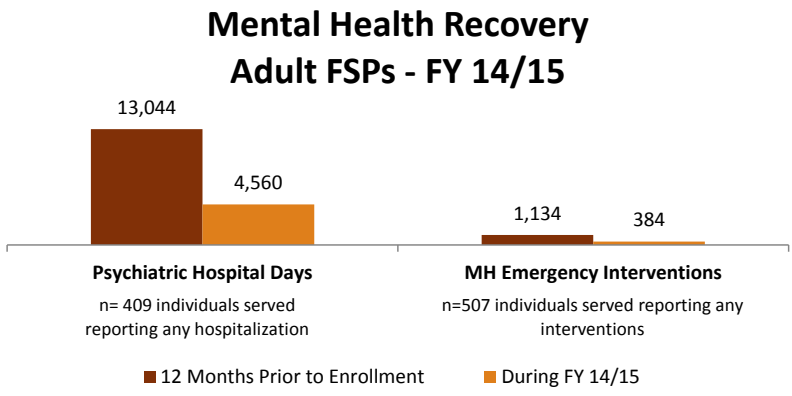
With additional funds added in FY 16/17, we will add one or more new programs and additional FSP slots.

Community Services and Supports (CSS)

Outcomes

A total of 999 adults were served during FY14/15 in the Adult FSP programs. Their success was evaluated by measuring a number of outcomes related to mental health recovery, housing, legal involvement, educational enrollment and employment.

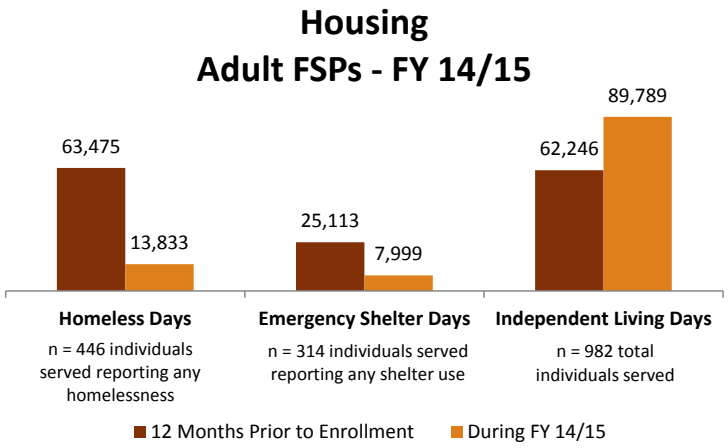
Mental health recovery was evaluated through changes in two measures: (1) number of days psychiatrically hospitalized, and (2) the number of times an adult served experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room visit, crisis assessment/WIC 5150 evaluation, or police response due to a mental health and/or substance use crisis). Support for the FSP programs' effectiveness in promoting recovery was observed through a 65% decrease in the total number of days adults served spent psychiatrically hospitalized during FY14/15, as well as a 66% decrease in the total number of mental health-related emergency interventions, from the 12 months prior to enrollment to the 12 months after enrollment (see graph below). The average decreases were statistically significant.[1]



[1] *Psychiatric Hospitalization Days: Prior M=31.9, SD=62.2; Since M=11.1, SD=25.1; t (408) = 6.29, p<.001, Cohen's d=.44 / Mental Health Emergency Interventions: Prior M=2.2, SD=3.5; Since M=0.8, SD=1.5; t (506) =8.76, p<.001, Cohen's d=.55*

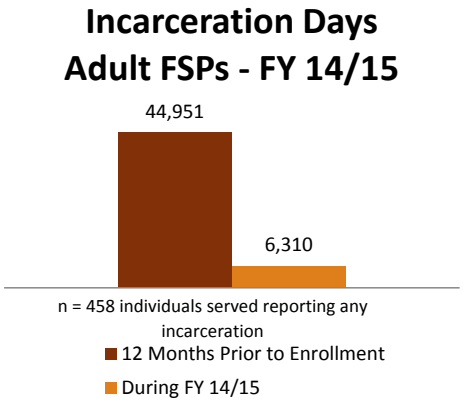
Another goal of the FSP programs is to prevent and reduce homelessness and to promote independent living. Consistent with prior years, FSP programs continued to improve the housing circumstances of their adults served. This success was seen in the dramatic 78% reduction in total days homeless during FY14/15 compared to the year prior to enrolling in the FSP. Adults served also reported a 68% decrease in the total number of days spent in an emergency shelter during FY14/15 (see graph on page 54). In addition, adults served active in FY 14/15 experienced a modest 44% increase in the total number of days they spent in independent living, which was defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement (see graph on page 54). Additional analyses showed that the average improvement for each measure was statistically significant.[1]

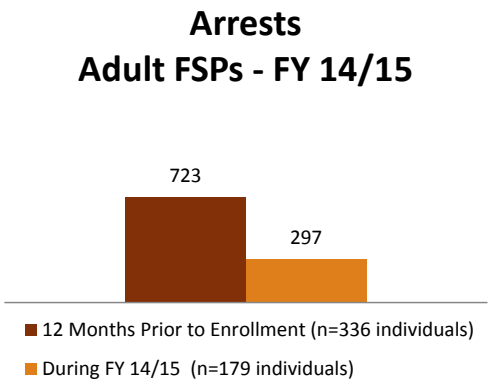
Community Services and Supports (CSS)



[1] *Homeless Days: Prior M=142.3, SD=126.3; Since M=31.0, SD=71.5; t (445) = 16.61, p<.001, Cohen's d=1.08 / Emergency Shelter Days: Prior M=80.0, SD=108.8; Since M=25.5, SD=56.3; t (313) =8.01, p<.001, Cohen's d=.63 / Independent Living Days: Prior M=63.4, SD=119.1; Since M=91.4, SD=140.8; t (981) =-5.74, p<.001, Cohen's d=.22*

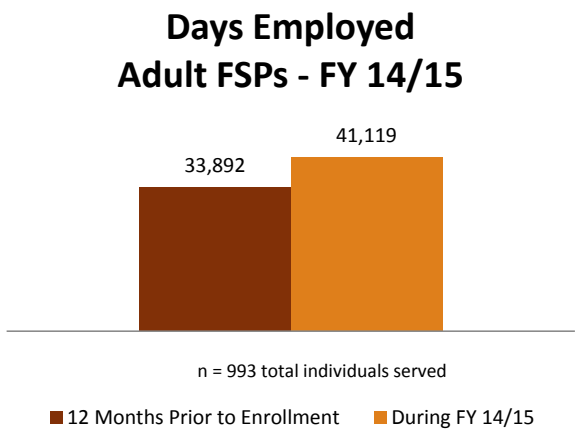
Outcomes related to decreasing involvement with the legal system were tracked using two measures: days incarcerated in jail or prison and number of arrests. The FSP programs continued to make substantial improvements in this area as evidenced by the 86% reduction in total incarceration days during FY 14/15 compared to the year prior to FSP enrollment (see left graph below). There was also a 59% decrease in the overall number of arrests reported during the same time period (see right graph below). The average decrease in days incarcerated was statistically significant.[1]





[1] *Incarceration Days: Prior M=98.1, SD=101.1; Since M=13.8, SD=29.6; t (457) = 17.13, p<.001, Cohen's d=1.13 / Arrest data not available for statistical testing*

The last outcome pertained to days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, homelessness and/or a legal history. Per new guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-house work, work experience, non-paid work experience and other gainful employment activity. Adults enrolled in an FSP experienced a modest 18% gain in total days employed during FY14/15 when compared to the year prior to enrollment (see graph below). The average change in days employed was statistically significant.[1]



[1] *Employment Days: Prior M=34.1, SD=88.5; Since M=41.4, SD=95.0; t(992) = -1.99, p<.05, Cohen's d=.08*

Community Impact

The Adult FSP programs continue to be a leading force for recovery in the community. The FSP programs have a strong base in participant-driven services which build on individual strengths to support reintegration into the community through employment, housing and social connection. The "Whatever It Takes" approach and field-based services break down barriers to accessing treatment. With the continued implementation of integrated services, the FSP programs have increased their collaboration particularly with community substance use programs and residential substance use treatment programs. In addition, the FSP programs that work in conjunction with the courts and probation continue to prioritize developing a system that reduces recidivism in the correctional system.

Community Services and Supports (CSS)

Changes/Challenges/Barriers

The Adult FSP programs consistently evaluate their processes and outcomes in order to make quality improvement changes. The most significant challenges for FSP programs have been: employment, co-occurring residential treatment, increase in referrals, and family inclusion.

FSP programs prioritize helping participants return to work as part of their recovery plan and developing meaningful roles in the community. Staffing changes were implemented to increase program focus on developing employment opportunities and activities. The FSP programs also increased collaboration with contracted employment programs to improve success in employment. FSP programs were enhanced to include more internal job opportunities to offer individuals different levels of employment experience.

The Adult FSP programs, particularly STEPS also prioritized family/significant other involvement in the recovery process. In this particular FSP program, it was identified that there is often a greater need for family inclusion during the recovery process. The FSP programs are addressing the need for family inclusion through social events, groups, family therapy, and family education.

Assisted Outpatient Treatment was implemented in Orange County in October 2014. Many individuals referred to AOT who accepted voluntary services were referred to the Adult FSP programs. Specifically, from FY13/14 to FY14/15, TAO experienced a 63% increase in enrollments.

FSP programs continue to serve more individuals with co-occurring substance use disorders and are utilizing residential treatment programs. The FSP programs have worked collaboratively with Residential Care and Housing to increase co-occurring services in residential treatment programs.

A2. Centralized Assessment Team (CAT) / Psychiatric Evaluation and Response Team (PERT)	
Estimated number to be served FY 16/17	2100
Annual Budgeted funds for FY 16/17	$4,007,323
Estimated Annual Cost Per Person Served	$1,908

Program Description

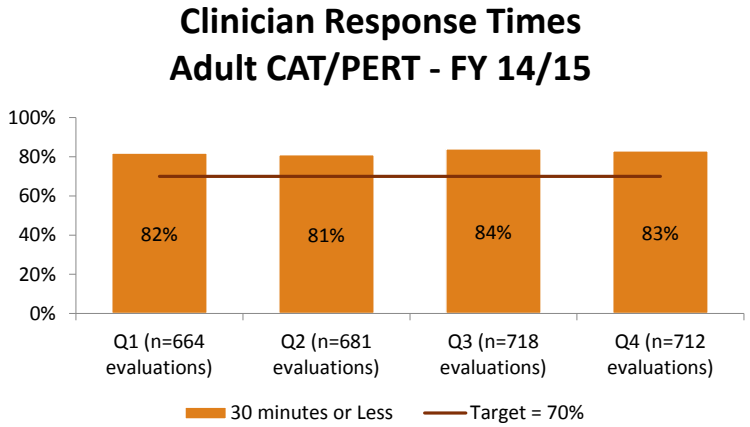
The Centralized Assessment Team (CAT) provides 24-hour-mobile response services to any adult who has a psychiatric emergency. This program assists law enforcement, social service agencies and families in providing mental health crisis intervention services. CAT is a multi-disciplinary program that conducts risk assessments, initiates involuntary and/or voluntary hospitalizations, provides resources and linkages and conducts follow up contacts for individuals evaluated.

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 adults with mental illness in accessing Behavioral Health Services, the PERT team also educates police on mental illness and provides them with the tools necessary to more effectively assist these adults. PERT provides a mental health clinician to ride along with a police officer to provide prompt response to adults experiencing a mental health crisis, assess their needs, and provide them with the appropriate care and linkages to other resources as needed in a dignified manner.

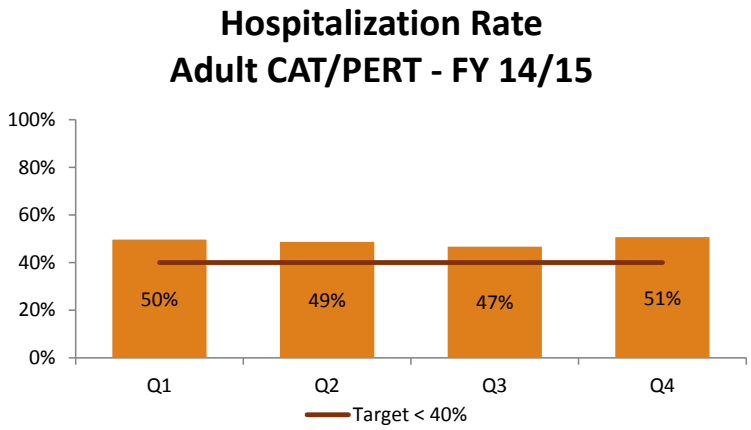
The target population is adults who are experiencing a mental health crisis.

Outcomes

The program's outcome is the efficiency with which CAT/PERT is able to respond to calls. This is measured by the number of minutes between the time a clinician dispatches for an evaluation and the time s/he arrives at the evaluation location. The goal is for the dispatch-to-arrival time to be 30 minutes or less 70% of the time. As can be seen in the graph on page 58, the target rate was exceeded all four quarters of FY14/15 despite the high call volume (i.e., over 2700 total evaluations) demonstrating that clinicians arrived in less than 30 minutes for over 80% of the calls for each quarter measured.



In addition, CAT/PERT examines the psychiatric hospitalization rate as a way of monitoring the severity of individuals' presenting problems and the availability of safe alternatives to inpatient services. Consistent with prior years, adults evaluated by CAT continued to be hospitalized at a rate of approximately 50%. Similar to TAY CAT, CAT/PERT has noted a growing number of adults served diagnosed with co-occurring disorders who are under the influence of alcohol or other substances at the time they are seen by CAT/PERT, which increases their risk and can increase level of care needs, thereby limiting their placement options.



Community Impact

The increased requests for PERT teams have been significant during FY 14/15. The increased utilization of this law enforcement/mental health partnership has enhanced the services provided to adults living with mental illness.

Changes/Challenges/Barriers

One challenge has been related to staffing. The transition of staff to the new PERT teams has decreased the number of staff available for community response. The challenge of maintaining the necessary staff to remain responsive to the community's needs is being addressed through the planned hiring of staff.

A3. Adult Crisis Residential	
Estimated number to be served FY 16/17	580
Annual Budgeted funds for FY 16/17	$3,751,229
Estimated Annual Cost Per Person Served	$6,468

Program Description

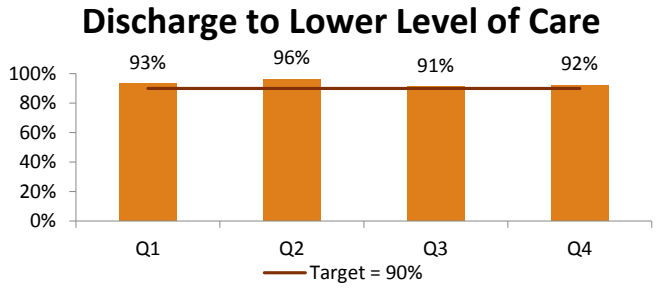
The Crisis Residential Program provides short-term-crisis intervention services to meet the needs of adults in a mental health crisis who may be at risk of psychiatric hospitalization. The program emulates a home-like environment in which intensive and structured psychosocial recovery services are offered 24 hours a day, 7 days a week. Admission to the program is voluntary and the average length of stay is 7-14 days. The program is person-centered and recovery-oriented and focuses on having adults 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 program also provides dual diagnosis services for adults who are experiencing a mental health crisis who also have substance use or use issues.

The Crisis Residential Program also provides assessment and treatment services that include individual and group counseling; monitoring psychiatric medications; substance use education and treatment; and family and significant-other involvement whenever possible. Each adult 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 adult 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 and are at risk for hospitalization.

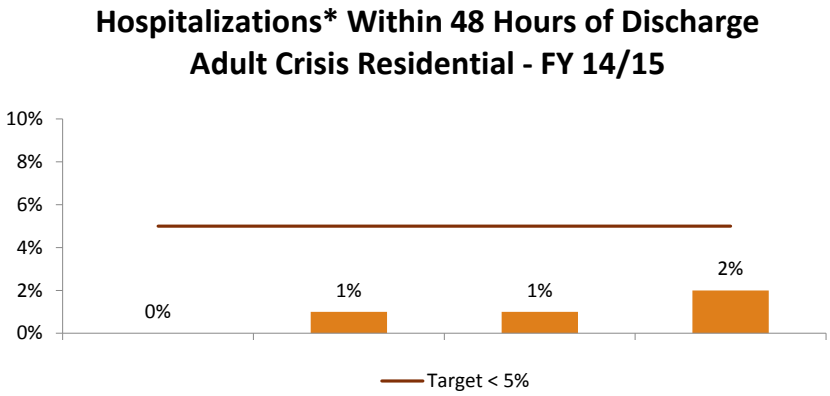
Outcomes

There was a total of 435 admissions to crisis residential services during FY 14/15 and success of the program was measured in two ways. The first outcome measure is the percentage of adults served who achieved crisis stabilization while in the program and were discharged to a less restrictive level of care such as an outpatient clinic, Full Service Partnership, or private psychiatrist/therapist. The target goal established by management is a 90% discharge rate to a lower level of care, which was achieved each quarter for FY 14/15 (please see graph on page 60).



n=435 admissions to Crisis Residential during FY

The second goal is to minimize discharges from the program before the adult served has achieved an adequate degree of stabilization. This is quantified as maintaining a psychiatric hospitalization rate of less than 5% within 48 hours of discharge to a lower level of care. As can be seen in the graph below, the target was achieved for all four quarters of FY 14/15 with rates ranging between 0-2%.



** Based on 403/435 individuals served who were discharged from Crisis Residential to outpatient services*

Community Impact

The Crisis Residential Program has assisted hundreds of adults who would have likely needed a higher level of care (i.e., hospitalization). This has reduced unnecessary stays in psychiatric hospitals and provided a healthy alternative for people experiencing an acute psychiatric episode in a therapeutic home-like environment.

Changes/Challenges/Barriers

A primary challenge has been the increased demand for Crisis Residential services and limited number of beds. A solicitation for additional beds is currently in process with a targeted start in 2016.

A4. Supported Employment	
Estimated number to be served FY 16/17	400
Annual Budgeted funds for FY 16/17	$1,321,417
Estimated Annual Cost Per Person Served	$3,304

Program Description

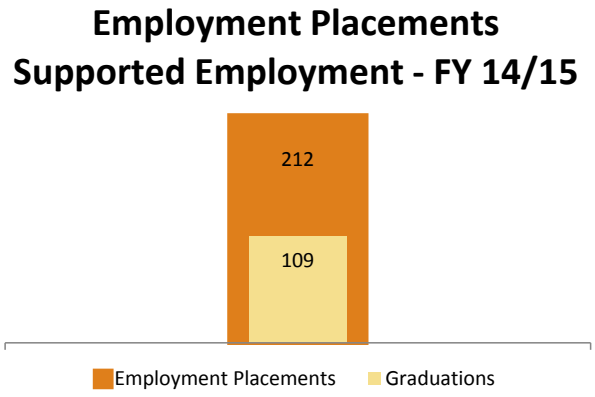
The Supported Employment program provides services which include both competitive and volunteer job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, job coaching, counseling, and peer support to adults with a mental illness and/or co-occurring substance use disorders. Services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

Program participants work with the Employment Specialists (ES) to locate job leads. The ES strives to build working relationships with prospective employers and is the main liaison between the employer and the program participant. The ES's also educate employers to understand mental illness and combat stigma. ES's are responsible for assisting participants with application submissions and assessments, interviewing, image consultation and transportation services. They also provide participants with one-on-one job support to ensure successful job retention. The ES maintains ongoing, open communication with clinical plan coordinators to promote positive work outcomes.

The target population consists of adults who are currently engaged in mental health treatment.

Outcomes

The Supported Employment Program served 425 participants in FY 14/15, which included 306 new enrollments. Performance of the program is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. In FY14/15, 51% of all employment placements resulted in a successful graduation from the program after achieving the employment milestone (see graph below). This graduation rate reflects an 11 percentage point increase from FY 13/14.



Community Services and Supports (CSS)

Community Impact

The program helps increase job opportunities for adults living with a mental illness.

Changes/Challenges/Barriers

In FY 2016-17, the program will be expanded to meet community demand. The expansion will enable the program to accommodate up to an additional 50 program participants.

A6. Program for Assertive Community Treatment (PACT)	
Estimated number to be served FY 16/17	850
Annual Budgeted funds for FY 16/17	$9,731,926
Estimated Annual Cost Per Person Served	$11,449

Program Description

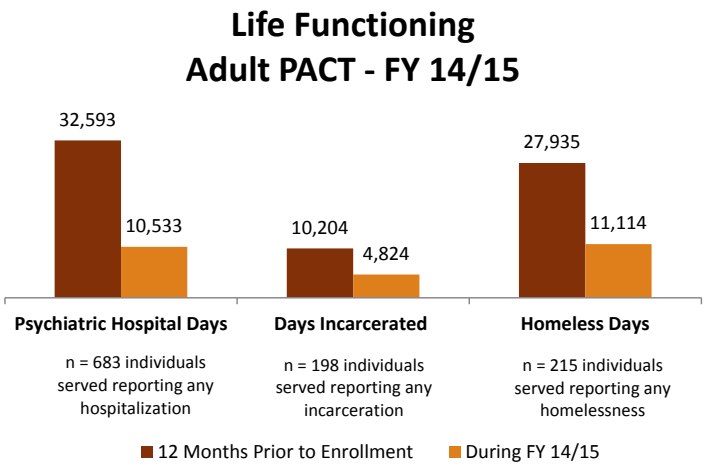
The Program for Assertive Community Treatment (PACT) is an individualized treatment approach that offers intensive case management, counseling and therapy, peer support, benefit acquisition, supportive educational and vocational services, linkage to community resources, and crisis intervention. PACT programs utilize multidisciplinary teams which include Mental Health Specialists, Clinical Social Workers, Marriage Family Therapists, Life Coaches, and Psychiatrists. The team provides many services in the field, seeing the adults in their homes, in hospitals, or in jail in order to reduce barriers to access treatment. The programs' overarching goals include engaging adults into voluntary treatment, and assisting them in reintegrating into the community through stable housing, education, employment, and linkage to community based support.

The target population is adults in Orange County who have a serious mental illness and/or co-occurring substance use disorders. Adults in PACT services typically have had multiple psychiatric hospitalizations or incarcerations and have not successfully engaged in traditional outpatient treatment.

Outcomes

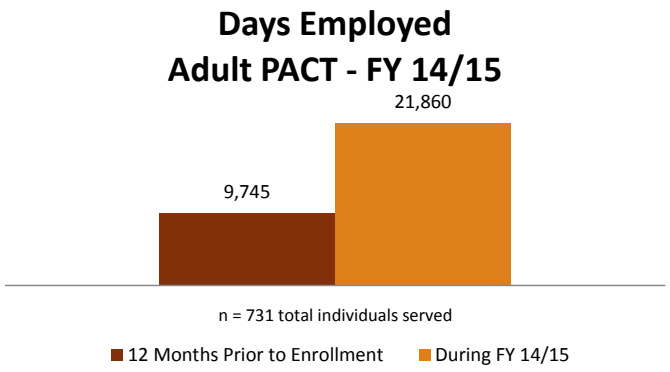
A total of 896 adults were served in the Adult PACT program during FY14/15. Similar to TAY PACT, the program evaluates its performance through several recovery-based outcome measures related to life functioning (i.e., psychiatric hospitalizations, homelessness, incarcerations) and independence/reintegration as measured by employment.

Adult PACT continued to be effective in helping adults served improve their life functioning. This was demonstrated by a 68% decrease in the total number of days adults served were psychiatrically hospitalized and a 53% decrease in the total number of days they had been incarcerated during FY 14/15 compared to the year prior to enrolling in PACT. In addition, adults served spent 60% fewer total days homeless during that time period (see graph on page 64). The average change for each of the three measures was statistically significant.[1]



[1] *Psychiatric Hospitalization Days: Prior M=47.7, SD=76.8; Since M=15.4, SD=54.5;t (682) = 9.36, p<.001, Cohen's d=.48 / Incarceration Days: Prior M=51.5, SD=70.5; Since M=24.4, SD=56.8; t (197) =4.26, p<.001, Cohen's d=.42 / Homeless Days: Prior M=129.9, SD=120.1; Since M=51.7, SD=92.5; t (214) =8.53, p<.001, Cohen's d=.73*

Adults enrolled in Adult PACT also achieved gains in independence during FY 14/15 compared to the year prior to enrollment as evidenced by a 124% increase in total number of days employed. The average increase in days was statistically significant.[1]



[1] *Employment Days: Prior M=13.3, SD=54.6; Since M=29.9, SD=87.5; t (730) = -4.95, p<.001, Cohen's d=.23*

Community Impact

The Program for Assertive Community Treatment (PACT) teams in Orange County target high-risk underserved populations which include monolingual Pacific Asian, Transitional Age Youth (TAY), adults and older adults living with mental illness. This program has consistently shown a reduction in psychiatric hospitalization and incarceration days.

Changes/Challenges/Barriers

PACT was expanded this year due to increasing referrals and in an effort to reduce the impact of this growing population on the adult outpatient behavioral health clinics. As a result, PACT will need to increase the number of clinical staff to serve them. PACT has also prioritized reaching out to underserved populations in the community by improving outreach strategies. In addition, with the implementation of the electronic health record, PACT was able to review and streamline the referral/intake process in order to increase immediate access to services. The new process provides more timely intervention and increased support for the adults referred during the admission process.

A7. Wellness Center Central	
Estimated number to be served FY 16/17	100 per day/ 6 days per week
Annual Budgeted funds for FY 16/17	$1,469,448
Estimated Annual Cost Per Person Served	$47

Program Description

The Wellness Center provides recovery interventions which are member-directed and embedded within the following array of services: peer supports, social outings and recreational activities. Services are provided by peer staff with lived experience with mental health problems. 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 members 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 member's family, friends and significant others

The Wellness Center supports individuals in 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 member base. These services facilitate and promote recovery and empowerment in individuals with mental illness.

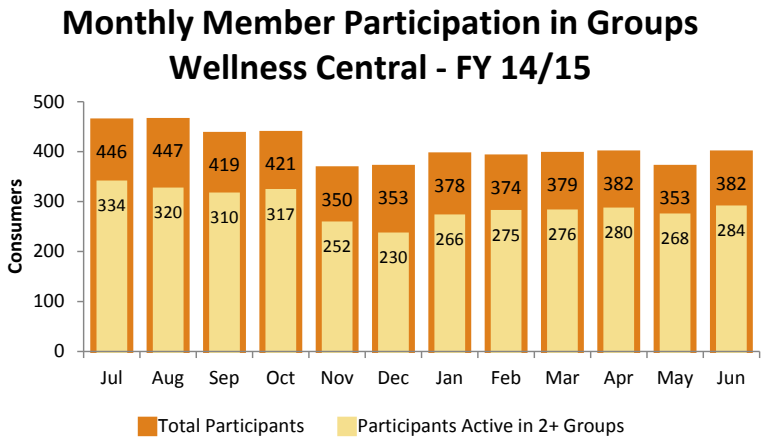
The philosophy of the Wellness Center draws upon cultural strengths and utilizes service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. The Wellness Center uses a Participant Advisory Board, a community town 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.

The target population consists of Spanish, Farsi and English speaking adults with a history of lived experience, but can serve anyone who meets criteria.

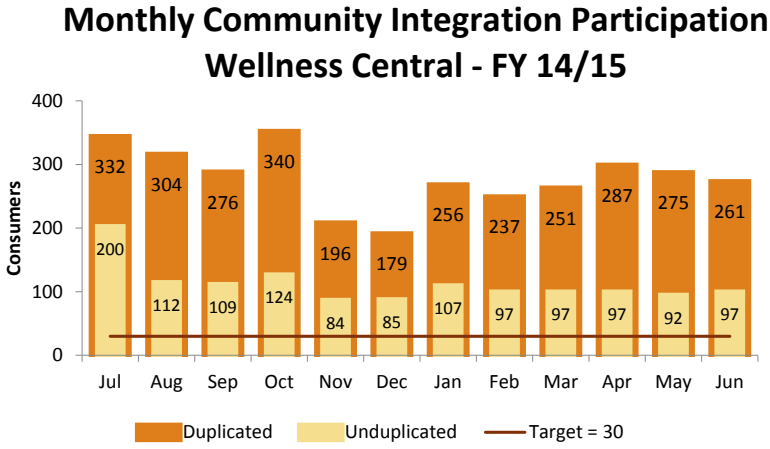
Outcomes

The Wellness Center assesses its performance in supporting member recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two ways. First, the Wellness Center encourages its members to engage in two or more groups or social activities each month. As can be seen in the graph below, the Center met this goal as the majority of members were actively engaged in multiple Wellness Center-sponsored activities (monthly averages ranged from 65% in December to 76% in May).

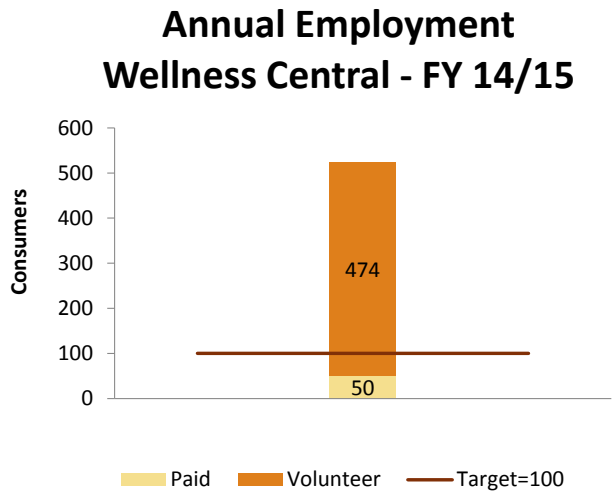
Community Services and Supports (CSS)



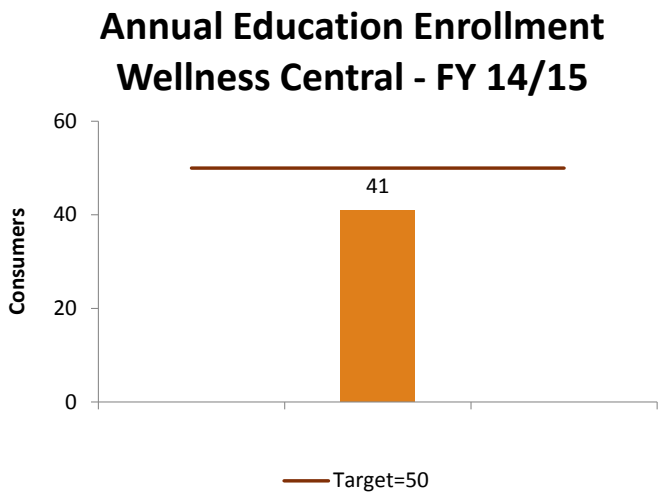
In addition, the Center has a monthly goal of encouraging 30 members to engage in community integration activities. In FY 14/15 Wellness Center Central was tremendously successful in exceeding this target and, as such, the program will work toward identifying a new goal for future years (see graph below).



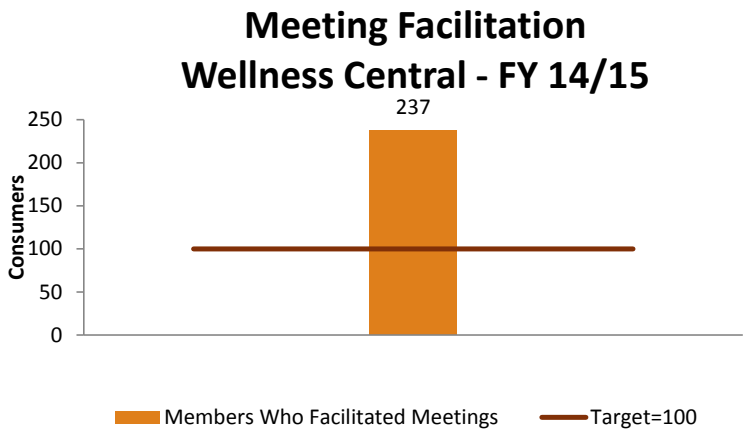
The Wellness Center also strives to increase a member's self-reliance, as reflected by employment and school enrollment. The annual goal is for 100 members to obtain employment, either paid or volunteer. The Center exceeded this goal for FY 14/15 largely due to the numbers of members in volunteer positions. The program will continue to work toward increasing the number of members who obtain paid employment.



The annual target for education enrollment is 50 members. During FY 14/15 the Wellness Center enrolled 41 members in education classes. This continues to be a challenging area for the program, and HCA program staff will continue to work with the provider to strategize on new ways to increase interest and enrollment in education classes by its members.



The annual target for member facilitated meetings is 100 members. During FY 14/15, 237 members facilitated all or portions of all community meetings held at the Wellness Center.



Community Impact

The program helps community members develop and maintain a healthy lifestyle. In addition, the program employs individuals with lived experience as staff.

Changes/Challenges/Barriers

A challenge for the program has been maintaining the Member Advisory Board (MAB). To address this challenge, subcommittees were added to the MAB to assist Board participants with their duties.

A7. Wellness Center West	
Estimated number to be served FY 16/17	50 per day/ 6 days per week
Annual Budgeted funds for FY 16/17	$750,000
Estimated Annual Cost Per Person Served	$48

Program Description

The Wellness Center provides recovery interventions which are member-directed and embedded within the following array of services: peer supports, social outings and recreational activities. Services are provided by peer staff with lived experience with mental health problems. 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 members 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 member's family, friends and significant others.

The Wellness Center supports individuals in 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 member base. These services facilitate and promote recovery and empowerment in individuals with mental illness.

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. The Wellness Center uses a Participant Advisory Board, a community town hall model, and participant 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.

The target population is Asian/Pacific Islanders and Latinos with a history of lived experience, but can serve anyone who meets criteria.

Outcomes

The program is in the process of being implemented.

Community Impact

This new site will increase access for those who seek activities in the community.

Changes/Challenges/Barriers

This is a new program that opened in February 2016.

A7. Wellness Center South	
Estimated number to be served FY 16/17	50 per day/ 6 days per week
Annual Budgeted funds for FY 16/17	$750,000
Estimated Annual Cost Per Person Served	$48

Program Description

The Wellness Center provides recovery interventions which are member-directed and embedded within the following array of services: peer supports, social outings and recreational activities. Services are provided by peer staff with lived experience with mental health problems. 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 members 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 member's family, friends and significant others.

The Wellness Center supports individuals in 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 member base. These services facilitate and promote recovery and empowerment in individuals with mental illness.

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. The Wellness Center uses a Participant Advisory Board, a community town hall model, and participant 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.

The target population consists of Spanish, Farsi and English speaking adults with a history of lived experience, but can serve anyone who meets criteria.

Outcomes

This program has just become operational January 2016. The following outcome measures are proposed:

- Achieve a monthly goal of 30 or more members who engage in community integration activities.
- Members engage in two or more groups/activities each month.
- Achieve an annual goal of 100 or more members who obtain employment, either paid or volunteer employment.
- Achieve an annual goal of 50 or more members who enroll in education classes.
- Achieve an annual goal of 100 or more members who facilitate all or portions of community meetings.

Community Services and Supports (CSS)

Community Impact

This site will increase access to activities in South Orange County.

Changes/Challenges/Barriers

This is a new program that opened in December 2015.

A8. Recovery Centers/Open Access	
Estimated number to be served FY 16/17	3,350
Annual Budgeted funds for FY 16/17	$9,158,531
Estimated Annual Cost Per Person Served	$2,734

Program Description

The Recovery Centers – The Recovery Center programs provide a lower level of care for adults who no longer need traditional outpatient treatment, but need to continue receiving medication and case management support. This program allows adults to receive self-directed services that focus on community reintegration and linkage to health care. An important feature is a peer-run support program in which adults are able to access groups and peer support activities. These services are delivered in an individualized, person-centered system of care that supports people in their unique stage of recovery. Services are focused on increasing self-reliance and independence in the community. Services include, medication management, individual and group counseling, case management, crisis intervention, educational and vocational services, and peer support activities.

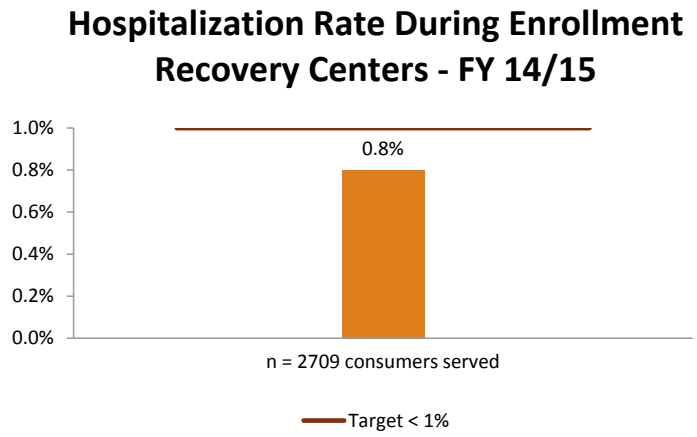
The target population includes adults, ages 18 and older, who are diagnosed with a serious mental illness and may have a co-occurring substance use disorder and who no longer require intensive outpatient behavioral health services.

Recovery Open Access Services – The Recovery Open Access Services provide urgent outpatient psychiatric support, immediate follow-up, and short-term integrated behavioral health services to adults discharging from psychiatric hospitals or jails. Services include face-to-face assessments, temporary medication support, crisis services, psychiatric health assessments, brief solution-focused counseling, follow-up services, and linkage to substance use disorder treatment and ongoing care.

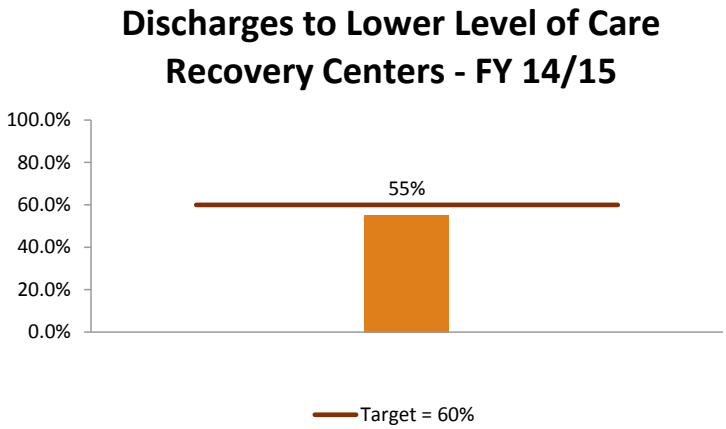
The target population includes adults, ages 18 and older, who are diagnosed with a serious mental illness and may have a co-occurring substance use disorder, and who require urgent behavioral health care.

