Cultural Competence Plan Update 2017

Prepared by:

Bijan Amirshahi, LMFT, LPCC

Evelyn Tran, MBA

Checklist of the 2017 Cultural Competence Plan Requirements Criteria

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Purpose

The Cultural Competence Plan Requirements (CCPR) per Title 9 California Code of Regulations §1810.410 provide updated standards and criteria for the entire County Mental Health System, including Medi-Cal services, Mental Health Services Act (MHSA), and Realignment as part of working toward achieving cultural and linguistic competence. Each county must develop and submit a cultural competence plan consistent with these CCPR standards and criteria (per California Code of Regulations, Title 9, Section 1810.410). "CCPR" in this document shall mean the county's completed cultural competence plan submission inclusive of all requirements. The original CCPR (2002), Department of Mental Health (DMH) Information Notice 02-03, addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) is designed to address all mental health services and programs throughout the County Mental Health System. This CCPR (2014) seeks to support full system planning and integration. This revised CCPR (2014) includes the most current resources and standards available in the field of cultural and linguistic competence, and is intended to move toward the reduction of mental health service disparities identified in racial, ethnic, cultural, linguistic, and other unserved/ underserved/ inappropriately served populations.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, cultural, and linguistic diversity within the County Mental Health System and to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

1. The focus on cultural competency is documented in a number of Behavioral Health Services (BHS) written policies. These include, but are not limited to:

a) BHS Policy 02.01.01 – Cultural Competency, requiring each division to follow the guidelines as for cultural competency as established by the State Department of Mental Health's Cultural Competency Plan.

b) BHS Policy 02.01.02. – Meeting Consumer Language Needs at Key Points of Contact, requiring that consumers have access to linguistically appropriate mental health services.

c) BHS Policy 02-01.03 – Distribution of Translated Materials, requiring the availability of cultural and linguistically appropriate written information in the County's threshold languages to assist consumers in accessing specialty mental health services.

d) BHS Policy 02.01.04 – Provider List – Cultural/Linguistic Proficiency, requiring that consumers have access to a list of County Mental Health Plan providers of Specialty Mental Health Services that includes alternatives and options for cultural/linguistic services.

e) BHS Policy 02.01.05 – Field Testing of Written Materials, requiring that written materials be field tested to ensure comprehension of the information provided.

f) BHS Policy 02.06.02 – Informing Materials for Mental Health Consumers, requiring that the County provide appropriate informing materials in the threshold languages and accurately document the provision of these materials as well as the Consent for Treatment and the Advance Directives.

g) BHS Policy 03.01.03 – Trainings Specifically Pertaining to Cultural competency, establishing a uniform method of reviewing the nature and adequacy of BHS trainings that address cultural issues.

h) BHS Policy 02.01.06 – Cultural Competency Committee, Committee Policies and Procedures to provide policy direction and procedural guidelines for the committee to function as a local forum for consumers, families, service providers and community representatives.

i) BHS Policy 02.01.02 – Meeting Consumer Language Needs, Requires staff to attempt to link a consumer to services in their primary language whenever possible, and to provide interpretive services as needed.

B. Behavioral Health Services (BHS) Contracts

Orange County's commitment to ensure that services are culturally competent is also documented in provisions that have been incorporated into service provider contracts. Although the language varies for specific contracts, below are some relevant examples.

1. The contract for Mental Health Services Act (MHSA) MHSA Community Services and Supports-funded Wellness Center provides that the contractor shall provide a program that is "culturally and linguistically appropriate." The contract also states that "The philosophy of the Wellness Center shall draw upon cultural strengths and utilize service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. Cultural competence shall be a continuous focus in the development of the programming, recruitment, and hiring of staff that speak the same language and have the same cultural background of the members that are to be served. This inclusion of Orange County's multiple cultures is assisting in maximizing access to services offered at the Wellness Center. The Orange County Health Care Agency (HCA) has provided training for all staff on cultural and linguistic issues."

2. The contract for Transitional Age Youth (TAY) Crisis Residential Services includes the requirement that "CONTRACTOR shall include bilingual/bicultural services to meet the needs of persons speaking in threshold languages as determined by COUNTY. Whenever possible, bilingual/bicultural therapists should be retained. Any clinical vacancies occurring at a time when bilingual and bicultural composition of the clinical staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless ADMINISTRATOR consents, in writing, to the filling of those positions with non-bilingual staff."

3. In addition, “CONTRACTOR shall provide services pursuant to this Agreement in a manner that is culturally and linguistically appropriate for the population(s) served. CONTRACTOR shall maintain documentation of such efforts which may include, but not be limited to: records of participation in COUNTY-sponsored or other applicable training; recruitment and hiring policies and procedures; copies of literature in multiple languages and formats, as appropriate; and descriptions of measures taken to enhance accessibility for, and sensitivity to, persons who are physically challenged.”

4. For the Prevention and Early Intervention (PE&I) contracts, language capability is a condition of employment and a specific program need to meet program goals. Specific contract language is used such as, "Contractor shall make every reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e. the unserved and underserved. In the staffing section of PE&I contracts, additional language is used, such as, "Contractor shall make its best effort to include bilingual/bicultural services to meet the diverse needs of the community threshold languages as determined by County. Whenever possible, bilingual/bicultural staff should be retained. Any staffing vacancies occurring at a time when bilingual and bicultural composition of the staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless Administrator consents..."

C. BHS documents to be available at Site Visit:

1. Mission Statement:

Behavioral Health Services’ (BHS) mission is to prevent substance use and mental health disorders: when signs are present, to intervene early and appropriately; and when assessments indicate that treatment is required, to provide the right type of treatment, at the right place, by the right person/program to help individuals to achieve and maintain the highest quality of health and wellness.

2. BHS Statements of Philosophy:

Partnering with our clients and the community, we value:

a) Excellence in all we do

b) Integrity in how we do it

c) Service with respect and dignity

3. HCA/BHS Goals

HCA's goals for BHS describe how we will achieve our vision and our mission – the value created, or the desired improvement in a condition that is of direct consequence to our clients and the public. Employees' individual performance measures are, in turn, based on the Agency's goals and strategic directions.

4. Strategic Plans

a) HCA has also identified two internal business strategies focused on our greatest asset, our employees.

b) Encourage excellence by ensuring a healthy work environment that values employees.

c) Support the workforce through the effective use of technological and other resources.

II. County recognition, value, and inclusion of racial, ethnic, cultural, and linguistic diversity within the system

A. Community outreach, engagement, and involvement efforts.

1. The HCA-BHS Office of Consumer and Family Affairs supports consumers and family members by providing information and education, facilitating access, working to reduce stigma and discrimination, supporting systems change, and fostering consumer and family empowerment. The office works with consumers of mental health services and their family members from the different cultural and ethnic groups in Orange County, Health Care Agency employees, community service providers and other organizations. The Office of Consumer and Family Affairs phone number is 714-834-5917.

2. The OC Links Information and Referral Line provides telephone and online support for anyone seeking information or linkage to any of the Health Care Agency's Behavioral Health Services. These services include children and adult mental health, alcohol and drug inpatient and outpatient services, crisis programs, and prevention and early intervention services. BHS recruits and hires culturally competent and bi-lingual OC Links staff, which currently includes English, Spanish, Vietnamese, Farsi, Arabic and Korean. Trained Navigators provide information, referral, and linkage directly to programs that meet the needs of callers, including multi-cultural and bi-lingual community based services. OC Links utilizes an online “Live Chat” feature to address people linking to services when speaking to someone on the phone isn’t an option, including deaf and hard of hearing clients. The OC Links phone number is 855-625-4657.

3. BHS provides Outreach and Engagement through the two programs: County-Operated BHS Outreach and Engagement and the Contracted Outreach and Engagement Collaborative.

The Behavioral Health Services Outreach and Engagement Team (BHS O&E) serves children, transitional-age youth and adults who are homeless or at-risk of homelessness and experiencing mild to serious behavioral health conditions while residing in Orange County.

The program's services focus on linking individuals to needed mental health, substance use, and other supportive services by addressing their barriers to accessing programs. This is accomplished through developing and building trusting relationships with individuals in the community and collaborating with other service providers.

BHS outreach staff connect with individuals in need by responding to referrals made directly from the community, as well as through regular outreach activities throughout the county. Any individual can request Outreach and Engagement assistance by calling the BHS toll-free triage line at (800) 364-2221. Services are provided in English, Spanish, Vietnamese, Farsi, Korean, Arabic, and Thai.

The Contracted Outreach and Engagement Collaborative focuses on preventing further development of behavioral health conditions and/or intervening early with the first signs and symptoms to prevent conditions from deteriorating. The program is designed to reach people of all ages who are vulnerable or experience mild to moderate behavioral health conditions. The collaborative has three providers: OCAPICA (1-844-530-0240), Child Abuse Prevention Center (1-888-955-6570), and Western Youth Services (1-844-243-0048), with each assigned to either the South, Central, or North region of Orange County. Services are provided in English, Spanish, Vietnamese, Mandarin, Cambodian, Farsi, and Arabic; and include Educational/Skill building workshops, support groups, short-term counseling and case management, and referral/linkage to additional support services.

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) who is responsible for cultural and linguistic competence.

The CC/ESM will report to, and/or have direct access to the Mental Health Director regarding issues impacting mental health concerns related to the identified racial, ethnic, cultural, and linguistic populations within the county.

A. The County shall include evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural and linguistic competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the County's racial, ethnic, cultural, and linguistic populations.

B. Written description of the cultural and linguistic competence responsibilities of the designated CC/ESM.

C. In September 2017, a new Multicultural Development Program (MDP) Coordinator/Ethnic Service Manager (ESM) was hired to take on the responsibilities for promoting the development of appropriate mental health services to meet the diverse needs of the County's racial, ethnic, cultural, and linguistic populations. The MDP Coordinator/ESM was also actively involved with and co-chaired the county-wide Ethnic Services Task Force, which addressed cultural and linguistic issues related to mental health services with ethnic and cultural providers in the community. The task force was essentially absorbed into the multiple stakeholder and task force meetings that led to the many new CSS, PEI and Innovations programs and services.

D. Responsibilities of the MDP Coordinator/ESM include, but are not limited to, the following:

1. Participate in the Cultural Competence plan and development of the Cultural Competence Committee and sub-committees.

2. Develop, implement and ensure accuracy of verbal interpretation and written translation (transliteration) services and materials into the threshold languages as well as American Sign Language (ASL).

3. Participate in all aspects of Mental Health Service Act (MHSA) program implementation strategies as well as performing required system evaluation and reports to the state DMH.

4. Develop, coordinate and facilitate the implementation of the state Department of Mental Health's required Cultural Competency Plan.

5. Provide cultural competence consultation, evaluation, and training/education for the entire behavioral health system of care, including County and service contractors, to ensure service deliveries are culturally and linguistically appropriate and in compliance with local and State mandates.

6. Identify local and regional cultural behavioral health needs of ethnically and culturally diverse populations as they impact County systems of care; make recommendations to department management.