Outcomes

Outcomes are only reported for the Recovery Centers because Recovery Open Access did not begin enrolling consumers until FY 15/16. During FY 14/15, the Recovery Centers served a total of 2,709 adults. Performance of the program was measured in two ways. The first is whether the program achieved its target of maintaining a psychiatric hospitalization rate of less than 1% while they were enrolled in the program. As can be seen in the graph on page 73, the Recovery Centers achieved this goal with a hospitalization rate of 0.8%.



In addition, the Recovery Centers strive to assist adults served in achieving community reintegration and greater independence by setting a goal of discharging 60% of the total population into a lower level of care. During FY 14/15 the program narrowly missed this goal with 55% of individuals served by the program being discharged to a lower level of care.



Community Impact

The transition to Recovery Open Access services has increased linkage for those who are released from a hospital or jail.

Changes/Challenges/Barriers

One change in our system of care from the previous year is that the two County-operated Recovery Center Services were transformed into Recovery Open Access Services. The County identified a need for immediate screening and evaluation services for those with urgent behavioral health care needs and adjusted the delivery of services to match that need.

A9/O4. Adult & Older Adult Peer Mentoring	
Estimated number to be served FY 16/17	930
Annual Budgeted funds for FY 16/17	$1,124,888
Estimated Annual Cost Per Person Served	$1,210

Program Description

The Peer Mentoring program will provide field-based supportive services to adults aged 18-59 years, and older adults 60 years of age and older, who have been diagnosed with a mental illness and who may also have a co-occurring disorder. The proposed program will consist of two Tracks, as described below:

Track One – Track One will serve adults and older adults referred from both County-operated and County-contracted outpatient clinics, as well as County-contracted FSPs, who are currently hospitalized or have a recent psychiatric hospitalization or have experienced multiple emergency room visits, and require assistance with linkage to services, reintegration into their homes and community, and achieving treatment goals identified by their treatment providers.

Track One peer mentors will be paired with adults and older adults to assist them in successfully transitioning from inpatient care back into community living by providing a comprehensive, collaborative approach that focuses on the development of life management and independent living skills. The peer mentors will support the individual's recovery goals in collaboration with their treatment providers, and will provide field-based supportive services which include peer counseling, assistance with accessing community services, and assistance in following up with inpatient care discharge plans and outpatient health care appointments.

Track Two – Track Two will serve adults and older adults who are pending discharge and referred from the County Crisis Stabilization Unit (CSU), and/or triage staff in identified regional hospital emergency rooms within Orange County in collaboration with the Hospital Association of Southern California. Track Two peer mentors will be assigned to work with specific hospitals and shall be paired with licensed Crisis Stabilization Unit (CSU) or emergency room triage staff to link identified adults and older adults to necessary community-based services. Services will be field-based, and will provide reassurance and encouragement, advocacy and education to the individuals and their families or significant support persons, assisting them to make and keep established appointments, and arrange transportation for those appointments. The focus will be on assisting the adults and older adults with managing their mental health treatment, developing a support network, and engaging in meaningful and productive roles.

The target population consists of adults and older adults with mental illness who are linked with Orange County Adult and Older Adult Behavioral Health Services.

Community Services and Supports (CSS)

Outcomes

Outcome data for this Annual Plan Update are based on FY 14/15 data. This program was not implemented at that time, and outcomes will be reported in the next Plan Update.

Community Impact

This program is intended to help adults and older adults with mental illness reintegrate into the community and provide valuable employment opportunities to individuals in recovery.

Changes/Challenges/Barriers

This is a new program that began in January 2016.

A10. Assisted Outpatient Treatment	
Estimated number to be served FY 16/17	125
Annual Budgeted funds for FY 16/17	$4,436,820
Estimated Annual Cost Per Person Served	$35,495

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 individuals with severe mental illness who meet certain criteria. This program became operational as of October 1, 2014.

An individual subject to AOT must live in the County and have a history of not participating in needed mental health treatment. The individual must be unlikely to survive safely in the community without supervision, based on an investigation and resultant clinical determination. All individuals placed on AOT must meet threshold criteria: the individual'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 individual 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 parties 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 individual is developed. The order is good for six months and can be renewed at that time if the criterion is still met.

Outcomes

During FY 14/15, there were 358 referrals and 695 inquiries (request for information only) from the community. Of the referrals, 97 individuals were linked to other services voluntarily without court intervention. These individuals were linked to Full Service Partnerships, County PACT programs, County Clinics and Substance Use Disorder programs based on the level of care necessary. A total of nine individuals went through the petition process with seven reaching a settlement agreement and two requesting a contested hearing. In both cases of the contested hearing, AOT was ordered. Of the remaining 252 referrals, 63 did not meet criteria for the program, 33 were engaged in services prior to the referral being made, and 19 had extended hospitalizations. Additionally, 32 had extended incarcerations longer that 60 days and 98 were unable to locate due to homelessness. For the remainder of the individuals referred, the petition was unable to be substantiated or the petition was withdrawn.

Community Services and Supports (CSS)

Community Impact

AOT was a new program this fiscal year and has had a notable impact on the community as evidenced by the number of individuals the AOT Outreach team has been able to engage in voluntary services. Ninety-seven individuals were linked voluntarily to services in the community that would have otherwise not been reached. AOT serves as another access point for families to call when their loved ones may benefit from AOT services.

Changes/Challenges/Barriers

One of the challenges with the AOT program that was not anticipated was the volume of those who were willing to accept voluntary services at the time of outreach. It was challenging for providers to be able to accommodate such a large number of referrals in a short period of time. Additional funding was added to the TAO Full Service Partnerships to mitigate this influx of referrals.

Another challenge faced by the AOT program was outreaching to the homeless population. Without an address, this population was difficult to locate on a consistent basis. A large segment of our referrals were "Unable to locate" as a result. This issue was compounded as the correctional system releases individuals during the early morning hours and hospitals discharge individuals before the Outreach team can link them to appropriate services. The AOT Outreach team has worked diligently with correctional mental health and the hospitals to increase collaboration and provide notice when an individual will be discharged. In some cases, appointments were successfully set up at the time of release or discharge.

A11. Mental Health Court – Probation Services	
Estimated number to be served FY 16/17	216
Annual Budgeted funds for FY 16/17	$696,000
Estimated Annual Cost Per Person Served	$3,222

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 they 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 use disorder 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.

Outcomes

Treatments for individuals served in the collaborative court programs is provided in the WIT FSP and the PACT Programs. Specific outcome data is reported under those separate programs.

A12. Drop-in Center – Civic Center	
Estimated number to be served FY 16/17	300
Annual Budgeted funds for FY 16/17	$500,000
Estimated Annual Cost Per Person Served	$1,667

Program Description

This will be a new program that will provide day time services and linkages to community supportive services for targeted homeless adults and older adults.

The target population is homeless adults and older adults within the Civic Center area.

This program was new in the FY 14/15 plan and is still not implemented. It is expected to be in FY 16/17.

Outcomes

Outcome data for this Annual Plan Update are based on FY 14/15 data. This program was not implemented at that time, and outcomes will be reported in the next Plan Update.

Community Impact

Outcome data for this Annual Plan Update are based on FY 14/15 data. This program was not implemented at that time.

Changes/Challenges/Barriers

This program is not yet implemented.

A13. Housing for Homeless	
Estimated number to be served FY 16/17	12-36
Annual Budgeted funds for FY 16/17	$2,000,000
Estimated Annual Cost Per Person Served	$55,556

Program Description

This program will assist the homeless adult population to move into permanent housing. Outreach and Engagement teams, County and County-contracted clinics, and the Coordinated Entry System will identify qualifying homeless adults and link them to a home for up to six months. Services will be designed to connect residents to permanent housing and include appropriate linkages to accomplish this goal. If residents are unable to secure appropriate housing, or if they choose to remain in the home, residents will have the option to stay longer than six months and utilize a Section 8 Tenant Choice Voucher or Shelter-Plus Care at the site

The target population includes homeless adults diagnosed with a serious mental illness and may have a co-occurring substance use disorder.

This program was new in the FY 14/15 plan and is still not implemented. It is expected to be in FY 16/17.

Outcomes

This is a new program. Outcomes will be collected once the program is implemented.

Community Impact

This program is not yet implemented.

Changes/Challenges/Barriers

This program is not yet implemented.

A14. Housing/Year Round Emergency Shelter	
Estimated number to be served FY 16/17	100 unduplicated
Annual Budgeted funds for FY 16/17	$1,367,180
Estimated Annual Cost Per Person Served	$13,672

Program Description

The *County of Orange's Ten Year Plan to End Homelessness* has been working to establish a year-round shelter for all homeless individuals. MHSA funding will be folded into that effort in order to secure beds for the homeless adults with mental illness. 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 adult served 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. It will house homeless adults with a severe and persistent mental illness (SPMI) throughout the year.

This program was new in the FY 14/15 plan and is still not implemented. It is expected to be in FY 16/17.

Outcomes

The program is not yet implemented. On November 17, 2015, the Orange County Board of Supervisors approved the purchase of a site located next to the 91 Freeway on Kraemer Place.

Community Impact

This will be Orange County's first year-round shelter.

Changes/Challenges/Barriers

The largest challenge to this program has been finding a site.

A15. Transportation	
Estimated number to be served FY 16/17	TBD
Annual Budgeted funds for FY 16/17	$1,000,000
Estimated Annual Cost Per Person Served	TBD

Program Description

This program will provide transportation assistance to adults with mental illness requiring assistance to get to their medical or behavioral health appointments.

The target population consists of adults who are receiving services through County or Contracted programs requiring assistance to keep medical and behavioral health appointments.

In preparation for this program to be implemented, BHS staff conducted a survey of 460 individuals at four outpatient clinics to determine what modes of travel were used, amount of time needed to reach location, reasons why appointments were missed, and what barriers related to transportation had a direct impact on the them. The survey will guide staff in developing a Request for Proposal (RFP) to have the program up and running within the year.

This program was new in the FY 14/15 plan and is still not implemented. It is expected to be in FY 16/17.

Outcomes

Outcome data for this Annual Plan Update are based on FY 14/15 data. This program was not implemented at that time, and outcomes will be reported in the next Plan Update.

Changes/Challenges/Barriers

Program has not yet been developed.

A16. Adult/TAY In-Home Crisis Stabilization	
Estimated number to be served FY 16/17	300
Annual Budgeted funds for FY 16/17	$1,500,000
Estimated Annual Cost Per Person Served	$5,000

Program Description

The program will provide 24/7 in-home crisis response, short term in-home therapy, case management, and rehabilitation services. The focus will be on maintaining family stabilization and preventing hospitalization and/or out-of-home placement.

The target population is adults aged 18 to 59 years of age who are experiencing a behavioral health crisis and are being considered for psychiatric hospitalization, but who do not meet criteria for admission.

Outcomes

Outcome data for this Annual Plan Update are based on FY 14/15 data. This program was not implemented at that time, and outcomes will be reported in the next Plan Update.

Changes/Challenges/Barriers

This program is going out for solicitation this fiscal year.

A18 and C11. Crisis Stabilization Unit – Urgent Care Center & Urgent Care Center Children	
Estimated number to be served FY 16/17	5100
Annual Budgeted funds for FY 16/17	$5,000,000 ($2,500,000 per program)
Estimated Annual Cost Per Person Served	$980

Program Description

In response to the rising demand for emergency psychiatric services and community concern regarding emergency room wait times for persons seeking mental health care, the HCA intends to establish an additional crisis stabilization unit (CSU). The CSU is envisioned to provide the community a 24/7 walk-in service as an alternative to presentation to hospital emergency rooms for persons who need urgent mental health assessment and stabilization. It would provide a more appropriate alternative for family, law enforcement officers, or others to bring persons who have a mental health need and are willing to accept service on a voluntary basis.

The CSU will operate on a 24/7 basis and services will include: psychiatric evaluation, medication management, nursing assessment, collateral history, and referral to the appropriate level of continuing care. Crisis stabilization is an outpatient services and therefore may evaluate and treat clients for no longer than 23 hours. The target population is persons who need walk-in services for psychiatric illness or emotional disorders who are willing to accept services on a voluntary basis. The preference is to serve persons of all ages. This is dependent upon whether the selected location will allow separate assessment and treatment areas for the different age groups.

Outcomes

Outcomes will be determined during solicitation process.

Community Impact

We are anticipating the CSU will serve hundreds of individuals who would have likely presented to emergency rooms and/or needed a higher level of care (hospitalization). This has reduced unnecessary stays in psychiatric hospitals and provided a healthy alternative for people experiencing an acute psychiatric episode.

Changes/Challenges/Barriers

This program is going out for solicitation this fiscal year.

A19. Dual Diagnosis Residential Treatment	
Estimated number to be served FY 16/17	TBD
Annual Budgeted funds for FY 16/17	$500,000
Estimated Annual Cost Per Person Served	TBD

Program Description

The Dual Diagnosis Residential Treatment program is designed to address the specialized needs of individuals with co-occurring mental health and substance use disorders. The program will be staffed by nurses, certified substance use counselors, licensed clinicians, and an MD. Program will be in a structured environment to address the needs of persons with mental illness and substance use disorders. Services include individual and group counseling, education, medication management, and vocational assistance.

As the program is developed more fully, numbers served and more specific information about the target population will be articulated.

Outcomes

This is a new program that will begin service in FY 16/17.

Changes/Challenges/Barriers

This is a new program that has not been implemented yet to determine changes/challenges/barriers.

Community Services and Supports (CSS)

O1. Older Adult Recovery Services	
Estimated number to be served FY 16/17	545
Annual Budgeted funds for FY 16/17	$1,668,135
Estimated Annual Cost Per Person Served	$3,061

Program Description

The Older Adult Recovery Program provides field and clinic based behavioral health services including case management, crisis intervention, medication monitoring, and therapy services (individual, group, and family). Services are provided with the aim of improving quality of life by reducing mental health symptoms and related impairments, reducing hospitalizations, increasing access to community and medical services, decreasing social isolation, and maintaining independence.

The Older Adult Recovery program serves older adults from diverse cultural groups such as African American, Latino, Vietnamese, Korean, and Iranian as well as non-English-speaking monolingual individuals, and those who are deaf or hard of hearing.

The target population includes older adults 60 years or older who are living with serious mental illness and who may also have a co-occurring substance use disorder, medical diagnoses, and multiple functional impairments. The older adults receiving this service are often isolated, homebound, and have limited resources.

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 (as measured by the PHQ-9); increase access to primary care (as measured by nursing assessments for newly admitted older adults); and improve level of recovery (as measured by the Milestones of Recovery Scale [MORS] for Older Adults, which includes unique elements in the area of skills and supports). Due to data collection problems, PHQ-9 and MORS data are not available for FY 14/15.

The program served 491 older adults in FY 14/15, 258 of whom were new admissions. Of the clients served, 116 had a nursing assessment completed.

Community Impact

Older Adult Recovery Services provides groups and activities on site and in the community to support older adults reintegrate into the community.

Community Services and Supports (CSS)

Changes/Challenges/Barriers

The Older Adult Recovery program provides a comprehensive access point for older adults in the community who are living with a serious mental illness. This population has unique service needs due to issues of aging such as limited mobility and co-occurring medical issues. The program addresses these needs by providing integrated care, collaborating with various community resources and primary care providers in their service delivery approach. It is often a challenge to transition individuals to a lower level of care due to limited community resources that can adequately meet the needs of older adults with mental illness and co-occurring disorders.

O2. Older Adult Full Service Partnership	
Estimated number to be served FY 16/17	184
Annual Budgeted funds for FY 16/17	$2,536,395
Estimated Annual Cost Per Person Served	$13,785

Program Description

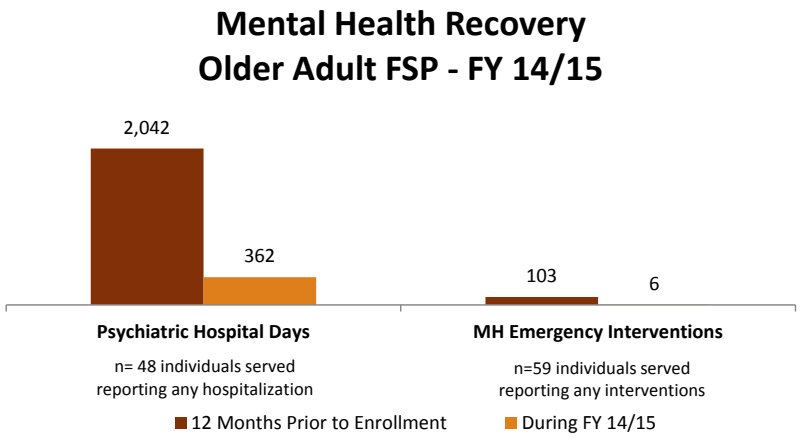
The Older Adult Full Service Partnership (FSP) program provides intensive community-based outpatient services which include; peer support, supportive education/employment services, transportation services, housing, benefit acquisition, counseling and therapy, integration and linkage with primary care, intensive case management, 24/7 on call response, crisis intervention, and co-occurring disorder treatment. These programs strive to reduce barriers to accessing treatment by bringing treatment out into the community. Older Adult FSP's provide services in a linguistically and culturally competent manner to the diverse underserved cultural populations in Orange County.

The target populations for the Older Adult FSP programs are older adults who have a mental illness and who are unserved, and who may be homeless or at risk of homelessness; involved in the criminal justice system or frequent users of inpatient psychiatric treatment or emergency rooms; or experiencing a reduction in personal and/or community functioning.

Outcomes

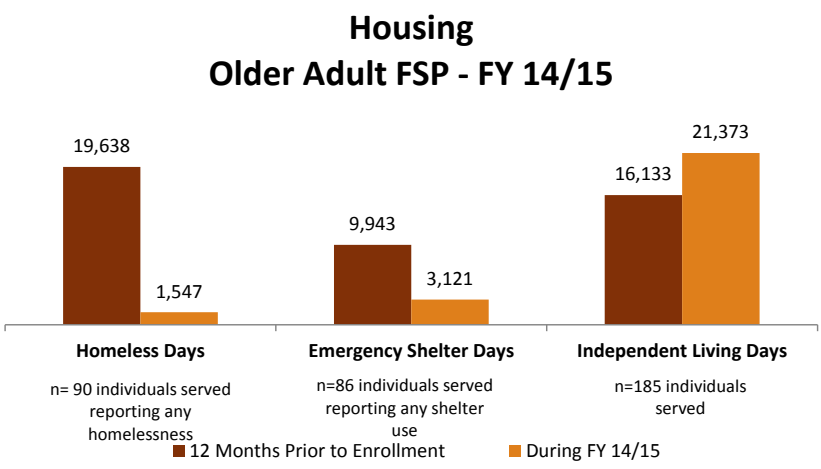
A total of 190 older adults were served during FY 14/15 in the Older Adult FSP. Outcomes were evaluated by measuring changes in mental health recovery, housing, and legal involvement.

Mental health recovery was evaluated through changes in two measures: (1) number of days psychiatrically hospitalized, and (2) the number of times an older adult served experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room visit, crisis assessment/WIC 5150 evaluation, or police response due to a mental health and/or substance use crisis). The FSP program effectively promoted recovery as evidenced by an 82% decrease in the total number of days spent psychiatrically hospitalized during FY 14/15 compared to the year prior to enrollment, as well as a substantial 94% decrease in the total number of mental health-related emergency interventions (see graph on page 89). The average decrease for both of these measures was statistically significant.[1]



[1] *Psychiatric Hospitalization Days: Prior M=42.2, SD=76.1; Since M=7.5, SD=15.6; t (47) = 3.35, p=.002, Cohen's d=.63 / Mental Health Emergency Interventions: Prior M=1.7, SD=1.6; Since M=0.1, SD=0.3; t (58) =7.48, p<.001, Cohen's d=1.43*

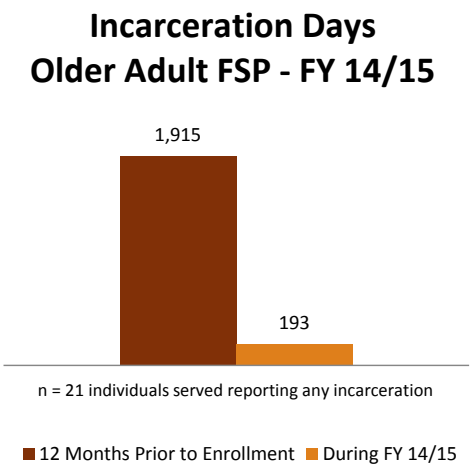
Another mission of the FSP program is to prevent and reduce homelessness and to promote independent living. Consistent with previous years, the program continued to improve the housing circumstances of the older adults served. This success was seen in the dramatic 92% reduction in total days homeless during FY 14/15 compared to the year prior to enrolling in the FSP program. Older adults served also reported a 69% decrease in the total number of days spent in an emergency shelter during FY14/15 (see graph below). The average decrease for both of these measures was statistically significant.[1] There was also a 32% increase in the total number of days spent in independent living. The average increase trended toward statistical significance.[1] Independent living was defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement (see graph below).

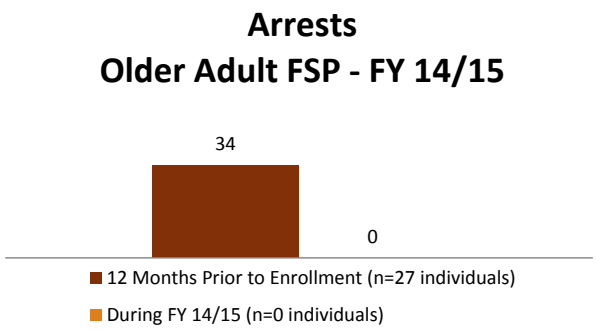


[1] *Homeless Days: Prior M=218.2, SD=135.6; Since M=17.2, SD=59.5; t (89) =11.84, p<.001, Cohen's d=1.92 / Emergency Shelter Days: Prior M=115.6, SD=136.0; Since M=36.3, SD=91.8; t (85) =4.12, p<.001, Cohen's d=.68 / Independent Living Days: Prior M=87.2, SD=138.9; Since M=115.5, SD=158.3; t (184) = -1.88, p=.06, Cohen's d=.19*

Community Services and Supports (CSS)

Outcomes related to decreasing involvement with the legal system were tracked using two measures: days incarcerated and number of arrests. The FSP program continued to make substantial improvements in this area as evidenced by the 90% reduction in total incarceration days during FY 14/15 compared to the year prior to FSP enrollment (see left graph below). Moreover, older adults involved with an FSP program reported zero arrests during FY 14/15 (see right graph below). The average decrease in incarceration days was statistically significant.[1]





[1] *Incarceration Days: Prior M=91.2 SD=104.9; Since M=9.2, SD=16.3;t (20) = 3.42, p=.003, Cohen's d=1.09 / Arrest data not available for statistical testing*

Community Impact

This FSP program provides groups and activities on site and in the community to support older adults served reintegrate into the community. These groups and activities include the Ambassador group, going to food banks, going to the wellness center, pampering day, mindfulness group, Seeking Safety group, independent living skills groups, grief and loss group, holiday activities, and many other groups and activities/outings to promote recovery.

Changes/Challenges/Barriers

Some of the challenges have been engaging our older adults to consistently participate in groups. There has been an increased effort in recruiting potential group participants, by engaging them in conversation about groups and benefits of group attendance, by placing reminder calls, by increasing socialization in the groups, assisting with and linking to transportation needs to attend groups. Feedback from older adults served is often elicited so that improvements can be made.

O3. Older Adult Program for Assertive Community Treatment (PACT)	
Estimated number to be served FY 16/17	74
Annual Budgeted funds for FY 16/17	$521,632
Estimated Annual Cost Per Person Served	$7,049

Program Description

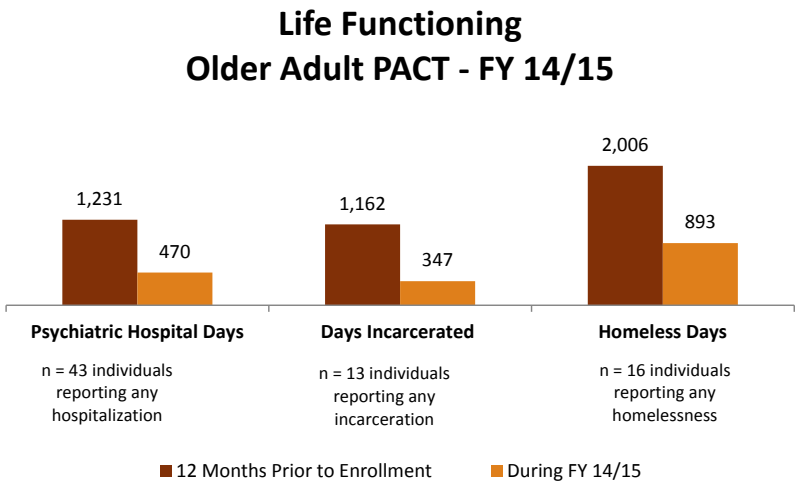
The Older Adult Program for Assertive Community Treatment (PACT) provides intensive community based services. It is an individualized treatment approach that offers intensive case management, counseling and therapy, peer support, benefit acquisition, supportive educational and vocational services, linkage to community resources, and crisis intervention. PACT programs utilize multidisciplinary teams which include mental health specialists, clinical social workers, marriage family therapists, life coaches, and psychiatrists. The team provides many services in the field, seeing the individuals at home, in hospitals, or in jail in order to reduce barriers to access treatment. The programs overarching goals include engaging individuals into voluntary treatment, and assisting them in re-integrating into the community through stable housing, education, employment, and linking to community based support.

The target population includes older adults who are 60 years old and older, who have been psychiatrically hospitalized and/or incarcerated due to their symptoms of mental illness within the past year. In addition, those who have repeated emergency room visits or excessive 911 calls due to behavioral health issues are also appropriate for PACT.

Outcomes

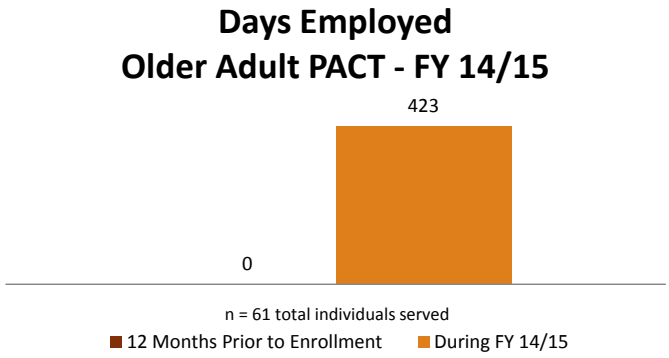
A total of 75 older adults were served in the Older Adult PACT program during FY14/15. Similar to the other PACT programs, Older Adult PACT evaluates its performance through several recovery-based outcome measures related to life functioning (i.e., psychiatric hospitalizations, homelessness, incarcerations) and independence/re-integration (i.e., employment).

Older Adult PACT continued to demonstrate success in improving the life functioning of older adults served, particularly with regard to hospitalizations. More specifically, there was a 62% decrease in the total number of days older adults served were psychiatrically hospitalized during FY 14/15 compared to the year prior to enrolling in PACT (see graph on page 92). The average decrease in hospitalization days was statistically significant.[1] There was also a 70% decrease in the total number of days they had been incarcerated and a 55% decrease in total days spent homeless (see graph on page 92). Although the average reductions for these two measures were not statistically significant, additional effect size analyses reflected that the overall magnitudes of change were substantive and statistical significance was likely obscured by small sample sizes.[1]



[1] *Psychiatric Hospitalization Days: Prior M=28.6 SD=41.7; Since M=10.9, SD=30.0; t(42) = 2.16, p=.04, Cohen's d=.49 / Incarceration Days: Prior M=89.4 SD=108.1; Since M=26.7, SD=39.0; t(12) =2.06, p=.06, Cohen's d=.77 / Homeless Days: Prior M=125.4 SD=152.8; Since M=55.8, SD=91.7; t(15) =1.37, p=.19, Cohen's d=.55*

Older Adult PACT saw minimal change in employment outcomes. Only 2 of 61 older adults served had obtained employment during FY 14/15 for a total of 423 days (see graph below). The average increase in days employed was not statistically significant.[1]



[1] *Employment Days: Prior M=0.0,SD=0.0; Since M=6.9, SD=41.4; t(60) = -1.31, p=.20, Cohen's d=.24*

Community Impact

In 2015, Older Adult PACT Program accepted 49 new admissions of older adults referred. PACT uses a "whatever it takes" approach in assisting older adults with SPMI to maintain independence in the community and improve quality of life.

Changes/Challenges/Barriers

A challenge has been to accommodate the requests for this level of service. In order to address this challenge, a full-time clinical position has been added to the Older Adult Services PACT program to provide services to an additional 15-20 older adults in Orange County.

Workforce Education and Training (WET)

Workforce Education and Training (WET)

A. Component Information

The MHSA Workforce Education and Training (WET) component addresses occupational community-based shortages in the public mental health system through training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings that promote wellness, recovery, and resilience to County staff and contracting community partners. The WET coordinator serves as a liaison to the Southern California Region of WET Administrators, and participates in regional planning activities to increase workforce diversity and opportunities in the public mental health system.

B. Program Information

WET supports a wide range of programs and services to a diverse constituency of County staff, contractor staff, consumers, family members, and other community members through six separate programs: (1) Workforce Staffing Support, (2) Training and Technical Assistance, (3) Mental Health Career Pathways Programs, (4) Residencies and Internships, (5) Financial Incentives Programs, and the (6) Loan Repayment Program. Each program will be discussed in greater detail below.

The WET FY 16/17 budget for the six programs is shown below in Table 1. The original WET allocation, a one-time funding source that accompanied the passage of Prop 63, was exhausted in June 2012. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET programs.

Table 1: FY 16/17 WET Budget

WET Programs	FY16/17 Budgeted Funds
1. Workforce Staffing Support	$375,324
2. Training and Technical Assistance	$1,049,657
3. Mental Health Career Pathways Programs	$917,000
4. Residencies and Internships	$199,876
5. Financial Incentives Programs	$174,789
6. Loan Repayment Program	$1,500,000
Total	**$4,216,646**

Workforce Education and Training (WET)

Table 2: WET Program Categories

	Active WET Programs	Number of Trainings/ Conferences FY14/15	Number of Attendees FY14/15
Workforce Staffing Support	Workforce Education &Training Coordination	66	2,268
	Consumer Employment Specialist Trainings	54	453
	Consumer Employment Specialist One-on-One Consultations	--	110
	Liaison to Regional Workforce Education & Training Partnership	--	2 (WET Coordinator and Assistant Coordinator)
Training and Technical Assistance	Training on Evidence-Based Practices	71	1,952
	Training led by Consumers or Family Members for Staff, Consumers/Family Members, and the Community	17	346
	Cultural Competence Training for Staff & the Community	22	770
	Training for Foster Parents & Others Working w/Foster Children & Youth	2	60
	Crisis Intervention Training for Law Enforcement	13	256
Mental Health Career Pathways	Recovery Education Institute	186	262 new enrollees
	Trainings led by Consumers or Family Members	37	--
Residency and Internship Programs	California Psychology Internship Council (CAPIC) Neurobehavioral Testing Unit Interns	--	4 Interns (volunteered 8,000 hours and administered 50 full psychological assessment batteries)
	Psychiatry Residents and Fellows	--	7 residents/ 3 fellows (provided 4,160 clinical hours)
Financial Incentive Programs	Financial Incentives: AA and BA stipends	--	8
	Financial Incentives: Graduate Degree Stipends	--	31
	TOTAL	**468**	**6,532**

Workforce Education and Training (WET)

1. Workforce Staffing Support

The Orange County WET plan identifies coordination with County Behavioral Health, contractors, consumers, family members, and the wider community as a key strategy to promote recovery, resiliency, and culturally competent services. Multidisciplinary staff members with language proficiency and culturally-responsive skills provide trainings and research, and also design and monitor WET programs. As the home of the Multicultural Development Program, staff also provide interpretation services at MHSA Steering Committee meetings and translate materials into the threshold languages of Spanish, Vietnamese, Korean, and Farsi. The goal of these activities is to provide linguistically appropriate behavioral health information and resources to underserved monolingual consumers and family members. A Consumer Employment Support Specialist works with Behavioral Health, contract partners, and community partners to educate consumers on disability benefits.

In FY 14/15, 54 trainings were offered to 453 consumers and providers on Ticket-to-Work, Reporting, Overpayment, & Housing, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to 110 consumers who requested more in-depth guidance sessions.

In addition to the above trainings, there were a total of 2,252 attendees who participated in 65 different trainings that focused on subjects such as Clinical Supervision, Law and Ethics, 5150 & 5585.5 Involuntary Hospitalization, Pharmacology and Drug Interactions, HIV/AIDS Overview and Update, Housing Placement, The Impact of Evidence-Based Practice on Clinical Supervision, Meeting of the Minds Conference, Milestones of Recovery, Recent Advances in Autism Research, Treatment Court Day, Hoarding Disorders, Mental Health Patients' Rights, and Human Trafficking and Clinical Interventions.

2. Training and Technical Assistance

Activities within this category include trainings on evidence-based practices, trainings provided by consumers and family members for staff and the community, trainings to develop multicultural competency among staff and the community, training for foster parents and others working with foster children and youth, and mental health training for law enforcement.

Training on Evidence-Based Practices – Trainings on Evidence-Based Practices serve to help mental health providers stay current on the best practices of their field. In FY 14/15, 72 trainings (see Table 3 on page 97) were provided to nearly 2,000 County and contracted staff, community partners, consumers and their family members on the following evidence-based practices.

Workforce Education and Training (WET)

Table 3: Trainings on Evidence-Based Practices

Trainings	Number Attended
Trauma-Focused Cognitive Behavior Therapy (TF-CBT)	148
TF-CBT Using Directed Play Therapy	78
Motivational Interviewing and Application	186
SAMHSA model of Anger Management for Behavioral Health	148
Clinical-track Applied Suicide Intervention Skills Training (ASIST)	140
Community-track safeTALK model of Living Works	164
Mental Health First Aid	420
Non-Violent Crisis Intervention	166
Seeking Safety	138
CATES: SBIRT Regional Training	201
CRN: CISM Training	52
Evidence-Based Tx for Substance Abuse Disorders	67
Medication Tx for Substance Use Disorders	44
TOTAL	**1952**

Trainings led by Consumers or Family Members – Training sessions are offered to county and county-contracted personnel to reduce stigma among staff in the mental health system and to raise awareness of behavioral health conditions across communities. Sessions are taught by and from the lived-experience perspectives of consumers and family members by either National Alliance on Mental Illness (NAMI) presenters or Peer Mentors. Sixteen NAMI Provider Education training sessions and one Peer Mentoring training was offered in FY 14/15.

Cultural Competence Training – Culturally responsive trainings are conducted to raise awareness and acceptance of cultural diversity among behavioral health providers and community partners. Trainings are offered on topics such as working with the Deaf and Hard-of-Hearing, Client Culture, Cultural Awareness in Disaster Response, Iranian-American population and Vietnamese-American population. 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. Twenty-two cultural responsive trainings were offered in FY 14/15.

Crisis Intervention Training for Law Enforcement – These best-practice classes on Crisis Intervention Training (CIT) ensure law enforcement officers are culturally sensitive to the mental health needs of the community. Police officers serve as not only the first responders to many mental health crises, but can also help provide linkages to available mental health resources in the community. This 16-hour training was conducted by a psychologist, subject matter experts, law enforcement, and contracted providers, along with the participation of consumers and their family members. Thirteen CIT classes were taught to a total of 256 Orange County law enforcement officers in FY 14/15.

A CIT II class is ready for implementation in summer 2016. It will cover topics including dementia, developmental disorders such as Autism Spectrum Disorder and how to work with Deaf and Hard-of-Hearing individuals. An Interactive Video Simulator with behavioral health scenarios will also be utilized to provide more hands-on training and prepare law enforcement officers and public safety personnel to identify the different needs of individuals grappling with mental health, substance use, dual diagnosis, and homelessness. In FY 16/17, CIT training will be offered in a modular format with 40 hours of training split among several training dates. This will allow law enforcement agencies more flexibility to maintain staffing levels while officers are taken out of duty to attend CIT training.

3. Mental Health Career Pathways

Mental Health Career Pathways helps individuals affected by mental health conditions prepare for the work force. Included in this category is the Recovery Education Institute (REI) Program that prepares consumers and family members who may 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 behavioral health. Most REI staff have personal lived experience and are themselves either consumers or family members of consumers. REI employs academic advisors and peer success coaches to mentor and tutor students. The outcomes for FY 14/15 are presented in Table 4.

Table 4: One-on-One Student Support Sessions

Support Session	Number of Students (duplicated)
Academic Advisement Sessions	1,714
Success Coach Contacts	1,751
TOTAL	**1952**

The program also collaborates with adult education programs and links students to local community colleges for prerequisite classes, as well as providing accredited college classes and certificate courses on site. In FY 14/15, a total of 223 workshops, pre-vocational classes, extended education classes, and college credit classes were offered (See Table 5 on page 99). Introduction to MS Excel Spreadsheets, Elementary Spanish, Introduction to Psychology, Public Speaking, Health Navigation Skill Development Training, Case Management, Vocational Skills Building, and College Survival were among the many offerings at REI. In FY14/15, 262 new students enrolled in REI.

Table 5: REI Courses Offered in FY 14/15

REI Courses	Total Number of Courses Offered	Number of Students Completing Courses (duplicated)
Workshops	127	467
Pre-Vocational Courses	66	370
Extended Education Courses	13	N/A
College Credit Courses	17	224
TOTAL	**223**	**1,061**

Additionally, REI partners with Saddleback College to offer a Mental Health Worker Certificate that prepares students to enter the public mental health labor force. Students gain knowledge and skills in the areas of cultural competency, benefits acquisition, the Recovery Model, co-occurring disorders, integrated services, early identification of mental illness, and evidence-based practices. To receive the certification, students must complete nine 3-unit courses and a 2-unit, 120-hour internship. In FY14/15, three students earned this certification. Here are some statements from students who have completed the certificate:

> "My experience at REI is great. I really like the program, the environment, and the support provided by staff and instructors. Instructors present the information very well. They engage students in class and the way they teach seems very effective. I get a lot out of these classes for my work. The staff are supportive at REI." R.F. (currently employed in the Mental Health field)

> "At REI, I can study from Beginning ESL and Basic Computers, to the higher level of classes. When I come here, I feel good and I feel safe. That's what REI helped give me." T.B. (volunteers at Vietnamese community centers)

> "With the help of the instructors and the staff here at REI, I completed my requirement for the Mental Health Worker Certificate." J.S. (obtained employment in the mental health field after graduating)

4. Residencies and Internships

Orange County BHS trains and helps support individuals who are considering working in the behavioral healthcare system. Four pre-doctorate California Psychology Internship Council (CAPIC) student interns were part of WET's Neurobehavioral Testing Unit (NBTU) and were supervised by a licensed psychologist. The NBTU interns volunteered 8,000 hours to BHS and provided 50 full psychological assessment batteries, with each battery ranging from 8 to 12 tests.

In collaboration with the Psychiatry Department at the University of California Irvine (UCI) School of Medicine, WET funded seven residencies and three fellowships in FY 14/15. The psychiatry residents and fellows provided a total of 4,160 clinical hours (see Table 6). In addition, trainings were provided to psychiatry residents and fellows to recruit talented physicians, reduce stigma, and enhance understanding from the consumer and family perspectives. The funded positions and training are one strategy used to address the shortage of child and community psychiatrists working in the public mental health system.

Table 6: Psychiatry Residents/Fellows Clinical Hours in FY 14/15

Psychiatry Supervisees	Total No.	Total Weekly Hours	Total FY 14/15 (Weekly Hours X 52)
Fellows	3	24	1,248
Residents	7	56	2,912
TOTAL	**10**	**80**	**4,160**

5. Financial Incentives Programs

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

In FY 14/15, tuition incentives were provided to 39 staff, 8 of whom were undergraduates and 31 of whom were Masters' degree candidates. A recipient shared the impact this program has had:

> "As a recipient of the MHSA WET Financial Incentive Program for the past 2 ½ years, I am sincerely grateful that I have been given the opportunity to attend graduate school and grow professionally. The support of this program has made it possible for me to attain the level of education that had previously been out of my reach and develop my career pathway in ways I had not imagined. I encourage the continued support for programs like this, especially for consumers like myself who could enhance lived experience with formal education to continue promoting the values of wellness, recovery, and resilience. I look forward to giving back through service and making this investment worthwhile."
>
> - M.S. (working as a peer support specialist and attending graduate school)

6. Loan Repayment Program

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 was 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 loan assumption. This additional OC-MHLAP program will help achieve staffing goals and enhance the quality of care to Orange County's population.

Outcomes

WET surveys all participants who participate in a WET program. The Age Range (Figure 1), Race/ Ethnicity (Figure 2 on page 102), and Primary Language Spoken at Home (Figure 3 on page 102) for WET program participants are shown below.

Figure 1. Age Range

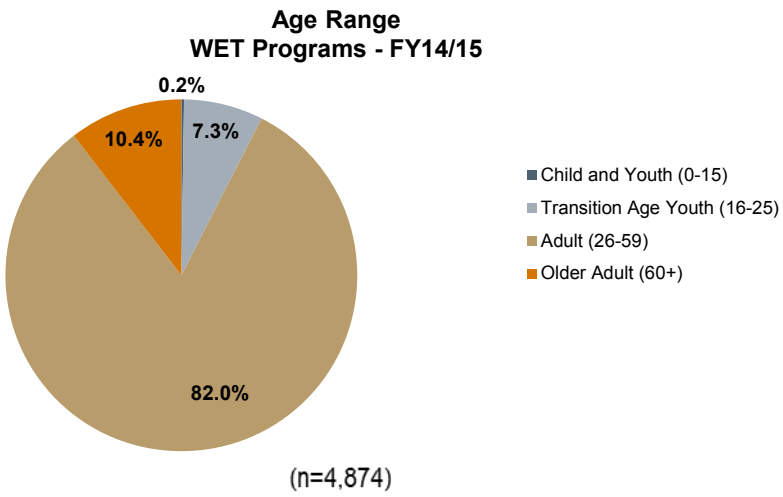


Figure 2. Race/Ethnicity

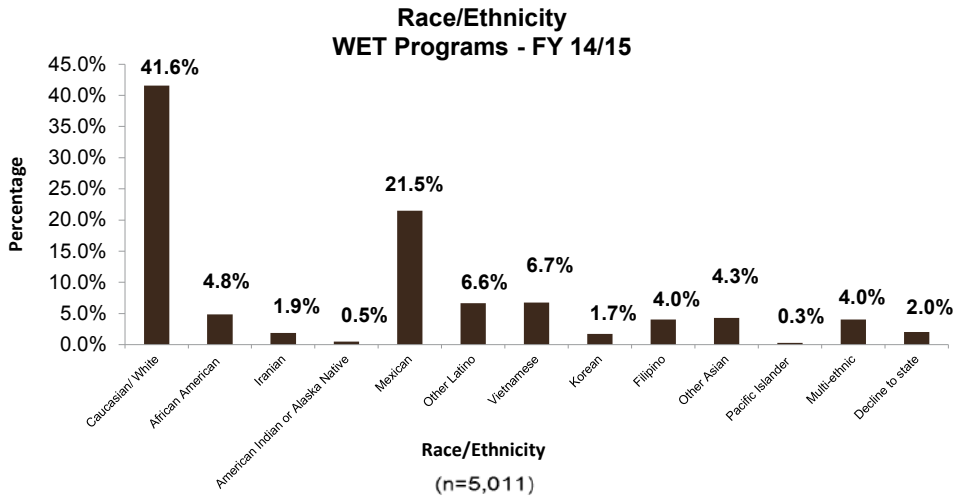
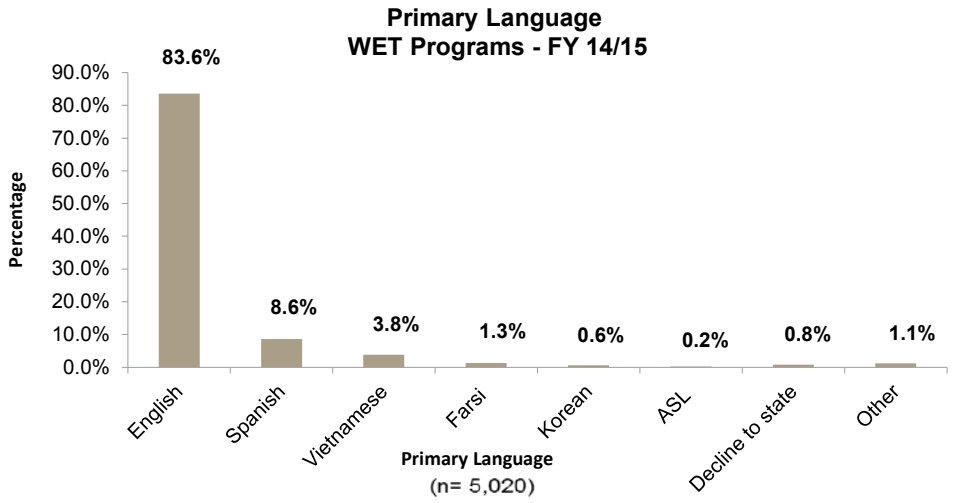


Figure 3. Primary Language



The survey also asked participants to indicate which underserved group, if any, they identify with. Responses were received from 1,454 attendees (22.2% of total attendees): 12.3% identified as lesbian, gay, bisexual, transgender, intersex or questioning (LGBTQ); 15.9% identified as veterans; 4% identified as Deaf and Hard of Hearing; and 85.9% identified with some other underserved population or declined to state any identification with an underserved group.

Workforce Education and Training (WET)

Overall Training Program Quality Ratings

Table 7 below shows the percentage of respondents who rated the program "above average" or "excellent" and the overall satisfaction for the different WET programs.

Table 7: Overall Training Program Quality Rating

Program	Number of Respondents	Percentage who rated the Program "Above Average" or "Excellent"	Overall Satisfaction Rating (out of 10)
WET Coordination Trainings	1,461	92.2%	8.9
Consumer Employment Support	419	88.8%	8.6
Trainings on Evidence-Based Practices	1,823	90.7%	8.9
Trainings Provided by Consumers and Family Members	281	92.5%	9.1
Cultural Competency Trainings	542	92.0%	8.8
Trainings for Foster Parents & Others Working with Foster Children & Youth	47	95.7%	9.0
Crisis Intervention Training for Law Enforcement	218	86.3%	8.4
REI Program	359	94%	9.1
Residency/Fellowship Training Program	7	85.7%	7.2

Prevention and Early Intervention (PEI)

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 to 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 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 County of Orange 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.

Prevention and Early Intervention (PEI)

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 16/17 Changes to the Plan

There were no major changes to PEI programs for the FY 16/17 Update and the recommendation for level funding for PEI programs was approved by the MHSA Steering Committee. The two Innovation projects (OC ACCEPT and OC4Vets) that were approved for continued funding were added to PEI in FY 15/16. The funding for these programs was shifted to PEI to allow for the continuation of these projects.

In order to gain administrative efficiencies, all Outreach and Engagement services (both PEI and CSS) are managed in the Prevention and Intervention division. CSS Outreach and Engagement Services (OES) continue to be funded by CSS, and the target population is those individuals with severe and persistent mental illness. All OES program outcomes are included in the PEI section of this Annual Plan Update.

The Mental Health Services Oversight and Accountability Commission (MHSOAC) released new regulations concerning the presentation and reporting of program information for the FY 16/17 update. The FY 16/17 update has a new format to address the new regulations, and includes the following new sections:

- Strategies to Improve Access
- Strategies for Non-Stigmatization and Non-Discrimination
- Community Impact
- Changes/Challenges/Barriers

Prevention and Early Intervention (PEI)

These changes reflect MHSA's focus on outreach and engagement to the underserved and underrepresented populations in the county, and also to address the specific needs of the community.

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

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

The revised PEI plan also continues to target the same priority populations:

- Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Children and Youth in Stressed Families
- Children and Youth at Risk for School Failure
- Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
- Underserved Cultural Populations

Early Intervention Program CF1. Stress-Free Families	
Estimated annual number to be served in FY 16/17	160
Annual Budgeted funds for FY 16/17	$534,693
Estimated Annual Cost Per Person (for direct service programs only)	$3,342

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 with stressors that make family members more vulnerable to behavioral health conditions. The program expects to serve approximately 160 families in FY 16/17. The majority of participants will be adult parents. The program provides a range of services intended to reduce risk for behavioral health problems. Services include 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.

The program intends to reduce prolonged suffering from behavioral health problems. To assess reduction in negative outcomes, the program measures improvements in parenting self-efficacy, social occupational functioning, and well-being. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages.

Strategies to Improve Access

By providing assessments and services in the home setting, program staff are able to observe and ascertain the needs of families in the environment in which they are occurring so that they are better able to tailor their interventions. The clinicians provide parenting education training on-site with families directly in their homes increasing the likelihood that techniques learned will be used by the parents going forward. Additionally, many participant families have limited resources, such as limited or no transportation and a lack of child care, so having a home- and field-based program eliminates these barriers, thereby improving access to the services. In FY 14/15, the program also provided 601 referrals and 109 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

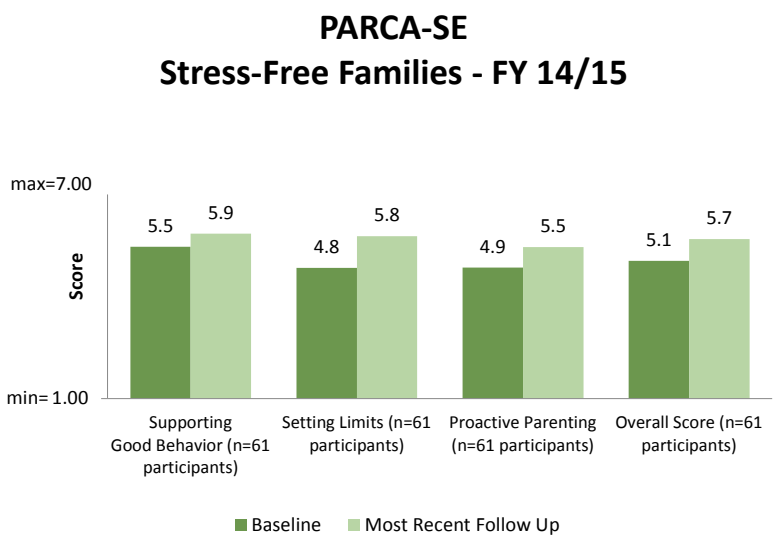
The program strives to make the services available to all Orange County residents, regardless of their background. The program provides services in English, Spanish and Vietnamese through staff who are bicultural/bilingual in Spanish and/or Vietnamese.

Outcomes

During FY 14/15, 135 families and 300 children were served by the program. The program uses principles of Triple P Positive Parenting Program and tip sheets to guide program services. As a demonstration of the program's effectiveness, the results for improvement in parenting self-efficacy and well-being are presented below.

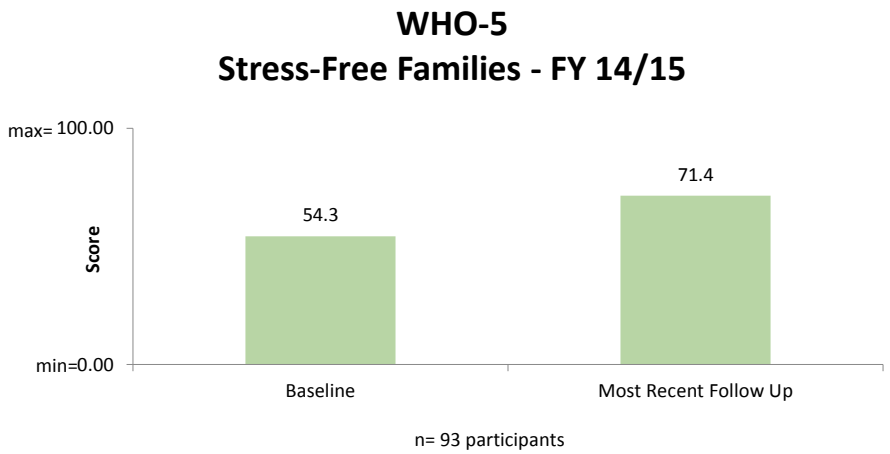
Parent participants completed the PARCA-SE (pre/post), which is a measure of confidence in parenting. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that parent participants' improvements were statistically significant[1] in all three subscales as well as the overall parenting self-efficacy score. These results indicate that overall confidence in parenting increased for participants enrolled in the program (see graph below).

[1]Supporting Good Behavior: t(60) =-3.08, p<.01, Cohen's d=.39 / Setting Limits: t(60) = -3.31, p<.01, Cohen's d=.45 / Proactive Parenting: t(60) = -3.42, p<.01, Cohen's d=.44 / Overall Score: t(60) = -3.80, p<.001, Cohen's d=.49



Participants also completed the WHO-5 Well-Being Index, which is a 5-item scale that assesses overall well-being. The developers of the scale indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 32%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2], indicating that participants' overall well-being improved (see graph below).

[2]*WHO-5: t(92) = -6.29, p<.001, Cohen's d=.66*



Community Impact

The program has provided services to more than 300 families since its inception and has improved personal functioning of the enrolled participants, as well as overall family functioning. The program also provides frequent consultation to Social Services Agency (SSA) which has improved SSA's ability to recognize mental health needs in those for whom an allegation of child abuse has been made. This recognition improves SSA's ability to provide families with timely and appropriate resources to further prevent child abuse/neglect.

Participants have also expressed that the program has had a positive impact on their lives. Below is an excerpt of a direct quote form a participant:

> "I highly recommend this program and all the workers in it! They helped me gain the confidence to gain control of my life and of my family again, especially with my children."

Changes/Challenges/Barriers

Program participants need extensive support and assistance to link with resources that are fundamental to life such as food and clothing. Without these necessities, participants' ability to participate meaningfully in the program is compromised. To mitigate this challenge, program clinicians are active case managers, providing referrals to families and diligently following through to ensure linkages to these necessary services.

The program is also dependent upon referrals from SSA and makes every effort to provide presentations to SSA staff and consult with them frequently in order to maintain a steady stream of referrals.

Early Intervention Program CF2. Orange County Center for Resiliency, Education and Wellness (OC CREW)	
Estimated annual number to be served in FY 16/17	80
Annual Budgeted funds for FY 16/17	$1,500,000
Estimated Annual Cost Per Person (for direct service programs only)	$18,750

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. Psychiatrists rate participants on psychosis symptom severity to determine severity of mental illness. The program expects to serve approximately 80 transitional age youth in FY 16/17.

Services include: psychiatric care; psychoeducation, cognitive-behavioral intervention, multi-family groups, development of long-term economic and social support, opportunities for physical fitness activity, vocational and educational support, social wellness activities, referral and linkage to community resources, services to address substance misuse, and Wellness Recovery Action Plans. The 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.

The program's purpose is to reduce prolonged suffering from untreated mental illness. To assess reduction in prolonged suffering, schizophrenia symptom severity is measured including positive symptoms (e.g., hallucination), negative symptoms (e.g., blunted affect), and general psychopathology symptoms. Additionally, the program measures reduction in negative outcomes by assessing underlying dimensions of recovery (i.e., level of risk, level of engagement, and level of skills and support), as well as global well-being. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in all threshold languages.

Strategies to Improve Access

The program implements various strategies to improve access to services for underserved populations. Outreach and engagement and community presentations and trainings to behavioral health providers, schools, hospitals, probation departments, and community resource fairs are used to improve awareness and access to program services. Field based assessments and community based services are used to increase access to services for underserved populations and people with housing or transportation barriers. Transportation assistance is provided to reduce transportation barriers and improve successful linkages and treatment adherence. Quarterly family workshops are offered on Saturdays and multi-family groups are offered in the evenings to increase access to services for family members who are working. Medication services are covered by the County's MedImpact program which allows for individuals without insurance to receive needed psychotropic medication. Services are offered to individuals regardless of citizenship or insurance status increasing the number of traditionally unserved populations that now can receive services. The clinic setting is centrally located in Orange County, near major freeways and streets with access to public transportation, to allow for participants to access services. Services are field based and cover the entire county to be available for all eligible Orange County residents with the first episode of psychosis. In FY 14/15, the program also provided 77 referrals and 34 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make the services available to all Orange County residents, regardless of their background by employing bilingual staff to meet the program's needs.

Program staff have clinical experience and/or background in working with ethnically diverse and underserved populations. Participants and families are matched with clinical staff that are bilingual and bicultural to improve communication and cultural sensitivity. Services are offered in English, Spanish, and Vietnamese. The program provides a welcoming environment and offer services to all Orange County residents regardless of socio-economic status, citizenship status, or ethnic/cultural background. Staff strive to make participants feel welcome and have a "meet all clients where they are at" approach to promote individualized services that focus on recovery, resiliency, education, and wellness from a first episode of psychosis.

Prevention and Early Intervention (PEI)

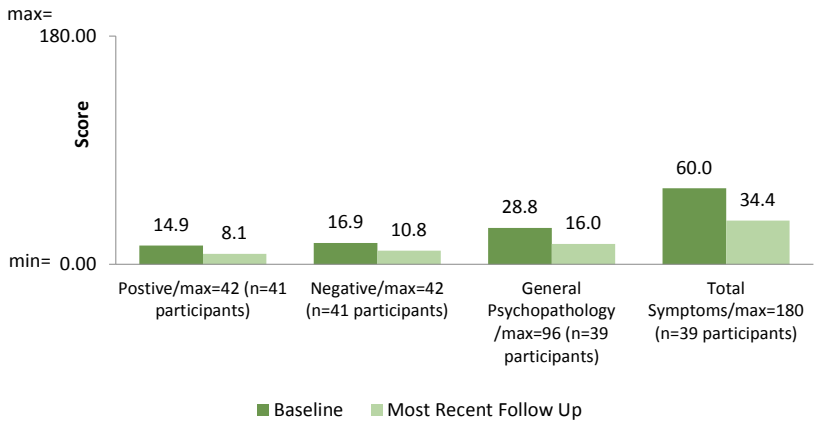
Outcomes

During FY 14/15, 79 target participants and 47 family members were served by the program. The program uses Early Detection and Intervention for the Prevention of Psychosis (EDIPP) and a Wellness Recovery Action Plan (WRAP) to guide program services. As a demonstration of the program's effectiveness, the results for reduction in schizophrenia symptom severity, dimensions of recovery, and well-being are presented below.

Psychiatrists rated participants using the Positive and Negative Syndrome Scale (PANSS), which is a 30-item measure of schizophrenia symptom severity. In addition to a Total Symptom score, the PANSS has three subscales: (1) Positive Symptoms (excess or distortion of normal functions, such as hallucinations or delusions), (2) Negative Symptoms (diminution or loss of normal functions, such as emotional withdrawal, blunted affect, or poor rapport), and (3) General Psychopathology Symptoms. Upon enrollment, participants' average scores were above clinical cut-points for positive, negative, and general psychopathology symptoms and at or below cut-points at post-tests. The results showed that participants' improvement in all three subscales as well as the total symptom score was statistically significant[1]. These results indicate that overall psychotic symptoms were reduced for participants enrolled in the program (see graph below).

[1]Positive Symptoms: t(40) = 6.06, p<.001, Cohen's d = .95 / Negative Symptoms: t(40) = 4.46, p<.001, Cohen's d=.70 / General Psychopathology: t(38) = 5.60, p<.001, Cohen's d = .90 / Total Symptom Score: t(38) = 5.75, p<.001, Cohen's d=.92

PANSS - Average Ratio Scores
OC CREW- FY 14/15



Clinicians also rated participants using the single-item Milestones of Recovery Scale (MORS) to assess underlying dimensions of recovery: (1) level of risk, (2) level of engagement, and (3) level of skills and support. Aggregate MORS data (n=57) showed that 83% of participants were rated 2 through 5 (high risk or poorly coping) at enrollment. Notably, at post-test, 48% were rated 6 through 8 (coping/rehabilitating or in early/advanced recovery) compared to only 17% at enrollment. Overall, 49% were rated higher on the MORS after participating in OC CREW.

Community Impact

The program saw an increase in referrals received by 43% compared to the previous fiscal year. During FY 14/15, staff provided 11 outreach activities to 135 individuals and facilitated 18 Continuing Education Trainings (CETs) to 397 individuals in order to increase awareness in the community regarding first episode psychosis. Participants have also described the impact that the program has had on their lives. Below is an excerpt of a direct quote from a participant:

> "My therapist has been an essential part of my recovery. More specifically she has helped me truly get to know myself better, learn to cope with difficult daily life situations and most of all bringing positivity and incredibly valuable advice."

Changes/Challenges/Barriers

In FY 14/15, the program was not fully staffed throughout the year. At times, this resulted in increased wait times for assessment appointments and assignment of cases to clinicians. Job recruitments were made to hire qualified clinicians for the program. Also, cross-training opportunities were available to clinicians within the division to help cover caseloads and reduce wait times.

Even with full staffing, the number of referrals to the program has been fewer than expected. The program is evaluating the need to expand eligibility criteria to serve a broader range of individuals who are experiencing their first episode of psychosis.

Early Intervention Program CF3. Orange County Postpartum Wellness (OCPPW)	
Estimated annual number to be served in FY 16/17	600
Annual Budgeted funds for FY 16/17	$1,913,072
Estimated Annual Cost Per Person (for direct service programs only)	$3,188

Program Description

The Orange County Postpartum Wellness program provides early intervention services to women who are pregnant and new mothers, up to one year postnatal, experiencing mild to moderate symptoms of depression and/or anxiety attributable to the pregnancy or recent birth of their child. Referrals to the program come from a variety of sources, from self-referral to hospitals or behavioral health outpatient facilities. Once a referral is screened and determined appropriate for services, a clinician is assigned to enroll the participant for services and conduct a clinical assessment. During the clinical assessment, a diagnosis is determined and a treatment plan is developed. The program expects to serve approximately 200 women between 16-25 years of age and 400 women between the ages of 26-59 years of age in FY 16/17.

The program focuses on addressing the needs of pregnant and postpartum women who may be living with perinatal or postpartum depression and/or anxiety. Services include assessment, case management, individual, family and group counseling, educational groups, wellness activities and coordination and linkage to community resources and community education.

The program intends to reduce prolonged suffering from perinatal or postpartum depression and/or anxiety. To assess reduction in prolonged suffering, decreases in depression symptom severity are measured. Additionally, anxiety and well-being are also assessed. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in all threshold languages.

Strategies to Improve Access

The program provides services in the field, primarily at the homes of participants or at an agreed upon community location. Additionally, the program provides transportation assistance when needed to assist participants in attending groups and wellness activities that are facilitated at the clinic. Program clinicians conduct outreach in order to raise awareness about services, increase access to services, and to offer psychoeducational presentations to other community providers. Having one Vietnamese-speaking clinician and one Farsi-speaking clinician also allows the program to outreach these underserved populations. Lastly, the program hopes to expand in the current and upcoming fiscal years to be able to provide off-site groups at various community locations throughout Orange County in order to increase participants' ability to attend groups.

Prevention and Early Intervention (PEI)

Being a field-based behavioral health program significantly increases access to services for underserved populations. A majority of participants have a number of psychosocial stressors that pose barriers to accessing treatment, such as lack of transportation, no access to child care, low household income, and lack of U.S citizenship. In addition to these psychosocial barriers, participants are frequently isolated and struggle to keep appointments or complete tasks due to their symptoms of depression and/or anxiety. Providing behavioral health services in the field addresses the aforementioned barriers to accessing services and allows the program to reach a much larger population. Additionally, in FY14/15, the program made 374 referrals and 140 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

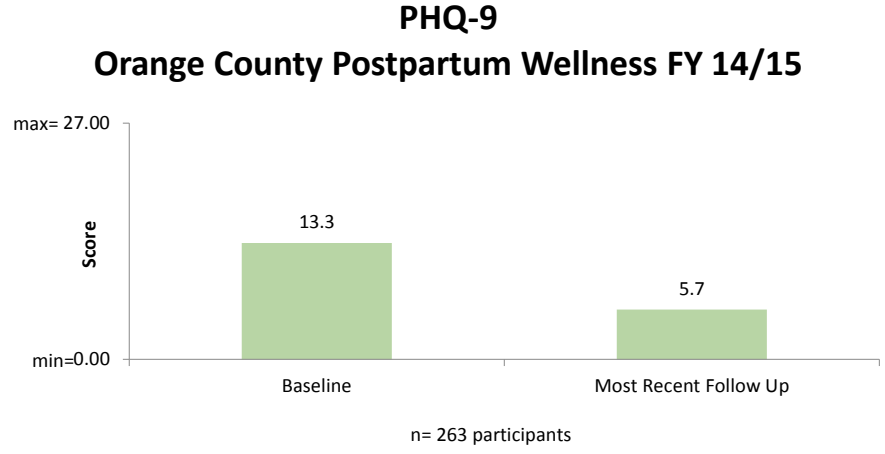
The County strives to make the services available to all Orange County residents, regardless of their background and provide services that are sensitive and responsive to participants' background. Additionally, the services are available in English, Spanish, Vietnamese and Farsi, which allows the program to provide services to people from diverse backgrounds.

Outcomes

During FY 14/15, 475 participants were served by the program. The program uses the Mothers and Babies Program and Cognitive Behavioral Therapy to guide program services. All clinicians and mental health specialists are required to learn the Mothers and Babies curriculum, which includes an instructor's manual and weekly handouts for participants, in order to effectively facilitate groups. Group facilitators use the instructor's manual to facilitate each group and maintain accurate documentation to track the content of each session. Once the group has completed the 12-week curriculum, the weeks reset at week one. As a demonstration of the program's effectiveness, the results for reduction in depressive symptomatology are presented below.

The PHQ-9, a 9-item measure that assesses symptom count and severity for depression (on a scale from 0 to 27), was administered to the program participants to measure and monitor depressive symptoms related to perinatal mood disorder. Upon enrollment, participants' average scores (13.29) were above the cut-point for *moderate* depressive symptom severity and at the lower end of *mild* severity at post-test (average post-test score = 5.69). The results showed that, overall, participants' decrease in depressive symptoms was statistically significant[1] when enrolled in early intervention services with the program (see graph below).

[1] *PHQ-9: t(262) = 18.22, p<.001, Cohen's d=1.13*



Community Impact

The program has served more than 1,000 pregnant and postpartum women since its inception, consistently demonstrating decreases in depression and anxiety symptom severity. The program works closely with the Social Services Agency in instances where mothers have expressed thoughts of harming themselves or their infants which has resulted in early intervention for these at-risk infants and other children in the home. Participants have also indicated that the program has had a positive impact on their lives. Below is an excerpt of a direct quote from a participant:

> "Estube contenta con el programa. Este programa me ayudo a que fuero otra vez la personal que yo antes era. Una mama feliz." [I was very happy with this program. This program has helped me become the person I was before. A happy mom.]

Changes/Challenges/Barriers

The program faced challenges related to position vacancies and leaves of absences. Being short-staffed at times resulted in increased wait times for participants accessing services. In order to mitigate this, participants who were able to come to the clinic for weekly groups were enrolled in services and attended groups until they were able to be assigned a clinician. Additionally, ongoing coverage has been needed for child care, phone screenings, and group facilitation. In order to mitigate this, program clinicians, as well as staff from other P&I programs still under development have assisted with coverage when needed.

Early Intervention Program CF4. Early Intervention Services for Older Adults	
Estimated annual number to be served in FY 16/17	600
Annual Budgeted funds for FY 16/17	$1,419,500
Estimated Annual Cost Per Person (for direct service programs only)	$2,366

Program Description

The Early Intervention Services for Older Adults provides behavioral health early intervention services to older adults 60 years of age and older who are experiencing the early onset of mental illness and/or those who are at greatest risk of developing behavioral health conditions due to isolation. The program is designed to reduce risk factors linked to older adults who are experiencing mental health illness later in life. These risk factors include: development or exacerbation of mental health disorders, substance use disorders, physical health decline, cognitive decline, elder abuse or neglect, loss of independence, premature institutionalization, suicide and premature death.

To determine the risk of early onset of mental illness, the program conducts an intake to assess risk factors and eligibility of potential participants. Once eligibility is established, the program conducts a comprehensive in-home assessment and screening which includes psychosocial assessment, screening for depression, and measures levels of social functioning, well-being and cognitive impairment. A geropsychiatrist is available to provide a psychiatric assessment to participants that have undiagnosed mental health conditions. It is estimated that the program will serve 600 older adults.

After a comprehensive screening and assessment is conducted, the program connects participants to trained life coaches and volunteers to develop individualized care 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. Geropsychiatric services are also available to consult with primary care physicians, participants and families.

The program's purpose is to reduce prolonged suffering from untreated mental illness. To assess reduction in prolonged suffering, decreases in depression symptom severity are measured. Additionally, social functioning and well-being are assessed. Participants are administered the first wave of assessments at intake, every six months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation reflects cultural competence as the majority of assessment tools taken by the participants are available in all threshold languages.

Strategies to Improve Access

The program builds relationships with community agencies and other individuals that may come into contact with the target group. By doing so, the program is able to identify unmet needs and barriers specific to the underserved communities and provide solutions to overcome those barriers. To increase access to services, the program provides services at locations most convenient for participants. Offering in-home services is the most effective way to access isolated older adults populations who are home bound or may no longer drive. Furthermore, providing participants with transportation solutions is proven to be an effective strategy to transition them to attend healthcare and community services. To increase access to services of monolingual, non-English speaking participants, the program provides services in Spanish, Korean, Vietnamese, Mandarin, Arabic and Farsi. In FY 14/15, the program also provided 4,823 referrals and 3,112 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

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

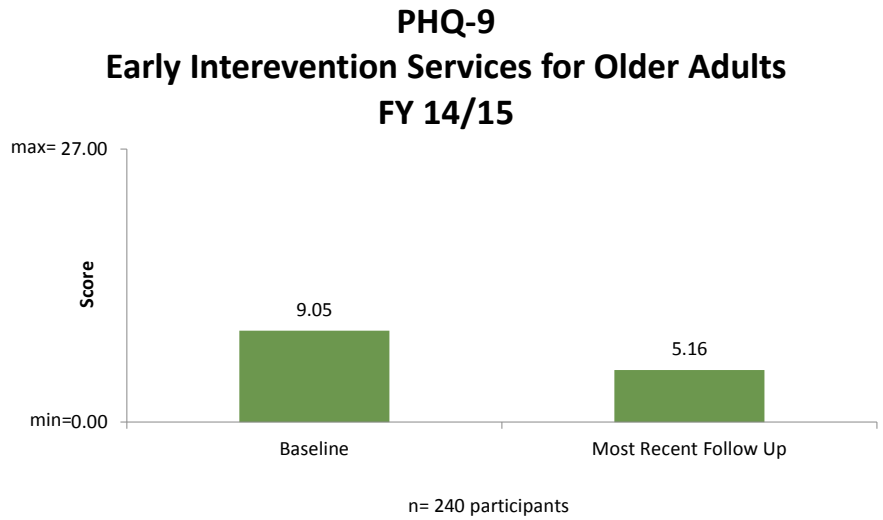
Outcomes

During FY 14/15, 510 participants were served by the program. The program implements a model based on the Evidence Based Program *Healthy IDEAS* (Identifying Depression, Empowering Activities for Seniors).[1] Healthy IDEAS integrates a systematic, team-based approach to identify and reduce the severity of depressive symptoms in older adults utilizing case management, community linkages, and behavioral activation services. To ensure fidelity, the program provides staff with a comprehensive training. The training addresses topics such as the overall program model, goals and deliverables of the program, evidence based interventions, education on mental health in older adults and theories of aging, behavioral activation techniques, ethical and legal considerations, cultural competence and humility, field safety, assessment tools and outcome measures, care planning, and effective communication strategies when working with older adults. In addition, the program conducts staff development workshops and in-services. Program staff are also supervised and evaluated on an on-going basis. As a demonstration of the program's effectiveness, the results for reduction in depressive symptoms and well-being are presented below.

[1]Evidence-Based Health Model endorsed by the National Council on Aging (NCOA), the Centers for Disease Control and Prevention (CDC), and the National Association of Chronic Disease Directors (NACDD).

Participants completed the Patient Health Questionnaire (pre/post), which is a 9-item scale that measures severity of depression symptoms. Scores on the scale range from 0 to 27, with higher scores indicating greater severity of depression symptoms. Additionally, the developers of the scale outlined cut points for none/minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27) depression severity. The results showed a statistically significant decrease in depressive symptomatology[1] (see graph below): participants, on average, reported on the high-end of mild depression symptoms at pre-test, but only reported on the low end of mild depression symptoms at post-test. Furthermore, fewer participants were in the higher depression severity categories at post-test as compared to pre-test.

[1]PHQ-9: t(240) = 10.92, p<.001, Cohen's d=.72



Community Impact

The program has experienced positive participant outcomes and includes improved mental health status, enhanced quality of life, increased social functioning, more effective management of behavioral health and chronic conditions, enhanced ability to live independently, increased community involvement and development of a supportive network. By providing services in Spanish, Vietnamese, Korean and Farsi, the program is able to reach, serve and impact non-English speaking participants. The program provides behavioral health self-stigma reduction, and effective outreach and early intervention services to minority populations in a culturally competent manner. Participants have also declared that the program has had a positive influence on their lives. Below is an excerpt of a direct quote from a participant:

> "I've been lonely most of my life and this program has helped me not only find a sense of joy and warmth, but given me a sense of relief. The best comparison I can give is a frog that was stuck and is now able to leap from one lily pad to another."

Prevention and Early Intervention (PEI)

Changes/Challenges/Barriers

Program implemented an expansion of psychiatrist functions. The functions were enhanced from offering one-time psychiatric screenings and diagnosis to participants, to offering follow-up visits and starting treatment/prescribing medication when needed. The change was adopted to fill a gap experienced by some participants who were uninsured or did not have a psychiatrist at the time of screening. The goal was to offer treatment options and start the path to recovery while they were connected with a medical home.

Transportation remains a barrier to traditional services. To overcome this barrier most services in this program are provided in the community. Program staff and volunteers travel to participants' homes, apartment complexes, senior centers and other locations. To encourage self-reliance, programs provide bus vouchers and teach participants to utilize the bus system. For participants that are hesitant to take the bus, staff travel with participants to teach them how to ride a bus, or seasoned bus riders are paired with new bus riders. Program staff also facilitate carpools between participants.

Another challenge is finding counseling services and other resources in the participants' preferred language. To overcome this challenge, the program hires staff and volunteers who speak the same language as the participants to address these needs by serving as interpreters/translators in circumstances where there are no available resources in the participants' preferred language.

Early Intervention Program CF5. Youth as Parents	
Estimated annual number to be served in FY 16/17	100
Annual Budgeted funds for FY 16/17	$500,000
Estimated Annual Cost Per Person (for direct service programs only)	$5,000

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. Participants in the program are given a comprehensive assessment to determine any early onset of a potentially serious mental illness. The program expects to serve approximately 100 participants in FY 16/17.

The program provides a range of services intended to reduce negative behavioral outcomes which include: case management, brief counseling, parenting training and education groups, and referral and linkage to community resources.

The program's purpose is to prevent prolonged suffering in youth parents and their children. To assess reduction in prolonged suffering and negative mental health outcomes, parenting self-efficacy, social occupational functioning, and global health are measured. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired baseline and most recent follow-up scores are used to analyze whether there was a significant improvement in these strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages.

Strategies to Improve Access

The program provides field-based services, eliminating barriers such as lack of transportation services for appointments or the need to arrange for childcare. In FY14/15, the program provided 50 referrals and 42 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

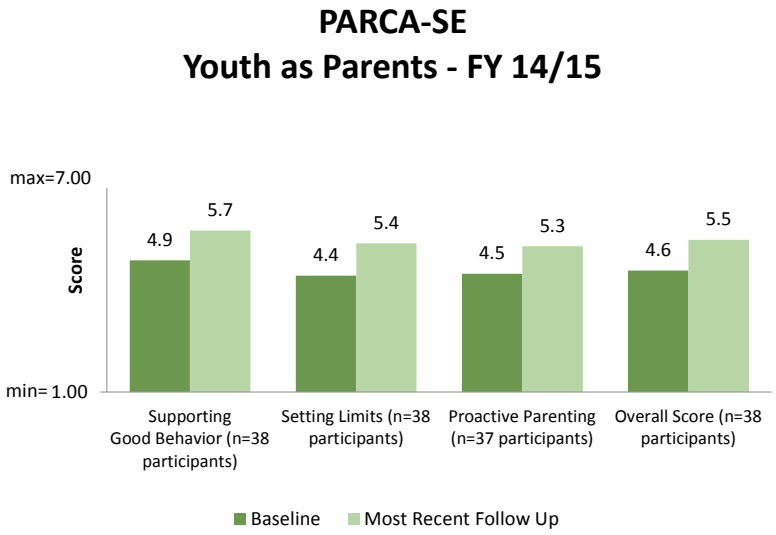
The program strives to make the services available to all Orange County residents, regardless of their background. The program has bilingual and bicultural staff to provide services in English and Spanish. Additionally, Vietnamese and Korean speaking clinicians from other P&I programs are available should participants need services in these languages.