7. Maintain an on-going relationship with community organizations, planning agencies, and the community at large.

E. In 2017, HCA BHS was reorganized. As part of the new organization, the Workforce Education and Training (WET) Program moved from the Authority and Quality Improvement (AQIS) unit to the new division of Navigation, Innovation and Training within the function area of the Children, Youth and Prevention Behavioral Health (CYPBH) unit. The CC/ESM is an administrator under the WET Program management.

F. The CC/ESM administers the Multicultural Development Program (MDP) which aims to promote health equity by enhancing culturally responsive and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides services such as Language Service Coordination, SSI/SSDI Disability Benefits and Employment Consultation and Training to culturally diverse clients, Culture and Mental Health Needs of the Deaf and Hard of Hearing Community Consultation and Training. Clinical trainings and education are conducted that include, but are not limited to topics such as Client Culture, Cultural Groups, Cultural Responsive Services, Stressed Families/Older Adult, People with Developmental Disability, People with HIV/AIDS, Refugees and Immigrants, Trauma-Exposed Individuals, Limited English Proficiency Culture, Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and more. In addition, consumer/peer supervision, culturally responsive and inclusive clinical consultation, culturally responsive and inclusive community research and advocacy are provided while identifying local and regional behavioral health needs of linguistically and culturally diverse populations as they impact County systems of care. MDP also assists in:

1. Developing, coordinating, and facilitating the implementation of a culturally responsive and inclusive plan for Orange County.

2. Developing, implementing, and ensuring the accuracy of verbal interpretation and written translation services and materials in all threshold languages.

3. Planning and organizing cultural diversity events at an organizational and community level, and

4. Supporting strategies and efforts for reducing racial, ethnic, cultural and linguistic disparities.

IV. Identify budget resources targeted for culturally and linguistically competent activities

A. The County shall include Evidence of a budget dedicated to cultural and linguistic competent activities.

1. HCA/BHS currently has two employees dedicated to interpreter and translation services in the Multicultural Development Program (MDP). Their languages include Spanish and Vietnamese. MDP/WET has additional bilingual staff who conduct translation and interpretation services in Farsi and Arabic as part of their job responsibilities. Additionally, there are more than 490 BHS bilingual staff who are able to provide interpreter services at either their assigned service site or as needed.

B. A discussion of funding allocations included in the identified budget above in Section A, also including, but not limited to, the following:

1. Interpreter and translation services:

a) Outside interpreter translation service providers that HCA/BHS currently contracts with include Language Line for interpreter and translation services and Global Works Inc. for ASL.

CRITERION 2: COUNTY MENTAL HEALTH SYSTEM UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The County shall include the following in the CCPR:

A. Summarize the County's general population by race/ethnicity, age, gender, and language. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

2.1 Total Population of Orange County

Gender	Population	Percent
Male	1,565,562	49.3%
Female	1,606,970	50.7%
Total Population	**3,172,532**	

Ethnicity	Population	Percent
White/Caucasian	1,299,559	41.0%
Hispanic or Latino	1,086,691	34.3%
Asian and Pacific Islander	640,738	20.2%
Black/African American	49,643	1.6%
Native American	6,652	0.2%
Multi Race/Other	83,015	2.6%
Other	6,234	0.2%
Total Population	**3,172,532**	

Age	Population	Percent
Under 18	712,641	22.5%
18-64	2,016,693	63.6%
65 and over	443,198	14.0%
Total Population	**3,172,532**	

Source: Censusreporter.org: U.S. Census Bureau (2016). *American Community Survey 1-year estimates.* Retrieved from *Census Reporter Profile page for Orange County, CA*

2.2 OC Youth Population (0-17)

Youth Age	*Population*	*Percent of Total Population*
(00-04)	187,000	5.9%
(05-11)	275,000	8.7%
(12-17)	249,000	7.8%
Youth Gender	*Population*	*Percent of Total Population*
Male	325,000	10.2%
Female	386,000	12.2%
Youth Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	216,000	6.8%
Hispanic/Latino	210,000	6.6%
Asian, Pacific Islander	182,000	5.7%
Black/ African American	8,000*	0.3%
Native American	-*	-*
Multi Race / Other	93,000*	2.9%
Youth Total Pop.	711,000	22%

**=statistically unstable. Complete data unavailable for these subpopulations*

Source: 2014 California Health Interview Survey

2.3 OC Adult Population (18+)

Adult Age (18+)	*Population*	*Percent of Total Population*
18-19	92,000	2.9%
20-24	248,000	7.8%
25-34	377,000	11.9%
35-44	486,000	15.3%
45-54	447,000	14.1%
55-64	363,000	11.4%
65+	361,000	11.4%
Total Adult	2,374,000	74.8%
Adult Gender	*Population*	*Percent of Total Population*
Male	1,184,000	37.3%
Female	1,192,000	37.6%
Adult Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	1,115,000	35.1%
Hispanic/Latino	561,000	17.7%
Asian, Pacific Islander	464,000	14.6%
Black / African American	61,000*	1.9%
Native American	16,000*	0.5%
Multi Race / Other	161,000	5.1%
Adult Total Pop.	2,374,000	74.8%

**complete data unavailable for these subpopulations*

Source: 2014 California Health Interview Survey

2.4 OC Language Population

Languages spoken at home	Population	Percent
English	1,558,350	53.8%
Spanish	770,012	26.6%
Vietnamese	172,876	6.0%
Other	129,608	4.5%
Korean	76,934	2.7%
Chinese	71,112	2.5%
Tagalog	48,176	1.7%
Persian	31,593	1.1%
Arabic	21,792	0.8%
Japanese	15,440	0.5%
Total	2,895,893	100.0%

Source: 2015 Data USA https://datausa.io/profile/geo/orange-county-ca/#intro

More than 46% of Orange County citizens are speakers of a non-English language, which is higher than the national average of 21.5%. In 2015, the most common non-English languages spoken in Orange County were Spanish, Vietnamese, Korean and Chinese.

II. Medi-Cal population service needs (Use current CAEQRO data if available.)
The County shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, age, gender and language as published in most recent CAEQRO reports. Additional demographic categories, social/cultural groups and languages may be addressed as data is available and collected locally).

2.5 Medi-Cal Penetration Rates

	County Population	County Population in Percent	Average Number of Medi-Cal Eligibles per month	Average Number of Medi-Cal Eligibles per month in Percent	Medi-Cal Beneficiaries Served	Medi-Cal Beneficiaries Served in Percent	Penetration Rate
Gender							
Male	1,565,562	49.3%	412,519	46.0%	12625	49.2%	3.06%
Female	1,606,970	50.7%	484,540	54.0%	12984	50.6%	2.68%
Age							
Under 18	712,641	22.5%	326,551	36.4%	10706	41.8%	3.28%
18-64	2,016,693	63.6%	479,716	53.5%	14379	56.1%	3.00%
65 and over	443,198	14.0%	90,792	10.1%	557	2.2%	0.61%
Ethnicity							
White/Caucasian	1,299,559	41.0%	153,065	17.1%	7941	31.0%	5.19%
Hispanic or Latino	1,086,691	34.3%	427,934	47.7%	13080	51.0%	3.06%
Asian and Pacific Islander	640,738	20.2%	84,841	9.5%	2114	8.2%	2.49%
Black/African American	49,643	1.6%	14,698	1.6%	1141	4.4%	7.76%
Native American	6,652	0.2%	1,442	0.2%	114	0.4%	7.91%
Other	89,249	2.8%	5,384	0.6%	557	2.2%	10.35%
Primary Language							
English	1,558,350	49.1%	476,635	53.1%	20,128	78.5%	4.22%
Spanish	770,012	24.3%	297,176	33.1%	4,223	16.5%	1.42%
Vietnamese	172,876	5.4%	83,101	9.3%	625	2.4%	0.75%
Farsi	31,593	1.0%	7,570	0.8%	130	0.5%	1.72%
Korean	76,934	2.4%	10,130	1.1%	104	0.4%	1.03%
Arabic	21,792	0.7%	3,938	0.4%	58	0.2%	1.47%
Other	264,336	8.3%	18,509	2.1%	374	1.5%	2.02%
Primary Language Total	2,895,893	91.3%	897,060	100.0%	25,642	100.0%	2.86%

Source: CA Medi-Cal Eligibility Data System (MEDS) Extract 2017

County and Medi-Cal Eligibles Population

The Male and Female populations are fairly represented in the county population. Female has a higher percentage in Medi-Cal Eligibles population compared to Male. There are measurable differences between the county population and the Medi-Cal Eligibles population especially for ages under 18 and ages 18-64. White/Caucasian and Asian and Pacific Islander ethnicity groups show strong differences in total county population and Medi-Cal Eligibles compared to other ethnic groups. The Hispanic/Latino population, 34.3% of total population, are overrepresented in the Medi-Cal Eligibles at 47.7%. English is the highest primary language in the county and it is also the highest percent of Medi-Cal Eligibles Population. Spanish is the second highest primary language in the county at 24.3%.

Medi-Cal Eligibles to Beneficiaries Served

Based on the Medi-Cal Eligibles and the number of Beneficiaries Served, the following groups are underrepresented: Female, Age 65 and over, Asian and Pacific Islander, Spanish speaking population, Vietnamese and Korean speaking populations. Age 65 and over comprises 10.1% of Medi-Cal Eligibles but with only 2.2% were served. There is a noticeable difference in the Spanish and Vietnamese speaking populations when comparing Medi-Cal Eligibles to Beneficiaries Served. Spanish takes up 33.1% of the Medi-Cal Eligibles but only 16.5% were served in Spanish. Vietnamese language is the third highest primary language recorded for Medi-Cal Eligibles at 9.3% and 2.4% were served in Vietnamese. Meanwhile, children under 18, White/Caucasian, Hispanic or Latino, Black/African American, Native American, and English language are overrepresented in Beneficiaries Served groups.

Penetration Rates

According to the MHP Final Report FY 2016-2017 from Behavioral Health Concepts, Inc., the Statewide Penetration Rate in 2015 was about 4.9%. Orange County's penetration rate is 2.9%. The average difference is 2%. Based on the table above, the penetration rate is higher than average for the following groups: White/Caucasian, Black/African American, and Native American. The Age group 65 and over and Vietnamese speaking populations are among the lowest penetration rates with less than 1%.

III. 200% of Poverty (minus Medi-Cal) population and service needs

The County shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender. Additional demographic categories, social/cultural groups and languages may be addressed as data is available and collected locally).

2.6 Poverty (minus Medi-Cal)

Race/Ethnicity	200% Poverty (minus Medi-Cal)
White/Caucasian	111,784
Hispanic/Latino	171,941
Black/African-American	4,637
Asian, Pacific Islander	84,593
Native American	*
Multi Race/Other	88,402
0-17	52,000
18+	362,000
Female	226,000
Male	186,000

**data unavailable for this subpopulation*

Source: 2014 California Health Interview Survey

The County shall include the following in the CCPR:

From the County's FY 2014-2015, FY 2015-2016, FY 2016-2017, 3-year program and expenditure CSS plan, extract a copy of the population assessment. If updates have been made to this adopted assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, age, gender, and language (other social/cultural groups may be addressed as data is available and collected locally).