Outcomes

During FY 14/15, 110 youth participants were served by the program. The program uses Triple P-Positive Parenting Program Tip Sheets to guide program services. As a demonstration of the program's effectiveness, the results for parenting self-efficacy and well-being are presented below.

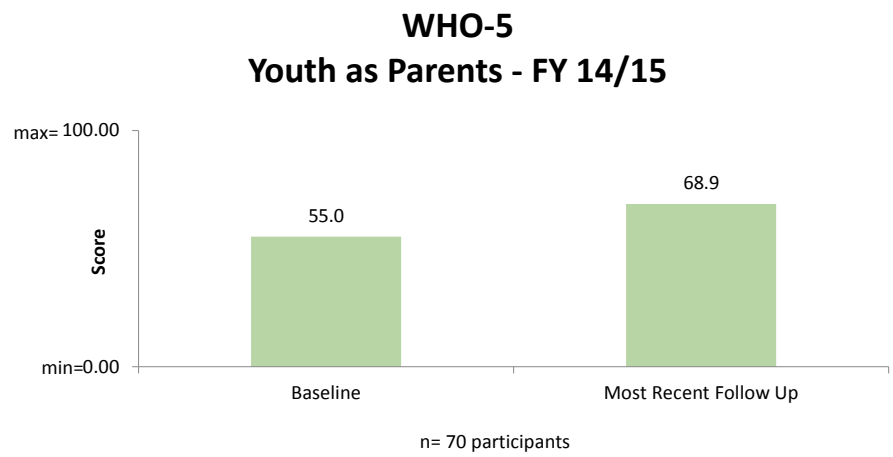
Participants completed the PARCA-SE (intake/follow-up), which is a measure of confidence in parenting self-efficacy. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that youth parent participants' improvement in all three subscales, as well as the overall parenting self-efficacy score was statistically significant[1]. These results indicate that overall confidence in parenting increased for participants enrolled in the program (see graph below).

[1]Supporting Good Behavior: t(37) = -3.87, p<.001, Cohen's d=.66 / Setting Limits: t(37) = -3.82, p<.001, Cohen's d=.64 / Proactive Parenting: t(36) = -3.28, p<.01, Cohen's d=.57 / Overall Score: t(37) = -4.05, p<.001, Cohen's d=.69



Participants also completed the WHO-5 Well-Being Index, which is a 5-item scale that assesses overall well-being. The developers of the scale indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 25%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2] indicating that participants' overall well-being improved (see graph on page 124).

[2]WHO-5: t(69) = -5.59, p<.001, Cohen's d=.67



Community Impact

The program has steadily increased their total number of participants served each year since program inception. In FY 14-15, there was a 13% increase from the previous fiscal year in number of individuals served. Participants have also expressed the impact that the program has had on their lives. Below is an excerpt of a direct quote from a participant:

> "[Staff] is very helpful, patient, and gives great advice, she is helping me to go to college and improve my life."

Changes/Challenges/Barriers

The program experienced challenges in increasing the numbers of participants from Vietnamese, Korean, and Farsi-speaking communities which are traditionally underserved in behavioral health settings. Vietnamese and Korean speaking staff from other programs have shared information about the program services during outreach events in order to increase referrals from these groups.

Participants in this program are often involved with other agencies or programs (such as Social Services Agency), which impacts their availability to make or keep appointments. Whenever possible, program staff obtain releases of information for other service providers so that they can coordinate and collaborate which can improve appointment adherence.

Early Intervention Program CF6. Community Counseling & Supportive Services	
Estimated annual number to be served in FY 16/17	600
Annual Budgeted funds for FY 16/17	$1,800,000
Estimated Annual Cost Per Person (for direct service programs only)	$3,000

Program Description

The Community Counseling and Supportive Services (CCSS) program provides behavioral health treatment services such as short-term counseling and psychiatric services for those not meeting the criteria at community mental health clinics. The program is designed to serve individuals of all age groups experiencing the early symptoms of depression, anxiety, alcohol and drug use, violence, and Post Traumatic Stress Disorder (PTSD) symptoms. The early onset of mental illness is determined through referrals and screening. The program expects to serve approximately 600 participants for FY16/17.

The program provides a range of services intended to reduce negative behavioral outcomes which include: screenings and collaborative assessments by multidisciplinary team, psychiatric services, individual case management, therapy, supportive counseling on site or at community field sites, outreach psychoeducational wellness groups, and referrals and linkages.

The program's purpose is to reduce prolonged suffering from untreated mental illness. To assess reduction in prolonged suffering, the reduction of symptom severity in the relevant mental illness (e.g., depression) for each participant is measured. Participants' global symptom and functioning, which assesses treatment progress and regress, is also measured. Additionally, the program measures reduction in negative outcomes by assessing global health. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages. Clinicians can also translate into languages that meet the program's needs.

Strategies to Improve Access

The program is designed to accept referrals from all County providers, community agencies and self-referrals. Master's level bilingual clinicians are available to conduct thorough telephone or in-office screens of all referrals to determine program suitability. Couples, family, and group counseling services are offered as adjunct services to support the family system.

Clinic services are provided on site, at a central location with access to various bus routes and freeways. Individuals interested in services can walk in to request an assessment during business hours. To increase access to care, evening business hours are available two days per week for enrolled participants.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make the services available to all Orange County residents, regardless of their background. The program has bilingual staff that speak Spanish, Vietnamese, and Korean. The program also has a clinician that is a bilingual Spanish speaking Veteran. If needed, there is access to a Farsi-speaking clinician in P&I that can provide language support or a County-contracted Language Line for interpretation/translation services.

Outcomes

In its initial year in FY14/15, 18 children, 33 TAY, 143 adults, and 17 older adults were served by the program. The program uses Cognitive Behavioral Therapy (CBT), Motivational Interviewing, and Seeking Safety to guide program services. The program started in May 2015 and initial outcomes demonstrating the program's effectiveness will be presented in the next Plan Update.

Changes/Challenges/Barriers

Recruitment of a psychiatrist and a behavioral health nurse has been a challenge which has impacted the ability to provide psychiatry services, but the program is actively recruiting for these positions. For participants who have limited access to a reliable means of transportation, the program has been able to provide transportation assistance to reduce this barrier.

Other PEI Program: Suicide Prevention Program Name CF7. Crisis Prevention Hotline	
Estimated annual number to be served in FY 16/17	6,500
Annual Budgeted funds for FY 16/17	$272,533
Estimated Annual Cost Per Person (for direct service programs only)	$42

Program Description

The Crisis Prevention Hotline is an accredited 24-hour, toll-free suicide prevention service available to anyone in crisis or experiencing suicidal thoughts or someone who is concerned about a loved one committing suicide. Services include immediate, confidential over-the-phone assistance for anyone seeking crisis and/or suicide prevention services for themselves or someone they know. Program counselors also initiate and assist in active rescues, when necessary. To assess degree of suicidal intent, callers are asked to rate their suicidal intentions at the beginning and end of each call. Additionally, counselors conduct follow-up calls for individuals who give their consent to ensure their continued safety. This extended care model supports a stronger safety net and reduces the likelihood of attempts and emergency room visits. Callers who are not experiencing a crisis are triaged and offered access to a WarmLine or other appropriate resources.

Strategies to Improve Access

The accessibility of the 24-hour Crisis Prevention Hotline, as well as the availability of chat services, allow individuals to access services at any time, wherever they are. The program also provides services in both English and Spanish. Additionally, the anonymity of the services provided also enables individuals to seek services who may otherwise not do so because of the stigma associated with mental illness, which is highly prevalent among certain cultural and ethnic groups. In FY 14/15, the program also provided 3,616 referrals.

Strategies for Non-Stigmatization and Non-Discrimination

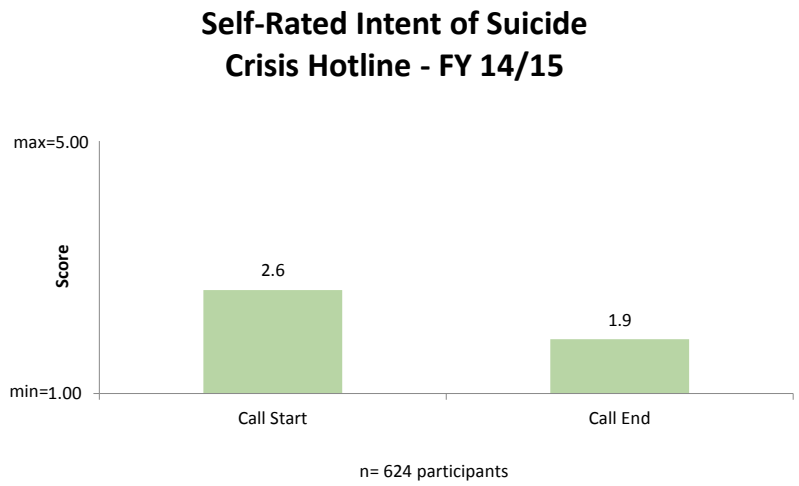
The program strives to make the services available to all Orange County residents, regardless of their background. The program has Spanish-speaking bilingual staff which enables callers to speak with someone in Spanish, should they prefer. In addition, volunteer staff who speak other languages are utilized whenever available, and a language line is used for all others not available onsite.

Prevention and Early Intervention (PEI)

Outcomes

During FY 14/15, 6,459 unduplicated callers were served by the program. The program uses the Applied Suicide Intervention Skills Training (ASIST) as their method to prevent suicide. Callers were asked to complete their Self-Rated Intent (pre/post), which is a 5-item scale that assesses self-rated suicidal intent. At the start and end of the call, callers were asked, "On a scale of 1-5, how likely are you to act upon your suicidal thoughts and feelings at this time, where 1 represents 'Not Likely' and 5 represents 'Extremely Likely'?" A movement to a lower risk category in the scale indicates that calling the program was effective in decreasing suicidal intent. The results showed a statistically significant decrease in the callers' suicidal intent from the start to the end of the call[1]. Additionally, fewer participants expressed extreme likelihood of suicidal intent at the end of the call as compared to the beginning of the call.

[1]*SRI: t(1,010) = 27.69, p<.001, Cohen's d=.88*



Community Impact

Call volume has increased 56% (from 5,113 to 7,998) since the program's inception in 2010. Additionally, in the past fiscal year alone, there were 47 staff-initiated rescues. Since 2011, there have been a total of 172 rescues. Callers have also expressed the tremendous impact the program has had on their lives. Below is an excerpt of a direct quote from a caller:

> "Thank you so much for your tremendous care. You've literally kept me alive. When I look back at the point I was at back when I first called to now, I can't even explain what a difference it is. It's unbelievable that there is a program like this; that there are people out there who I can reach out to and offer this level of care. Thank you so much."

Changes/Challenges/Barriers

The program is under-utilized by many ethnic communities. To promote the services, California Mental Health Authority is using culturally appropriate materials to target under-served ethnic populations, including Vietnamese and Farsi speaking communities. The program collaborates with partner organizations in order to conduct outreach, reduce stigma, and educate the community about available services. Additionally, the program has expanded their services to be inclusive of friends and family members who have been impacted by a loved one's suicide.

Early Intervention Program CF8. Survivor Support Services	
Estimated annual number to be served in FY 16/17	120
Annual Budgeted funds for FY 16/17	$270,693
Estimated Annual Cost Per Person (for direct service programs only)	$2,256

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. The program also serves individuals who have recently experienced the loss of someone to suicide or who they themselves have attempted suicide and may be suffering from depression. The early onset of potentially serious mental health illness is determined through referrals from partner agencies and self-referrals. The program is expecting to serve approximately 200 participants in FY 16/17.

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.

To measure reduction in prolonged suffering, decreases in depression severity and ability to cope with loss due to suicide are assessed. Participants are administered the assessments at intake, and again at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction in depression severity and improvement in ability to cope. The evaluation reflects cultural competence as the assessment tools taken by the participants are specific to their unique experience associated with losing someone to suicide and/or having thoughts about committing suicide.

Strategies to Improve Access

The program continues outreach to increase knowledge and access for underserved populations. Outreach to community members is made at a variety of settings such as community events, cultural events and fairs, schools, parent and family education events, colleges, and more. Program staff and community partners provide outreach services in many of the threshold languages including Spanish, Korean, Arabic and Farsi. In addition, once referrals for support groups and counseling are made, the program understands the increased engagement many survivors need to begin services. This is typically due to the stigma associated with suicide or mental illness. Many suicide loss survivors are ready for support at varying times after their loss and the program understands this unique aspect. If the survivor does not follow through with starting services directly after the referral, the program provides follow up by reaching out later to assess readiness for services. Support groups and counseling is provided in the threshold languages mentioned above.

Prevention and Early Intervention (PEI)

The program is located centrally in Orange County and is accessible from anywhere in the Southern California area, situated near five major freeways. The program also offers home/field visits as needed and community partners also provide counseling and support groups at their locations in different parts of Orange County to assist with minimizing cultural barriers to treatment. In FY 14/15, the program also provided 866 referrals and 361 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

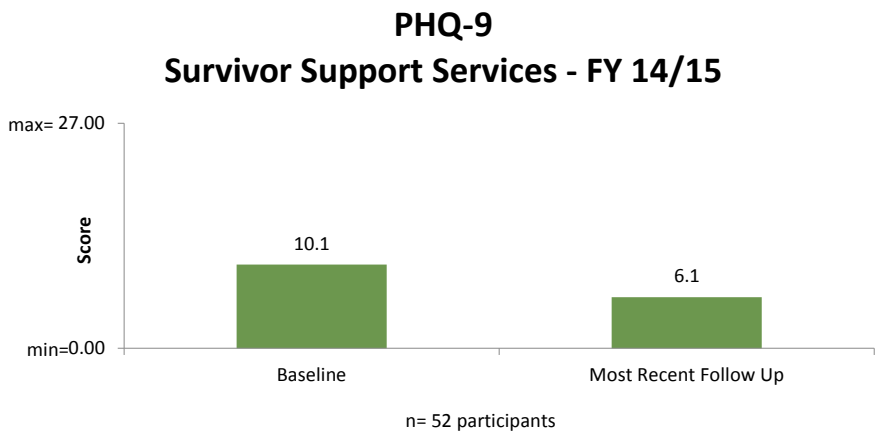
The County strives to make the services available to all Orange County residents, regardless of their background and provides services that are sensitive and responsive to participants' background.

Outcomes

During FY 14/15, 119 participants were served by the program. The program uses Applied Suicide Intervention Skills Training (ASIST), which is a practice-based standard to guide program services. As a demonstration of the program's effectiveness, the results for reduction in depressive symptoms are shown below.

Participants completed the Patient Health Questionnaire (pre/post), which is a 9-item scale that assesses severity of depression symptoms. Scores on the scale range from 0 to 27, with higher scores indicating greater depression symptoms. Additionally, the developers of the scale outlined cut points for none/minimal (0-4), mild (5-9), moderate (10-14), moderately severe (15-19), and severe (20-27) depression severity. The results showed that participants, on average, reported moderate depression symptoms at pre-test, but only reported mild depression symptoms at post-test. Additionally, this change in scores was statistically significant[1] (see graph below). Furthermore, fewer participants were in the higher depression severity categories at post-test as compared to pre-test.

[1]PHQ-9: t(51) = 5.71, p<.001, Cohen's d=.82



Community Impact

In FY 14/15, the program started the first cycle of the Survivors of a Suicide Attempt support group (SOSA) in Orange County. This is the first group of its kind, dedicated to support suicide attempt survivors in Orange County.

Changes/Challenges/Barriers

Referrals into the program provided by community partners who serve primarily ethnic communities are still limited due to the stigma and shame associated with mental illness in these populations. The program has increased outreach in Spanish and has formed workshops for survivors of suicide loss with a psychoeducational focus. The language expansion and focus on education paired with support resulted in successful workshop support groups for Spanish-speaking survivors. Some of these Spanish speaking survivors became interested in individual supportive counseling. Community partners are utilizing this approach to address cultural barriers and stigma. The other challenge has been referrals for the SOSA group due to the service being new. The program has initiated relationships with hospital's emergency department and a wellness center. The program plans to foster these referral relationships and form others to increase SOSA groups.

Prevention and Early Intervention (PEI)

Prevention Program CF9. Parent Education and Support Services	
Estimated annual number to be served in FY 16/17	3,300
Annual Budgeted funds for FY 16/17	$507,590
Estimated Annual Cost Per Person (for direct service programs only)	$154

Program Description

Parent Education and Support Services program serves parents and caregivers of children 0 to 12 years of age who are at risk of negative mental health outcomes. Parents are referred to the program from other community agencies, schools, or other mental health prevention and early intervention programs that have assessed participants and identified the need for parent education. The program expects to serve approximately 3,300 parents in FY 16/17.

The program's purpose is to prevent and reduce prolonged suffering of negative mental health outcomes in children by teaching parents effective parenting skills that promote protective factors. The program provides parenting education classes, individual interventions, and child care sessions to participants. To assess reduction in negative outcomes, participants' parenting self-efficacy and well-being are measured. Participants are administered the assessments at intake and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages.

Strategies to Improve Access

The program improves access by conducting classes at locations that are accessible to participants including school sites, family resource centers, hospitals and shelters. By adding convenient locations, the program addresses the barrier of lack of transportation among participants. In addition, the classes are held in the morning and evening with childcare provided to ensure that underserved populations have access to services needed.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make the services available to all Orange County residents, regardless of their background. The program employs bilingual Spanish-speaking staff which meets the program's needs. Parent training is available in English and Spanish.

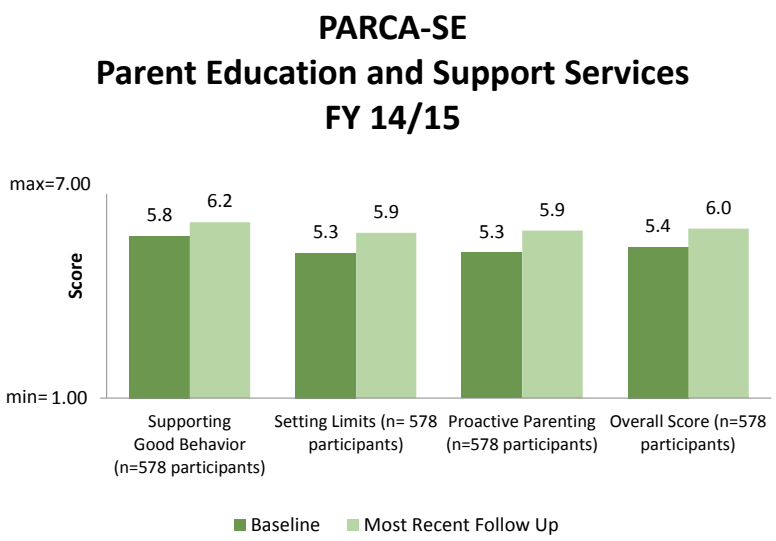
Prevention and Early Intervention (PEI)

Outcomes

During FY 14/15, 3,513 participants were served by the program. The program uses the Community Parent Education Program's Parenting Curriculum to guide program services. As a demonstration of the program's effectiveness, the results for improvement in parenting self-efficacy and well-being are presented below.

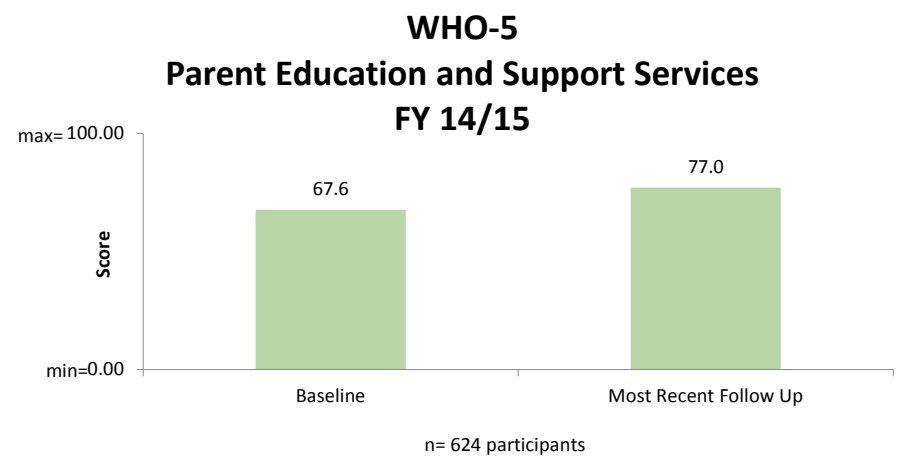
Parent participants completed the PARCA-SE (pre/post), which is a measure of confidence in parenting. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that parent participants' improvement was statistically significant[1] in all three subscales as well as the overall parenting self-efficacy score. These results indicate that overall confidence in parenting increased for participants enrolled in the program.

[1]Supporting Good Behavior: t(577) = -9.16, p<.001, Cohen's d=.38 / Setting Limits: t(577) = -10.64, p<.001, Cohen's d=.44 / Proactive Parenting: t(577) = -11.49, p<.001, Cohen's d=.48 / Overall Score: t(577) = -12.27, p<.001, Cohen's d=.51



Participants also completed the WHO-5 Well-Being Index, which is a 5-item scale that assesses overall well-being. The developers of the scale also indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 14%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2] indicating that participants' overall well-being dramatically improved (see graph below).

[2] *WHO-5: t(623) = -11.87, p<.001, Cohen's d=.48*



Community Impact

The program continues to integrate their services in the community and has had success working with several shelters and other non-traditional locations to meet the needs of the participants. Below is an excerpt from a direct quote form a participant.

> "Para mi en lo personal me ayudo muchisimo para poder vivir feliz con mi familia y hacer conciencia para el bienestar familiar y comprender un poco a nuestros hijos de acuerdo asu edad." [For me personally, [the classes] helped me a lot to be able to live happily with my family and to be aware of the well-being of the family, as well as to better understand our children accordingly to their age.]

Changes/Challenges/Barriers

A challenge that the program faces is retention of parents over a period of 10 sessions. To mitigate this challenge, the program works to reduce barriers such as lack of transportation and childcare by conducting the program in locations that are convenient to participants and by providing childcare.

Prevention Program CF10. Family Support Services	
Estimated annual number to be served in FY 16/17	1,600
Annual Budgeted funds for FY 16/17	$718,424
Estimated Annual Cost Per Person (for direct service programs only)	$449

Program Description

Family Support Services serves families with children 13-18 years of age and families struggling with behavioral health issues. The program collaborates with various school counselors, as well as community and mental health agencies throughout the county to help assess the needs of the members of the community. By working closely with individuals who know the community and working directly with students and parents, the program targets those who will benefit from the prevention service. The program relies on referrals from school administrators, teachers, community centers and church staff to identify those individuals who are most at risk and who need the program services. The program expects to serve approximately 1,600 adults per year.

The program supports and educates families on 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. 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.

The program's purpose is to reduce prolonged suffering from behavioral health issues. To assess reduction in negative outcomes, improvements in positive parenting behaviors, protective factors, and overall well-being are measured. Participants are administered the first wave of assessments at intake and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant improvement in strength-based measures. The evaluation reflects cultural competence as the surveys are available in most threshold languages.

Strategies to Improve Access

In addition to English, services are available in multiple languages including Spanish, Vietnamese and Farsi, which increases access to services for monolingual, non-English speakers. The program provides the parent education courses in settings where parents regularly visit and have access to, such as community centers, school, churches, county libraries, and the county jail. The program also provides services near larger intersections, major streets, and major bus routes. The program schedules the services at various times throughout the day (morning, afternoons, and evenings) which allows parents who work during the day to attend evening classes and parents who work swing or late shift to attend morning sessions. The program provides childcare during classes. Additionally, the program's childcare program utilizes a curriculum to teach the children social skills that parallel what parents are learning in the parenting course. For participants who do not have transportation, the program provides transportation assistance.

Strategies for Non-Stigmatization and Non-Discrimination

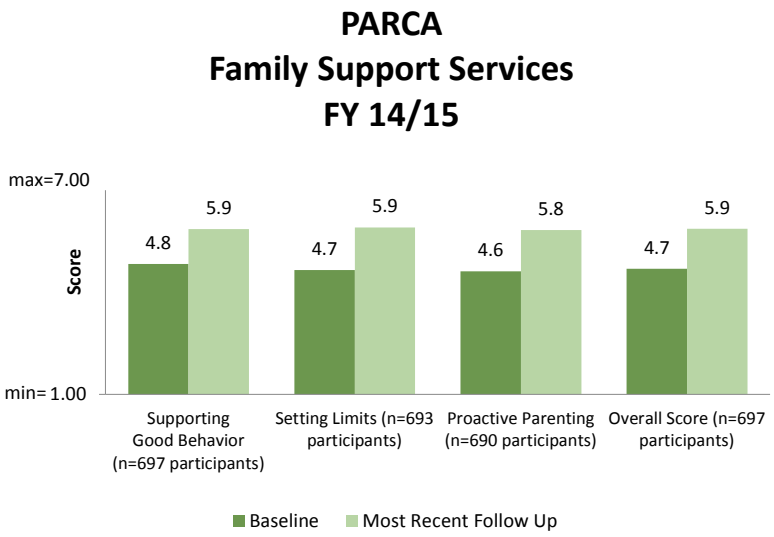
The program strives to make the services available to all Orange County residents, regardless of their background and provides services that are sensitive and responsive to participants' background. The program employs staff who are bilingual in English and Spanish, Vietnamese, and Farsi. Parenting services are available in English, Spanish, Vietnamese and Farsi. Group support and family matching services are available in English, Vietnamese and Spanish. Peer mentoring and childcare services are available in English and Spanish.

Outcomes

During FY 14/15, 2,623 participants were served by the program. The program uses Common Sense Parenting to guide program services. To ensure fidelity, all parent trainers are required to attend a two-week comprehensive Common Sense Parenting training at the program's National Campus prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month. The program utilizes a Common Sense Parenting Model Fidelity tool that was developed by the program's National Evaluation Department and used nationally. In addition, every parent trainer is required to pass a yearly credentialing process in which they are evaluated on all aspects of teaching the Common Sense Parenting material. As a demonstration of the program's effectiveness, the results for improvement in positive parenting behaviors and overall well-being are presented below.

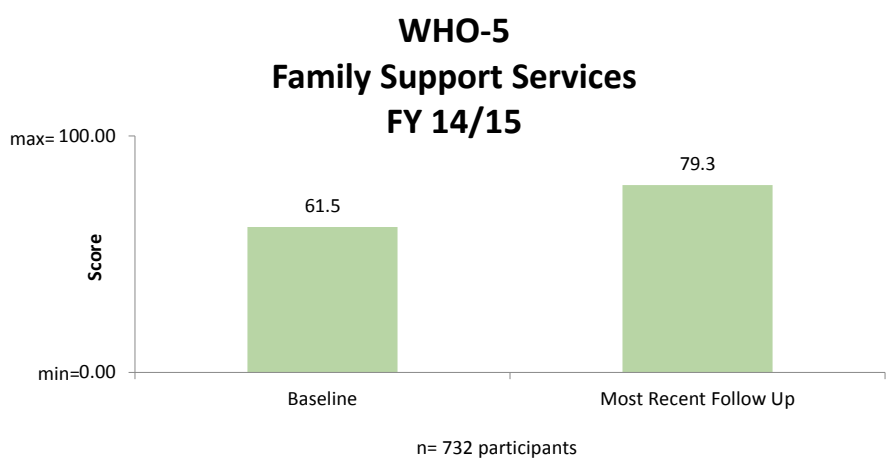
Parent participants completed the PARCA (pre/post), which is a measure of positive parenting behaviors. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting behavior scores were also computed. The results showed that parent participants' improvement in all three subscales, as well as the overall parenting score was statistically significant[1]. These results indicate that overall positive parenting behaviors increased for participants enrolled in the program (see graph below).

[1]Supporting Good Behavior: t(696) = -24.29, p<.001, Cohen's d=.95 / Setting Limits: t(692) = -26.60, p<.001, Cohen's d=1.05 / Proactive Parenting: t(689) =-26.11, p<.001, Cohen's d=1.03 / Overall Parenting: t(696) = -28.35, p<.001, Cohen's d=1.12



Participants in the Parent Training Program also completed the WHO-5 Well-Being Index. The results showed that participants with matched pre- and post-tests scores increased their scores by 29%. Additionally, the change in scores from pre- to post-test was statistically significant[2], indicating that participants' overall well-being dramatically improved (see graph below).

[2]*WHO-5: t(731) = -25.34, p<.001, Cohen's d=.10*



Community Impact

Program parenting classes are offered throughout the county in a variety of locations. In addition, the program successfully implemented a pilot parenting training series in the jails in FY 14/15. Participants have also expressed that the program has had a positive impact on their lives. Below is an excerpt of a direct quote from a participant:

> "Personally, I learned new techniques that I didn't know before and the program has helped me a lot to improve as the mother of my family."

Changes/Challenges/Barriers

The program's Family Matching service was challenged with recruitment of family matching participants in the summertime when school is typically out of session and families may be on vacation or busy with summer activities. To mitigate this challenge, the program partnered with local community organizations, including Family Resource Centers, which may have direct contact with potential participants during the summer, and conducted family days in the park with these organizations to engage families in family matching.

Prevention and Early Intervention (PEI)

Prevention Program CF11. Children's Support and Parenting Program	
Estimated annual number to be served in FY 16/17	650
Annual Budgeted funds for FY 16/17	$1,400,000
Estimated Annual Cost Per Person (for direct service programs only)	$2,154

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 use disorder 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. The program expects to serve approximately 300 children and 350 adults in FY16/17.

The program provides a range of services intended to reduce risk factors for children and youth and increase protective factors through parent training and family-strengthening programs. Services include family assessment, group interventions for children, teens and parents, brief individual interventions to address specific family issues, referral/linkage to community resources, and workshops.

The program's purpose is to prevent and reduce prolonged suffering of negative mental health outcomes in children by teaching parents effective parenting skills that promote protective factors and resiliency in the family. The program assesses reduction in negative outcome by measuring parenting self-efficacy and well-being. Participants are administered the assessments at intake and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages.

Strategies to Improve Access

The program continues to expand services at Family Resource Centers throughout Orange County in an effort to increase access for families without a reliable means of transportation or funds. Program staff have found that many at-risk families are already utilizing local Family Resource Centers and adding services to these sites improves community awareness of the program and enhances access for participants. In FY 14/15, the program also provided 305 referrals and 107 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

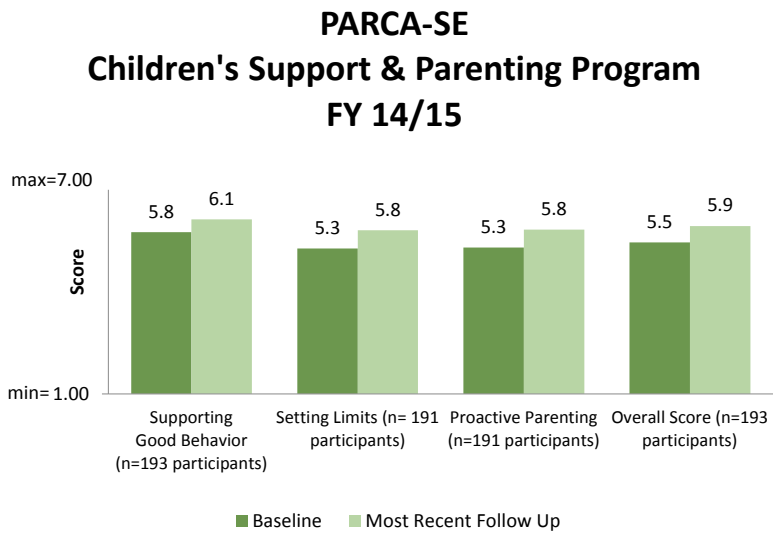
The program strives to make the services available to all Orange County residents, regardless of their background. Program staff are bilingual in Spanish and Vietnamese.

Outcomes

During FY 14/15, 645 target participants were served by the program. The program utilizes the Strengthening Families curriculum which is an Evidence Based Practice. All staff have been trained by a certified trainer for the curriculum and adhere to it when they present the material to participants. As a demonstration of the program's effectiveness, the results for parenting self-efficacy and global health are presented below.

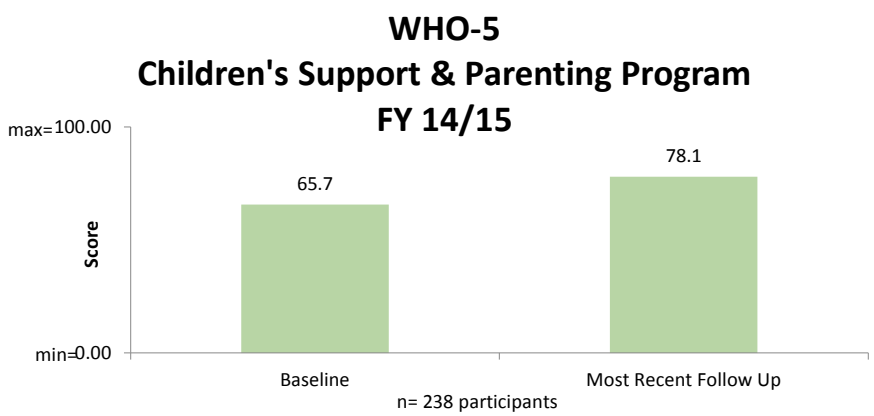
Parent participants completed the PARCA-SE (pre/post), which is a measure of confidence in parenting. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that parent participants' improvement in all three subscales as well as the overall parenting self-efficacy score was statistically significant[1]. These results indicate that overall confidence in parenting increased for participants enrolled in the program.

[1]Supporting Good Behavior: t(192) = -4.95, p<.001, Cohen's d=.36 / Setting Limits: t(190) = -6.05, p<.001, Cohen's d=.44 / Proactive Parenting: t(190) = -6.00, p<.001, Cohen's d=.44 / Overall Score: t(192) = -6.40, p<.001, Cohen's d=.46



Participants also completed the WHO-5 Well-Being Index, which is a 5-item scale that assesses overall well-being. The developers of the scale also indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 11%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2], indicating that participants' overall well-being improved.

[2]*WHO-5: t(237) = -5.70, p<.001, Cohen's d=.37*



Community Impact

The program successfully continued its pattern of increasing the number of participants served each year. This is important because families who have completed the program report improvements in protective factors, such as their perceived social support, knowing what to do as a parent, and family functioning/resiliency. Participants have also expressed how the program has had a positive impact on their lives. Below is an excerpt of a direct quote form a youth participant regarding what they liked about the program:

> "I can be open with everyone about my thoughts. I also liked how it improves my way of thinking and it helped me better to solve problems."

Changes/Challenges/Barriers

The program is increasing visibility and communication with local Family Resource Centers in an effort to increase enrollment and retain participants for the duration of the series. Outreach within communities surrounding the Family Resource Centers will also be enhanced. The implementation of the Strengthening Families curriculum in early 2016 is also anticipated to benefit new enrollments and retention by providing a more intensive curriculum tailored to address issues that are more specific to high-risk families who may have substance use or behavioral health issues.

Prevention and Early Intervention (PEI)

Prevention Program CF12. Stop The Cycle	
Estimated annual number to be served in FY 16/17	450
Annual Budgeted funds for FY 16/17	$1,000,000
Estimated Annual Cost Per Person (for direct service programs only)	$2,222

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. The program is expecting to serve approximately 210 children and 240 adults in FY16/17.

The 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; and brief individual interventions.

The program's purpose is to reduce prolonged suffering. To assess reduction in negative outcomes, the county measures improvements in parenting self-efficacy and well-being. Participants are administered the assessments at intake and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation reflects cultural competence as assessment tools taken by the participants are available in most threshold languages.

Strategies to Improve Access

The program continues to expand services in the school setting to address the growing needs of families dealing with alcohol and other drug use, poor school attendance and performance, family conflict, arguing and violence, social media, and out of control behaviors. Assistance with transportation improves access for those who are without reliable methods of transportation. Provision of childcare also improves access as many of these families do not have the means to afford childcare. In addition to community settings, services are provided in the schools because the setting is familiar to families and more easily accessible as it is located within their neighborhood. The program also has bilingual Spanish-speaking staff and can provide services to Spanish-speaking participants. Additionally, in FY 14/15, the program made 141 referrals and 36 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

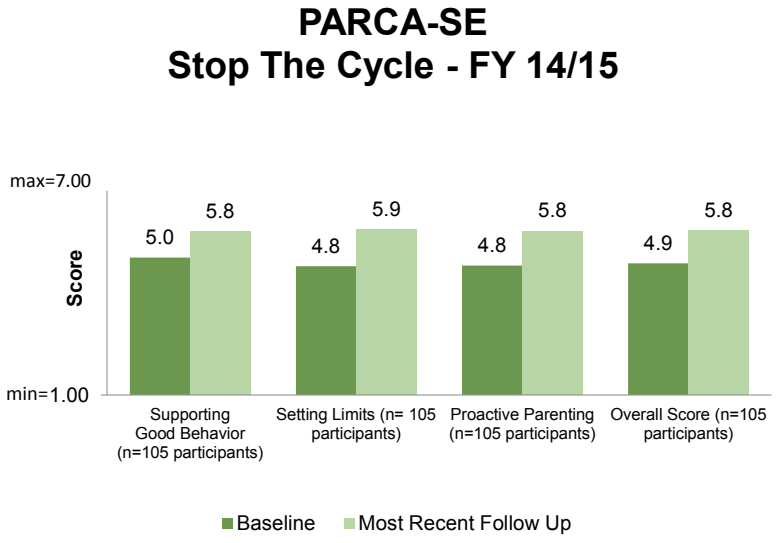
The program strives to make the services available to all Orange County residents, regardless of their background and provides services that are sensitive and responsive to participants' background.