2.7 Population Assessment

	County Wide Estimated Total Population		County Wide Estimated Population Living at or Below 200% FPL	
	N	%	N	%
Ethnicity				
Black/African American	66,000	2%	15,000	1%
Asian/Pacific Islander	649,000	21%	203,000	18%
Hispanic/Latino	772,000	25%	521,000	47%
Native American	15,000	1%	-*	
White/Caucasian	1,330,000	43%	210,000	19%
Other	254,000	8%	158,000	14%
Age				
Children (0-17)	711,000	23%	357,000	32%
TAY (18-24)	340,000	11%	129,000	12%
Adults (25-59)	1,505,000	49%	505,000	46%
Older Adults (60+)	529,000	17%	118,000	11%
Gender				
Males	1,508,000	49%	439,000	40%
Females	1,578,000	51%	668,000	60%

**data unavailable for this subpopulation*

Source: 2014 California Health Interview Survey

CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

I. Identified unserved/underserved/inappropriately served target populations:

The target populations include, but are not limited to: ethnic and cultural minorities (e.g., Latino, Vietnamese, Korean, Iranian, Middle Eastern, the Deaf and Hard of Hearing community, and the Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning (LGBTIQ) community); people with limited English proficiency; homeless individuals and families; frail, isolated older adults; trauma-exposed people (including veterans); Children and TAY involved (or at risk of becoming involved) in the juvenile justice system, at-risk of school failure, aging out of the foster care system, or in stressed families; and individuals experiencing behavioral health issues.

II. Identified strategies/objectives/actions/timelines:

A. CSS Plan

a. Strategies: In the Orange County CSS Plan the following strategies for reducing disparities have been implemented:

i. The Peer Support and Wellness Center (i.e. "The Wellness Center") provides services to walk-in adults, 18 years of age and older, who have been diagnosed with a serious mental illness, may also have a co-occurring substance use disorder, and have demonstrated progress in their recovery. Activities are designed to encourage and empower members to seek interests and passions outside of the adult system of care, and offer a pathway for full integration back into the community. Assistance is also offered with employment readiness, job searching, and educational opportunities.

ii. The development and placement of mental health services in locations where the unserved and underserved seek out services is established by working with primary care facilities in Little Saigon, Garden Grove, Santa Ana and Anaheim. It is an ongoing development of networks with other healthcare practitioners that see those who have mental illness years before they walk through the doors of the county mental health system or any other mental health providers in the community.

iii. Outreach efforts have included local leaders in ethnic communities (cultural brokers), who can assist in the dissemination of Behavioral Health Services materials and information. This type of a partnership with community leaders, clergy, etc., helps increase trust and belief in a behavioral health system that may be foreign to most. Outreach, which includes other forms of media, such as radio stations and non-English language newspapers/periodicals helps assist greatly in the dissemination of information and resources.

iv. Services must be provided in the languages of the populations served. A large portion of the unserved/underserved populations in Orange County speak a language other than English. In order to better serve these populations, qualified staff are recruited who speak Spanish, Vietnamese, Korean Farsi and Arabic. All written materials used by clients are translated into the threshold languages. Due to the significant shortage of human service professionals who are bilingual/bicultural, additional strategies must be developed to effectively recruit and retain qualified multi-cultural and bilingual staff. WET and MDP provide language training to culturally competent staff.

v. The County has a partnership with several local universities to provide tuition reimbursement for staff who would like to pursue a Bachelor's or advanced degree in Social Work and Marriage and Family Therapist programs. Classes are offered on county sites in the evening, making it more accessible by staff. To date, a number of support staff have worked through the program and are now clinicians in the system. This method of "growing our own" staff is particularly important for those bi-lingual staff who want to further their education and shift from a support staff position to a clinical staff position.

Program for Assertive Community Treatment

The Program for Assertive Community Treatment (PACT) teams in Orange County target high risk underserved populations such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth (TAY) community, mentally ill adults and older adults. The target population for the Transitional Age Youth PACT program is diverse. In particular, the program targets the underserved ethnic populations of Latinos, Vietnamese, Korean and Iranian, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing.

TAY PACT

Program Description:

The Program for Assertive Community Treatment (PACT) teams in Orange County target high-risk underserved populations such as the monolingual Pacific Asian community, mentally ill Transitional Age Youth (TAY) community, mentally ill adults and older adults. To qualify for PACT services, individuals have to have a mental illness diagnosis, may have co-occurring substance use disorder, and have had at least two psychiatric hospitalizations and/or incarcerations due to a mental health condition within the past year. In addition, treatment at a lower level of care must have failed to maintain the person's stability.

The target population for the Transitional Age Youth PACT program is diverse and includes chronically mentally ill TAY, ages 18 to 26. In particular, the program targets the underserved ethnic populations of Latinos, Vietnamese, Korean and Iranian, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing. Assertive Community Treatment is a best practices model and Orange County PACT teams work to improve their fidelity to this model. The program provides consumer focused, recovery-based services, and provides intervention primarily in the home and community in order to overcome barriers to access or engagement. Collaboration with family members and other community supports are stressed in this multidisciplinary model of treatment. The treatment team is comprised of a multidisciplinary group of professional staff, including Clinical Social Workers, Marriage Family Therapists, Mental Health Specialists, Psychiatrists, and a Supervisor. This team provides medication services, individual and group therapy, substance abuse and family therapy. In addition, supportive services such as money management and linkage are offered. The focus of recovery for this population is to address age appropriate developmental issues such as re-integration into school and employment developing and sustaining social support systems, and attaining independence. This program is sensitive to the individual needs of the Transitional Age Youth consumer, and staff is knowledgeable of the resources and issues for this population.

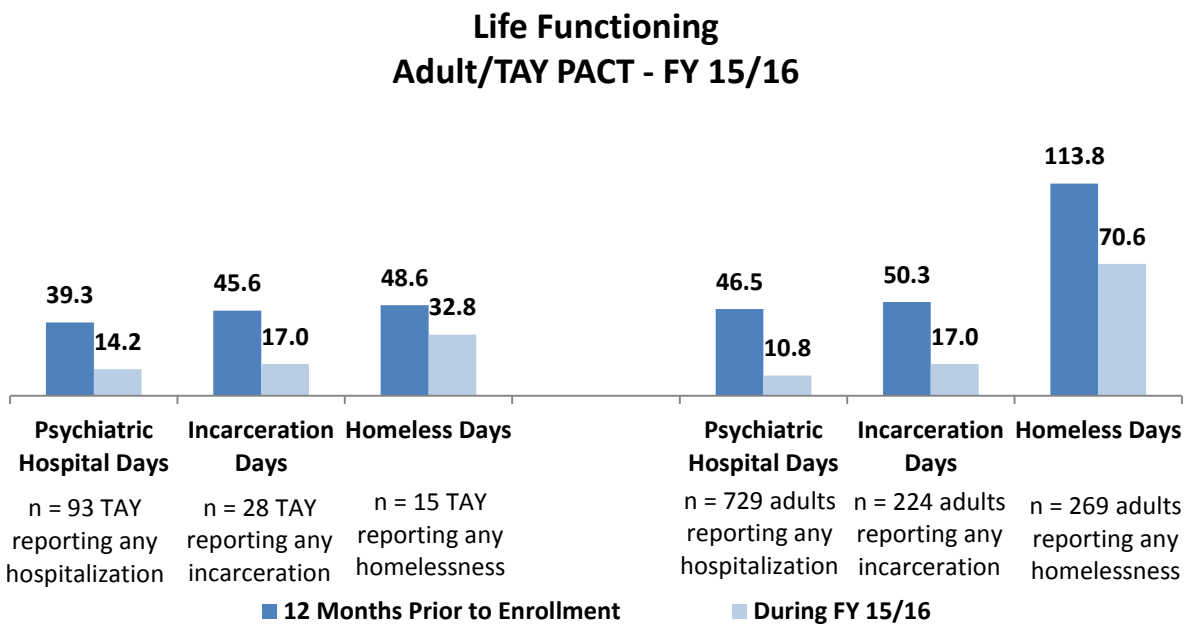
The TAY population served in this program struggles with the onset of acute and chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. This is a crucial developmental stage for these individuals in attaining independence and skills needed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

Outcomes:

A total of 143 TAY and 940 adults were served in the Adult/TAY PACT programs during FY 15/16. Similar to Older Adult PACT, these programs evaluate 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/TAY PACT assisted individuals in improving their life functioning during FY 15/16. This was demonstrated by a 64% decrease in the average number of days TAY spent psychiatrically hospitalized compared to the year prior to enrolling in PACT (see left side of graph below). This difference was statistically significant and small-to-modest in its effect size, which is a measure of practical significance.[1] TAY also reported a 66% decrease in the average number of days incarcerated and a 38% decrease in the average number of days spent homeless during FY 15/16 relative to the year prior to enrolling in PACT. The lack of statistical significance for incarceration days may be attributable, in part, to the small sample size (n=28) combined with the wide range of reported jail days, as the calculated effect size was small-to-modest in magnitude and comparable to that of psychiatric hospitalization days, which was statistically significant. Similarly, the decrease in homelessness was not statistically significant, although this test should be regarded as strictly exploratory due to the very small sample size (n=15).

Similarly, adults enrolled in PACT reported functional gains during FY 15/16 (see right side of graph below). More specifically, they reported a 77% decrease in the average number of days spent psychiatrically hospitalized, which was statistically significant and moderate in effect size. Adults also reported a 66% decrease in the average number of days incarcerated and a 37% decrease in the average number of days spent homeless in FY 15/16 compared to the year prior to enrolling in PACT. These decreases were statistically significant and small-to-moderate in their effect sizes. [1]



[1] *TAY Psychiatric Hospitalization Days: Prior M=39.3, SD=60.1; Since M=14.2, SD=32.4; t (92) = 3.54, p=.001, Cohen's d=.38*
TAY Incarceration Days: Prior M=45.6, SD=73.9; Since M=17.0, SD=24.3; t (27)=1.81, p=.082, Cohen's d=.37
TAY Homeless Days: Prior M=48.6, SD=52.1; Since M=32.8, SD=58.7; t (14)=0.78, p=.45, Cohen's d=.20
Adult Psychiatric Hospitalization Days: Prior M=46.5, SD=74.8; Since M=10.8, SD=29.2; t (728) = 12.54, p<.001, Cohen's d=.52
Adult Incarceration Days: Prior M=50.3, SD=73.6; Since M=17.0, SD=36.2; t (223) =5.95, p<.001, Cohen's d=.42
Adult Homeless Days: Prior M=113.8, SD=121.1; Since M=70.6, SD=107.8 t (268) =4.42, p<.001, Cohen's d=.27

Older Adult PACT

The Older Adult Program of 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 program's overarching goals include engaging individuals into voluntary treatment and assisting them in reintegrating into the community through stable housing, education, employment, and linking to community based support.

The target population includes older adults who are ages 60 and older, who have been psychiatrically hospitalized and/or incarcerated due to their symptoms of mental illness twice 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.

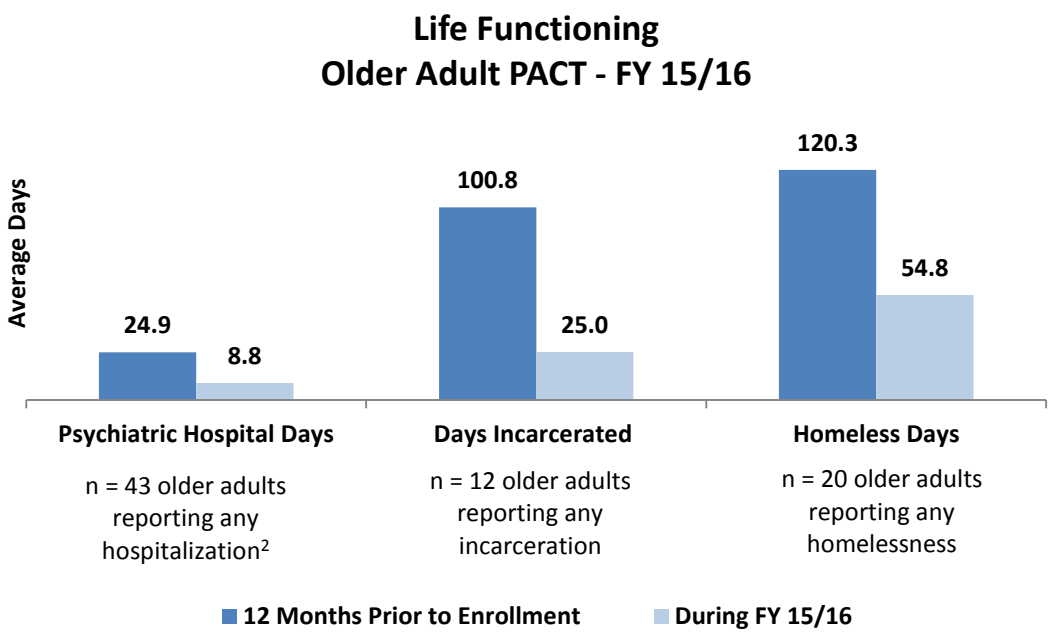
The population struggles with the acute and chronic symptoms of mental illness and consumers often present with multiple diagnoses and multiple functional impairments. This population requires frequent and consistent contact to engage and remain in treatment. The target population is multicultural and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

Outcomes:

A total of 75 older adults were served in the Older Adult PACT program during FY 15/16. Similar to the other PACT programs, the program 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 adults served in PACT reported a 65% decrease in psychiatric hospitalization days during FY 15/16 compared to the year prior to joining the program (see graph below). This decrease was statistically significant and moderate in its effect size,[1] which is a measure of real-world significance or observability of change.

In addition, older adults reported a notable decrease in the average number of days spent incarcerated (75% decrease) and a moderate decrease in the average number of days spent homeless (54% decrease) during FY 15/16 (see graph below). While both of these changes were also statistically significant,[1] due to the consistently low number of older adults who report experiencing either incarceration or homelessness from year to year, the statistical analyses should be regarded as exploratory.



[1] *Psychiatric Hospitalization Days: Prior M=24.9 SD=32.5; Since M=8.8, SD=16.3; t(42) = 3.07, p <.01, Cohen's d=.50*
Incarceration Days: Prior M=100.8 SD=106.0; Since M=25.0, SD=73.5; t(11) = 2.58, p <.05, Cohen's d=.77
Homeless Days: Prior M=120.3 SD=148.1; Since M=54.8, SD=106.5; t(19) = 2.20, p <.05, Cohen's d=.51

[2] *Two adults were excluded from this analysis because their extended hospitalizations were due to the unavailability of a discharge location with an appropriate level of care and not due to medical necessity.*

Crisis Assessment Team

The Crisis Assessment Team (CAT) provides 24-hour-mobile response services to any adult who have a psychiatric emergency. This program assists law enforcement, social service agencies and families in providing mental health crisis intervention services. Bilingual/bicultural staff members work with family members to provide information, referrals and community support services.

Children's CAT

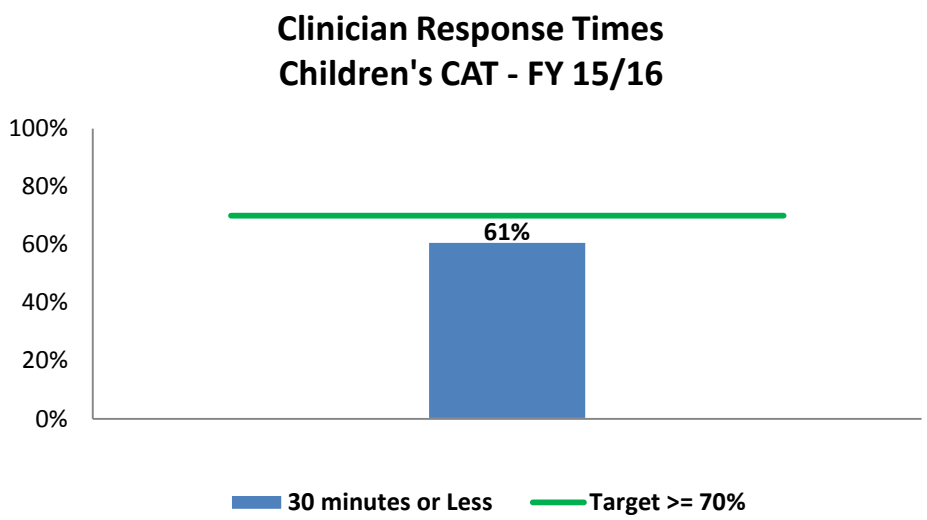
Program Description:

The Children's Crisis Assessment Team (CAT) responds to psychiatric emergencies for any youth under 18 years of age, anywhere in the county. The team operates 24 hours a day, 365 days per year. The purpose of the team is to intervene in crisis situations. If safety cannot be assured, the CAT member will write a 72-hour hold and facilitate the child's placement in a psychiatric hospital. If the child can be successfully treated at a less restrictive level of care, the team member will assure that the linkage is made. The team has been expanded as the workload has increased.

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 (the time staff leaves where they are, office or other evaluation site, to respond to the call) for an evaluation and the time they arrive at the evaluation location. As can be seen in the graph below, the goal is for the dispatch-to-arrival time to be 30 minutes or less at least 70% of the time. The program's 61% response rate for FY 15/16 fell short of this goal and is attributable to staffing shortages and a consistent trend of call volume increasing during peak rush-hours.

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 continued to be hospitalized at a rate of 42%.



Transitional Age Youth CAT

Program Description:

The Crisis Assessment Team (CAT) provides mobile response, including mental health evaluations/assessment, 24 hours per day, 7 days per week, for those who are experiencing a mental health crisis. In response to psychiatric emergencies, staff provides crisis intervention, assessments for lower levels of care, evaluations for involuntary hospitalizations, and assistance for police, fire, and social service agencies. Bilingual/bi-cultural staff members work with family members to provide information, referrals, and community support services.

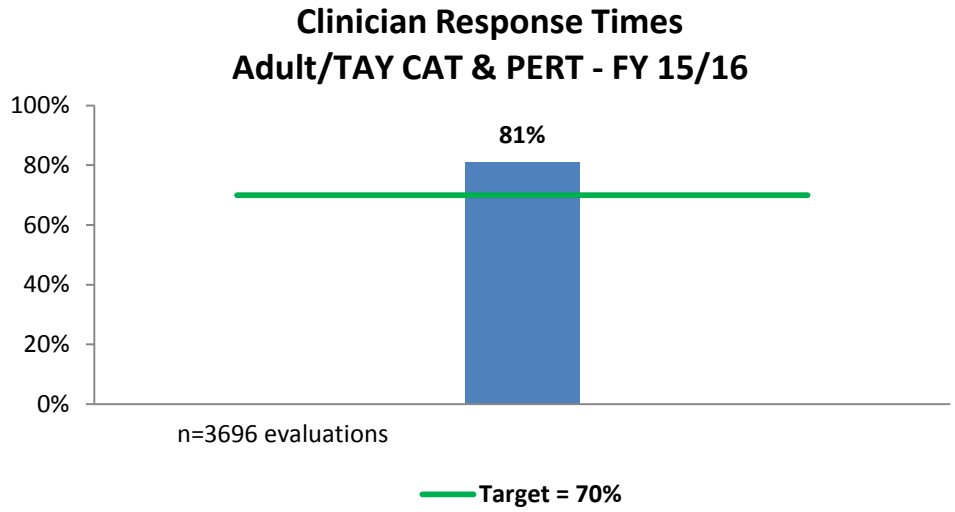
The Crisis Assessment Team has a Transitional Age Youth (TAY) component that provides specialized services to adults from 18-25 years of age. This program currently has three staff members that have expertise and additional training in working with the TAY population.

The Psychiatric Evaluation and Response Team (PERT) is a specialized unit designed to create a behavioral health and law enforcement response team. While the primary purpose of the partnership is to assist individuals in need 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 individuals who are living with mental illness. PERT provides a behavioral health clinician to ride along with a police officer to provide a prompt

response to individuals in need, including an assessment and provide them with the appropriate care and linkages to other resources as needed in a dignified manner.

Outcomes:

TAY CAT and the Adult CAT/PERT teams conducted a total of 3,696 evaluations during FY 15/16. 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 Adult/TAY CAT and PERT for FY 15/16. In addition, the average clinician response time for the fiscal year was just under 21 minutes.



Crisis response teams also examine 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/PERT continued to be hospitalized at a rate of approximately 50%. The program has noted a growing number of adults diagnosed with co-occurring disorders who are under the influence of alcohol or other substances at the time of evaluation, which can elevate their risk and increase level of care needs, thereby limiting their placement options.

Supported Employment

Program Description:

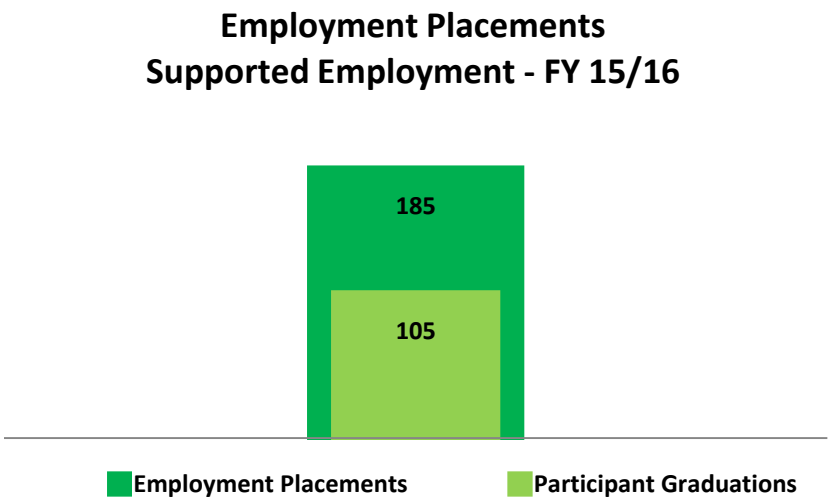
The Supported Employment program provides services which include both competitive and volunteer job placement, ongoing work-based vocational assessments, benefits planning, individualized program planning, job coaching, counseling, and peer support to adults with a mental illness and/or co-occurring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

Participating adults work with a team of Employment Specialists (ES) and Peer Support Specialists (PSS). The ES assist participants with locating job leads. They strive to build working relationships with prospective employers and are the main liaisons between the employers and program participants. The ES also educate employers to understand mental illness and combat stigma. The ES 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 maintain ongoing, open communication with clinical plan coordinators to promote positive work outcomes.