Outcomes

During FY 14/15, 383 participants were served by the program. The program uses Parent Project curriculum to guide program services. All parent facilitators receive a 40-hour Parent Project Facilitator training to assist families with recognizing the developmental needs of teens, gain practical experience addressing behavioral interventions, and identify effective strategies to engage their children. The facilitators are provided with a manual they use throughout the course and the parents are provided with manuals as well which helps to ensure fidelity to the model. As a demonstration of the program's effectiveness, the results for improvement in parenting self-efficacy are presented below.

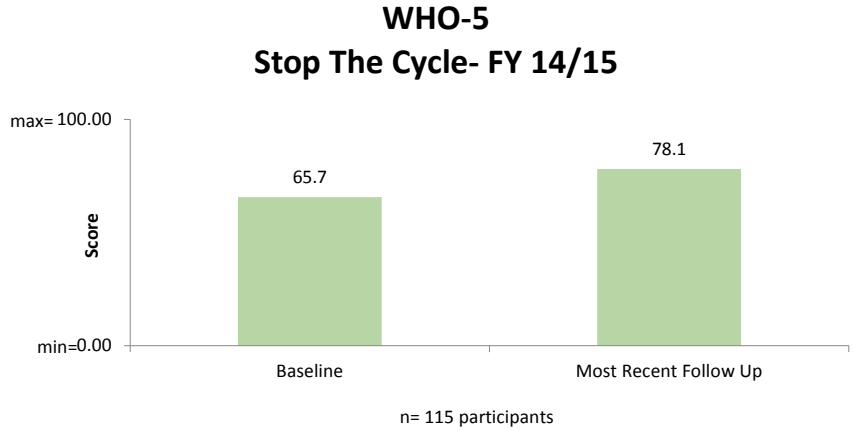
Parent participants completed the PARCA-SE (pre/post), which is a measure of confidence in parenting. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that parent participants' improvement in all three subscales as well as the overall parenting self-efficacy score was statistically significant[1] (see graph below). These results indicate that overall confidence in parenting increased for participants enrolled in the program.

[1]Supporting Good Behavior: t(104) = -6.80, p<.001, Cohen's d = .67 / Setting Limits: t(104) = -8.93, p<.001, Cohen's d = .96 / Proactive Parenting: t(104) = -8.87, p<.001, Cohen's d = 0.91 / Overall Score: t(104) = -9.35, p<.001, Cohen's d = .99



Participants also completed the WHO-5 Well-Being Index, which is a 5-item scale that assesses overall well-being. The developers of the scale also indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 19%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significantly[2], indicating that participants' overall well-being improved (see graph below).

[2]*WHO-5: t(114) = -6.12, P<.001, Cohen's d = .57*



Community Impact

The program continues to expand service areas throughout Orange County to meet the needs of diverse school-age at-risk populations. Schools that have hosted the program have reported that they are seeing improvements in school connectedness, respect for teachers, and improved demeanors for the teens whose families participated. Participants have also declared that the program has had a positive impact on their lives. Below is an excerpt of a direct quote from a participant:

> "This program has helped me maintain my calm and think of a better way to approach my son so that I may have a better relationship with him and understands his problems."

Changes/Challenges/Barriers

In the past three years the predominant focus of outreach was to the juvenile justice system via the Youth Reporting Centers. The program has since placed its primary focus on schools throughout Orange County to intervene early with families to address the current trends regarding youth involvement with drugs, gangs, and media in an effort to decrease youth involvement in the juvenile justice system, decrease school expulsions, decrease bullying and potential for school failure, and recognize the developmental needs of teens.

The program works with "high-risk" families who are dealing with issues such as substance use, mental health issues, and incarceration of family members. This population has a greater tendency to drop out or to be inconsistent in attendance. When this occurs, program staff have followed up with the family by phone or via field visit to provide support, determine if linkage to community resources is needed, and to maintain a connection with the family so that they might return to complete the program.

Prevention and Early Intervention (PEI)

Prevention Program CF13. Outreach and Engagement Services	
Estimated annual number to be served in FY 16/17	18,000
Annual Budgeted funds for FY 16/17	$3,819,044
Estimated Annual Cost Per Person (for direct service programs only)	$212

Community Services and Supports (CSS) Outreach and Engagement (C2, T2, A5)	
Estimated annual number to be served in FY 16/17	550
Annual Budgeted funds for FY 16/17	$1,769,933
Estimated Annual Cost Per Person (for direct service programs only)	$3,218

Program Description

The Outreach and Engagement Services (OES) provides mental health prevention services to unserved and underserved populations of all ages throughout Orange County. The program is designed to reach those who have had life experiences that make them vulnerable to behavioral health conditions, but are hard to reach in traditional ways because of cultural, linguistic or economic barriers. Using a triage system that includes a combination of evidenced based pre-screening and screening measures, and in-person or phone intake interactions, the risk of target populations is determined. Individuals and groups are screened to determine what services are needed along the continuum of support and are provided services based upon an established level of risk which spans the continuum from at-risk through mild, moderate, severe and persistent mental illness. The target populations include: children; transitional age youth; adults; older adults; participants from social services or juvenile justice system; individuals on probation; monolingual non-English speakers; recent immigrants; refugees; homeless individuals; deaf and hard of hearing individuals; lesbian, gay, bisexual, transgender, intersex and questioning (LGBTQ); and unsheltered homeless. CSS OES focuses their efforts on children, TAY, and adults who are Seriously Emotionally Disturbed and Mentally Ill (SED/SMI), and also homeless or on the verge of homelessness. PEI OES expects to serve approximately 18,000 individuals in FY 16/17. CSS OES expects to serve 270 individuals in FY 16/17.

The Prevention and Early Intervention program is designed to prevent the development of mental health conditions and/or intervene early in their manifestation to prevent conditions from becoming worse. Outreach activities include community events (e.g. health fairs, community festivals, door-to-door outreach, street outreach, and presentations). Engagement activities include individual interventions (e.g. crisis intervention, individual client education skill development, needs assessment, wellness/case management, service plan development/follow up, short-term counseling services and life coaching), educational and skills building workshops/presentations, support groups, and referrals and linkages. These activities work to build protective factors and developmental assets which in turn reduce the vulnerability of participants served. Connecting participants to appropriate mental health and supportive services can stop the progression of behavioral health conditions and prevent those conditions from getting worse.

In addition, the CSS OES assists the unserved or underserved populations with accessing culturally and linguistically appropriate full service partnerships, mental health services, and/or linkages with other needed community resources.

The program intends to reduce prolonged suffering from behavioral health issues. To assess reduction in prolonged suffering, the reduction of symptom severity in the relevant mental illness (e.g., depression) for each participant is measured. Additionally, the program measures reduction in negative outcomes by assessing global health. Participants are administered the first wave of assessments at intake and at program exit. Paired-samples t-tests of pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strength-based measures. The evaluation will reflect cultural competence as program staff are capable of providing services in all threshold languages and are trained in providing services to vulnerable populations.

Strategies to Improve Access

The services are provided by adapting a regional approach which allows programs to become experts in that particular region to better reach and serve participants. Outreach is designed to target individuals that are hard to reach, such as members of ethnic/racial minority groups and unsheltered homeless individuals, through traditional outreach methods. All services are enhanced by the mobility of team members and are designed to serve participants where they live, shop, congregate, worship, work, go to school or recreate. Another strategy is developing collaborative relationships with outside agencies (e.g., schools, places of worship, law enforcement agencies, hospitals, social service agencies, non-profit agencies, juvenile justice, probation, fire authority staff, veterans services, community centers, motels, shelter staff, apartment complexes, other behavioral health service agencies, etc.) that come into contact with the target populations and provide referrals into the program. Providing services out in the community allows programs to reach those who would not normally access services due to being isolated due to cultural, linguistic, or socioeconomic reasons. The program also links individuals to necessary services.

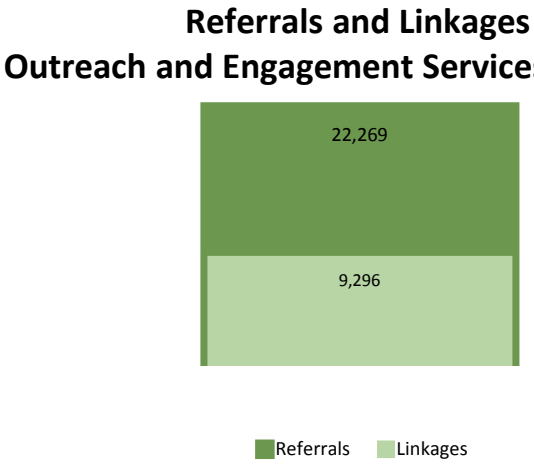
Strategies for Non-Stigmatization and Non-Discrimination

Due to the stigma associated with mental illness that runs deep within diverse communities, the O&E programs recruit diverse staff and volunteers who are knowledgeable about the communities they serve. Programs follow the premise that it is not enough for staff to speak the language, but they also need to know the religious and cultural nuances and traditions of that particular community. Partnering with community agencies that come into contact with target populations also assists the programs to gain trust within a particular community. These strategies allow program staff to gain access to and develop trust with participants and their families which in turn reduces the stigma of seeking services. Additionally, programs focus 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.

Prevention and Early Intervention (PEI)

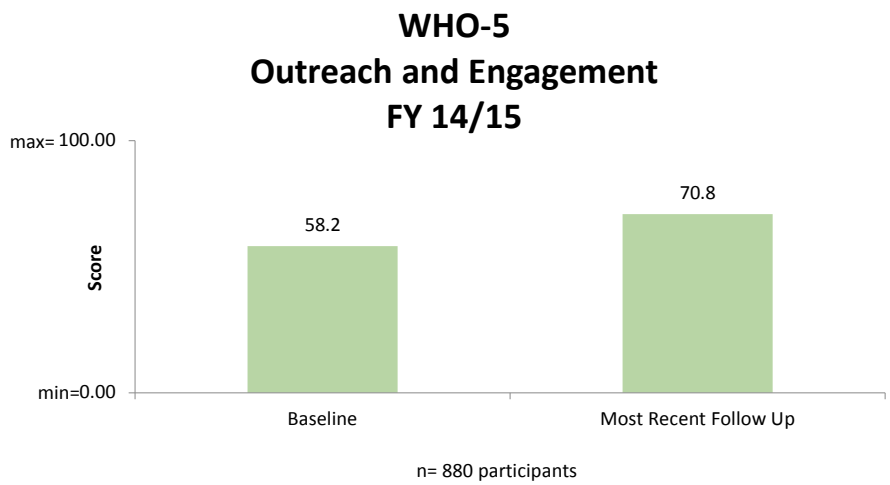
Outcomes

During FY 14/15, 21,249 enrolled participants were served by the program. The top referral and linkage categories are mental health care, family support services, food and nutrition assistance, legal services/advocacy, and child development and education.



Participants also completed the WHO-5 Well-Being Index (pre/post), which is a 5-item scale that assesses overall well-being, where higher scores indicate greater well-being. The developers of the scale also indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 22%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2] indicating that participants' overall well-being improved (see graph below).

[2] *WHO-5: t(879) = -15.63, p<.001, Cohen's d=.53*



Prevention and Early Intervention (PEI)

Community Impact

The program has impacted the community by targeting those who would not normally seek services, by assessing those individuals and connecting them to appropriate services, and finally, by filling the gap in services if the participant cannot be connected due to lack of insurance, immigration status, or lack of services provided in the participant's preferred language, etc.

Changes/Challenges/Barriers

This year, the program offered services to participants within a particular geographic region of the county. The rationale for this change was to increase the knowledge about that particular region vis a vis the target populations, such as the population's needs and available resources, in order to better serve the participants. Another change in services is the addition of short-term counseling and therapy that is available to participants enrolled in program services.

For many Orange County residents, one barrier to seeking services is transportation. By bringing information (outreach) and services such as case management and counseling (engagement) to the participants, this barrier has been reduced. Another challenge is participants' reluctance to submit personal information or enroll in engagement services, which has been addressed by intentional efforts to partner or outreach with trusted agencies/organizations. Building trust with participants, especially with new immigrant and refugee populations also reduces this ongoing barrier to seeking services.

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

Prevention Program CF14. WarmLine	
Estimated annual number to be served in FY 16/17	25,000
Annual Budgeted funds for FY 16/17	$441,556
Estimated Annual Cost Per Person (for direct service programs only)	$18

Program Description

WarmLine is telephone-based, non-crisis support for anyone struggling with mental health and substance use issues. Each caller is screened for eligibility and assessed for needed mental health information, support, and resource services. The staff providing the services has been through a similar journey, either as a consumer of mental health or substance use services, or as a family member of an individual receiving these services. The WarmLine operates Monday through Friday, between 9 a.m. to 3 a.m., and Saturday and Sunday from 10 a.m. to 3 a.m. The program expects to provide services to approximately 25,000 individuals in FY 16/17. WarmLine services are provided to increase access to mental health support and resources for all Orange County residents to reduce prolonged suffering from behavioral health problems. WarmLine also provides services for those who need support between treatment sessions.

The program intends to reduce prolonged suffering from behavioral health problems through the provision of mental health information, support and referral services. The program uses a one-item assessment of mood at the beginning and each of each call. Callers are asked to assess their mood and its severity at the beginning and end of each call. The evaluation reflects cultural competence because services are available in most threshold languages. The WarmLine also has access to the language line to assist callers who speak a different language.

Strategies to Improve Access

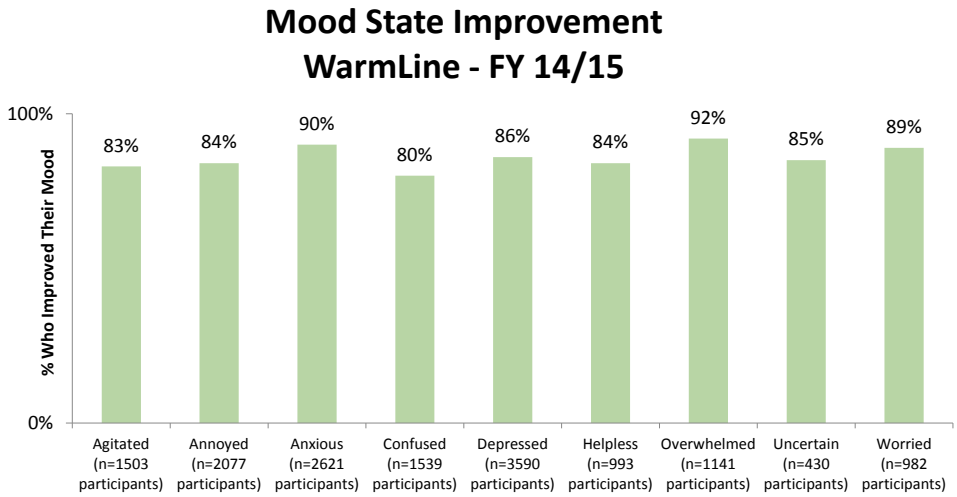
Program staff participate in local community health fairs and events to reduce stigma and discrimination of mental illness and increase access, awareness and benefit of WarmLine services. The program is collaborating with providers serving Orange County's diverse communities to increase awareness of WarmLine services. WarmLine advertising funds are targeted to media serving Orange County's diverse communities. WarmLine services are located in a single call center to assure effective management, training, teamwork, and fidelity to policies and procedures that attend to the needs of Orange County's diverse communities. Services are available in English, Spanish, Vietnamese and Farsi. A toll free number is advertised to assure access to all Orange County residents. In FY 14/15, the program also provided 6,386 referrals.

Strategies for Non-Stigmatization and Non-Discrimination

WarmLine callers are often afraid to access mental health services due to stigma and/or lack of knowledge about mental health resources. The program provides services via phone and chat services so that callers, who may otherwise not seek out mental health services because of the associated stigma, may be comfortable doing so. WarmLine uses mentors who are individuals living with mental illness or family members of an individual living with mental illness. Staff is provided comprehensive training in empathy, active listening, and suicide assessment. WarmLine mentors provide information and support about mental illness to reduce stigma and encourage treatment and the effective use of family support systems and community resources. Representatives from Orange County's diverse communities are invited to attend staff meetings to promote understanding and methods to reach these communities. Call monitoring is used for training purposes to assure non-stigmatizing and non-discriminatory services.

Outcomes

During FY 14/15, the program received 36,211 calls. The NAMI Family-to-Family curriculum and Motivational Interviewing are two evidence based practices that are used to reduce negative outcomes. Family-to-Family serves as the foundation for understanding mental health issues such as holistic and trauma-informed care, stages of recovery, bio-psycho-social elements of mental illness, medication, confidentiality and effective communication with individuals living with mental illness. Active listening, a person-centered motivational interviewing skills, is especially useful with callers in the pre-contemplative or contemplative stages of decision making about stigma and mental illness. This skill is also effective in establishing rapport and building empathy. WarmLine also uses Positive Psychology, which is a resilience-based model addressing positive emotions, individual traits and institutions, and trains mentors to direct focus to the positive influences in the caller's lives such as, character, optimism, emotions, relationships and resources in order to reduce risk factors and enhance protective ones. As a demonstration of the program's effectiveness, the percentage of participants who reported improved mood from the start to the end of the call in the different mood states is presented below.



Prevention and Early Intervention (PEI)

Community Impact

Since its inception in 2010, the WarmLine has serviced 103,199 individuals who call in to seek emotional help. In November of 2012, the Warmline increased its operating hours to include 11 p.m. to 3 a.m., and as a result the WarmLine received an additional 12,635 calls. WarmLine's greatest asset is its operational hours, where service is provided 18 hours a day for 7 days a week. This factor allows individuals with mental illness or their family members to reach out even when their doctor's or therapist's office is closed. Most recently in FY 14/15, the WarmLine reached 37,009 individuals.

Changes/Challenges/Barriers

Many of Orange County's diverse communities have difficulty openly discussing mental health issues and seeking help. WarmLine network services have utilized advertising in community-based media, participated in outreach events, invited community members to staff meetings and increased the bi-lingual staff capacity. There are new efforts to partner with the faith community and local organizations to leverage relationships, increase awareness of WarmLine services and promote help seeking behavior. Additionally, for many non-English speaking communities, utilizing a telephone-based service may be stigmatized and this results in the underutilization of this service among these communities. In order to mitigate this challenge, the program is continuously outreaching to these communities.

Other PEI Program: Access and Linkages Program CF15. Professional Assessors	
Estimated annual number to be served in FY 16/17	3,550
Annual Budgeted funds for FY 16/17	$536,136
Estimated Annual Cost Per Person (for direct service programs only)	$151

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 as described below.

The Court Support 4 Vets program provides assistance with navigating the system for the veteran who is experiencing legal issues possibly as a result of his/her behavioral health condition. Services include screening, assessment, motivational interviewing, and supportive counseling to engage veterans in order to provide clinical case management and referral/linkages to community resources.

At two family health clinics, a modified SBIRT (Screening, Brief Intervention, and Referral to Treatment) integrated behavioral health screening tool is used to assess medical patients for signs and symptoms of anxiety, depression, substance use problems, family violence exposure, and exposure to trauma. When visiting the family medicine clinics, patients are offered screenings and re-screenings (each time they visit the clinic) conducted by licensed behavioral health clinicians. Patients who screen positive receive a brief intervention during the same clinic visit and are referred to appropriate community services. For patients who screen positive for one or more behavioral health issues, clinicians make telephone follow-up calls approximately one week after screening to assess patients' well-being and inquire about whether they followed through on their previous referrals.

At senior centers, a Nurse Case Manager provides medical screenings (e.g., glucose, blood pressure), group education, health fairs, behavioral health screenings (e.g., depressive symptoms), case management, and referrals and linkages to meet medical and social/behavioral health needs of older adults.

Numbers Served by Age Groups

The Professional Assessors program is estimated to reach 3,550 adults and older adults in FY16/17. During FY14/15, the Court Support 4 Vets program enrolled 20 new veterans into the clinical case management program referred by various Orange County courts, and 414 community members and/or potential participants were reached during outreach activities. At family health clinics, 5,541 screenings or re-screenings were conducted with patients using the SBIRT integrated behavioral health screen (3,180 were re-screens for patients who had previously been screened at the clinic). The Nurse Case Manager at senior centers served 1,411 older adults.

Strategies to Improve Access

In FY14/15, the Court Support 4 Vets program made 37 referrals and 11 linkages to outside services on behalf of enrolled participants in the clinical case management program. The majority of those linkages were to mental health/counseling services and legal services/advocacy. The Family Health Clinic modified SBIRT program provided 1,492 referrals for the patients who screened positive for one or more behavioral health issues and 527 referrals for patients who did not screen positive but were considered "at risk" for behavioral health issues. Based on telephone and in-clinic repeat contacts, SBIRT clinicians found that 58% of patients followed up on the referrals they were given. The Nurse Case Manager at senior centers provided 143 referrals and 91 linkages to help older adults access appropriate County and community resources.

Strategies for Non-Stigmatization and Non-Discrimination

The County strives to make the services available to all Orange County residents, regardless of their background and provides services that are sensitive and responsive to participants' backgrounds. One strategy employed by Professional Assessors to reduce stigma and discrimination barriers to receiving behavioral health services is providing those services in locations other than mental health settings. By offering services in medical clinics, senior centers, and courts (familiar settings where at-risk individuals might be more comfortable receiving related services), the program is more likely to be successful helping individuals access behavioral health services they need (e.g., using medical screenings as a gateway and opportunity to address behavioral health issues).

Outcomes

In line with Court Support 4 Vets program objectives, screening tools and outcome measures are used to assess participants' progress in behavioral outcomes. The Personal Growth Initiative Scale II (PGIS-II) measures an individual's active and intentional involvement in changing and developing as a person. There is evidence that personal growth initiative is strongly positively related to psychological well-being and negatively related to psychological distress. The World Health Organization Well-being Index (WHO-5) measures self-reported global well-being. The program uses a repeated measures design with enrolled participants. Participants are administered the first wave of screeners and assessments at intake, and relevant measures are administered every three months during program participation and at program exit. Paired-samples of pre-test and post-test scores are used to analyze whether there was a significant improvement in strengths-based measures. Also tracked annually as outcomes, are the numbers and types of referrals and linkages to support services. Due to the small sample size with matched pre- and post-tests, statistical testing of these outcomes is inappropriate and any observed differences cannot be interpreted validly and reliably. Therefore, changes in this program's tracked behavioral health outcomes are used only by program staff for individual participant case management, goal setting, and progress monitoring.

During FY14/15, at family health clinics, 5,541 screenings or re-screenings were conducted with patients using the SBIRT integrated behavioral health screen. Of those, 23% (n=1,302) screened positive for a behavioral health issue. The vast majority of positive screens indicated depression and/or anxiety symptoms, but some patients also showed signs of problematic alcohol and/or drug use, violence exposure, trauma, or co-occurring issues. Notably, 42% of all positive screens identified an "untreated" issue (i.e., an issue that had not been treated/addressed in the previous month). Based on aggregated data tracked over time, 67% of all patients who were re-screened showed no behavioral health issues at initial or follow-up screening, while 12% showed improvements in behavioral health symptoms. In contrast, 15% showed persistent symptoms over time, and 6% showed a worsening of symptoms over time (i.e., went from having no signs of behavioral health issues at initial screening to having signs of one or more behavioral health issues at the time of re-screening).

During FY14/15, the Nurse Case Manager served 1,411 older adults in eight community senior centers. A total of 1,502 services were provided, including medical screenings and behavioral health screenings, group education and health fairs, case management, in-home visits, and clinic visits.

Community Impact

By collaborating with veterans' courts, family health clinics, and senior centers, this program is impacting the community in terms of increased access to behavioral health services in community settings. The Court Support 4 Vets program employees are both clinicians and military veterans. This is very important to the veteran participants and allows the program to build a positive reputation in the community through the use of "veterans helping veterans." Therefore, outreaching and educating veterans about resources in the community is a very specific process requiring people with a deep understanding of military service and protocol. According to one participant's report, the Court Support 4 Vets program provided him an opportunity to communicate to the Court his commitment to an improved personal "wellbeing" and stabilization resulting in a reduced legal sentence and "best case scenario."

Changes/Challenges/Barriers

There have been no changes to the program/strategy/target populations for the Court Support 4 Vets program. However, the WHO-5 measure of self-reported global well-being has been replaced (as of FY15/16) with the National Institutes of Health's (NIH) PROMIS Global Health scale. The WHO-5 questions may not be particularly appropriate for military veterans. Additionally, the WHO-5 has not performed particularly well for this population in measuring changes from pre- to post-test. The 10-item PROMIS Global Health scale is also more useful for intervention planning and progress monitoring, given its subscales for Global Mental Health and Global Physical Health as well as items regarding Social Health and General Health. In FY 14/15, the Court Support 4 Vets program experienced challenges associated with staff turnover and issues regarding the consistent dissemination of information to petitioners/respondents regarding the Domestic Violence Diversion program. Despite these challenges, the program established collaborations with court personnel and developed solid professional relationships to support the veteran through the legal system. Additionally, the program conducted new outreach events and activities to promote the program. The program receives many more referrals than those actually enrolled. For every referral, the staff member attends court with the potential participant. If the person agrees to the program, then they enroll. If they decline the program or court is dismissed, then there is no enrollment. The process requires time and human capital, but is worth it if the program helps a veteran connect to resources they need.

Prevention and Early Intervention (PEI)

In FY 14/15, the Nurse Case Manager indicated that one challenge is very few seniors are willing to admit to having behavioral health issues, possibly due to generational stigma. The program is considering ways to address this which might include conducting screenings in a different manner for the next fiscal year.

In FY 14/15, the SBIRT program at family health clinics started documenting their services within an electronic health record, which will simplify data collection and interpretation.

Prevention and Early Intervention (PEI)

Early Intervention Program SF1. School-Based Mental Health Services	
Estimated annual number to be served in FY 16/17	800
Annual Budgeted funds for FY 16/17	$2,000,000
Estimated Annual Cost Per Person (for direct service programs only)	$2,500

Program Description

School-based Mental Health Services provides early intervention services in schools targeting students with mild to moderate depression, anxiety, and substance use problems. The early onset of mental illness is determined through referrals and screening. The program is currently in its pilot phase and has not been fully implemented. As such, the program expects to serve 400 participants in FY15/16, the first year of operation.

The program focuses on reducing prolonged suffering from negative behavioral health problems via screening and assessments, individual counseling, family counseling, group counseling, case management, psycho-educational groups, life skills and coping classes, and referrals and linkages.

The program's purpose is to reduce prolonged suffering from untreated mental illness. To assess reduction in prolonged suffering, the reduction of symptom severity in anxiety, depression, substance use and post-traumatic stress is measured. Additionally, the program measures reduction in negative outcomes by assessing well-being. Participants are administered the first wave of assessments at intake, every three months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strengths-based measures. The evaluation reflects cultural competence as assessment tools are also available in Spanish, which meets the program's needs.

Strategies to Improve Access

The program is implemented in the school setting, thereby providing access to students and families that might not seek help on their own. The program also has the ability to target particular schools/districts to tap into specific designated populations if needed.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to students and parents in participating schools and provide services that are sensitive and responsive to participants' background. Additionally, the majority of program staff are bilingual Spanish-speakers and services can also be provided in Korean and Vietnamese if necessary, allowing the program to provide services to people from diverse backgrounds.

Prevention and Early Intervention (PEI)

Outcomes

The program uses Cognitive Behavioral Therapy and Motivational Intervention for Trauma in Schools to guide program services. The program started its pilot phase in June of 2015 and outcomes will be presented in following Plan Updates to demonstrate the program's effectiveness.

Community Impact

The program is currently being piloted in school districts that have demonstrated a high need for services.

Changes/Challenges/Barriers

The program is currently being piloted and challenges will be reported after they have been identified.

Early Intervention Program SF2. School Based Behavioral Health Intervention and Support-Early Intervention Services	
Estimated annual number to be served in FY 16/17	16
Annual Budgeted funds for FY 16/17	$400,000
Estimated Annual Cost Per Person (for direct service programs only)	$25,000

Program Description

This program serves families with children in grades 1-8 experiencing challenges in attention, behavior and learning, and/or Attention Deficit/Hyperactivity Disorder (ADHD). Children are screened by clinicians to determine behavioral health issues that need to be addressed. The program funds 16 approved children each fiscal year. 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.

To measure reduction in prolonged suffering as a result of untreated mental illness, ADHD symptomatology is assessed. Clinicians also identify and track target behaviors of children to monitor improvement. The program also measures children's early literacy skills and magnitude of stress in the parenting role. Clinicians and parents assess children's behaviors at the beginning and end of the academic year. Target behaviors are observed daily and assessed for progress weekly. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strengths-based measures.

Strategies to Improve Access

The program serves low-income families from cities throughout the County who would otherwise not have access to the services provided by the program due to financial constraints. The setting of the classrooms and the facility are ideal for the types of services and intervention that are provided by the program.

Strategies for Non-Stigmatization and Non-Discrimination

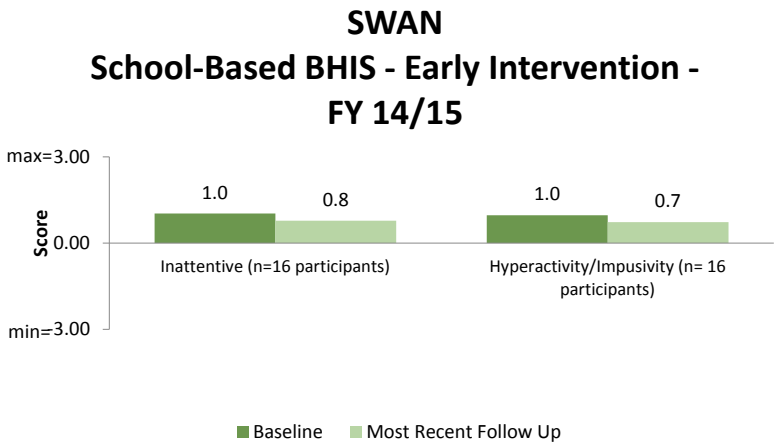
The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. Classes are taught in English in the school setting. However, the program employs staff who are bilingual in English and Spanish, Mandarin, Vietnamese, Korean, Farsi and French and can provide services to families who are non-English speaking. In addition, the program has translation services for other languages. Furthermore, unlike traditional schools, where students are pulled out of regular classroom instruction for their individual service plans, the program fully integrates behavioral interventions along with academic instruction in the classroom during school hours. This results in mitigating the risk for stigma while building self-esteem. Parents are also required to learn to use the same behavioral interventions at home. This ultimately creates a supportive environment for the students to learn academics and new behavior modifications.

Outcomes

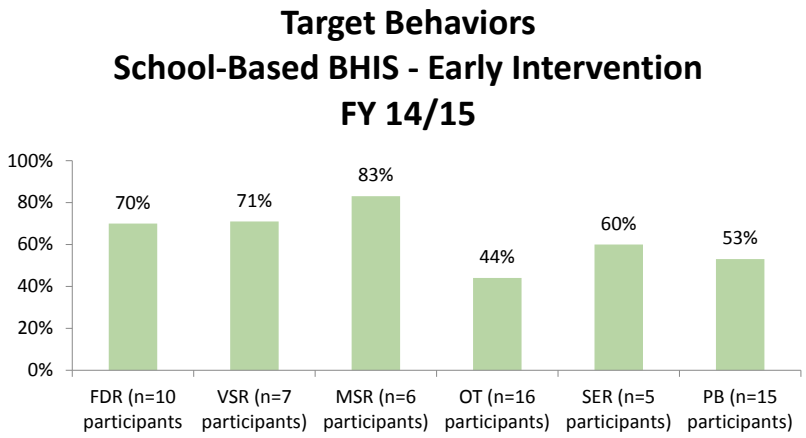
During FY 14/15, 24 target participants and 49 parents/caregivers were served by the program. The program uses the Community Parent Education Program COPE Parenting Curriculum to guide program services. As a demonstration of the program's effectiveness, the results for reduction in ADHD symptomatology and successful achievement of target behaviors are presented below.

Parents rated their children on the Strengths and Weaknesses of ADHD Symptoms and Normal Behavior (SWAN) Rating Scale (pre/post), which assesses ADHD symptomatology comprised of inattentive and hyperactive/impulsive items. Negative numbers indicate greater attention, motor self-regulation and inhibition. Positive numbers indicate greater inattention, hyperactivity and impulsivity. The results showed that although participants did not significantly improve in inattentive symptomatology, they did significantly improve in hyperactivity and impulsivity symptomatology[1], meaning participants improved in motor regulation and showed greater inhibition in behaviors (see graph below).

[1] *Inattentive: t(15) = -1.54, p=.14, Cohen's d=.42 / Hyperactivity/Impulsivity: t(15) = 2.18, p<.05, Cohen's d = .56*



Clinical staff also worked with enrolled child participants to identify and correct target behaviors by setting goals. Target behaviors are specific to each child's needs and are monitored and assessed on a daily basis to measure improvement over time. When a participant achieves the target behavior goal, another target behavioral goal is introduced to the participant. Participants have three to four target behavior goals at a time. Target behaviors are categorized into the following themes: Following Directions/Rules (FDR), Verbal Self-Regulation (VSR), Motor Self-Regulation (MSR), On-Task (OT), Social-Emotional Regulation (SER), and Prosocial Behaviors (PB). The results showed that overall participants in the program successfully achieved their target behaviors (see graph on page 159).



Community Impact

The program filled all allotted slots, and a wait list was established for potential candidates. Additionally, the school expanded with adding 6th and 7th grade classes during this time period. In FY 14/15, the school added an 8th grade class. Since inception, the program has provided services to 42 unduplicated students and 75 unduplicated parents/caregivers, for a total of 117 served. 22 students successfully transitioned to a traditional school setting. Families who have completed both the six and 12-month follow-ups have indicated that 89% (8 of 9) were attending public schools. Participants have also expressed how the program has had an impact on their lives. Below is an excerpt of a direct quote from a parent participant who successfully transitioned to a public school setting after attending the program:

> "Now that he is in public school, the skills he learned (from the program) helped him with solving conflict and he interacts with others better. He can stay on task and complete his work right away, which he avoided before. Overall his behaviors have improved and he's a totally different kid since being at your school. It was a great experience being in your program not just for him, but for our family too."

Changes/Challenges/Barriers

One challenge is getting parents to attend the multi-family groups when they have work schedule conflicts. To address this challenge, the program offers flexible schedules and classes multiple days of the week to accommodate the families. Additionally, the program offers one-on-one consultations to accommodate the family's needs. Another challenge is access to basic needs such as food, clothing, shelter, transportation and healthcare among socioeconomically-disadvantaged families, which impacts the well-being of the student along with the family unit.

Staff have worked with families to teach parents self-advocacy techniques and how to ask for assistance. The parents learn how to identify resources and to obtain those services. The program increased its marketing efforts at fairs and community events. They have collaborated with the Prop 10 funded program "Help me Grow," which is a consortium of community resources for children at risk. The program also provides referrals to community resources.

Prevention and Early Intervention (PEI)

Prevention Program Name SF3. School Readiness and Connect the Tots	
Estimated annual number to be served in FY 16/17	1,650
Annual Budgeted funds for FY 16/17	$1,800,000
Estimated Annual Cost Per Person (for direct service programs only)	$1,091

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. Risk is determined by administering screening tools to assess behavioral and socio-emotional issues. The program expects to serve approximately 650 children and 1,000 parents.

The program focuses on reducing risk factors for emotional disturbance in young children and promoting school readiness, preparing them for academic success. Services include child and family needs assessment, parent education and training, case management, and referral and linkage to community resources.

The program's purpose is to reduce the prolonged suffering caused by behavioral problems. To assess reduction in prolonged suffering, parent participants' self-efficacy in parenting, parental stress, and well-being are measured. Participants are administered the first wave of assessments at intake, every 3 months of program participation, and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction of prolonged suffering and improvement in strengths-based measures. Taking language preference into account, outcome measures are either provided in the participants' languages or can be translated into the threshold languages by clinicians.

Strategies to Improve Access

By conducting screenings out in the community and providing assessments and services in the home setting, program staff are able to identify and observe the needs of young children in the environment in which they are occurring. Completing parenting training curriculum directly in the families' homes increases the chances of success in implementing the techniques learned. By seeing participants in their homes, program staff have the opportunity to see and work with the entire family. Additionally, many participant families have limited resources, such as limited or no transportation and a lack of child care, which keeps them from accessing services. Additionally, in FY14/15, the program made 589 referrals and 276 linkages.

Strategies for Non-Stigmatization and Non-Discrimination

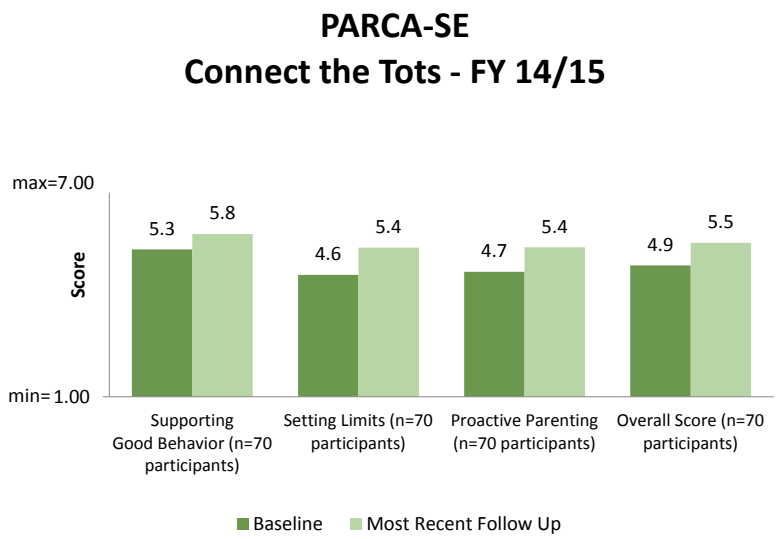
The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' backgrounds. The program has staff who are bilingual in Spanish, Korean and Vietnamese, which allows the program to provide services to families from diverse backgrounds. For additional language needs, translation services are available.

Outcomes

During FY 14/15, 556 target children and 778 parents were served by the program. The program uses the materials and principles from Triple P Positive Parenting Program to guide program services. Mental Health Workers utilize the most appropriate form of Triple P to meet families' needs. Such interventions may include the provision of Triple P Tip Sheets that target behavioral issues, or the implementation of Level III, Level IV, Family Transitions or Stepping Stones.