Peer Support Specialists (PSS) are individuals with lived experience from the recovery of behavioral health and substance use challenges who have skills learned in formal training and/or professional roles. The PSS deliver services in a behavioral health setting to promote mind-body recovery and resilience. The PSS, as part of the Employment Teams, provide training and support to adults who are working and/or volunteering in the community, and assist the ES in teaching work duties and modeling appropriate behavior. The PSS are also responsible for assisting adults in preparing for job placement, improving job retention, ensuring the quality of work at job sites and strengthening partnerships with employers and referring clinics.

Outcomes:

The Supported Employment Program served 419 participants in FY 15/16, which included 304 new enrollments. Program performance is evaluated by the number of participants who graduate after achieving the State of California job retention benchmark of 90 days in paid employment. In FY 15/16, 105 of the 185 (57%) job placements resulted in a successful graduation from the program after achieving the employment milestone (see graph below). This graduation rate reflects a 6 percentage point increase from FY 14/15.



Wellness Center

Three Wellness Center programs in Orange County have been established for adults diagnosed with a serious mental illness and who may have a co-occurring disorder. These individuals are further along in their recovery and continue to work on their recovery, but require a support system to assist them in maintaining their stability while continuing to progress in their personal growth and development.

All three of the Wellness Centers provide a safe and nurturing environment for each individual to achieve his or her vision of recovery while providing acceptance, dignity and social inclusion. The programs are consumer-run, utilizing staff with a history of participating in mental health services, and are committed to providing peer-to-peer promotion and community integration of emotional, physical, spiritual and social domains.

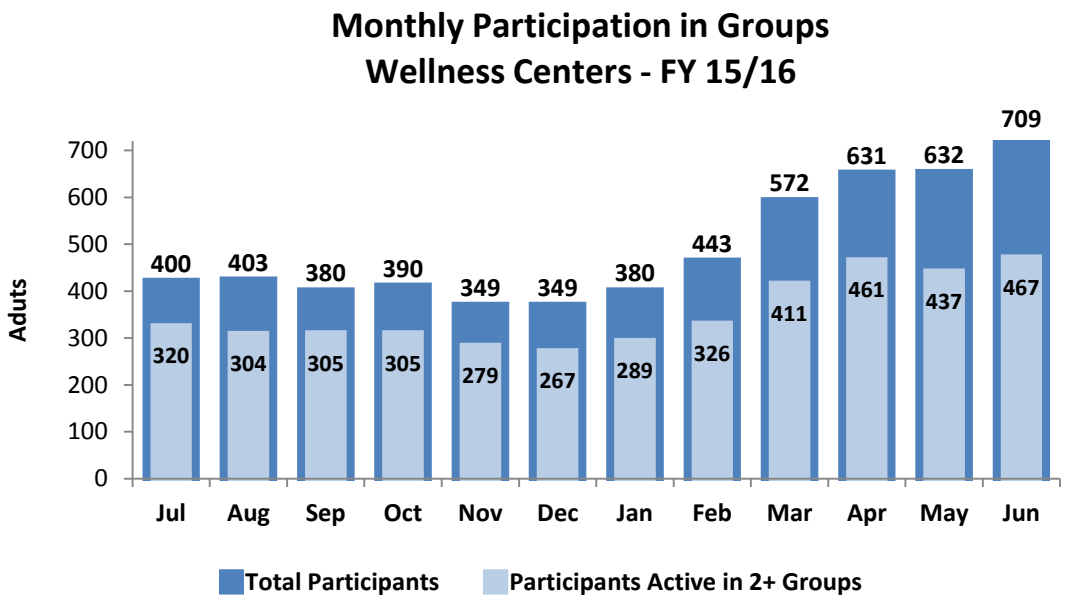
The Wellness Centers are located in Orange (Wellness Center Central), Garden Grove (Wellness Center West) and Lake Forest (Wellness Center South). The South and West locations are new and opened in December 2015 and February 2016, respectively. Wellness Center West has a unique, dual track program that provides groups, classes and activities both in English and in monolingual threshold

languages to meet the cultural and language needs of the population located in the City of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings and recreational activities. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer support in a non-judgmental environment. A wide variety of weekend, evening and holiday social activities are provided for members to increase socialization and encourage (re)integration into the community. The ultimate goal is to reduce reliance on the mental health system and to increase self-reliance by building a healthy network of support which may involve the members' family, friends, or significant others.

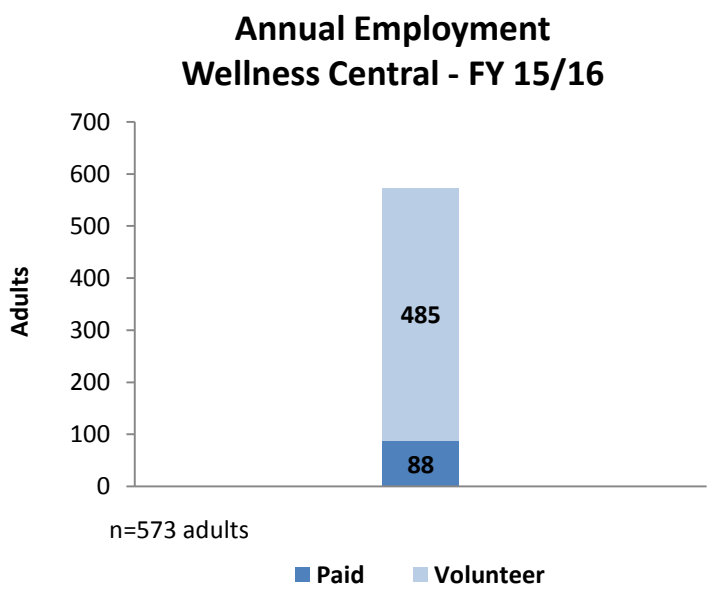
The Wellness Centers utilize Member Advisory Boards, a community town hall model, and member satisfaction and Quality of Life surveys to make decisions on programming and activities.

The Wellness Centers served 1,787 total adults during FY 15/16. The programs assess performance in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two inter-related ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph below, the Centers met this goal as the majority of adults who attended the Wellness Centers were actively engaged in multiple Center-sponsored activities throughout the year (monthly averages ranged from 66% in June to 80% in July, September and November).



Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. In FY 15/16, 977 (55%) adults had participated in community integration activities.

The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. Eighty adults enrolled in education classes during FY 15/16. Thus, this remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in education classes. In contrast, 573 adults (32% of total served) were involved in employment during FY 15/16, largely due to the numbers in volunteer positions (see graph below). The programs will continue their efforts to engage members in employment and work toward increasing the number who obtain paid positions.



Finally, during FY 15/16, 341 adults had facilitated all or portions of community meetings at the Wellness Centers. Meeting facilitation is encouraged as a way to help promote recovery by building self-esteem and confidence in one's own abilities.

Adult and Older Adult Peer Mentoring

The Adult and Older Adult Peer Mentoring program provides field-based supportive services to adults ages 18-59 years, and older adults 60 years of age and older, who have been diagnosed with a serious mental illness (SMI) and who may also have a co-occurring disorder. The Peer Mentoring program consists of three Tracks to serve clients, as detailed in the Program Description below.

Program Description

Track One

Track One serves clients referred from both County-operated and County-contracted Outpatient Clinics, as well as County-contracted Full Service Partnerships, who require assistance achieving short term treatment goals identified by their treatment providers that are part of a larger, overall treatment plan. Peer Mentors will support the clients' 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. Additionally, Track One shall serve clients who are currently hospitalized or have had a recent psychiatric hospitalization or have experienced multiple Emergency Room visits, and require assistance with re-integration into their homes and community, and linkage to necessary community-based services. Peer Mentors will be paired with clients 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. These services are designed to assist the individual in reducing the incidence of re-hospitalization and support their reintegration into the community.

Track Two

Track Two serves clients who are pending discharge and referred from the County's Crisis Stabilization Unit (CSU), as well as identified regional hospital Emergency Departments within Orange County, in collaboration with the Hospital Association of Southern California, with the goal of linking clients coming out of a crisis with their behavioral health appointments and services as recommended in their discharge plans. Peer mentoring services are field-based, and will provide reassurance and encouragement, advocacy and education to the client and their families or significant support persons, assisting clients to make and keep established appointments, and arrange transportation for those appointments.

Track Three

Track Three is a new service implemented in 2017, and is a component of the Department of Health Care Services Whole Person Care (WPC) Grant. The overarching goal of the WPC projects are the coordination of health, behavioral health, and social services, as applicable, in a client-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.

Track Three shall specifically focus on assisting homeless SMI clients, or those at risk of homelessness, who are also Medi-Cal beneficiaries, to sustain their housing placements for greater than six months. Track Three Peer Mentors will accept referrals from HCA's Behavioral Health Services Outreach and Engagement (BHS O&E) team, who have been working with clients eligible for housing placements through Orange County's Coordinated Entry system. Once a housing option has been identified and secured for an eligible client, the BHS O&E team will refer the client to the Track Three program for ongoing services.

Track Three Peer Mentors shall provide individual housing and tenancy sustaining type of services, which support the individual to become a successful tenant in his/her housing placement. These services may include, but not limited to, assisting clients with landlord

negotiations, housekeeping, food shopping and preparation, financial management, medication management, transportation, medical care, arranging utilities, phone, and insurance, and accessing natural supports and community services. It is anticipated that the Peer Mentoring Track Three program will serve a minimum of 80 clients on an annual basis.

Outcomes:

For Track One, of the 100 adults and older adults served in the program during FY 15/16, 70 individuals (70%) successfully completed their goals with assistance from their Peer Mentor. The most common types of goals for which individuals were referred included improving socialization by increasing the frequency of engaging in outside activities on a weekly basis, and assisting individuals with completing applications for housing. Because this was the first year of implementation, not all outcome measures were in place at program launch. Thus, complete results will be reported in future plan updates.

For Track Two, of the 157 adults and older adults served in the program for FY 15/16, 85 individuals (54%) were successfully linked to services.

Older Adult Recovery Program

The Older Adult Recovery Program serves individuals 60 years of age or older who are living with persistent mental illness. The Recovery Program provides the initial Mental Health Assessment in the consumer's home, hospital or location of clients' preference. This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian as well as non-English-speaking monolingual individuals and individuals who are deaf and hard of hearing. Older adults receiving this service are often very isolated, homebound and have limited resources. This population is disproportionately represented in the suicide statistics as well as victimization statistics.

Program Description:

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

This program serves clients from diverse cultural groups such as Latino, Vietnamese, Korean, and Iranian as well as non-English-speaking monolingual individuals and individuals who are deaf and hard of hearing. The target population struggles with acute and

chronic symptoms of mental illness and often presents with co-occurring diagnoses and multiple functional impairments. Older adults receiving this service are often very isolated, homebound and have limited resources. This population is disproportionately represented in the suicide statistics as well as victimization statistics.

Outcomes:

In FY 15/16, the program served 546 older adults, 251 of whom were new admissions. One of the program's goals is to increase access to primary care as measured by the number of nursing assessments completed. Of the total older adults served, 92% (n=232) had a nursing assessment completed during FY 15/16.

Integrated Community Services Project

The Integrated Community Services (ICS) project is a collaboration between County Behavioral Health Services and contracted community medical clinics that provide access to integrated medical and mental health services to County and community participants. The ICS model creates one health home for participants, bringing culturally and linguistically competent providers together to meet the needs of a diverse population. Mental Health Therapists, Peer Specialists (i.e., consumers or family members), Psychiatrists, Primary Care Physicians, and Registered Nurses work as an integrated team to provide coordinated care. This collaboration with community medical clinics and county mental health programs is a healthcare model that will prove to bridge the gaps in service for the underserved low-income community and increase overall health outcomes for the participants involved.

Program Description:

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

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

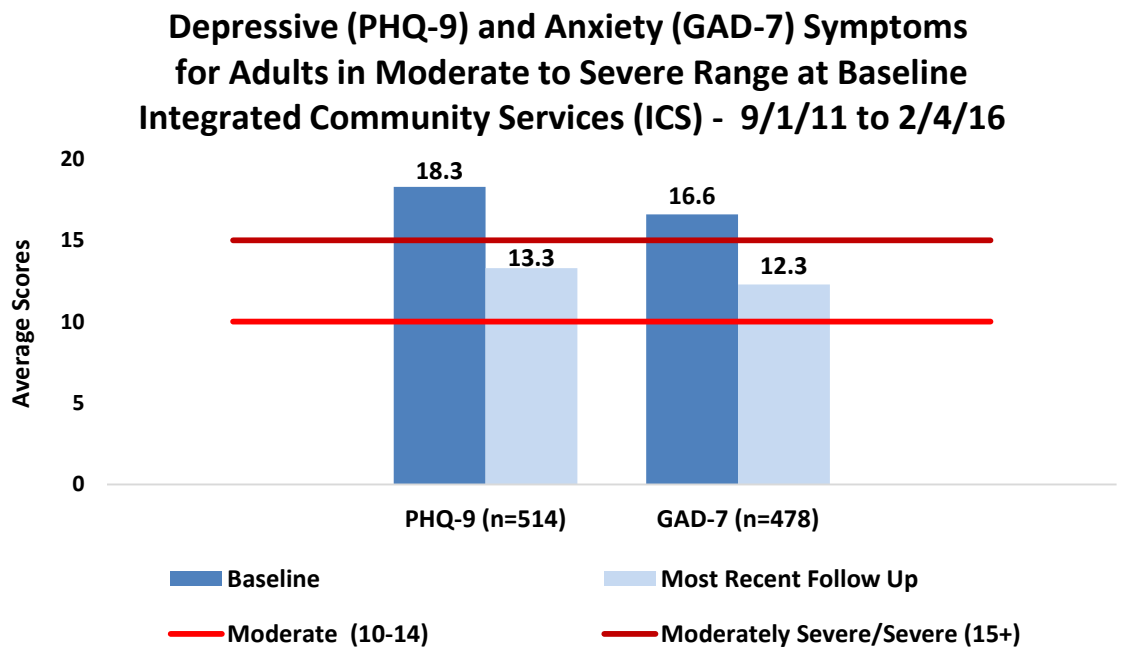
Outcomes:

Because ICS only recently moved to CSS, outcomes reported here are for the entire duration of the ICS Innovation project and not limited to FY 15/16. In future updates, outcomes will be reported by FY similar to other CSS programs.

A total of 1,087 adults participated in ICS as an Innovation project between September 2011 and February 2016. ICS monitored both mental health symptoms and physical health markers to assess program impact.

Improvement in mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity, and the GAD-7, a commonly used measure of anxiety symptom severity. Adults who scored in the clinical range for depression severity at baseline (i.e., score $\geq$ 10) reported a statistically significant decrease in symptoms at their most recent follow up (see left side of graph below).[1] This improvement in average depression scores was notable and decreased from the moderately severe range to the moderate range between baseline and most recent follow up (Cohen's *d* = .70).[1]

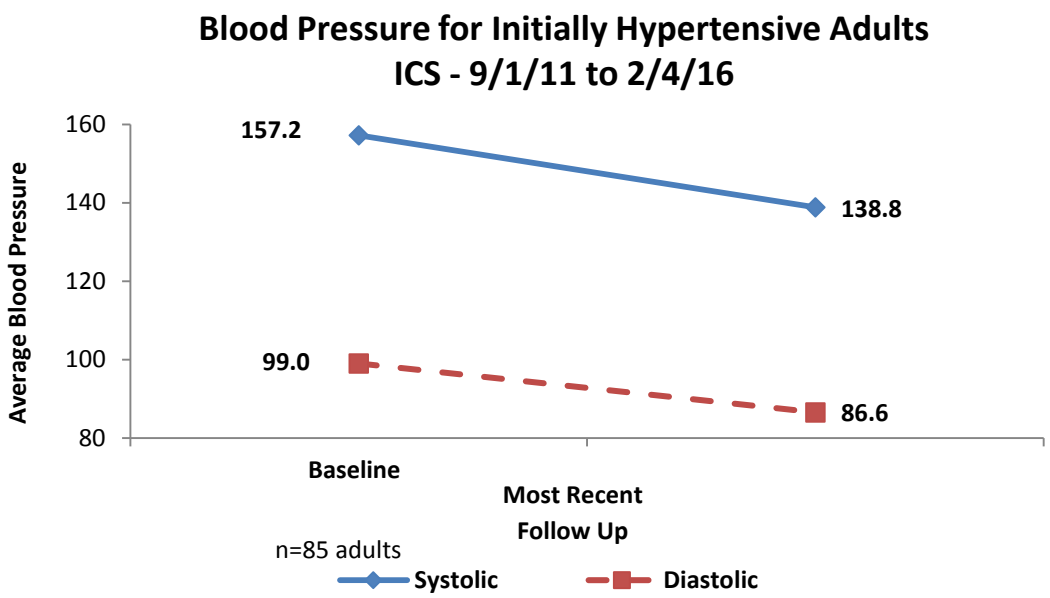
Similarly, adults who scored in the clinical range on anxiety symptom severity at baseline (i.e., score $\geq$ 10) reported a statistically significant decrease in their symptoms at their most recent follow up (see right side of graph below).[1] Again, the improvement in average scores was notable, having decreased from the severe range at baseline to the moderate range at most recent follow up (Cohen's *d* = .76).[1]



[1]PHQ-9: Prior M=18.3, SD=5.0; Since M=13.3, SD=7.2; t (513) = 15.40, p<.001, Cohen's d=.70
GAD-7: Prior M=16.6, SD=3.6; Since M=12.3, SD=6.3; t (477) = 15.56, p<.001, Cohen's d=.76

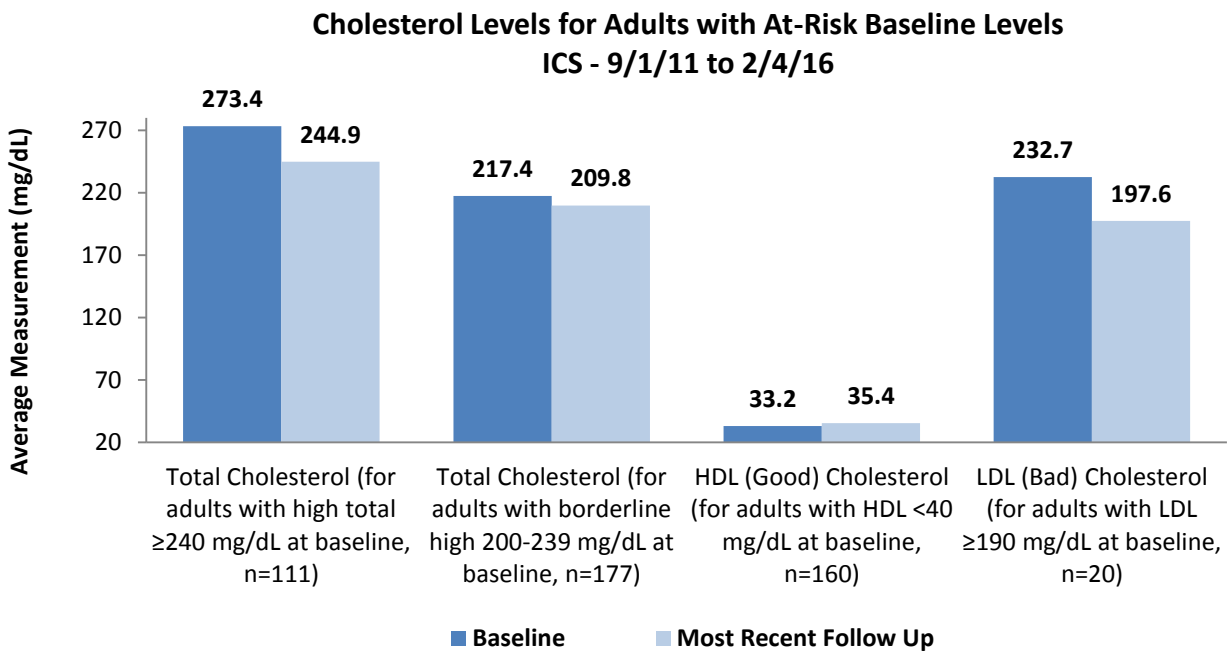
In addition to mental health assessments, ICS maintains continual tracking of adults' health outcomes (biometrics). Two of the physical measures taken at medical visits include blood pressure and lipid panels (total cholesterol, HDL/"good" cholesterol, LDL/"bad" cholesterol).

Adults with two or more blood pressure measurements and who fit criteria for high blood pressure or hypertension at baseline (i.e., BP ≥ 140/90) demonstrated a decrease in both their systolic and diastolic blood pressure measurements by an average of about 12% while enrolled in ICS (see graph below). These improvements were statistically significant and reflected notable clinical improvement (Cohen's *d* = .83 and .96 for systolic and diastolic blood pressure measurements, respectively).[1]



[1] *Systolic: Prior M=157.2, SD=15.0; Since M=138.8, SD=20.3; t (84) = 7.52, p<.001, Cohen's d=.83*
Diastolic: Prior M=99.0, SD=6.8; Since M=86.6, SD=12.0; t (84) = 8.50, p<.001, Cohen's d=.96

In addition, adults with two or more cholesterol measurements who met criteria for at-risk cholesterol levels at baseline (i.e., High Total ≥240 mg/dL, Borderline High Total = 200-239 mg/dL, HDL <40 mg/dL, and/or LDL ≥190 mg/dL) showed statistically significant[1] improvement in their total cholesterol and/or HDL/LDL levels while enrolled in ICS (see graph below). Effect sizes indicated that the improvements were more observable for those who were initially identified as having high total cholesterol (*d*=.52) and high LDL levels (*d*=.60) than for those who were initially identified as having borderline high total cholesterol (*d*=.34) or low HDL (*d*=.33).