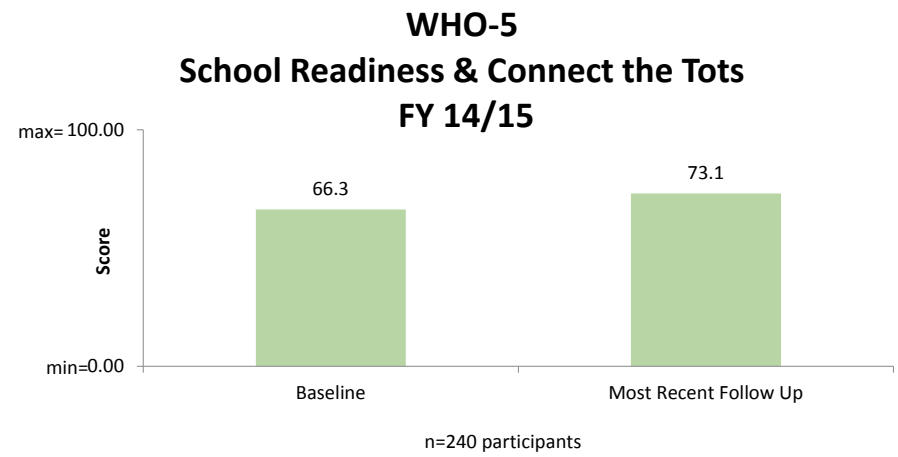
Parent participants completed the PARCA-SE (pre/post), which is a measure of confidence in parenting. This scale has three subscales: Supporting Good Behavior, Setting Limits, and Proactive Parenting. Overall parenting self-efficacy was also computed. The results showed that parent participants' improvements in all three subscales, as well as the overall parenting self-efficacy score were statistically significant[1] (see graph below). These results indicate that overall confidence in parenting increased for participants.

[1]Supporting Good Behavior: t(69) = -4.40, p<.001, Cohen's d=.55 / Setting Limits: t(69) = -6.19, p<.001, Cohen's d=.77 / Proactive Parenting: t(69) = -5.14, p<.001, Cohen's d=.65 / Overall Score: t(69) = -6.27, p<.001, Cohen's d = .80



Parent participants also completed the WHO-5 Well-Being Index (pre/post), which is a 5-item scale that assesses overall well-being, where higher scores indicate greater well-being. The developers of the scale also indicated that a 10% increase in percentage scores from pre- to post-test signifies a significant change in well-being. The results showed that participants with matched pre- and post-tests scores increased their scores by 13%, surpassing this threshold. Additionally, the change in scores from pre- to post-test was statistically significant[2] indicating that participants' overall well-being improved (see graph below).

[2]*WHO-5: t(238) = -6.12, p<.001, Cohen's d=.40*



Community Impact

A primary impact of the program on the community served is the early identification of and opportunity to address behavioral health needs experienced by families with young children across Orange County. Additionally, screening efforts at community schools and other organizations have resulted in the enhanced ability of community partners to plan and improve services. Lastly, through participation in community collaborative groups, such as the Developmental Screening Network, the program has expanded the reach of messaging related to the importance of early childhood screening and intervention. This has also contributed substantially in the efforts to build relationships in Orange County that advocate for screening services so that future mental health problems can be mitigated, reducing the risk of school failure.

Prevention and Early Intervention (PEI)

Changes/Challenges/Barriers

Two challenges that the program faces are the periodic low referral rate of new clients and participants dropping out of services prior to completion of their goals. In the last two years, in an effort to increase the referral base, the program team has worked to inform community providers about its services and establish effective partnerships to better identify and serve families in need. Between August and October of 2015 alone, nearly 250 children received developmental screenings from these efforts. Another shift that was made to address the early drop out of families was to provide services that better met the unique needs of participant families served. The training of staff in the Triple P Positive Parenting Program's more specialized curriculum, Family Transitions and Stepping Stones, enabled program staff to provide new services to address the needs of some participating families.

In addition, the program is encountering issues beyond child behavior problems and parent education. Many participants come from families who are in the midst of separation/divorce and are dealing with the court system. Problems can be further complicated by a lack of resources, such as inadequate housing and families at or near the poverty level. Program staff make referrals to services that address these issues, taking a family-focused approach.

Other PEI Program: Access and Linkages Program SF4. College Veterans Program (The Drop Zone)	
Estimated annual number to be served in FY 16/17	50
Annual Budgeted funds for FY 16/17	$150,000
Estimated Annual Cost Per Person (for direct service programs only)	$3,000

Program Description

The College Veterans Program (The Drop Zone) provides services to military veterans enrolled at college campuses. Student veterans face unique issues and challenges when transitioning from active military duty to civilian and student life. Prior to this program, there was an identified need for more veteran counselors in Orange County community colleges to help veterans navigate the various support services and resources available to them. Student veterans have access to appointments with a Behavioral Health Services clinician who is also a veteran. Services include behavioral health screening and assessment to determine whether further evaluation and referrals to behavioral health services are needed, individualized case management, and referrals and linkages to appropriate community resources. Once a referral is made, the clinician will follow-up with the participant to ensure a linkage was made. Clinicians discuss with the client about the appropriateness and desire for change if linkages are not made.

Military status is a unique demographic relevant to this program, as the intended target population is military veterans, as well as active and reserve military service members. This program involves collaboration between County Behavioral Health Services, Veterans Service Office, Veterans Resource Centers, and local community colleges. Services are provided on campus to assist with the unique issues and challenges faced by veterans transitioning to civilian and student life, with the ultimate goal of helping student veterans succeed at college (ultimately reducing school failure or drop-out rates among student veterans) and in their reintegration into the community and family life. Behavioral health indicators measured across participants include symptoms related to depression, anxiety and/or post-traumatic stress disorder (PTSD) at intake, as well as pre/post strengths-based measures of global health/well-being and personal growth initiative (i.e., readiness for change, planning skills, use of resources, and intentional behavior to grow/change).

Numbers Served

The College Veterans Program is estimated to reach 50 individuals in FY16/17. In FY14/15, 21 student veterans were enrolled into case management services (29% age 16-25 years old, 71% age 26-59 years old, 74% male, 44% White, 22% Hispanic/Latino, 90% preferred spoken language). The program also reached over 500 individuals during outreach activities, including providing referrals to non-enrolled student veterans seeking resources.

Strategies to Improve Access

College Veterans Services staff are currently placed at community college campuses to enhance access for this target population. This program is not located in a mental health setting because student veterans are best reached on college campuses, where they can best access and be linked to behavioral health services and other services they may need. In FY14/15, the program made 87 referrals and 49 linkages to outside services. The vast majority of the linkages were to food and nutrition services, education services, transportation, employment services, and behavioral health services.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. This program is staffed by military service members or Veterans who can address the specific and unique needs of student veterans (including the stigma associated with seeking behavioral health services and how those services might impact Veterans Administration benefits or be reported to the VA).

Outcomes

In line with program objectives, screening tools and outcome measures are used to assess participants' progress in behavioral outcomes. The Personal Growth Initiative Scale II (PGIS-II) measures an individual's active and intentional involvement in changing and developing as a person. There is evidence that personal growth initiative is strongly positively related to psychological well-being and negatively related to psychological distress. The World Health Organization Well-being Index (WHO-5) measures self-reported global well-being.

The program uses a repeated measures design with enrolled participants. Participants are administered the first wave of screeners and assessments at intake, and relevant measures are administered every three months during program participation and at program exit. Paired-samples of pre-test and post-test scores are used to analyze whether there was a significant improvement in strengths-based measures. Also tracked annually as outcomes, are the numbers and types of referrals and linkages to support services. Due to the small sample size with matched pre- and post-tests, statistical testing of these outcomes is inappropriate and any observed differences cannot be interpreted validly and reliably. Therefore, changes in this program's tracked behavioral health outcomes are used only by program staff for individual participant case management, goal setting, and progress monitoring.

Community Impact

By collaborating with local colleges, this program is impacting the community in terms of increased support for and retention of student veterans in higher education. Additionally, the College Veterans Program employees are both clinicians and military veterans. This allows the program to build a positive reputation in the community through the use of "veterans helping veterans." Below are a few quotes from participants highlighting the impact the program has had on their lives.

"I am very appreciative of all the help [clinician] has gotten for me. He was able to connect me with support services that helped me with gas and food along with the VSO to help me get a disability rating. The support [clinician] has provided was a direct contribution to my overall health and well-being."

Changes/Challenges/Barriers

There have been no changes to the program/strategy/target population. However, the WHO-5 measure of self-reported global well-being has been replaced (as of FY15/16) with the National Institutes of Health's (NIH) PROMIS Global Health scale. The WHO-5 questions may not be particularly appropriate for student veterans. Additionally, the WHO-5 has not performed particularly well for this population in measuring changes from pre- to post-test. The 10-item PROMIS Global Health scale is also more useful for intervention planning and progress monitoring, given its subscales for Global Mental Health and Global Physical Health, as well as items regarding Social Health and General Health.

In FY 14/15, the College Veterans Program experienced challenges related to staff turnover. Additionally, Memorandum of Understanding (MOU) renewals between the County and college campuses took longer than expected to be approved, so the program was not able to start enrolling new participants until late January 2015, impacting the number of participants served. The program also has limited visibility because it has only one staff member. Despite these challenges, the program was able to assist student veteran participants assimilating into college life. Since February 2015, one staff member took over the program and has helped it to grow, utilizing trust and rapport skills with the student veterans and faculty on campus. He continues to help student veterans in their transition from military life to academic life through supportive counseling, connections to resources, and access to services. Furthermore, the program is expanding to additional community colleges in FY 16/17.

Prevention and Early Intervention (PEI)

Prevention Program SF5. School Based Behavioral Health Intervention and Support	
Estimated annual number to be served in FY 16/17	20,500
Annual Budgeted funds for FY 16/17	$1,749,589
Estimated Annual Cost Per Person (for direct service programs only)	$85

Program Description

The School-Based Behavioral Health Interventions and Support program provides a combination of prevention and intervention services to empower families, reduce risk factors, build resiliency, and strengthen culturally appropriate coping skills in students. Services are provided in elementary, middle and high schools (2a) in school districts that have the highest indicators of behavioral issues, including dropout rates, expulsion, and suspensions. The program expects to serve approximately 18,700 children and 1,800 adults in FY 16/17.

The program focuses on providing services and curriculum for students and their families for the purpose of preventing and/or intervening early with behavioral health conditions. 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.

The program provides a multi-tiered approach. The first level, Classroom Prevention, is a universal approach that utilizes an evidence-based curriculum with learning modules that focus on key learning objectives such as self-concept, life-skills, positive decision making, and respect. Students exhibiting higher level problem behaviors are provided Student-Based Interventions the second tier of services, which utilizes a smaller, more individualized student-group approach to address areas such as bullying, anger management, conflict resolution, drug prevention, and self-esteem. Finally, those students who do not improve or display symptoms indicative of higher level needs or behavioral health conditions receive the third tier of services, Family Intervention, which also include early intervention services focusing on family skill-building and is intended to improve family communication, relationships, bonding, and connectedness.

The program's purpose is to prevent behavioral health problems and to provide students with coping skills to better address behavioral health problems, thereby decreasing prolonged suffering. The value of a prevention program is to maintain and improve protective factors and to prevent negative outcomes before they occur.

The program assesses social emotional and high-risk behavioral outcomes, self-concept, and use of non-violent strategies. The program also assesses reduction in disruptive behaviors and ADHD/ Hyperactivity Impulsivity behaviors for those students who needed the third level of service. Participants are administered the assessment at intake and at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant reduction in negative outcomes and improvement in the strengths-based measures. The evaluation reflects cultural competence by utilizing assessment tools that are age appropriate and appropriate for the school environment.

Prevention and Early Intervention (PEI)

Strategies to Improve Access

The school setting allows for the largest number of students to benefit from prevention and early intervention services. The program targets schools with the highest need that are also in greater need of prevention services. This program provides direct services in the classroom, which allows students to receive lessons in their current learning environment. This approach reduces classroom disruption and encourages student comfort and compliance. Staff serve all students in the classroom which also assists in reaching students/families that may be more difficult to reach outside of school hours.

Strategies for Non-Stigmatization and Non-Discrimination

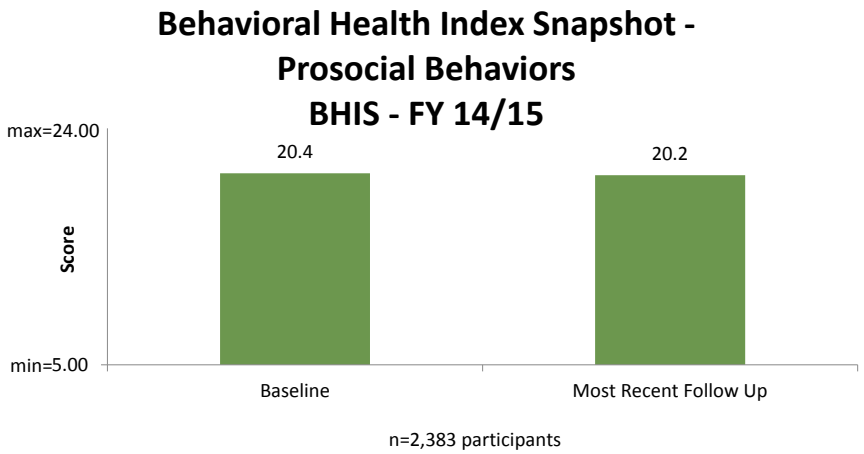
The program strives to make services available to students and parents in participating schools and provide services that are sensitive and responsive to participants' background. The program also employs bilingual staff which meets the program's needs.

Outcomes

During FY 14/15, 16,087 student participants, 1,225 parent/guardian participants, and 892 school staff participants were served by the program. The program uses Positive Action in the Universal level (Tier 1) and Strengthening Families for Family Interventions (Tier 3) to guide program services. As a demonstration of the program's effectiveness, the results for maintenance of strengths-based outcomes (i.e., prosocial behaviors and self-concept) are presented below.

Participants in the Classroom Prevention program completed a Behavioral Health Index Snapshot Scale (pre/post), which assesses social emotional development and high-risk behaviors, where higher scores indicate greater social emotional development or engagement in high risk behaviors. The results showed that participants maintained their high scores on prosocial behaviors[1] (see graph below). These results indicate that positive social emotional development outcomes remained high for participants enrolled in the program.

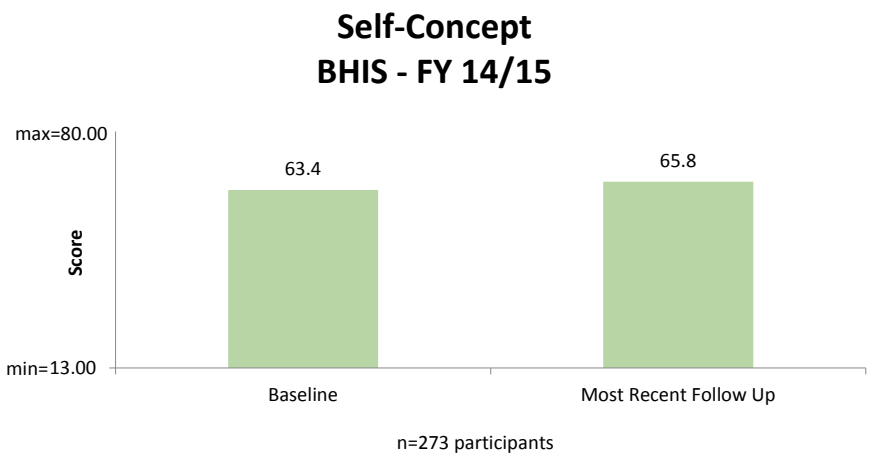
[1] *Prosocial Behaviors: t(2,382) = 3.16, p<.01, Cohen's d=.07*



Prevention and Early Intervention (PEI)

Participants in the Student-Based Interventions (SBI) completed a scale that was adapted from the Self-Concept Scale for Children. The scale consists of adjectives intended to ask children about their feelings about themselves, with higher scores indicating more positive self-concept. The results showed that participants' improvement in self-concept was statistically significant[2] (see graph below).

[2] *Self-Concept: t(272) = -2.57, p<.05, Cohen's d=.17*



Community Impact

This program continues to build capacity in the community in the 2015-2016 school year through collaboration with the Orange County Mental Health Coalition. For FY 14/15, more than 16,000 students were provided Classroom Prevention and Student Based Intervention services in 28 schools within five Orange County school districts. The service area expands further in FY 15/16 to include an additional school district and will serve a total of 30 school sites.

Participants have also expressed the impact that the program has had on their lives. Below are a few excerpts of direct quotes from participants:

> "This was a great program for our students. We are so glad that they were able to be a part of it. The lessons were great and opened up the doors to many conversations."

> "The lessons had objectives that were clear to students and helpful in leading to a more positive outcome when confronted with conflict."

Changes/Challenges/Barriers

The program faced barriers and challenges that are common to programs that provide school-based services. Implementing school based services is a complex multifaceted process that involves coordination and decision making at all levels of school administration. As a result, obtaining an official Memorandum of Understanding (MOU) from each school district is a time consuming process and consequently, access into each school is delayed and staggered throughout the school year. Other notable challenges faced when providing services include: changes in class sizes, and limited available classroom time. Strategies have been developed to streamline the process of recruiting schools. Rapport building and strengthening relationships with administrators has been key to obtaining MOUs in a timely manner so that service delivery can begin.

Prevention and Early Intervention (PEI)

Prevention Program SF6. Violence Prevention Education	
Estimated annual number to be served in FY 16/17	12,775
Annual Budgeted funds for FY 16/17	$1,287,751
Estimated Annual Cost Per Person (for direct service programs only)	$101

Program Description

The Violence Prevention Education (VPE) program's goal is to reduce violence and its impact in the schools, local neighborhoods and families. The target population is students, teachers, and parents. There are six programs under the Violence Prevention Education component. The program expects to serve approximately 10,700 children and 2,075 adults in FY 16/17.

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 negatively 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 – The Crisis Response Network 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 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 students, staff, administrators and parents on prevention of bullying and cyber-bullying. This program is composed of two key components that address bullying. The first component consists of anti-bullying presentations conducted at multiple school sites and intends to impact the overall school climate. The second component addresses cyber-bullying through the traditional approach focused on classroom-based curriculum.

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.

The program's purpose is to prevent violence among youth. To assess reduction in negative outcomes, the program assesses resilience, as well as knowledge and skills associated with preventing violence (e.g., conflict resolution skills), which serve as protective factors. Participants take a questionnaire at the end of each training session to evaluate whether the trainings improved resilience, knowledge and skills.

Strategies to Improve Access

This program improves access by providing services directly to school sites. Student presentations and campaigns generally target the whole school and provide a comprehensive approach to bullying or conflict resolution. Crisis Response activities also provide individual and group interventions at sites that are impacted by crisis at school sites. This approach allows for all students in need of assistance to be served in a uniform manner based on the topic at hand. Educational opportunities are also available to parents and school staff.

The school based approach offers inclusion of all students including those who may not be able to be reached outside of the school site. The sub-components of Safe from the Start and GRIP provide activities for students in alternate situations and circumstances. Safe from the Start provides services to non-traditional sites such as domestic violence shelters and alternative living sites. This allows for families to be served outside of the traditional school setting.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. Program services are linguistically and culturally appropriate and are open to all Orange County residents. The programs utilize trained professionals, school-staff, law-enforcement, peers, and even local celebrities to ensure that participants are engaged with service activities. This approach utilizes various methodologies of service delivery to best reach all populations.

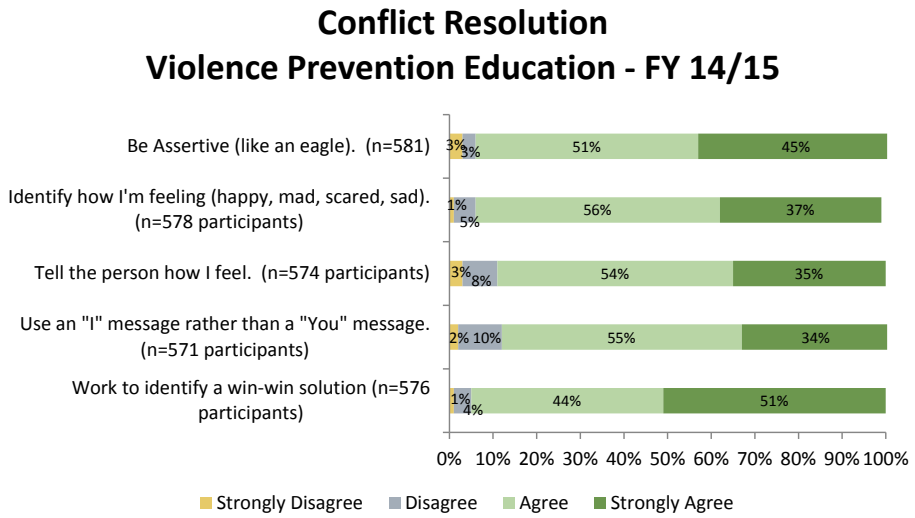
Outcomes

During FY 14/15, 20,320 children and 3,741 adults were served by the program across all services. The program uses several evidence-based and practice-based standards specifically for each service provided which includes: Safe from the Start, Conflict Resolution, PAL, Crisis Incident Stress Management, "ONE" Bullying, Common Sense Parenting, and Gang Reduction Intervention Partnership Curriculum. As many of these are program specific curriculums, fidelity is maintained by providing refreshers and staff training to ensure appropriate implementation.

Prevention and Early Intervention (PEI)

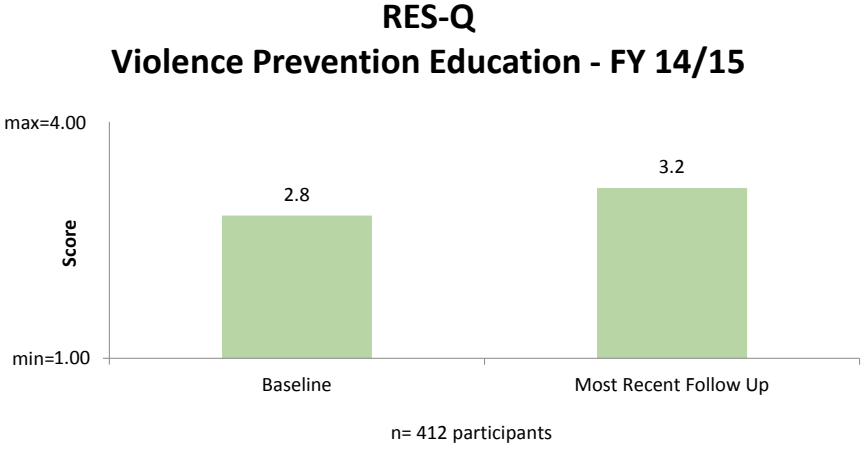
As a demonstration of the program's effectiveness, examples of outcomes on perceived skills and resilience are presented below.

The Conflict Resolution program administered a tool which assesses youth participants' degree of agreement to questions related to their ability to resolve conflicts because of the training. The results below showed that across all strategies students expressed agreement that they will try to employ the conflict resolution skills they learned in the program (see graph below).



Some participants also completed the RESQ (pre/post), which is a 20-item assessment developed by HCA for children/youth designed to assess youth resilience (e.g., "I can achieve my goals despite obstacles"). The results showed that participants' improvement in resilience was statistically significant[1] (see graph below).

[1] *RESQ: t(411) = -14.67, p<.001, Cohen's d=.72*



Prevention and Early Intervention (PEI)

Community Impact

The program's goal is to reduce violence and its impact in schools, local neighborhoods and families. This programming has a strong impact on the local community and creates educational opportunities for students, staff, parents and the community. Services are open and available to all schools/districts in Orange County. This includes non-traditional school sites, charter and access schools, after-school programs and private schools. Some notable community impacts include:

- The Crisis Response Network has recently experienced a trend of student suicides that have adversely affected local schools and the surrounding community. This service mitigates the impact that self-harm and violence has on individuals and the community and assists those who have experienced trauma due to local tragedies.
- The Safe from the Start program has provided much needed services to domestic violence shelters throughout the local community. These services help educate pregnant teens and parents on the importance of the early years of child development and teach them about the negative impacts that violence can have on a growing mind. This is especially noteworthy given the experience of those who currently reside at these shelters. A pilot program is underway which allows for multiple sessions for participants.
- Media Literacy is also an important addition that offers parents the ability to be more aware of the threats and exploitation of youth via technology. This course teaches parents about setting appropriate ground rules for their child and being more cognizant of the danger of the internet. This information allows families to make informed decisions on their child's use of digital technology and better assess the potential for misuse or exploitation.
- Anti-Bullying activities have been conducted at multiple school sites by engaging student ambassadors to pledge to combat bullying on their campus. This activity is followed by a school-wide pledge and an appearance of a local celebrity who tells his or her story about standing up to bullying. These activities help strengthen school community and encourage open and honest dialogue about bullying incidents on campus.
- The GRIP program has been effective in providing case management services to youth in Orange County. This program encourages youth to avoid high-risk behavior and be more involved in positive decision making via case management goals. The program also provides wrap-around curfew and truancy sweeps which force youth off the streets and back into the classroom. The Californian State Association of Counties (CSAC), which highlights effective and innovative prevention and intervention programs across California, selected GRIP for this honor.

Changes/Challenges/Barriers

The program has faced challenges associated with the coordination of school services. These barriers are often due to the constraints of the schools and corresponding districts. Changes in the school environment such as common core implementation, impacted class schedules and changing school calendars, often result in the need to modify, delay, or reschedule services.

Prevention and Early Intervention (PEI)

The program has found the need to adjust service delivery to focus on new or modified curriculums and approaches which serve students and parents in a larger group setting. This has resulted in trainings that are often held in one assembly presentation rather than multiple classroom sessions. The program has shifted their approach to adjust services to meet the changing needs of schools and districts.

In the GRIP program, case managers are constantly encouraging parents to engage with their child by facilitating the establishment of positive social support networks. This is accomplished by creating an open environment with other parents, the school and local law enforcement. The program assists with this coordination by offering parents an opportunity to be involved as greeters in their child's school and encouraging an environment of rapport building with law enforcement. This is an innovative strategy as many communities are often intimidated by law enforcement officials. Youth and their families also meet regularly with case managers to resolve and overcome challenges together.

Prevention Program SF7. Transitions	
Estimated annual number to be served in FY 16/17	2,250
Annual Budgeted funds for FY 16/17	$915,236
Estimated Annual Cost Per Person (for direct service programs only)	$407

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 program defines and determines risks based on the target population's age group where developmental transitions may lead to engagement in behavioral health problems. The program expects to serve approximately 2,000 students and 250 parents in FY 16/17.

The program provides a range of services intended to develop protective factors and create resilience in youth to better meet new academic and social challenges and educate parents about how they can assist their transitioning youth. Services include curriculum provided in the classroom and workshops for parents and caregivers.

The program's purpose is to prevent behavioral health problems and/or to provide students with coping skills to better address behavioral health problems, thereby decreasing prolonged suffering. Youth participants complete an assessment tool that measures resilience and knowledge about concepts taught in the program, such as how to be a successful student, building relationships, and communication skills. Participants are administered the assessment pre-test at intake and the post-test at program exit. Paired pre-test and post-test scores are used to analyze whether there was a significant improvement in the strengths-based measures. The evaluation reflects cultural competence by providing assessments in Spanish which meets the needs of the individuals served in this program.

Strategies to Improve Access

The program provides services in English and Spanish and has the capacity to provide services in Vietnamese. Because the program is provided in schools, students have better access to program services. Furthermore, school campuses are a less intimidating location for parents than a mental health setting to receive services because there is far less stigma around these prevention topics when they are provided at a school rather than a mental health setting.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to students and parents in participating schools provide services that are sensitive and responsive to participants' background. The program has Spanish-speaking bilingual staff, which enables participants to receive services in Spanish.

Prevention and Early Intervention (PEI)

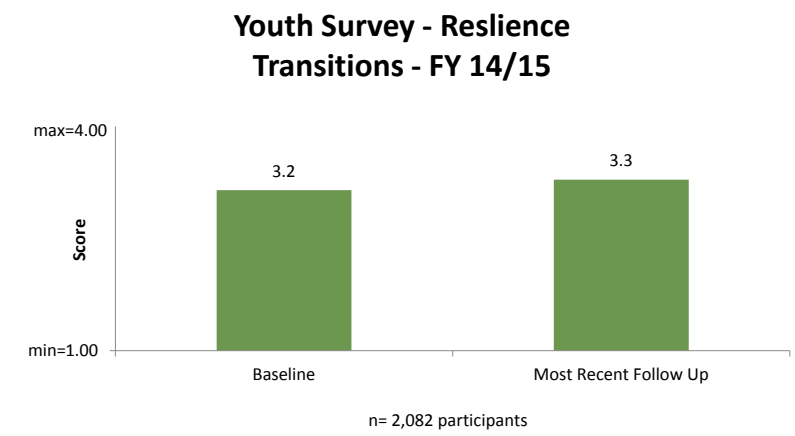
Outcomes

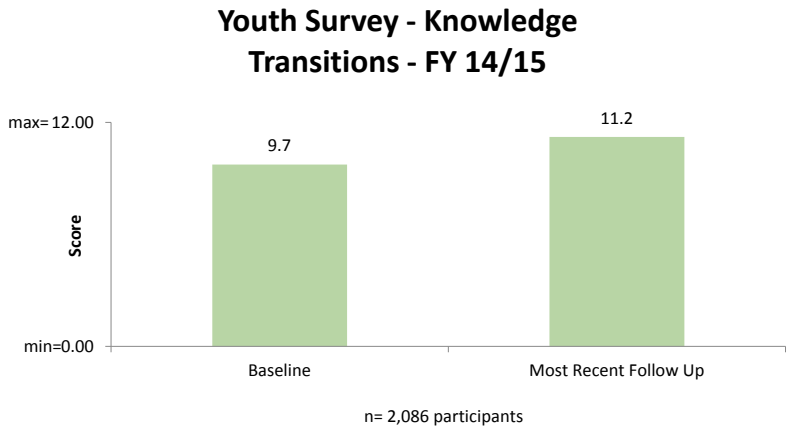
During FY 14/15, 2,628 student participants and 460 parents were served by the program. The program uses a curriculum that was developed from the Towards No Drugs evidence based practice.

The curriculum has been updated based on evaluation and feedback from students, teachers, administrators and parents. To maintain fidelity, all facilitators use the same PowerPoint presentations and worksheets to guide each session. As a demonstration of the program's effectiveness, the results for the outcomes of resilience and knowledge about concepts taught in Transitions are presented below.

Youth participants completed the Transitions Youth Survey (pre/post). The survey has two components. The first component is a 7-item scale from the 2012 California Healthy Kids Survey, High School Module B, which measures resilience (e.g., "I try to work out problems by talking or writing about them."). The second component is a 13-item multiple-choice test which measures knowledge about concepts taught in the program focused on helping students be successful, building relationships, and communication skills (e.g., "Which is the most successful form of communication?"). The results showed that participants maintained their high resilience scores and improved their knowledge. Scores between pre- to post-test were also statistically significant[1]. These results suggest that the program had a positive impact on students (see graph below).

[1] *Resilience: t(2,081) = -14.32, p<.001, Cohen's d=.32 / Knowledge: t(2,085) = -29.54, p<.001, Cohen's d =.65*





Prevention and Early Intervention (PEI)

Community Impact

The program served over five times more parents and one-and-a-half more students from the previous fiscal year. The opportunity for parents to be educated on the same topics that the students are exposed to in class creates opportunities for communication between parents and children around these topics. Additionally, services were provided to 9 different schools in 5 school districts.

Changes/Challenges/Barriers

Increasing the reach of the program to school districts beyond those in which it is currently offered has been a challenge. Staff continue to do outreach with districts that are not receiving program services in order to educate and build relationships with community partners.

Prevention and Early Intervention (PEI)

Prevention Program SF8. K-12 Coping Skills to Manage Stress	
Estimated annual number to be served in FY 16/17	4,340
Annual Budgeted funds for FY 16/17	$120,000
Estimated Annual Cost Per Person (for direct service programs only)	$28

Program Description

K-12 Coping Skills to Manage Stress will train teachers with students in grades K-12. The anticipated start date for the program is early in FY 16/17. The program strives to reduce the risk of mental illness resulting from unhealthy coping strategies among youth by building protective factors. The program expects to serve 4,270 elementary and secondary grade-level students and 70 teachers in FY 16/17.

The program will train teachers to integrate stress-management, self-management, and self-awareness strategies in their classrooms to support students' well-being, academic performance, and social-emotional growth. Studies have consistently shown that there is a link between stress management and self-awareness practices and improvement in children's well-being and behavior. Teachers will incorporate a variety of resilience, stress management, and self-awareness skills including breathing, cognitive reframing, and other relaxation practices within the classroom. Through the training, participants will also be able to recognize the signs and symptoms of stress and its impact on the mind, body, learning, and social emotional development. The teachers will use a "tool-box" approach in utilizing the curricula where they can select from a variety of age-appropriate and culturally sensitive strategies.

The program will strive to reduce prolonged suffering from behavioral health issues resulting from unhealthy coping strategies by building coping strategies and protective factors into daily lives.

Strategies to Improve Access

The program will train 70 teachers each year to implement stress-management, self-management, and self-awareness strategies across schools in Orange County. Implementing the program directly in classrooms enhances the ability of the program to provide access to as many Orange County students as possible, and alleviates any barriers related to transportation.

Strategies for Non-Stigmatization and Non-Discrimination

The program will strive to make services available to students and teachers in participating schools and provide services that are sensitive and responsive to participants' background. The program will specifically train teachers to use practices that incorporate culturally sensitive considerations, so that the program will be inclusive for students from diverse backgrounds.

Outcomes

The program will use stress-management and mindfulness, which are trauma-informed approaches to guide program services. As part of the program planning process, appropriate assessment tools will be chosen to measure program impact.

Other PEI Program: Access and Linkages Program SE1. Information and Referral / OC Links	
Estimated number of referrals to be made to those with Mental Illness in FY 16/17	8,760
Annual Budgeted funds for FY 16/17	$1,000,000
Estimated Annual Cost Per Person (for direct service programs only)	$114

Program Description

OC Links, the Behavioral Health Services (BHS) Information and Referral Line, provides telephone and internet chat-based support for anyone seeking information or linkage to any of the Health Care Agency's Behavioral Health Services. It serves as a single access point for any community member seeking behavioral health services through the County of Orange's Health Care Agency (HCA)/ Behavioral Health Services department. Comprehensive BHS services include children and adult mental health, alcohol and drug inpatient and outpatient, crisis, and prevention and early intervention services. Callers can be potential participants, family members, friends of anyone seeking out resources, or providers seeking information about Behavioral Health programs and services.

Trained navigators provide screening and assessment, information, referral, and linkage directly to the programs that meet the needs of callers. Because the navigators are clinicians, they are able to work with callers experiencing the full continuum of behavioral health conditions. Navigators assess callers to determine the most appropriate level of service needed and link them to the service that best meets their needs within the Behavioral Health Continuum of Care.

OC Links currently funds an additional clinical position for information and referral placed at Emergency Treatment Services (ETS), now called CSU (Crisis Stabilization Unit). This clinician assesses and makes referrals/linkages to individuals and their families using the CSU either in person or by telephone. This assists the individuals and families in linking to ongoing services after their initial mental health crisis.

Numbers Served by Age Groups

OC Links, the Behavioral Health Services Information and Referral Line had its two-year anniversary in October 2015. In FY14/15, 10,134 callers were served by OC Links (65% of callers were female; <1% were age 15 or younger, 13% age 16-25 years old, 76% age 26-59 years old, and 11% age 60+ years old; 93% of calls were conducted in English, 6% in Spanish, 1% in Vietnamese, and <1% in other languages; 52% of callers were White, 33% Hispanic/Latino, 8% Asian/Pacific Islander, 4% Black, 3% Middle Eastern, and 0.5% American Indian/Alaska Native).

Strategies to Improve Access

OC Links is a toll-free phone number (855-OC-Links) where callers can reach navigation staff of the Behavioral Health Information and Referral Line between the hours of 8 a.m. and 6 p.m., Monday through Friday. Navigators make every attempt to link callers directly to services while callers are still on the line. In addition, individuals can access information about resources 24/7 and a LiveChat option to communicate with a Behavioral Health Navigator (during operating hours) is available on the OC Links web page at www.ochealthinfo.com/oclinks.

Various advertising strategies, in multiple languages, have been used to increase the public's awareness of OC Links as a resource and point of access into behavioral health services. Currently, the program has OC Links information and phone number displayed on rotation every day at the Civic Center Plaza message board. In addition, a bus ad campaign placed OC Links posters on buses throughout Orange County. These ads were posted in English, Spanish, and Vietnamese and covered bus routes in North, Central, and South Orange County. OC Links has had advertising on Public Access Cable Television Community Resource displays as well.

OC Links also has a presence on social media and on the internet. Advertising is posted on Facebook and Twitter weekly, with the OC Links website address linking people back to the OC Links web page where they can get information and connect to LiveChat with the Navigators.

Finally, outreach includes distribution of OC Links info cards (in English, Spanish, Vietnamese, and Farsi) at schools and colleges, community organizations, businesses, court houses, libraries, resource fairs, and many other locations covering the entire county. In addition, a program representative goes out weekly to local businesses and non-profits to introduce OC Links and offer info cards.

In FY14/15, the program made 9,952 referrals. The vast majority of those referrals were resource inquiries (8,341) and general inquiries (894), in addition to follow-up inquiries (420), referrals to "211" (250), crisis calls (37), and referrals to Custodian of Records (10).

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. OC Links includes a Telecommunications Device for the Deaf (TDD) number (714-834-2332) for hearing impaired callers. In order to better serve the needs of monolingual Orange County residents, the program has navigators who speak Spanish, Vietnamese and Farsi. The program also has access to a language line translation service to serve the language needs of any caller. Over the last two years, more than 150 community presentations on OC Links and the Behavioral Health Continuum of Care have been completed. These presentations focus on the importance of stigma reduction and access to behavioral health services for all members of the Orange County community. Delivering services in multiple languages that are provided by bilingual/bicultural navigators is a positive strategy for non-stigmatization and non-discrimination.

Outcomes

A total of 10,134 callers were served by OC Links in FY14/15. Utilization of OC Links continues to increase annually, as evidenced by an increase in monthly calls from an average of 721 per month in 2014 to an average of 1,025 calls per month in 2015. Among the callers who answered three questions regarding their satisfaction with OC Links, 90% agreed with each of the following statements: (1) "You would recommend OC Links to a friend or someone you know;" (2) "During this call/chat you received the help you needed;" and (3) "You will use what you learned during this call/chat to access community resources that are available to you."