[1]High Total Cholesterol: Prior M=273.4, SD=44.6; Since M=244.9, SD=54.0; t(110) = 5.42, p<.001, Cohen's d = .52
Borderline High Total Cholesterol: Prior M=217.4, SD=10.6; Since M=209.8, SD=23.3; t(176) = 4.20, p<.001, Cohen's d = .34
At-risk HDL Cholesterol: Prior M=33.2, SD=4.7; Since M=35.4, SD=8.1; t(159) = -3.83, p<.001, Cohen's d = .33
At-risk LDL Cholesterol: Prior M=232.7, SD=39.5; Since M=197.6, SD=74.8; t(19) = 2.38, p<.05, Cohen's d = .60

Inter-Agency County Collaboration: The Courtyard (Transitional Center)

In October 2016, in response to the escalating homeless population in the Santa Ana Civic Center area and under the guidance of the Orange County Board of Supervisors, The Courtyard transitional center was established at the former Santa Ana Transit Terminal. A non-profit organization was contracted to oversee the operations at The Courtyard center, which provides emergency shelter beds and services such as showers, laundry facilities and storage for personal belongings. In addition, HCA BHS, the Social Services Agency assists with linkages to benefits and the Health Care Agency Public Health Nursing Division provides linkages to health care services and case

management. A separate non-profit agency coordinates meals, clothing, toiletries, and many other donations provided by several local non-profit and faith-based organizations.

Given that mental illness, co-occurring substance abuse and homelessness are often inextricably intertwined, Orange County's CSS, PEI, and non-MHSA Behavioral Health Services programs have been providing the following services at The Courtyard center:

- BHS Outreach and Engagement (O&E) staff regularly connects with Courtyard residents to build trust and attempt to link those in need of behavioral health care to appropriate services.
- Similarly, BHS outpatient clinic staff actively provides outreach, brief counseling, and referrals and linkages to mental health and substance use services for the residents at The Courtyard. Referral and linkage for medical detox are also provided.
- In the first few months the center was open, the CSS Adult/TAY Crisis Assessment Team (CAT) clinicians were stationed on-site to provide outreach, referrals and linkages, and crisis assessments, as needed. Due to the low frequency of crisis evaluations, CAT clinicians are no longer stationed at The Courtyard and instead are called to respond to behavioral health crises on an as needed basis.
- More recently, The MHA (Mental Health Association) Courtyard outreach team, which is funded by MHSA and replaces the CSS Drop-In Center program originally funded to serve the Santa Ana Civic Center area, was established at The Courtyard center. The team offers outreach, linkages, hygiene kits, counseling and education to the adults at the center. Moreover, the team operates during evening hours Monday through Friday and daytime hours on the weekend to ensure that behavioral health services continue to be provided outside of the normal hours of operation.

In FY 2016-2017, the programs[1] made a total of 24,830 duplicated contacts with Courtyard residents, provided 2,987 referrals and linked 1,375 residents to services. This high number of contacts reflects the diligence with which the BHS and MHA staffs continually reach out to and connect with The Courtyard center residents about the services and support available to them. As the residents build trust and rapport, first with the outreach teams and then with "the system," it is anticipated that the linkage rate will continue to grow as more residents begin to follow up on service referrals. Top linkage categories include behavioral health services, legal services, housing and entitlement programs.

WET Plan

[1] The contacts and linkages reflect the activity of MHA Courtyard outreach team, O&E, BHS outpatient clinic and CAT staff.

Many strategies for reducing disparities were included in the Orange County WET Plan. These include, but are not limited to the following:

Cultural Competence Training for Staff and the Community

Cultural Competence training includes many topics, including cultural competence topics related to Lesbian, Gay, Bisexual and Transgender individuals, co-occurring disorders in the Asian/Pacific Islander community, and interpreter certification training. The WET Plan develops and provides effective culturally competent training and education to clinicians, service providers and the community about the Latino, Vietnamese, Korean, Iranian and Arabic cultures; cultural competence courses for nurses; development of educational and training that address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County; and support for staff to translate materials into the threshold languages so that monolingual consumers/family members or community members can participate in services. The WET Plan also includes learning opportunities as well as training materials for persons who are Deaf and have limited English or other written language reading skills. In FY 2016-2017, WET also provided three Mental Health First Aid (MHFA) trainings in Spanish to 45 staff and community members.

In addition to the need for training public behavioral health staff, stakeholder meetings identified a need to reach out to unserved and underserved communities in their own language, using culturally relevant concepts. The goal is to raise awareness about mental illness and resources available for consumers and family members. Such efforts involve collaborating with existing community agencies, such as churches, ethnic-specific clinics, community centers, media outlets, and other health providers, using staff speaking languages other than English, including American Sign Language. The target population includes unserved and underserved ethnic and cultural client groups, including consumer and family member perspectives.

The County has prioritized skills development and strengthening of community organizations involved in providing essential services. It is doing this by providing education and technical assistance to organizations serving and/or interacting with same client target populations as BHS. Orange County's Workforce Education and Training (WET) component is one mechanism for strengthening the community's capacity to better serve those needing public mental health services. An example of this is the Crisis Intervention Training (CIT) in the WET component.

The Orange County Health Care Agency Behavioral Health Workforce Education and Training Program contracted with the Golden West College Justice Training Center since the inception of the Crisis Intervention Training (CIT) for Law Enforcement program in 2008. Since then, a total of 2,405 law enforcement officers in Orange County have been trained thus far. The CIT program has now been expanded to include a new CIT II program which features an interactive simulator loaded with behavioral health scenarios.

The addition of the simulator is a "state of the art tool" which many programs have yet to implement. This addition would add 8 additional hours to the CIT program bringing it to a total of 24 hours of training. The system is interactive with numerous behavioral health scenarios in the field which law enforcement and emergency personnel may encounter on a daily basis. The simulator is described as an effective, realistic learning environment for security professionals producing "judgment evaluation and force options training" which meets training needs for this population. The trainings are all Peace Officer Standards and Training (POST) and Standards and Training for Corrections (STC) Certified for law enforcement.

CIT III is a new program session which is an added component to the overall CIT Training Program. In an overall review of the program, it has been deemed necessary to identify several critical aspects that enhance and strengthen the program's previous sessions. For participants completing all three sessions, a CERTIFICATE OF COMPLETION will be issued with the following criteria:

CIT I	Basic	16 hours
CIT II	Intermediate	8 hours
CIT III	Advanced	16 hours
Certificate of Completion:		40 hours

The Certificate of Completion certifies that the participant received 40 hours of specialized training in CRISIS INTERVENTION. CIT III was taught on November 2017.

Community Education

Education and training activities are designed to impart basic understanding by providing clear definitions of prevention and early intervention to community members and providers. Emphasis is also placed on skill building and recommended best-practice models for providers and partners who are implementing prevention and early interventions in the community and health care systems. Conferences and trainings provided by BHS are collaborative with the community in the planning, funding and implementation process to include and present diverse, multicultural, lived-experience perspectives from consumers, family members, veterans, first responders, community providers, health and behavioral health systems with the underlined emphasis on addressing co-occurring issues and providing culturally competent services. The County provides these trainings free of charge to community members. Some examples of trainings include suicide alertness for everyone—Tell Ask Listen Keepsafe (safeTALK), and Mental Health First Aid (MHFA-Youth, Adults, and Public Safety versions). MHFA is also taught in Spanish using materials written in Spanish. HCA has also partnered with members of the faith communities to provide trainings and a conference related to integrating behavioral health services with

spirituality. The HCA WET program also supports trainings by community partners by providing continuing education credits—Mental Health Association, National Association of Mental Illness—Orange County, Regional Center, Orange County, and Orange County Department of Education.

Trainings Led by Consumers or Family Members

Consumer and Family Member-led 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. In FY 15/16, 109 individuals attended the five Provider Education training sessions taught by the National Alliance on Mental Illness (NAMI) consumer and family member presenters with lived-experience. In addition, a CAAC Behavioral Health Stakeholder Conference conducted by consumer and family member presenters with lived experience was offered to 148 community partners and providers.

The Recovery Education Institute

Program Description:

The Mental Health Career Pathways program helps individuals living with mental health conditions prepare for the workforce. Courses are provided through the Recovery Education Institute (REI), which prepares individuals living with mental illness and their family members to pursue a career in behavioral health. REI provides training on basic life skills, career management and academic preparedness, and offers certified programs needed to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff possess personal lived experience. In FY 15/16, REI provided 140 total trainings, 105 of which were led by individuals living with mental illness or their family members.

REI contracts with Saddleback College to offer a Mental Health Worker Certificate that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental illness, and evidence-based practices, to name a few. To receive the certification, students must complete nine three-unit courses and a two-unit, 120-hour internship. In FY 15/16, four students earned this certification. In addition, REI/Saddleback College added courses in alcohol and drug studies, which integrate theory and practical experience to develop the skills necessary to work with individuals who are experiencing substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies.

Financial Incentive Programs

As part of the current Three-Year Plan, the Financial Incentives Programs category now contains two tracks: the Financial Incentive Program for college students and the Psychiatrist Loan Repayment Program. The former program provides financial incentive stipends to BHS County employees at the Bachelor (BA/BS) and Masters (MA/MS) levels to expand a diverse bilingual and bicultural workforce. The Orange County WET Office collaborates with numerous colleges and universities to provide stipends to students who, in return, are encouraged to work for County or County-contracted agencies upon their graduation. In FY 15/16, tuition incentives were provided to 20 staff, one of whom was an undergraduate and 19 of whom were Masters' degree candidates.

Beginning in FY 15/16, Financial Incentives Programs introduced the Orange County Mental Health Loan Assumption Program (OC-MHLAP) for psychiatrists. This track aims to address the shortage of community psychiatrists working in the Public Mental Health System (PMHS) due to strong recruiting competition from private sector organizations and other governmental agencies. To be eligible for the track, an award recipient must work in the County public mental health system in exchange for the loan assumption. This additional OC-MHLAP program will help achieve staffing goals and enhance the quality of care to Orange County's population by improving the recruitment and retention of qualified psychiatrists. In FY 15/16, five psychiatrists participated in the Loan Repayment Program.

Prevention and Early Intervention

The Prevention and Early Intervention (PEI) Programs targets individuals and families at risk of behavioral health problems and has the following 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, Youth at Risk of or Experiencing Juvenile Justice Involvement and Underserved Cultural Populations. To date, the PEI Programs listed below have been implemented focusing on these PEI priority populations as indicated in the PEI Plan. These programs include representation by staff who are multicultural and multilingual in the threshold languages as well as other languages. These programs provide services out in the community where individuals and families are already receiving critical supports, further removing barriers to receiving our services. Furthermore, all our programs seek to educate the community to eliminate and reduce the stigma and discrimination associated with behavioral health problems and accessing behavioral health services.

The original Plan consisted of 8 project areas with a combined total of 33 programs. 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. The re-packaged Plan maintained all services, but re-organized them into three Service Areas: Community Focused Services, School Focused Services, and System Enhancement Services.

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.

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

1. Disparities in Access to Mental Health Services
2. Underserved Cultural Populations
3. Statewide Projects for Stigma Reduction

OC4Vets

OC4Vets is a Mental Health Services Act project in partnership with the OC Community Resources Veterans Service Office and the Workforce Investment Board. Services are aimed at assisting military veterans and their families to become aware of and to access needed community and behavioral health services. In addition to the standard Veterans Service Office services (i.e., assistance with application for compensation, pensions, and other VA related benefits), participants are provided brief screening, case management, linkages for medical, mental health, substance use disorders, housing, job skills enhancement, employment, work sustainment coaching, and other services as required.