Community Impact

To help spread awareness of the OC Links program, there have been many presentations and trainings at various community sites. In FY14/15, 53 presentations were provided to organizations, schools, universities, and other community partners, and OC Links participated in 84 events in the community.

Participants have also expressed the impact that the program has had on their lives. Below are a few excerpts of direct quotes from participants:

> A caller had been incarcerated and was clean from heroin, yet worried about relapse. The navigator warm-linked him to a community recovery maintenance program as a support. The caller was very appreciative and shared, "I am so ready this time and I've been so worried I won't be able to handle being out [of jail]. Thank you for your kindness."
>
> A school psychologist called looking for resources for a family with a struggling youth. The youth was experiencing anger and aggression in both home and school settings and had MediCal. The navigator assessed the behavioral health needs of the youth and provided a community family program as a resource. The school psychologist shared, "You have no idea how valuable you guys are, thanks so much."

Changes/Challenges/Barriers

The program continues to face challenges in educating the community about OC Links and services available through the program. As trainings or briefings are conducted with schools, police patrols, fire departments, and the general community, those who miss trainings report a lack of awareness about OC Links when asked. The program continues to work on publicizing OC Links services. Strategies used this past year to mitigate these challenges have included community-wide bus ad campaigns and newspaper inserts created to educate the general public about OC Links.

Prevention Program SE2. Training, Assessment and Coordination Services	
Estimated annual number to be served in FY 16/17	N/A
Annual Budgeted funds for FY 16/17	$984,777
Estimated Annual Cost Per Person (for direct service programs only)	N/A

Program Description

The Training, Assessment, and Coordination Services program serves Prevention and Intervention priority populations, their family members, and any community member working with these priority populations, including first responders and teachers. PEI priority populations include trauma-exposed individuals, individuals experiencing onset of serious psychiatric illness, underserved cultural populations, and children and youth in stressed families and at risk of school failure/juvenile justice involvement. The program's primary goal is to provide a variety of relevant behavioral health related trainings/supports to better understand, identify, and address the potential mental health needs of the PEI priority populations and help these populations in accessing/utilizing local community mental health resources. In addition, included in this program are training and supports provided by the BHS Disaster Response Program. Psychological First Aid trainings are provided throughout the county to prepare staff for a crisis response.

Strategies to Improve Access

A needs assessment was completed to assess the County's training needs and this process included representation from all the PEI priority populations including family members and providers working with these populations. Some of the initial needs and strategies identified included providing more training in southern regions of Orange County; trainings in Vietnamese, Korean and Farsi; and the need for on-going technical assistance after an initial training to reinforce learning. In addition, the increased need for culturally nuanced mental health awareness training coupled with information for accessing services was identified as a priority.

Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. The trainings to be provided will specifically address non-stigmatization and non-discrimination toward those living with mental illness and those seeking services. This was also a concern that was identified in the needs assessment.

Outcomes

The training needs assessment final report was completed in January 2016. The findings from this report will guide future training opportunities and targeted efforts to meet the communities' needs that were identified.

Prevention and Early Intervention (PEI)

Community Impact

In FY 14/15, 94 individuals were provided Psychological First Aid interventions in one-on-one and group meetings, which included debriefing, information gathering, safety and comfort, practical assistance, and information on coping and self-care. The types of incidents that required assistance were related to consumer/staff deaths, assaults, threats and stabbings.

Changes/Challenges/Barriers

The training needs assessment took longer than expected to allow more time for community members to participate to ensure needs were adequately assessed across Orange County.

Prevention Program SE3. Training in Physical Fitness and Nutrition	
Estimated annual number to be served in FY 16/17	100
Annual Budgeted funds for FY 16/17	$50,000
Estimated Annual Cost Per Person (for direct service programs only)	$500

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 and trained staff, a personalized fitness program, as well as group support and nutrition education classes. This service is available to individuals receiving Behavioral Health Services and serves as a supplemental service to those participants enrolled in other programs. The program is estimated to serve 100 participants per year.

Strategies to Improve Access

By providing gym memberships at no cost, the service allows individuals with limited income to meet their physical fitness and mental health goals that may be set in their care, service or wellness plan.

Strategies for Non-Stigmatization and Non-Discrimination

BHS strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background.

Outcome

During FY 14/15, 49 participants were served by the program.

Community Impact

This supportive service allows for adults receiving behavioral health services to meet the physical fitness goals developed in their care, service or wellness plans.

Case managers have also expressed their satisfaction with the impact that the program has had on their client's lives. Below is an excerpt of a direct quote form a case manager:

> "The Goodwill Gym is a powerful force to wellness for our clients."

Changes/Challenges/Barriers

The main challenge and barrier for participants is transportation to the gym. To mitigate this barrier, some county behavioral health providers provide transportation assistance to the facility.

Other PEI Program SE4. Mental Health Community Educational Events	
Estimated annual number to be served in FY 16/17	N/A
Annual Budgeted funds for FY 16/17	$214,333
Estimated Annual Cost Per Person (for direct service programs only)	N/A

Program Description

Mental Health Community Educational Events, formerly known as Community-Based Stigma Reduction Art Event Services, provide educational and artistic events that informs the public about mental illness, mental health resources that are available, and stigma related to mental illness. These events also support self-confidence and hope in people living with mental illness and their family members. The program educates the general public about the abilities and experiences of those living with a behavioral health issue. Events include art workshops and exhibits, musical and dance performances representing many cultures, and other stigma reducing activities. These events provide consistent messages aimed at ending the silence of mental illness.

This PEI program had two approaches to reducing stigma in the community. The first approach was called "Drawing out the Stigma" and was a stigma reduction campaign that included a series of art workshops and community art exhibits. This was concluded by a family festival and a short documentary that followed the campaign from the beginning to the end. The campaign targeted participants from different ethnic groups. This included representation from the Vietnamese, Arab, Persian, Korean, Latino and Chinese communities, where the stigma of mental illness runs deep and often prevents families from seeking help. The second approach was called "Unlocking Stigma." This event provided education, arts, and entertainment to reduce the stigma associated with mental illness. Attendees of the two events participated in an interactive information gathering activity at local venues in Orange County including the Bella Terra Mall in Huntington Beach, as well as the Irvine Spectrum Center in Irvine. The interactive information gathering activity was complemented with additional activities such as a fashion show, dance performances, and keynote presentations from individuals that have overcome mental illness. Local organizations were also present to provide additional information and relevant resources for participants of the event. Cultural activities were developed to meet the needs of specific populations, but also allowed for inclusion of all Orange County residents.

Strategies to Improve Access

The program is implemented to be inclusive of those living with mental illness, as well as those who have loved ones living with mental illness. Events were selected in locations that were specific to the demographics of the target populations where stigma is particularly prevalent. This included a variety of ethnic groups and was inclusive of multiple cultures, religions, and languages. Community partners who specialize in working with key cultural populations were involved in this process to improve access. The setting of the stigma reduction art fairs allows individuals to experience the activities within their local communities. This also provides an opportunity for local partner agencies that provide support and resources to interact with local residents living with mental illness.

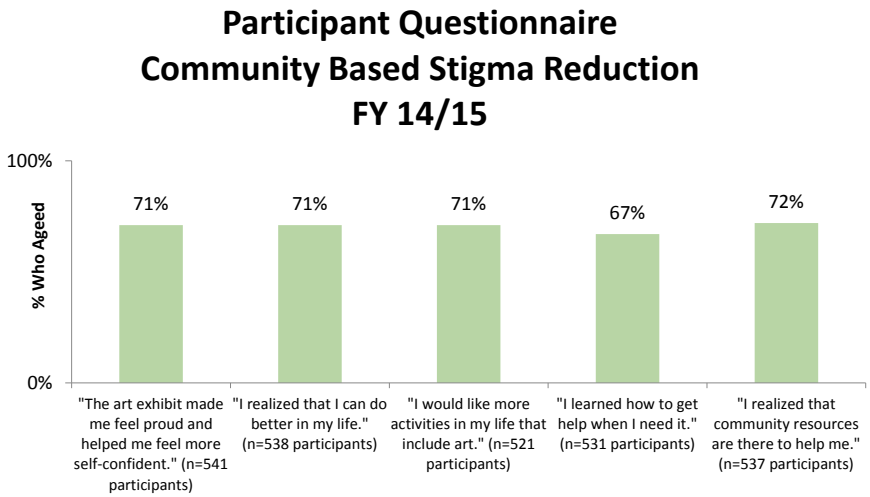
Strategies for Non-Stigmatization and Non-Discrimination

The program strives to make services available to all Orange County residents and provide services that are sensitive and responsive to participants' background. One of the many strategies used is having participants learn how to express their thoughts and feelings around the stigma of mental illness by using traditional and expressive art forms such as poetry, music and dance. The participants' artwork was then displayed at seven community based locations and was open to the public. These displays attempted to educate the community and help dispel the negative perception associated with living with mental illness. This strategy is employed because art is one of the few forms that is capable of transcending multiple groups of people regardless of status, ethnicity, culture, or mental illness. When art can be appreciated, it opens the door to acceptance. Creating and appreciating artwork also builds self-esteem and allows people living with mental illness to define themselves by their abilities rather than their disabilities.

Outcomes

During FY 14/15, 4,136 participants were served by the program. Research indicates that stigma is a barrier to recovery and it negatively affects participation in mental health care services. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), one of the causes of social exclusion and discrimination associated with mental illness is a misperception that people who have mental illness lack the same interest and abilities as everyone else. Evidence points to the fact that stigma reduction art events such as plays, skits, art shows, and other similar events can increase knowledge and reduce the stigma of mental illness. All of the program activities that are conducted are guided by research. Outcomes provided below indicate this research is in line with practice-based results. As an example of program effectiveness, an outcome from one of our programs is presented below.

Consumer participants in the Art Exhibits and Family Festival were asked to complete a questionnaire that assessed the impact of the exhibit on their perceptions about their own experiences suffering from mental illness (e.g., "This art exhibit made me feel proud and helped me feel more self-confident"). The results showed that the majority of consumer participants felt positively about themselves and learned how to seek help due to the exhibits and festival (see graph below).



Community Impact

The stigma events engaged a total of 4,136 participants. The "Unlocking Stigma" event provided activities to the Farsi and Vietnamese speaking population and included respected artists, performers, and speakers that engaged the respective communities. These events targeted cultural communities, but also engaged the general public by hosting events in common areas such as malls and shopping centers. The "Drawing out Stigma" activity built momentum at the community level as well by providing an eight week art workshop series at seven different community agencies which serve various ethnic populations.

These targeted communities often represent non-English speaking monolingual participants. Activities were provided in multiple-languages including: Mandarin, Cantonese, Vietnamese, Korean, Spanish, Farsi and Arabic. These activities allow for participants to be able to comfortably discuss mental health even given the cultural stigma associated with opening up this dialogue. The resources provided by the organizations also expose the community to other recreational classes, counseling and wrap-around services that help make ethnic-specific health access and other needs easier for their target communities. Members of cultural communities often prefer to talk to families, a local spiritual or religious person in their community, and/or pray or perform healing practices which is a much different perspective than that of seeking a traditional medical practitioner.

Participants of these events stated that they were more likely to view individuals within the context of their whole being rather than solely understood by their symptoms. They also reported that those living with mental health symptoms were capable and resourceful and were able to create new social groups and companionships.

A festival was held at the end of all the activities and was held at a cultural arts center and museum called Muzeo. This featured more than 200 art pieces from student and professional artists from Arab, Persian, Afghan, Korean, Latino, Chinese and Vietnamese communities.

Activities also involved the community at large, local service providers, and staff from the local Board of Supervisors. Media engaged in reporting on these activities and articles were posted in the Arab America as well as the OC Register.

Participants and community members have also expressed the impact that the program has had on their lives. Below are a few excerpts of direct quotes from participants:

> "The artwork lets me know or believe that there are people and organizations and efforts out there that support the self-realization of individuals who live with mental illness. This gives me hope."

> "The stigma arts workshop was a very meaningful experience. I learned how precious and special I am. I enjoyed how the music therapy and abstract drawing helped me refresh my mind. The instructor made the activities very enjoyable and I learned how to express my feelings through the arts. It was nice to find new ways to be happy!"

Changes/Challenges/Barriers

The program experienced challenges related to the timing of activities. Since many cultural communities have varying festivals and activities, not all cultural communities were able to participate in all activities. For example, the culmination festival coincided with the Holy Month of Ramadan and many practicing Muslims were unable to participate. The short time length of the program may have also limited the opportunity for participants to continually find their voice through art. Other challenges faced included: working with venues that provided restrictions on fairs that were related to mental health, working with a number of cultural groups at a given time, and ensuring material was relevant and sensitive to all populations.

Challenges were mitigated by adjusting schedules to best meet the needs of participants and by involving a diverse group of staff who are knowledgeable with sensitive populations and are cognizant of stigma and resources for those living with mental illness. These communities and providers assisted in problem solving and adjusting approaches to best meet the needs of the programing.

Prevention Program SE5. Statewide Projects	
Estimated annual number to be served in FY 16/17	35,946
Annual Budgeted funds for FY 16/17	$900,000
Estimated Annual Cost Per Person (for direct service programs only)	$25

Program Description

Statewide Projects serves the community at large from Orange County.

Activities include 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.

Strategies to Improve Access

The program uses state- and county-wide social marketing campaigns/websites to educate the public about mental illness and increase access to mental health services. In addition, the program identified service utilization gaps among ethnic and racial communities and as a result they conducted 11 community workshops, reaching 187 residents. Additionally, 17 community health workers were trained in the El Rotafolio training, that utilizes safeTALK, a suicide prevention curriculum in Spanish and additionally learned to conduct community presentations on the topic of suicide prevention.

Strategies for Non-Stigmatization and Non-Discrimination

The program utilizes a campaign/website known as Each Mind Matters (www.eachmindmatters.org) to educate the community about stigma related to mental health and create a forum making it safe to reach out for help. The campaign is also in Spanish (i.e., “Sana Mente”). In addition, stigma and discrimination reduction programs were developed specifically to reduce stigma associated with mental illness among high school and college students, thereby changing school climate. The first is called Walk in our Shoes, which is a play designed to reduce stigma associated with mental illness and dispel myths, and provides the opportunity to discuss mental health challenges in an open and honest format. Another program, Directing Change, is a video competition among high school and college students that focuses on reducing stigma and promoting suicide prevention. Youth learned about suicide prevention and mental health resulting in the creation of a public service announcement that is used to further educate the community.

Outcomes

RAND Corporation evaluated the Walk in our Shoes program (www.walkinourshoes.org) and found that there was a significant increase in five key knowledge items about mental health and wellness. Participants also expressed that they would provide emotional support to a friend with mental health problems. Additionally, 87% of students that have been involved with Directing Change Student Video Contest (www.directingchange.org) increased their understanding of the importance of standing up for someone living with mental illness.

Community Impact

The Suicide Prevention program within the last fiscal year distributed more than 100,000 suicide prevention materials in English, Spanish, Chinese, Hmong, Lao, Khmer, Korean, Tagalog, and Vietnamese to 14 different organizations in Orange County. These efforts focused on educating the community to recognize the warning signs of suicide, to know the right words to say and to know where to find help. The Suicide Prevention program also reached 2,100 students from six different schools with the Walk in our Shoes program. The Directing Change program received 11 film submissions from students from 14 high schools and the University of California, Irvine. Additionally, a winning film from Orange County was shown in three different local movie theatres for a week.

Participants have also expressed the impact that the program has had on their lives. Below is an excerpt of a direct quote from a participant:

> "I think that the real change that is going to come from this contest [Directing Change] is going to be happening for the rest of our students' lives as they encounter these life challenges and come at them from an empathetic perspective."

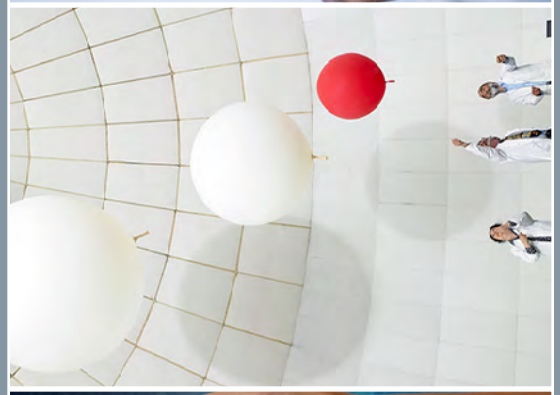
For higher education, the program is supporting and promoting Active Minds on college campuses. These are student-led mental health chapters, which are currently on five OC college campuses. In November, the program co-hosted the National Active Minds Conference in Orange County, bringing chapters from all over the US to Orange County to train students and faculty on best practices for addressing campus mental health.

As part of Media Outreach Training efforts, 150 media professionals were trained on the guidelines for reporting on mental health and these guidelines were adopted by the AP Stylebook, used by the majority of journalists in the United States.

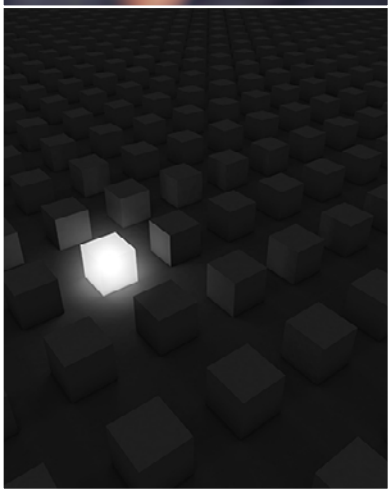
Changes/Challenges/Barriers

The program faced challenges in reaching the broader Orange County community due to limited resources. To mitigate these challenges and to reach a larger geographic area, we collaborated with our community partners to build a network to expand our reach in Orange County.

Innovation (INN)



Innovation (INN)



A. Component Information

An Innovative (INN) project is defined as one that contributes to learning rather than one with a primary focus on providing a service. INN projects can be conceived of as research projects to evaluate the effectiveness of new approaches and practices. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an INN project contributes to learning in one or more of the following three ways:

1. Introduce a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention;
2. Make a change to an existing practice in the field of mental health, including, but not limited to, application to a different population;
3. Apply to the mental health system a promising community-driven practice or approach that has been successful in non-mental health contexts or settings.

In addition 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 groups;
2. Increase the quality of mental health services, including measurable outcomes;
3. Promote interagency and community collaboration related to mental health services or supports or outcomes;
4. Increase access to mental health services.

All INN projects include five components consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320: community collaboration; cultural competence; client and family-driven mental health system; wellness, recovery and resilience focused; and integrated service experience. The development of INN project ideas involves an extensive stakeholder process. Once project ideas are developed, HCA Innovations administrative staff engage in ongoing discussions with the Mental Health Services Oversight and Accountability Commission (MHSOAC) until they are approved. Projects are expected to be operational from one to three years - although in some instances the length of the project may be extended. At the end of operation, a thorough evaluation of each project will be conducted. By their very nature, not all INN projects will be successful. Projects deemed "unsuccessful" will be discontinued. Projects showing positive outcomes will be considered for continued funding, however another funding source must be identified. All findings will be shared with the MHSA Steering Committee.

Innovation (INN)

Group 1 INN included nine projects that were implemented beginning in FY11/12. The nine projects were:

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. Orange County Community Cares Project
7. Project Life Coach
8. Training Services to Meet the Mental Health Needs of the Deaf Community
9. Brighter Futures (formerly Consumer Early Childhood Mental Health)

A major objective of all Group 1 projects was to assess the impact of having peer specialists involved in service delivery and support, posing the overarching question: "Can a well-trained consumer/family member be an effective paraprofessional in all clinical settings?" All INN funding for Group 1 projects has ended. Data for all nine programs will be analyzed and summarized in a final report, which will be submitted to the MHSOAC.

Group 2 INN projects were approved by the MHSOAC on April 24, 2014. The five approved projects are:

1. Step Forward Project: Collaborative Courts On-site Engagement (formerly On-site Engagement in Collaborative Courts)
2. Religious Leaders Behavioral Health Training Services
3. Access to Mobile Cellular/Internet Devices for Improving Quality of Life
4. Strong Families – Strong Children: Behavioral Health Services for Military Families
5. Developing Skill Sets for Independent Living

In FY 15/16, the Step Forward Project, Religious Leaders Behavioral Health Training Services, and Strong Families-Strong Children Behavioral Health Services for Military Families began implementing services. The remaining two projects are currently in the procurement process and will commence in FY 16/17.

Innovation (INN)

Innovation Staff and Peer Specialists from Group 1 Projects.

The development of Group 3 INN projects involved a robust community stakeholder process, which was detailed in the Community Program Planning section of the MHSA FY 15/16 Annual Plan Update. The MHSA 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 Project
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. LGBTQ Homeless Project
10. Immigrant Screening and Referrals
11. Whole Person Healing Initiative

Group 3 INN projects are currently in the development phase. Specific project details, including numbers served, budget and outcomes will be provided in future plans as they become available. The Innovations administrative staff are participating in ongoing discussions with the MHSOAC to approve the recommended projects.

Innovation (INN)

Group1. INN 1./CSS A17* Integrated Community Services (ICS)	
Estimated annual number to be served in FY 16/17	600*
Annual Budgeted funds for FY 16/17	$1,848,000*
Estimated Annual Cost Per Person Served (for direct service programs only)	$3,080*

*This project can no longer be funded through Innovations. Ongoing funding for this project was assumed by Community Services and Supports (CSS) beginning in February 2016.

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, 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 bridges 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 behavioral health clinics. On the community side, County therapists and psychiatrists work within contracted and subcontracted primary care sites. ICS 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.

Outcomes

The ICS project launched on September 1, 2011 and will transition to Community Services and Supports (CSS) beginning in February 2016. From the project launch date to December 31, 2015, ICS served 1,720 unduplicated participants. Participant demographics were as follows:

Participant Demographics
September 1, 2011 – December 31, 2015

Ethnicity	%	Language	%	Gender	%	Age	%
African American	3.55	English	66.10	Male	43.55	16-25 years (TAY)	5.69
Asian/PI	36.10	Farsi	0.17	Female	56.22	26-59 years	79.83
Caucasian	34.48	Korean	6.40	Transgender	0.17	60+ years	14.48
Hispanic/Latino	19.42	Spanish	4.53	Unknown	0.06		
Native American	0.81	Vietnamese	20.47				
Other	2.27	Other	1.10				
Unknown	3.37	Unknown	1.22				
TOTAL	**100**	**TOTAL**	**100**	**TOTAL**	**100**	**TOTAL**	**100**

Innovation (INN)

Outcomes from a previous analysis, which was reported in the MHSA Plan Update FY 14/15 and examined data from the project launch date (September 1, 2011) to June 30, 2014, demonstrated the positive effects of the project. The analysis found significant improvements in anxiety and depressive symptomatology. Results also found significant weight loss for those whose initial Body Mass Index (BMI) measurement classified them as obese (BMI>30), and significant decreases in blood pressure for those whose initial Blood Pressure (BP) classified them as hypertensive (BP>140/90). Final outcome data will be captured and reported to the MHSA Steering Committee as well as incorporated into a final report for the MHSOAC.

Group1. INN 4/PEI CF17 OC ACCEPT	
Estimated annual number to be served in FY 16/17	150*
Annual Budgeted funds for FY 16/17	$420,000*
Estimated Annual Cost Per Person Served (for direct service programs only)	$280*

*This project can no longer be funded through Innovations. Ongoing funding for this project was assumed by Prevention and Early Intervention (PEI) beginning in February 2016.

Program Description

OC ACCEPT provides community-based behavioral health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTQ) and the important people in their lives. The project specializes in addressing issues that are common in the LGBTQ 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. Project services include: individual and/or family counseling; case management; peer mentoring; community-based supportive services; outreach, engagement and linkage services; support and discussion groups; health and wellness activities; and educational and vocational support. The project also raises awareness and reduces stigma by providing education about the LGBTQ population to the community at large.

Outcomes

OC ACCEPT launched on July 1, 2011 and will transition to Prevention and Early Intervention (PEI) beginning in February 2016. From the project launch date to December 31, 2015, OC ACCEPT served 274 unduplicated participants. Participant demographics were as follows:

Participant Demographics
July 1, 2011 – December 31, 2015

Ethnicity	%	Language	%	Gender	%	Age	%
African American	4.01	English	84.31	Male	59.85	0-15 years	5.47
Asian/PI	10.95	Spanish	11.31	Female	23.72	16-25 years (TAY)	40.15
Caucasian	41.61	Vietnamese	2.55	Transgender	14.23	26-59 years	49.64
Hispanic/Latino	33.94	Other	1.46	Other	1.09	60+ years	4.74
Other	4.01	Unknown	0.36	Unknown	1.09		
Unknown	5.47						
TOTAL	**100**	**TOTAL**	**100**	**TOTAL**	**100**	**TOTAL**	**100**

Outcomes from a previous analysis, which was reported in the MHSA Plan Update FY 14/15, demonstrated the positive effects of the project. The analysis found significant improvements in anxiety and depressive symptomatology. Final outcome data will be captured and reported to the MHSA Steering Committee as well as incorporated into a final report for the MHSOAC.

Innovation (INN)

Group1. INN 5/PEI CF 16 OC4VETS	
Estimated annual number to be served in FY 16/17	100*
Annual Budgeted funds for FY 16/17	$996,047*
Estimated Annual Cost Per Person Served (for direct service programs only)	$9,960*

*This project can no longer be funded through Innovations. Ongoing funding for this project was assumed by Prevention and Early Intervention (PEI) beginning in February 2016.

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 navigators, and supportive services staff with expertise in housing and employment resources. This project reaches out to veterans not yet integrated into the Department of Veterans Affairs (VA) system or unaware of their need for behavioral health services. Project services include: case management; behavioral health screening and assessment; employment and housing supportive services; referral and linkage to community resources; outreach and engagement activities; and community trainings.

Outcomes

OC4Vets launched on July 1, 2012 and will transition to Prevention and Early Intervention (PEI) beginning in February 2016. From the project launch date to December 31, 2015, OC4Vets served 527 unduplicated participants. Participant demographics were as follows:

Participant Demographics
July 1, 2012 – December 31, 2015

Ethnicity	%	Language	%	Gender	%	Age	%
African American	11.39	English	75.14	Male	78.94	0-15 years	0.59
Asian/PI	4.55	Spanish	12.33	Female	15.56	16-25 years (TAY)	6.29
Caucasian	41.56	Korean	0.38	Declined to state	0.76	26-59 years	70.33
Hispanic/Latino	16.70	Other	3.80	Other	0.19	60+ years	22.79
Native American	0.57	Unknown	8.35	Unknown	4.55		
Other	11.57						
Unknown	13.66						
TOTAL	**100**	**TOTAL**	**100**	**TOTAL**	**100**	**TOTAL**	**100**

Innovation (INN)

Outcomes from a previous analysis, which was reported in the MHSA Plan Update FY 14/15, demonstrated the positive effects of the project. The analysis found significant improvements in anxiety and depressive symptomatology. Results also indicated a statistically significant decrease in PTSD symptomatology scores. Final outcome data will be captured and reported to the MHSA Steering Committee as well as incorporated into a final report for the MHSOAC.

Innovation (INN)

Group2. INN 1. Step Forward Project: Collaborative Courts On-site Engagement	
Estimated annual number to be served in FY 16/17	200
Annual Budgeted funds for FY 16/17	$224,015
Estimated Annual Cost Per Person Served (for direct service programs only)	$1,120

Program Description

The Step Forward Project provides resources, education, and support to individuals in Orange County's Collaborative Court System, their family members, and/or support persons. This project makes a change to an existing behavioral health practice by (a) making services available to court participants with any serious persistent behavioral health concerns; (b) engaging family members in behavioral health education and supportive services; (c) providing behavioral health education classes and supportive services on-site in Collaborative Courts; and (d) expanding the role of peer counselors to include behavioral health educators.

These services are available to individuals, age 18 and older, with serious behavioral health conditions who are individuals within Orange County's Collaborative Court System, their family members and support persons. Services include behavioral health education, case management, supportive counseling, and referrals and linkages to community resources. Peer counselors facilitate one-on-one or group education courses on-site at the Collaborative Courts. Education courses cover a range of topics including: substance abuse, symptom management, medication management, relationship management, goal setting, stigma, life skills and personal finance.

This project is consistent with the general standards of MHSA (identified in the original act and Title 9, CCR, section 3320): community collaboration; cultural competence; client and family driven mental health system; wellness, recovery, and resilience focused; and integrated service experience.

This project is contracted for a total of two years. It is expected that this time frame will allow Orange County Health Care Agency Behavioral Health Services sufficient time to assess the progress of this project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested county and state agencies.

The continuation of this project will depend on various factors, including data outcomes, stakeholder recommendation/approval, and the contractor's decision to continue services using alternative funding. If an alternative source of funding is not identified, the final year will focus on the referral, linkage, and/or transfer of all active participants to comparable services to maintain best practice and continuity of care.

Innovation (INN)

Proposed Outcomes

In order to understand whether the new/changed practice (i.e., providing behavioral health education for court participants with a behavioral health diagnosis and their family members/support persons, providing such services on-site in Collaborative Courts, and expanding the role of peer specialists as behavioral health educators) makes a positive contribution to the field of mental health, this project will assess changes in participants' knowledge regarding a breadth of behavioral health topics; their overall health/well-being; their understanding about how to access community resources/services that are available to them; and the rate at which those participants link to appropriate supportive services to which they are referred. Paired samples t-test of pre- and post-test measures of program and course knowledge, and also the PROMIS Global Health, will be used to assess reductions in prolonged suffering.

Participant enrollment and data collection for this project began in the middle of FY15/16, so initial impact and outcome data will be available to report in the FY17/18 update.

Group 2. INN2. Religious Leaders Behavioral Health Training Services	
Estimated annual number to be served in FY 16/17	60
Annual Budgeted funds for FY 16/17	$259,450
Estimated Annual Cost Per Person Served (for direct service programs only)	$4,324

*This project does not provide direct services.

Program Description

The Religious Leaders Behavioral Health Training Services project is designed to increase access to services by utilizing a train-the-trainer model to provide basic behavioral health skills training to religious leaders throughout Orange County. Although there have been efforts to educate the religious community on addressing behavioral health in ministry, this project makes a change to an existing behavioral health practice by training religious leaders to become trainers themselves. Furthermore, religious leaders have the opportunity to tailor the basic behavioral health trainings to include culturally specific information. Bringing behavioral health training to the religious community offers a promising direction to increase access to behavioral health care, reduce stigma and improve community collaboration.

This project is designed to serve a broad base of faith based organizations and religious establishments throughout Orange County. Project staff will recruit and train 60 religious leaders in basic behavioral health training annually. Religious leaders will in turn provide ongoing behavioral health trainings for community members and congregants and serve as a gateway to refer those in need to professional services, as appropriate. Potentially, up to 1,800 community members from various religious organizations will be trained in basic behavioral health skills.

This project is consistent with the general standards of MHSA (identified in the original act and Title 9, CCR, section 3320): community collaboration; cultural competence; client and family driven mental health system; wellness, recovery, and resilience focused; and integrated service experience.

This project is contracted for a total of three years. It is expected that this time frame will allow Orange County Health Care Agency Behavioral Health Services sufficient time to assess the progress of this Innovations project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested county and state agencies.

The continuation of this project will depend on various factors, including data outcomes, stakeholder recommendation/approval, and the contractor's decision to continue services using alternative funding.

Innovation (INN)

Proposed Outcomes

In order to understand whether the new/changed practice (i.e., increasing access to behavioral health services by training religious leaders to become behavioral health trainers themselves, as they inform and serve as a behavioral health liaison/resource for their respective religious communities) makes a positive contribution to the field of mental health, this project will assess changes in religious leaders' knowledge, attitudes and beliefs regarding a breadth of behavioral health topics; their confidence as a behavioral health trainer; and the rate at which congregants/community members trained by religious leaders link to appropriate supportive services to which they are referred.

Participant enrollment and data collection for this project started in the middle of FY15/16. Initial impact and outcome data will be available to report in the FY17/18 update.

Group 2. INN3. Access to Mobile Cellular/Internet Devices for Improving Quality of Life	
Estimated annual number to be served in FY 16/17	50
Annual Budgeted funds for FY 16/17	$271,946
Estimated Annual Cost Per Person Served (for direct service programs only)	$5,439

*This project is currently in the procurement process and expected to commence services in FY16/17.

Program Description

The primary purpose of this project is to increase access to behavioral health services by providing mobile smartphones with internet capability to low-income adults and older adults with SPMI or co-occurring behavioral health/substance use disorder who do not have access to technology such as mobile/cellular/internet devices. Participants must be living in supportive housing, transitional housing, and/or participating in full service partnership (FSP) projects in Orange County. This project utilizes peer specialists to assist participants in using technology to: reduce barriers to accessing behavioral health services, reduce isolation, increase social support networks, increase self-reliance and manage behavioral health treatment. Services will include one-on-one peer support, group training in technical assistance, social networking, and coordination with County and community behavioral health/supportive projects. With the support and guidance of peer specialists, individuals will learn how to effectively use technology to benefit their social support, vocational goals, physical health, mental health and housing circumstances.

This project is consistent with the general standards of MHSA (identified in the original act and Title 9, CCR, section 3320): community collaboration; cultural competence; client and family driven mental health system; wellness, recovery, and resilience focused; and integrated service experience.

This project is expected to be contracted for a total of three years. It is expected that this time frame will allow County of Orange Health Care Agency Behavioral Health Services sufficient time to assess the progress of this Innovations project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested county and state agencies.

The continuation of this project will depend on various factors, including data outcomes, stakeholder recommendation/approval, and the contractor's decision to continue services using alternative funding. If an alternative source of funding is not identified, the final year will focus on the referral, linkage, or transfer of all active participants to comparable services to maintain best practice and continuity of care.

Innovation (INN)

Proposed Outcomes

In order to understand whether the new/changed practice (i.e., improving access to behavioral health services and quality of life by providing mobile smartphone technology, training, peer specialist support and case management services) makes a positive contribution to the field of mental health, this project will assess changes in participants' access to behavioral health services, social isolation and support networks, self-reliance and management of behavioral health treatment, and overall quality of life/well-being. Paired samples t-test of pre- and post-test measures of the PROMIS Global Health, and one or more measures of behavioral health indicators such as social isolation, social support and independence), will be used to assess reductions in prolonged suffering.

Innovation (INN)

Group 2. INN4. Strong Families-Strong Children: Behavioral Health Services for Military Families	
Estimated annual number to be served in FY 16/17	50
Annual Budgeted funds for FY 16/17	$445,904
Estimated Annual Cost Per Person Served (for direct service programs only)	$8,918

Program Description

The Strong Families-Strong Children: Behavioral Health Services for Military Families project offers services to the families of Veterans affected by mental health problems. The program addresses mental health issues facing Veterans that may affect the whole family, such as posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use and other mental health issues. These services are designed to increase access to underserved groups by providing case management and counseling services to military families who may be involved in behavioral health programs.

The project is staffed with clinicians and peer navigators with experience and knowledge of military culture and issues. Services include: outreach and engagement, screening and assessment, peer navigator case management, clinical case management, workshops/educational support groups, and clinical counseling utilizing the Families OverComing Under Stress (FOCUS) program, a group treatment for PTSD/TBI.

This project is consistent with the general standards of MHSA (identified in the original act and Title 9, CCR, section 3320): community collaboration; cultural competence; client and family driven mental health system; wellness, recovery, and resilience focused; and integrated service experience.

This project is contracted for a total of three years. It is expected that this time frame will allow County of Orange Health Care Agency Behavioral Health Services sufficient time to assess the progress of this Innovations project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested county and state agencies.

The continuation of this project will depend on various factors, including data outcomes, stakeholder recommendation/approval, and the contractor's decision to continue services using alternative funding. If an alternative source of funding is not identified, the final year will focus on the referral, linkage, and/or transfer of all active participants to comparable services to maintain best practice and continuity of care.

Innovation (INN)

Proposed Outcomes

In order to understand whether the new/changed practice (i.e., increasing access to behavioral health services by providing peer navigator support and clinical case management services to address the family component of the behavioral health issues facing veterans and military personnel) makes a positive contribution to the field of mental health, this project will assess changes in participating families' overall family functioning, communication and support.

Participant enrollment and data collection for this project started in the middle of FY15/16. Initial impact and outcome data will be available to report in the FY17/18 update.

Group 2. INN5. Developing Skill Sets for Independent Living Project	
Estimated annual number to be served in FY 16/17	100
Annual Budgeted funds for FY 16/17	$389,526
Estimated Annual Cost Per Person Served (for direct service programs only)	$3,895

*This project is currently in the procurement process and expected to commence services in FY16/17.

Program Description

The primary goal of this project is to prepare individuals with SPMI to live well and if possible, independently. This project will provide an opportunity for individuals to learn daily living skills through a behavioral health lens, and educate individuals about the relationship between behavioral health management and independent living. It is anticipated that teaching independent living skills with a focus on improving individuals' ability to manage their behavioral health will increase the breadth and quality of supportive services to individuals seeking to live independently, which will thereby increase their opportunities to succeed and retain stable housing.

Services will be provided to adults and older adults who are living with SPMI or co-occurring behavioral health/substance use disorders. Potential participants include individuals who have been typically dependent on others to manage their day to day needs; individuals who have not had the opportunity/ circumstances to live in a residence without supervision; individuals who are homeless or at risk of homelessness, have had a history of homelessness/transiency or unstable housing situations; or individuals who are recently paroled. Potential participants must also express interest and commitment to developing independent living skills and be willing to receive behavioral health treatment.

Services will include outreach and engagement, assessment and screening, independent living skills training, case management, peer specialist support, and coordination with County and community behavioral health and supportive housing projects. Peer specialists will teach participants how to manage their behavioral health independently on a daily basis, which includes: medication management, behavioral health symptom management, behavioral health system navigation, cooking, paying bills, shopping, cleaning, laundry and conflict resolution. Peer specialists will also teach participants about County/community services and resources that may be beneficial to their independent living. Instruction will take place in natural settings, with the ability to teach each module separately based on participant needs. Through active engagement, the participant can learn various skills and become knowledgeable about services that will help them manage their behavioral health, live well and independently.

This project is consistent with the general standards of MHSA (identified in the original act and Title 9, CCR, section 3320): community collaboration; cultural competence; client and family driven mental health system; wellness, recovery, and resilience focused; and integrated service experience.

Innovation (INN)

This project will be contracted for a total of three years. It is expected that this time frame will allow County of Orange Health Care Agency Behavioral Health Services sufficient time to assess the progress of this Innovations project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested Counties and State agencies.

The continuation of this project will depend on various factors, including data outcomes, stakeholder recommendation/approval, and the contractor's decision to continue services using alternative funding. If an alternative source of funding is not identified, the final year will focus on the referral, linkage, and/or transfer of all active participants to comparable services to maintain best practice and continuity of care.

Proposed Outcomes

In order to understand whether the new/changed practice (i.e., teaching skills as they relate to behavioral health challenges encountered by individuals with SPMI; educating participants on independent living skill sets through a behavioral health lens) makes a positive contribution to the field of mental health, this project will assess changes in participants' understanding of behavioral health resources, independent living skill sets, and overall quality of life/well-being.

Group 3. INN1. Continuum of Care for Veteran and Military Children and Families	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$405,160
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Continuum of Care for Veteran & Military Children and Families project seeks to increase access among the underserved veteran/military children and families in Orange County by bringing together a coordinated approach to serve veteran and military-connected children, spouses/partners, and family members through a consortium of nonprofit and public partners. Using a community-based, Family Resource Center (FRC) platform, our Peer Navigators will serve as a centralized resource for referral entities and the larger military network, creating a user-friendly, easy access system for connecting veterans and their families to behavioral health and supportive services. Services provided by Peer Navigators include outreach (via community presentations, magnet events, etc.), primary participant communication, education, and linkage to resources that support healthy and successful family functioning.

This project will primarily serve Orange County Veteran and military-connected children, spouses, and family members, while also including the veteran or active service member to provide guidance, community resource information, referral and linkage, safety net/basic needs, financial and career coaching, family resiliency training, teletherapy, evidence based domestic violence prevention, education projects, and intensive behavioral health and trauma treatment. This project is intended to improve the ability to identify, engage, and meet the service gaps for military families. Overall, this would increase community resources available to veteran family members, reduce the impact of military related issues such as PTSD and domestic violence, and improve their overall quality of life.

Group 3. INN2. Community Employment Services	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$671,426
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Community Employment Services project provides 100% on-site peer support, employment coaching and training to help individuals living with SPMI build their job readiness and independent living skills. This project will provide services to adults and older adults living with SPMI who have not worked for a significant period of time, have expressed a desire to work, and need one-on-one support to reach vocational goals. Potential participants must be Orange County residents who are legally eligible for employment under federal and state law. Potential participants must also be receiving behavioral health treatment throughout the duration of the project. Project staff will collaborate with individuals to identify vocational goals, job interests, and specific support and training needed to achieve stated goals. Utilizing a peer-to-peer model, a trained peer specialist (individual/family member with lived experience in mental illness and recovery) will work alongside individuals to provide comprehensive supportive services related to employment readiness. The goal of this project is to empower individuals living with SPMI to reach their vocational goals, which will thereby increase self-esteem, provide a sense of purpose, pride and dignity to the participant, and contribute to increased well-being.

Innovation (INN)

Group 3. INN3. Employment and Mental Health Services Impact	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$445,161
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

Currently there are no employment centers that provide on-site support to address the emotional and behavioral health symptoms associated with unemployment and the job seeking experience. The Employment and Mental Health Services Impact project is designed to increase access to services through the co-location and integration of behavioral health clinicians at existing local employment centers. This project will offer behavioral health support, education, and counseling as related to supporting successful transition from unemployment to active job searching to gaining unsubsidized employment. Clinicians will have the capacity to address behavioral health issues associated with unemployment as part of the employment center environment and integrated case management team. The co-location of behavioral health and employment services will allow an innovative point of entry into the behavioral health system for individuals unaware of the impact of their symptoms or reluctant to seek services at a behavioral health clinic. The goal of this project is to improve the unemployed job seeker's emotional and behavioral health, which will thereby increase access to behavioral health and support services, contribute to successful employment, and result in employment retention.

Innovation (INN)

Group 3. INN4. Veteran Student Needs Assessment and Treatment	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$571,827
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Veteran Student Needs Assessment and Treatment project is designed to increase access to services among veteran students. This project makes a change to an existing behavioral health practice by offering behavioral health tool/skill building in a social and applied learning environment to serve veterans who are experiencing difficulties in the educational system. Behavioral health providers with experience or knowledge of military culture will instruct and/or work side-by-side with veterans 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. This educational intervention will provide veteran students with the tools and methods to replace persistent negative thoughts and the skills to create positive interactions, which will thereby build a sense of purpose in their educational pursuits, improve academic success and increase their social support.

Group 3. INN5. Shared Housing Project	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$376,361
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Shared Housing Project is designed to increase access to underserved groups by developing a network of shared housing options through business and consumer determined standards. The development of housing standards introduces a new behavioral health practice or approach that will identify key elements of quality shared housing along with a process to review homes to ensure they meet these basic standards. In partnership with a range of local resources, including the Health Care Agency and its contractors (i.e., 2-1-1, OC Partnership, and local hospitals) the Shared Housing Project will offer a voluntary process that owners of shared housing in Orange County can apply to join. A listing of homes that have completed the process would be made available to Orange County residents and healthcare providers. This project will not provide direct services; however, through this process the Shared Housing project will offer a network of housing options which will thereby increase availability, access and housing standards for individuals living with SPMI.

Group 3. INN6. Child Focused Mental Health Training for Religious Leaders	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$550,104
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Child Focused Mental Health Training for Religious Leaders project is designed to increase the access to behavioral health services within religious communities. This project will target a variety of faith based organizations and religious establishments to recruit their leaders to receive basic behavioral and behavioral health training on common childhood mental illness such as anxiety disorders, depression, and attention deficit hyperactivity disorder (ADHD). Services and key activities will include: training and education of pastors (ministers of all faiths); educational resources and workshops for families in an environment where there is comfort and trust; outreach during congregational events; and an established referral network that enables pastors and/or their designees to link families to services that are timely and effective. Families will be able to approach pastors with behavioral health challenges, and pastors will be capable of and empowered to provide referrals to community resources, as well as workshops provided at the church. The goals of this project include: creating a safe and supportive environment where families can seek guidance on mental illness without judgment or stigma at their congregation; and increasing the number of individuals living with SPMI who can be reached by using a train-the trainer method that will be sustainable after the project's end.

Group 3. INN7. Job Training and On-Site support for TAY	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$2,095,407
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Job Training and On-site Support for Transitional Aged Youth (TAY) project makes a change to an existing approach by providing 100% on-site job coaching to transitional age youth living with serious and persistent mental illness (SPMI). It utilizes an innovative method of using behavioral health coaching at the actual site of employment to help participants build confidence and manage behavioral health symptoms that are interfering with workplace performance. The goal of this project is to increase the quality of services for TAY with SPMI, including better treatment outcomes by creating a confidence-building environment where the participants will be able to learn skills related to gaining employment (e.g. interviewing skills, resume writing, etc.), employment issues and concerns (e.g. tardiness, workplace expectations, etc.), and appropriate interpersonal skills. Services will include on-site job coaching, on-site behavioral health coaching, case management, individual/group counseling, educational and employment workshops, and referrals and linkages to resources.

It is anticipated that this project will increase employment readiness and retention. The 100% on-site employment and behavioral health coaching is expected to: (1) ease the participants' transition into an independent employment setting thereby improving their employment stability; (2) allow coaches to address problematic behaviors with participants when they first arise in the workplace rather than waiting until the problem has developed into an actionable problem that derails the participants' employment and future undermining their confidence; and (3) teach participants ways to manage their behavioral health symptoms in the workplace thereby empowering the participants in their recovery.

Innovation (INN)

Group 3. INN8. Developing and Testing Effective EBPs for Children	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$260,011
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

According to the National Child Traumatic Stress Network (NCTSN), the effectiveness of treatment for traumatic stress in children and youth are based on cognitive-behavioral approaches. These approaches include teaching children stress management and helping them create a coherent "narrative" or story of what happened. More importantly, these approaches involve the parents. Parents play an important role in treatment by participating in interventions with the therapist and helping the child practice new therapeutic strategies at home. Currently, treatment models such as Integrative Treatment of Complex Trauma (ITCT) and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) have both been identified as empirically supported treatments and promising practices in treating traumatized children and adolescents. This current project proposes bringing together the strengths from current empirically supported trauma models, such as TF-CBT and ITCT, to create an innovative, comprehensive and trauma-informed treatment manual for children and youth. This innovative trauma-informed manual will then be tested for its effectiveness at various county/community children's mental health clinics in Orange County. This project is meant to increase the quality of services, including better outcomes for working with children with complex trauma by developing a more comprehensive trauma treatment model and testing its effectiveness at various children's behavioral health clinics in Orange County.

Group 3. INN9. LGBTQ Homeless Project	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$1,071,827
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The LGBTQ Homeless Project introduces a new application to the behavioral health system by addressing LGBTQ homelessness through a combination of behavioral health services. This project is designed to increase access to services for the LGBTQ community, targeting the needs of those who are homeless or at-risk of becoming homeless. Services will include family reunification, preventative methods to address homelessness, behavioral health, and LGBTQ safe housing placements. This project utilizes a preventative model to assist those individuals who are currently housed, but are in imminent danger of homelessness by using strategies such as mediation, public assistance projects and flex funding to retain housing placements. The goal of this project is to create LGBTQ specific transitional living and emergency shelter beds in Orange County, thereby increasing safe housing options and access to behavioral health services for this population.

Group 3. INN10. Immigrant Screening and Referrals	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$432,479
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Immigrant Screening and Referrals project is designed to increase access to services among immigrants in Orange County. This project makes a change to an existing approach by creating culturally and linguistically competent services for refugees and entrants. Services and key activities of this project will include: behavioral health assessment, community-based support, individual and/or family therapy, and group psycho-educational classes on topics such as financial literacy, job readiness, and school readiness for children to help them assimilate into the mainstream culture.

Group 3. INN11. Whole Person Healing Initiative	
Estimated annual number to be served in FY 16/17	TBD*
Annual Budgeted funds for FY 16/17	$928,427
Estimated Annual Cost Per Person Served (for direct service programs only)	TBD*

*This project is currently under development. Additional details will be available once the project is approved by the MHSOAC.

Program Description

The Whole Person Healing Initiative project is a new integrative health care approach that brings together physical, behavioral and spiritual health in one location. The project is designed to increase the quality of services, including better outcomes, by incorporating the component of spirituality into primary care and behavioral health services. Services will include: counseling, psychoeducation, peer support services, prayer support groups, spiritual healing techniques as related to the religion/spirituality (R/S) of the patient, and referrals and linkages to various R/S communities in Orange County. Physicians, nurses and behavioral health clinicians in this project will be trained about holistic care that includes healing the patient as a whole so that the integration of R/S can happen at both physical and behavioral health care.

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 Facilities and Technological needs. Orange County received slightly more than $37 million for this component. Of that amount, 35% was allocated to Capital Facilities and 65% was allocated to Technology.

Use of Capital Facilities Funds

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

Programs that occupy the Tustin Street Facility include the:

1. Adult Crisis Residential Program, which serves as an alternative to hospitalization for individuals with acute and chronic mental illness.
2. Wellness/Peer Support Center, which 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.
3. Education and Training Center, which provides support to consumers and their families who want to enhance living skills or basic education, or 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).

Capital Facilities and Technological Needs

Use of Technology Funds

County of Orange 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 a standard designed to benefit the clients we serve. This is a large project that has been divided into 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.

The first phase of the project plan culminated in the completion of enhanced functionality to our EHR (Integrated Records Information System or IRIS), and successful implementation at our pilot clinic. The enhancements included documentation software designed to help clinicians avoid common errors, as well as electronic prescription software to help psychiatrists manage clients' prescriptions. Additional technical improvements to 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 provide for increased consumer/family access to computers and the internet at several BHS outpatient County operated clinics.

We are in the middle of the second phase of our project this year. This will include continued progress implementing the EHR 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. To date, the implementation of the EHR at the County-operated outpatient Mental Health clinics has gone very well and user acceptance is very high.

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 Behavioral Health Services, as appropriate, including the continued compliance with the federal EHR Meaningful Use program.

MHSA Housing Program Update

Diamond Apartments in Anaheim.

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 severe 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 117 new housing units, including two projects which were built with CSS One-Time Funds. Those 34 units are not included in the table below. Twenty-nine units* (this number does not include 9 MHSA occupied units that are not financed through MHSA funding) that are currently under construction will be completed by summer 2016 and an additional 10 units** will begin construction in April 2016 with anticipated completion in the fall of 2017. An additional 38 units*** have secured a commitment of MHSA funds, and if successful in the first tax credit round of 2016, will be leased-up by spring 2018. When all construction and projects are completed the MHSA Housing program is anticipated to have created at least 194 units of permanent housing for eligible tenants and their families.

Of the original allocation, all MHSA funds have been committed to projects. The following is an account of the original $33 million allocation plus interest earned which is assigned to CalHFA.

MHSA Housing Program Update

The additional $3.5 million that was allocated during the CSS planning process will be added to the recently allotted $5 million to extend the MHSA Housing program into another phase. The original $33 million allotment has been spent and/or allocated, and CalHFA, to which our housing money was assigned, is initiating a Phase Two Program for counties wishing to participate. This second phase will allow Orange County to continue creating new units of affordable housing for the MHSA target population, SPMI individuals who are homeless or at risk of homelessness.

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 2016-17.

	MHSA Units	Total Units	Capital	COSR*	Total
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	$ 550,306	$ 850,000	$1,400,306
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
Henderson House*	14	32	$1,771,442	$1,771,442	$2,550,798
Depot at Santiago**	10	70	$1,265,320	$ 350,000	$1,615,320
Fullerton Heights***	24	36	$3,150,000	$3,150,000	$6,300,000
Oakcrest Heights***	14	51	$1,699,143	$ 851,655	$2,550,798
Totals	**160**	**602**	**$18,725,754**	**$15,467,266**	**$34,193,020**

*Capitalized Operating Subsidy Reserves

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**

MHSA Housing Program Update

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
Alegre Family Apts.	11	0	1	104
Totals	**77**	**6**	**5**	**343**

MHSA Project in Construction	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Lincoln Ave. Apts.	15	0	1	70
Henderson House, Rehab	14 Bedrooms, shared condos	0	0	14
Totals	**29**	**0**	**1**	**84**

MHSA Projects Near Construction Start	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total Units including MHSA
Depot at Santiago	10	0	1	70
Totals	**10**	**0**	**1**	**70**

MHSA Projects in the "Pipeline"	One Bedroom MHSA Units	Two Bedroom MHSA Units	Manager's Unit	Total MHSA Units	Total Units leveraged including MHSA	Comments
Fullerton Heights	18	6	1		36	Reposting compete, requested 6 additional units. Awaiting final CalHFA approval, additional financing.
Oakcrest Apartments (formerly Savi Ranch II)	7	7	1		51	Reposting compete, requested 7 additional units. Awaiting final CalHFA approval, additional financing.
Totals	**25**	**13**	**2**		**87**	
Grand Totals	**166**	**28**	**10**	**194**	**669**	

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Funding Summary

County: Orange

Date: 3/31/16

	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 FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	87,424,001	39,231,989	20,855,694	0	7,468,299	
2. Estimated New FY2016/17 Funding	107,552,105	28,680,561	7,170,140			
3. Transfer in FY2016/17[a/]	(4,975,642)			4,975,642		
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	190,000,464	67,912,550	28,025,834	4,975,642	7,468,299	
D. Estimated FY2016/17 Expenditures	131,593,772	34,952,761	11,090,858	4,975,642	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.

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Orange Date: 3/31/16

	Fiscal Year 2016/17					
	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	7,320,033	6,654,575	665,458	0	0	0
2. T1 - TAY Full Service Wraparound	9,277,915	8,434,468	843,447	0	0	0
3. A1 - Adult Full Service Partnership	25,862,481	21,771,114	3,967,708	85,784	0	37,875
4. O2 - Older Adult FSP & Support & Intervention Systems	2,802,093	2,536,395	262,728	2,971	0	0
5. A11 - Mental Health Court - Probation Services	696,000	696,000	0	0	0	0
6. FSP Percent of Non Admin Programs Below	17,731,255	14,884,401	2,720,300	16,016	0	110,539
Non-FSP Programs						
1. C2 - Children's Outreach & Engagement	11,123	11,123	0	0	0	0
2. C3 - Children's In-Home Crisis Stabilization	1,170,344	759,836	410,508	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	1,833,169	956,942	716,658	0	0	159,568
6. C7 - OC Children with Co-Occurring MH Services for Children	3,000,000	2,000,000	1,000,000	0	0	0
7. C8 - Outpatient Mental Health Services Expansion: Children and Youth	1,300,000	650,000	650,000	0	0	0
8. C9 - Dual Diagnosis Support Services	0	0	0	0	0	0
9. C10 - Medi-cal Match: Dual Diagnosis Support Services	470,250	427,500	42,750	0	0	0
10. C11 - Children's Crisis Stabilizaiton Unit (Urgent Care)	2,062,500	1,875,000	187,500			
11. T2 - TAY Outreach & Engagement	11,577	11,577	0	0	0	0
12. T3 - TAY Crisis Residential Services	127,395	119,895	7,500	0	0	0
13. T4 - TAY Mentoring Program	147,380	147,380	0	0	0	0
14. T5 - TAY- CAT	272,267	272,267	0	0	0	0
15. T6 - TAY PACT	840,086	672,069	168,017	0	0	0
16. A2 - Adult CAT	3,486,580	2,965,419	513,125	7,861	0	175
17. A3 - Adult Crisis Residential	4,289,586	3,338,594	950,993	0	0	0
18. A4 - Supportive Employment	1,057,134	1,057,134	0	0	0	0
19. A5 - Adult Outreach & Engagement	136,593	136,593	0	0	0	0
20. A6 - Adult PACT	8,659,827	7,201,625	1,423,653	22,885	0	11,663
21. A7 - Wellness Center	2,642,809	2,642,809	0	0	0	0
22. A8 - Recovery Center Program	11,416,229	8,975,360	2,437,672	3,196	0	0
23. A9 - Adult Peer Monitoring	245,812	245,812	0	0	0	0
24. A10 - Assisted Outpatient Treatment	2,218,410	2,218,410	0	0	0	0
25. A12 - Drop in Center	500,000	500,000	0	0	0	0
26. A13 - Housing for Homeless	1,700,000	1,700,000	0	0	0	0
27. A14 - Housing and Year-Round Emergency Shelter	1,298,821	1,298,821	0	0	0	0
28. A15 - Transportation Program	500,000	500,000	0	0	0	0
29. A16 - In-Home Stablization Services	1,425,000	1,425,000	0	0	0	0
30. A17 - Integrated Community Services	1,848,000	1,848,000	0	0	0	0
31. A18 - Crisis Stabilization Unit (Urgent Care)	2,500,000	2,500,000	0	0		0
32. A19 - Dual Diagnosis Residential Treatment	500,000	500,000	0	0		0
33. O1 - Older Adult Recovery Services	2,433,213	1,568,047	849,617	15,549	0	0
34. O3 - Older Adult PACT	591,400	438,171	131,412	21,817	0	0
35. O4 - Older Adult Peer Mentoring	586,605	586,605	0	0	0	0
36. H1 - CSS MHSA Housing Program Assigned Funds	100,319	100,319	0	0	0	0
36. H2 - Transfer to CalHFA*	5,000,000	5,000,000				
CSS Administration	19,409,512	19,310,914	0	0	0	98,598
Total CSS Program Estimated Expenditures	150,363,064	131,593,772	18,174,794	176,079	0	418,418
FSP Programs as Percent of Total	50.3%					

* No administrative cost has been added to this line item and this amount is excluded from the "FSP Programs as Percent Of Total"

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Orange Date: 3/31/16

	Fiscal Year 2016/17					
	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	1,049,657	1,049,657				
3. Mental Health Career pathways Programs	917,000	917,000				
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					
18.	0					
19.	0					
20.	0					
WET Administration	758,996	758,996				
Total WET Program Estimated Expenditures	4,975,642	4,975,642	0	0	0	0

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Orange

Date: 3/31/16

	Fiscal Year 2016/17					
	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 Co. 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 Hotline	272,533	272,533				
8. CF8 - Survivor Support Services	270,693	270,693				
9. CF16 - OC4VETS	996,047	996,047				
10. CF17 - OC Accepts	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 - Warm Line	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 / OC Links	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	0	0				
Total PEI Program Estimated Expenditures	34,952,761	34,952,761	0	0	0	0

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Orange

Date: 3/31/16

	Fiscal Year 2016/17					
	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 3 INN Programs						
1. INN1-Contiuum of Care for Veteren & Military Children and Families	405,160	405,160				
2. INN2-Community Employment Services	671,426	671,426				
3. INN3-Employment and Mental Health Services Impact	445,161	445,161				
4. INN4-Veteran Student Needs Assessment & Treatment	571,827	571,827				
5. INN5-Shared Housing Project	376,361	376,361				
6. INN6-Child Focused MH Training for Religious Leaders	550,104	550,104				
7. INN7-Job Training & On-Site support for TAY	2,095,407	2,095,407				
8. INN8-Developing and Testing Effective EBP's for Children	260,011	260,011				
9. INN9-LGBTQ Homeless Project	1,071,827	1,071,827				
10. INN10-Immigrant Screening & 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				
TOTAL GROUP 3	**9,213,664**	**9,213,664**				
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	224,015	224,015				
2. INN2-Religious Leaders Mental Health First Aid	259,450	259,450				
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	445,904	445,904				
5. INN5-Skill Sets for Independent Living Project	389,526	389,526				
Group 2 Administration Cost	286,352	286,352				
TOTAL GROUP 2	**1,877,193**	**1,877,193**				
GRAND TOTAL OF INN Group 1 and 2	**11,090,858**	**11,090,858**	0	0	0	0

Budget Exhibit

FY 2016-17 Annual Update - Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Orange

Date: 3/31/16

	Fiscal Year 2016/17					
	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					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	164,475	164,475				
Total CFTN Program Estimated Expenditures	4,164,475	4,164,475	0	0	0	0

EXHIBIT A:
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: 714-834-7024
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 5/10/16
Signature Date

County: Orange

Date: May 10, 2016

EXHIBIT B:
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 5/10/16
Signature Date

I hereby certify that for the fiscal year ended June 30, 2015, 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 12/17/15 for the fiscal year ended June 30, 2015. I further certify that for the fiscal year ended June 30, 2015, 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.

Salvador Lopez for Eric Woolery
County Auditor Controller / City Financial Officer (PRINT)

Salvador Lopez 5/10/16
Signature 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)

APPENDIX I:
MINUTES FROM MENTAL HEALTH PUBLIC HEARING

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
TEL: (714) 834-5481
MHB Website:
http://ochealthinfo.com/bhs/about/mhb

Tuesday, May 10, 2016
9:00 a.m. – 10:30 a.m.

Meeting Location
Neighborhood Community Center
ADAMS Room
1845 Park Avenue
Costa Mesa, CA 92627

MINUTES
Page 1 of 3

Members Present: Alisa Chatprapachai, Brian Jacobs, Judith Lewis, Karyn Mendoza, Carolyn Nguyen, Michaell Rose, Gregory Swift

Members Absent: Supervisor Andrew Do, April Guajardo

Call to Order at 9:12 a.m. by Michaell Rose

Welcome and Introductions
- Pledge of Allegiance
- Member introductions

Approval of Minutes – Action Item
- March 23, 2016
  - Carolyn Nguyen made a motion to approve the minutes from the March 23, 2016 meeting and Karyn Mendoza seconded the motion with no corrections. The minutes were approved for the record. Vote: 7 yes/ 0 no
- April 27, 2016
  - Gregory Swift made a motion to approve the minutes from the April 27, 2016 meeting and Alysa Chatprapachi seconded the motion with no corrections. The minutes were approved for the record. Vote: 7 yes/ 0 no

Public Comment
- Steve McNally expressed his concerns on the advertisement of the Mental Health Board Meeting and the Public Hearing. He suggested for fliers to be advertised as well as having the MHSA draft plan available at the local libraries.

APPENDIX I:
MINUTES FROM MENTAL HEALTH PUBLIC HEARING

County of Orange
Mental Health Board

405 W. 5th Street
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Tuesday, May 10, 2016
9:00 a.m. – 10:30 a.m.

MINUTES
Page 2 of 3

Announcements

- Michaell Rose provided information on SB 1273, MHSA Crisis Stabilization Services. She advised the board that she will be representing the Mental Health Board while testifying for the Senate and she asked the board for their support in this matter.

Open MHSA Public Hearing

- Opening Remarks: Jeff Nagel, BHS Director of Operations
  - 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 shared information about the plans' implemented changes for easier navigation. He provided a detailed presentation highlighting some facts and history about MHSA and its components. He also provided information on the two (2) public comments that were received on the plan. Finally, he provided information on the community planning involvement and stakeholder driven process for the MHSA Annual Plan Update FY 2016/2017.

- Guest Speakers
  - A total of seven (7) individuals spoke in support of the MHSA Annual Plan Update Fiscal Year 2016-2017. These individuals represented a consumer, family member, professional, and public interest point of view.

- Public Comment
  - There were a total of five (5) public comments; one (1) individual shared his concerns on the availability of crisis stabilization unit beds in Orange County. Four (4) individuals shared their appreciation and support for MHSA funded programs and services, in particular the Full Service Partnerships.

APPENDIX I:
MINUTES FROM MENTAL HEALTH PUBLIC HEARING

County of Orange
Mental Health Board

405 W. 5th Street
Santa Ana, CA 92701
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Tuesday, May 10, 2016
9:00 a.m. – 10:30 a.m.

MINUTES
Page 3 of 3

Close Public Hearing and MHB Vote: Action Item – Approved

- Michaell Rose called for a motion to approve the MHSA Annual Plan Update Fiscal Year 2016-2017. Gregory Swift made a motion to approve the plan and Carolyn Nguyen seconded the motion. The MHSA Annual Plan Update Fiscal Year 2016-2017 was unanimously approved with a 7 yes/0 no vote.

Adjournment

- 10:49 am

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 ORDERS FROM THE BOARD OF SUPERVISORS

ORANGE COUNTY BOARD OF SUPERVISORS

MINUTE ORDER

May 24, 2016

Submitting Agency/Department: HEALTH CARE AGENCY

Approve Plan Update for Mental Health Services Act, Proposition 63 programs and services, 7/1/16 - 6/30/17 ($186,777,508); 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. 61

Special Notes:

Copies sent to:

HCA – Jeff Nagel

5/27/16

I certify that the foregoing is a true and correct copy of the Minute Order adopted by the Board of Supervisors, Orange County, State of California.
Robin Stieler, Clerk of the Board

By: _____
Deputy

1

APPENDIX II:
MINUTE ORDERS FROM THE BOARD OF SUPERVISORS

Agenda Item 61

AGENDA STAFF REPORT

ASR Control 16-000634

15H16

MEETING DATE:	05/24/16
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):	Jeff Nagel (714) 834-6587
	Mary Hale (714) 834-6032

SUBJECT: Mental Health Services Act Annual Plan Update FY 2016-17

CEO CONCUR	COUNTY COUNSEL REVIEW	CLERK OF THE BOARD
Concur	No Legal Objection	Discussion 3 Votes Board Majority

Budgeted: N/A **Current Year Cost:** N/A **Annual Cost:** FY 2016-17 $186,777,508

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: 6/2/2015 #33

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, 2016, through June 30, 2017, in the amount of $186,777,508.
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 2016-17 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,

Page 1

APPENDIX II:
MINUTE ORDERS FROM THE BOARD OF SUPERVISORS

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 Technological Needs, Prevention and Early Intervention, and Innovation.

On May 13, 2014, the Board approved the MHSA Three Year Program and Expenditure Plan FY 2014-15, FY 2015-16 and FY 2016-17, and on June 2, 2015 approved of the FY 2015-16 MHSA Annual Plan Update. The Annual Plan Update is a comprehensive look at all of the MHSA programs, including the descriptions; outcomes from the previously completed fiscal year; challenges and budgets for the upcoming fiscal year. 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 2016-17 MHSA Plan Update is consistent with the Three-Year Plan already approved by the Board of Supervisors, and was developed with significant community input. The MHSA Steering Committee approved the FY 2016-17 MHSAA program budgets and expansions after review and recommendation from the relevant subcommittees.

Many programs are consistent with feedbacks from the Board Ad Hoc and Board of Supervisor comments at the recent Board meeting. Included in the FY 2016-17 Plan Update is funding for a new Crisis Stabilization Unit (CSU), funding for a new Dual Diagnosis Residential Treatment program, additional funding for MHSA housing, and expansions for eight existing programs based. The FY 2016-17 MHSA Plan Update was posted and distributed throughout the community on April 8, 2016, for a 30-day public comment period. At the end of the public comment period, a public hearing by the Mental Health Board was held on May 10, 2016, and the Plan Update was approved.

The FY 2016-17 MHSA Plan Update includes allocation of available Community Services and Supports dollars to support expanded and enhanced mental health and supportive services consistent with the Mental Health Services Act. Using an extensive stakeholder planning process to identify gaps and needs in the behavioral health system of care, this year's MHSA FY 2016-17 Plan Update includes 72 million dollars spread across the next five years has been allocated to successful programs, or new programs that will address the identified gaps and needs.

The Health Care Agency requests the Board approve the FY 2016-17 MHSA Plan Update as referenced in the Recommended Action.

FINANCIAL IMPACT:

Appropriations and revenues are included in the Health Care Agency's FY 2016-17 Requested Budget.

STAFFING IMPACT:

N/A

ATTACHMENT(S):

Attachment A - FY 2016-17 MHSA Plan Update and Expenditure Report

APPENDIX III:
PUBLIC COMMENTS

County of Orange
Health Care Agency, Behavioral Health Services
MHSA Office
405 W. 5th St. Suite 354
Santa Ana, CA 92701

Phone: (714) 834-3104 E-mail: mhsa@ochca.com

Mental Health Services Act
Plan Update FY 15/16

30-Day Public Comment Form

April 8, 2016 to May 9, 2016

PERSONAL INFORMATION			
Name	Mary Palafox		
Agency/Organization			
Phone number	714-323-0423	E-mail	mmfox@ymail.com
Mailing address (street)	11942 Woodlawn Ave		
City, State, Zip	Santa Ana	CA	92705

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☒	Family member	☐	Education
☐	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

I didn't have time to read the whole budget, but I was hoping some new programs could be funded to help private conservators. We need help in the areas of counseling, communication skills, activities of daily living schedules, and mental health court. (which hopefully should be An option for the more severely disabled offender) This would help save the county money if more families were willing to take on private LPS conservatorship, & provide food/clothing/shelter. Thank you!

APPENDIX III: PUBLIC COMMENTS

Response to Comment #1

I/we definitely agree that we need to expand our training/services regarding private conservatorpships. I just spoke to Dr. Nagel this morning about how we can do so within the existing plan/budget for FY 16/17 and he believes that can be done. We can expand the description and funding in the next 3 Year Plan – beginning in 2017/18.

The Public Guardian facilitates quarterly re-appointment training for Private Conservators (in the evenings at the PG training room), i.e. PG deputies and staff send fliers to the private conservators they are aware of, and Dr. Skahen from Chapman provides the training. For new Private Conservators, the PG deputies provide training to Private Conservators during an app. 1 hour meeting to orient them to the process, the requirements, etc., and give them a copy of the latest Private Conservator Handbook written by County Counsel, as well as assist them as needed with follow up questions and information. And Jim Farrell provides a monthly Private Conservator Support Group, which meets on a Saturday at the Christ Cathedral (formerly Crystal Cathedral).

APPENDIX III:
PUBLIC COMMENTS

County of Orange
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Mental Health Services Act
Plan Update FY 15/16

30-Day Public Comment Form

April 8, 2016 to May 9, 2016

PERSONAL INFORMATION			
Name	Madeline Hall		
Agency/Organization	CHOC Children's Foundation		
Phone number	714-509-8682	E-mail	mhall@choc.org
Mailing address (street)	1201 W. La Veta Ave.		
City, State, Zip	Orange	CA	92868

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
X	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

We are grateful for the County's support of the Co-occurring Clinic at CHOC that will continue – and grow -- to serve more children and teens who have medical conditions like epilepsy, cancer, asthma and diabetes along with mental health challenges. There is an increasing level of awareness that those with chronic/serious medical conditions are 2-5 times more likely to develop mental health conditions than their physically healthy peers.

There are 3 additional points I would like to raise as the FY17 plan is implemented and the County begins to think about the next 3-year effort:

1) **The adult mental health problem will never have a long-term solution without attention to children, with identification of and intervention for troubling issues as early as possible. These issues are not limited to those children whose behavior makes them, as some have termed, "hard to love". They also include those children who are withdrawn and isolated, and those who have difficulty making friends.**
2) **Additional attention will be needed to children coming to local emergency rooms for help. CHOC sees about 1000 kids per year who have a primary psychiatric diagnosis in Orange and at CHOC at Mission (children in the Mission ED). A better system is needed (irrespective of insurance type and with appropriate consents) for timely treatment, tracking, and connection to schools, churches and community organizations that can strengthen the circle of care around these kids and families.**
3) **We hope that opportunities in Innovations Group 3 can move forward. Of note is the work with faith communities on pediatric mental health which is quite different from the current project but could certainly be linked. Thank you.**

APPENDIX III:
PUBLIC COMMENTS

Response to Comment #2

With regard to your comment, I wanted to let you know that we are absolutely moving forward with the Group 3 Innovation projects. We worked with our stakeholders to identify some truly innovative approaches, and we are hopeful that MHSOAC will be supportive of the approaches we have submitted. With regards to the kids being in the ER with psychiatric needs, we are hopeful that the development of two or more Crisis Stabilization Units can be part of the solution. That issue will require more than just CSUs to resolve, but CSUs can certainly be part of the solution.

Again, thank you for your comments.

APPENDIX III:
PUBLIC COMMENTS

County of Orange
Health Care Agency, Behavioral Health Services
MHSA Office
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Phone: (714) 834-3104 E-mail: mhsa@ochca.com

Mental Health Services Act
Plan Update FY 15/16

30-Day Public Comment Form

April 8, 2016 to May 9, 2016

PERSONAL INFORMATION			
Name	Cindy Kim		
Agency/Organization	CHOC Children's Hospital		
Phone number	714-509-8481	E-mail	ckim@choc.org
Mailing address (street)	1201 W. La Veta Ave.		
City, State, Zip	Orange	CA	92868

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
x	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

As a licensed psychologist, I work with children and adolescents with feeding problems across childhood. At CHOC we have specialized services for children with feeding problems (such as non-oral feeders), children who struggle with obesity, and children with eating disorders such as anorexia and bulimia. I have also worked closely with young children with Avoidant/Restrictive Food Intake Disorder (ARFID). Research suggests that children with ARFID are at greater risk to develop more severe forms of eating disorders such as Anorexia and Bulimia.

I am always concerned with seeing children who are potentially headed in the direction of receiving a diagnosis of Anorexia. Sadly, Anorexia has the highest mortality rate of any psychiatric disorder, with research suggesting a mortality rate of 4% and over 5% for individuals with Eating Disorders NOS. When children are admitted to CHOC for medical stablization, their vital signs are so severely impacted, they are risk of dying. I see children and families struggle with this disorder and wish that we had more intensive support for both the children and their families once they are released from CHOC after medical stablization. Ideally family based services that could include a home component should be offered so parents can have support as they try to get their children to eat again. Unfortunately when parents go home, their children often relapse into old eating patterns as the structure of the hospital is no longer available. Children can take hours to eat even a snack and may refuse to eat or drink. Trying to navigate this extreme behavior can be very upsetting and difficult for parents and can lead to relapse for their children. As approximately 1 in 250 young women will experience Anorexia Nervosa, usually starting in adolescence, it is a prevalent problem. I would ask that we continue to find ways to support programs to provide intensive services to children and families.

APPENDIX III:
PUBLIC COMMENTS

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Mental Health Services Act
Plan Update FY 15/16

30-Day Public Comment Form

April 8, 2016 to May 9, 2016

PERSONAL INFORMATION			
Name	Adrianne Alpern		
Agency/Organization	CHOC Children's Hospital		
Phone number	714-509-8481	E-mail	aalpern@choc.org
Mailing address (street)	1201 W. La Veta Ave.		
City, State, Zip	Orange	CA	92868

MY ROLE IN THE MENTAL HEALTH SYSTEM			
☐	Person in recovery	☐	Probation
☐	Family member	☐	Education
x	Service provider	☐	Social Services
☐	Law enforcement/criminal justice	☐	Other (please state)

COMMENTS

I recently began seeing children in the CHOC Co-Occurring Clinic and have seen the positive impact this new and innovative clinic has had on the lives of these children. We have been able to follow children and adolescents throughout their medical treatment and work closely with medical teams to help address serious mental health diagnoses that can negatively effect their medical treatment. I have just begun working closely with other agencies to design and implement more intensive services for children and adolescents whose diabetes is so out of control it is putting their lives at risk. I have seen children's anxiety and depression significantly reduce and their ability to care for themselves increase. In addition, if we can teach adolescents to successfully manage their chronic disorder, we can likely reduce disease morbidity in adulthood.

I am still worried about the impact of children with eating disorders. We are seeing children younger and younger diagnosed with severe eating disorders, with the average age of children admitted to CHOC in the last year being 13 years old. We know that if we can not erradicate this disease in the first or second hospitalization, these children are likely to live with an eating disorder for the rest of their lives, increasing societal costs greatly and reducing their ability to live up to their potential. While we are providing outpatient treatment for these children and adolescents, we recognize that more intensive services are desperately needed to support the family. We know that for adolescents, family based treatment is the only treatment that has demonstrated efficacy. If we could offer more intensive, home based services, we believe that we could shorten treatment times and reduce future lengthy hospitalizations.

APPENDIX III: PUBLIC COMMENTS

Response to Comments #3 and #4

Thank you very much for your comments on the challenges faced by children and adolescents in the county who have eating disorders. In the beginning of FY 15/16 HCA provided funding to begin implementation of a new program to address the needs of children with co-occurring mental health and chronic acute severe physical illness, special needs and eating disorders. In addition, $2 million in Community Services and Supports funding was added in the FY 16/17 MHSA Annual Plan Update to the co-occurring (medical and mental health) category. We appreciate your participation in the stakeholder planning process and calling attention to this important issue. Thank you again for your comments.