Program Description:

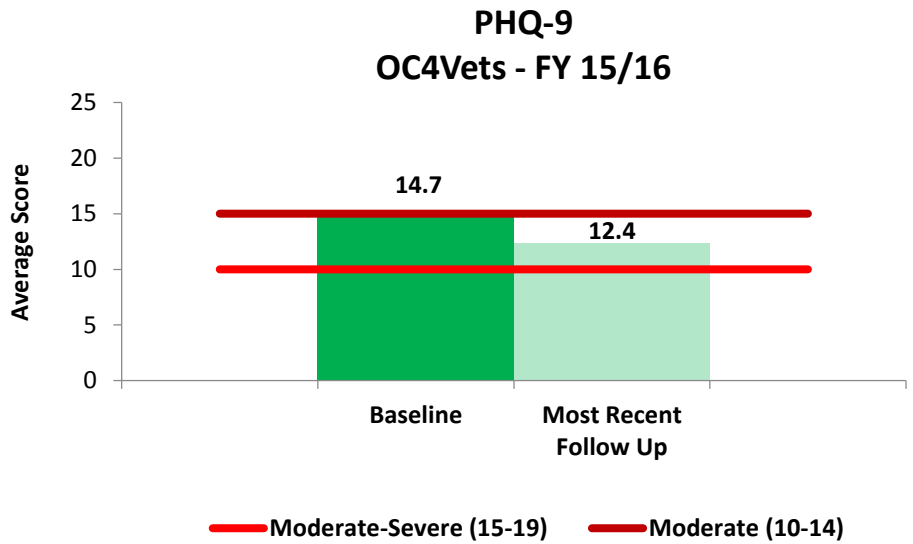
OC4Vets serves Orange County residents who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service. Hosted by the Orange County Veterans Service Office (VSO), this collaborative project aims to increase access to underserved groups, providing a participant-focused environment for veterans or families within the local military and veteran community.

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

Outcomes

During FY 15/16, 180 participants were served by OC4Vets. The program intends to reduce prolonged suffering as assessed through changes in scores on the PHQ-9, which is a measure of depressive symptom severity. Veterans completed the measure at intake, every three months of program participation and at program exit. The difference between intake (baseline) and the most recent follow-up was used to analyze whether there was a significant reduction of prolonged suffering. The evaluation also reflects cultural competence as the assessment tool completed by participants was available in all threshold languages.

Results showed that, overall, veterans' decrease in depressive symptoms was statistically significant and small-to-moderate in effect size, which is a measure of real-world significance or observability of change.[1] In addition, average scores at baseline fell just below the cutoff for *moderately severe* depression (i.e., 15, dark red line in graph), whereas average scores at the most recent follow up were in the *moderate* range (i.e., 10-14, between red lines in graph). Taken together, these findings are consistent with the goal of early intervention services to prevent symptoms of depression from becoming severe and disabling among those served.



[1]PHQ-9: Baseline M=14.7, SD = 7.2; Follow up M=12.4, SD=7.8; t (65) = 2.52, p<.05, Cohen's d = .31

OC ACCEPT

Program Description:

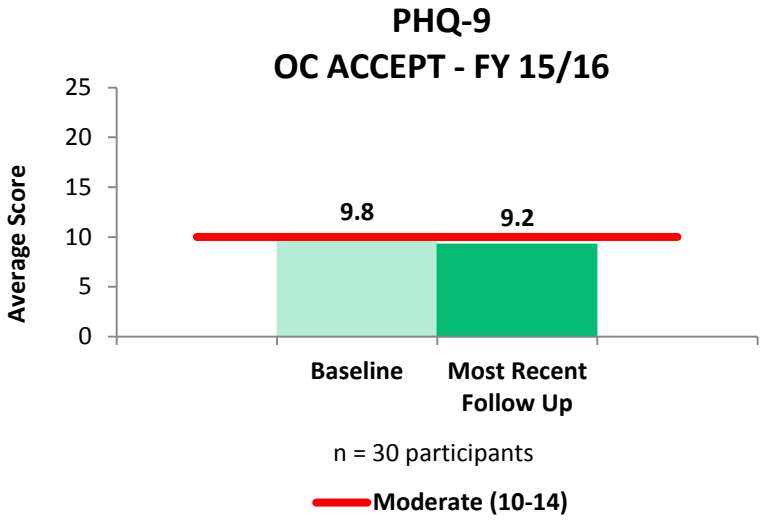
OC ACCEPT (Acceptance through Compassionate Care, Empowerment, and Positive Transformation) provides community-based mental health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and the important people in their lives. The program specializes in addressing issues that are common in the LGBTIQ community, such as confusion, isolation, grief and loss, depression, anxiety, suicidal thoughts, self-medication with drugs, high risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness, and lack of familial support. OC ACCEPT seeks to increase access to underserved groups and provide a safe environment with acceptance and compassion for individuals to express their feelings, build resilience, become empowered, and connect with others for support. Services are provided in English and Spanish.

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

Outcomes:

During FY 15/16, 112 participants were served by OC ACCEPT. The program aims to reduce prolonged suffering as assessed through changes in scores on the PHQ-9, which is a measure of depressive symptom severity. Participants were administered the measure at intake, every three months of program participation and at program exit. The difference between intake (baseline) and the most recent follow-up was used to determine whether there was a significant reduction of prolonged suffering. The evaluation also reflects cultural competence as the assessment tool completed by the participants was available in all threshold languages.

As can be seen in the graph below, average scores at baseline and the most recent follow up were both just below the clinical cutoff (i.e., 10), indicating that participants generally reported symptom severity that fell in the upper limit of the *mild* range. The difference in scores was not statistically significant, which indicates that participants did not experience a worsening of symptom severity and is consistent with the goal that early intervention prevents symptoms of depression from becoming severe and disabling among those served.



[1]PHQ-9: Baseline M=9.8, SD = 7.5; Follow up M=9.2, SD=5.4; t(29) = 0.50, p=.62, Cohen's d=0.10

During FY 15/16, staff provided 24 trainings/presentations and 84 outreach activities to engage the community in awareness. The program has helped LGBTIQ participants and their families improve their overall functioning and helped break down the stigma related both to behavioral health and the LGBTIQ community.

Innovation Plan

The importance of having programs provided by ethnic- or culturally specific community based organizations is strongly emphasized by HCA BHS, and is a major component in developing the County's Innovation Plan. The Innovation Plan consists of a number of projects, several of which are target specific ethnic or cultural groups, including the LGBTIQ community, veterans, the deaf community, Asian/Pacific Islanders and Latinos. Providers chosen for these programs are operated and staffed by people from the same groups. Below is a brief description of each of these programs.

An Innovative project is defined as one that contributes to learning rather than one with a primary focus on providing a service. Innovation (INN) programs can be conceived of as research projects to evaluate the effectiveness of new approaches and practices. By their very nature, not all INN projects will be successful.

Those projects deemed “unsuccessful” will be discontinued. To continue, those projects showing positive outcomes, another funding source must be identified. All of the current Orange County Innovation Projects serve one or more of the following purposes:

1. Increase access to underserved group

2. Increase the quality of services, including better outcomes

3. Promote interagency collaboration

4. Increase access to services

The initial Group 1 Innovation projects all shared a common theme, which was the involvement of consumers and family members (Peer Specialists) to provide services and/or direct the activities involved in the projects.

Employment Works

Employment WORKS is a supportive employment program that offers individuals who are seriously and persistently mentally ill the opportunity to participate in supported employment services. The program offers individualized job placement and supportive vocational services.

Project Together Mentor Program

The Mental Health Association-Project Together Mentor Program (MHA-PT) provides mentoring services for serious emotionally disturbed (SED) children and youth and seriously mentally ill (SMI) transitional age youth who are receiving mental health treatment services through the County of Orange HCA, for both county operated or contracted programs. MHA-PT incorporates mentoring best practices, and mentor services are initiated by the clinician of a child's/teen's county or contract agency. All mentors are matched based on shared cultural and linguistic needs of the children, youth and families, and the clinician determines when a child/teen or parent/guardian will benefit from a mentor. The clinician supports the mentor-mentee relationship, and meets and advises the mentor on a regular basis.

Multi-Cultural Development Program

The Multicultural Development Program (MDP) aims to promote health equity by enhancing culturally responsive and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides services such as Language Service Coordination, SSI/SSDI Disability Benefits and Employment Consultation and

Training to culturally diverse clients, Culture and Mental Health Needs of the Deaf and Hard of Hearing Community Consultation and Training. Clinical trainings and education are conducted that include, but are not limited to topics such as Client Culture, Recovery, Cultural Groups, Cultural Responsive Services, Stressed Families/Older Adult, People with Developmental Disability, People with HIV/AIDS, Refugees and Immigrants, Trauma-Exposed Individuals, Limited English Proficiency Culture, Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex, and more. In addition, consumer/peer supervision, culturally responsive and inclusive clinical consultation, culturally responsive and inclusive community research and advocacy are provided while identifying local and regional behavioral health needs of linguistically and culturally diverse populations as they impact County systems of care. MDP also assists in 1) developing, coordinating, and facilitating the implementation of a culturally responsive and inclusive plan for Orange County; 2) developing, implementing, and ensuring the accuracy of verbal interpretation and written translation services and materials in all threshold languages; 3) planning and organizing cultural diversity events at an organizational and community level, and 4) supporting strategies and efforts for reducing racial, ethnic, cultural and linguistic disparities.

Deaf and Hard of Hearing Program

A licensed Marriage and Family Therapist, who is a member of the deaf community and has lived-experience within the culture, has been identified to provide behavioral health services such as psychosocial assessment and individual counseling to deaf and hard of hearing residents of Orange County. Currently, these services are provided at the Community Counseling and Supportive Services program in Orange which is a central location within the County. It is anticipated that these services will be offered in the future at the site of a community non-profit organization that provides a host of other services to deaf and hard of hearing persons with a mission to ensure their equal access to the same opportunities afforded their hearing counterparts. In this way, it is anticipated that more individuals will be aware of and able to access these important services.

CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

I. The County has a Cultural Competence Committee, or other group that addresses cultural and linguistic issues and has participation from cultural groups, that is reflective of the community.

A. The County shall include a brief description of the Cultural Competence Committee or other similar group (place within the County organizational structure, organizational structure of the committee, frequency of meetings, functions, and role).

1. Community Action Advisory Committee

b) HCA/BHS has utilized the Community Action Advisory Committee (CAAC) since 2005 in a Cultural Competence advisory function. This committee is composed of consumers and family members representing various ethnic and cultural groups in Orange County who are interested in actively participating in planning for MHSA services. Their mission is to advise Health Care Agency Behavioral Health Services (HCA BHS) on issues related to the delivery of mental health services in Orange County funded through the Mental Health Services Act (MHSA). The goal is to assist the Health Care Agency in ensuring that these services are of high quality, accessible, culturally competent, client-driven, consumer and family focused, recovery and resiliency-focused and cost-effective.

a) The committee hears presentations about both current services and those that are proposed. They provide input to the planning process; review and comment on draft MHSA plans; and make recommendations related to MHSA services. During summer 2011, the committee was reorganized to ensure a diversity of perspectives was represented.

c) The categories selected are:

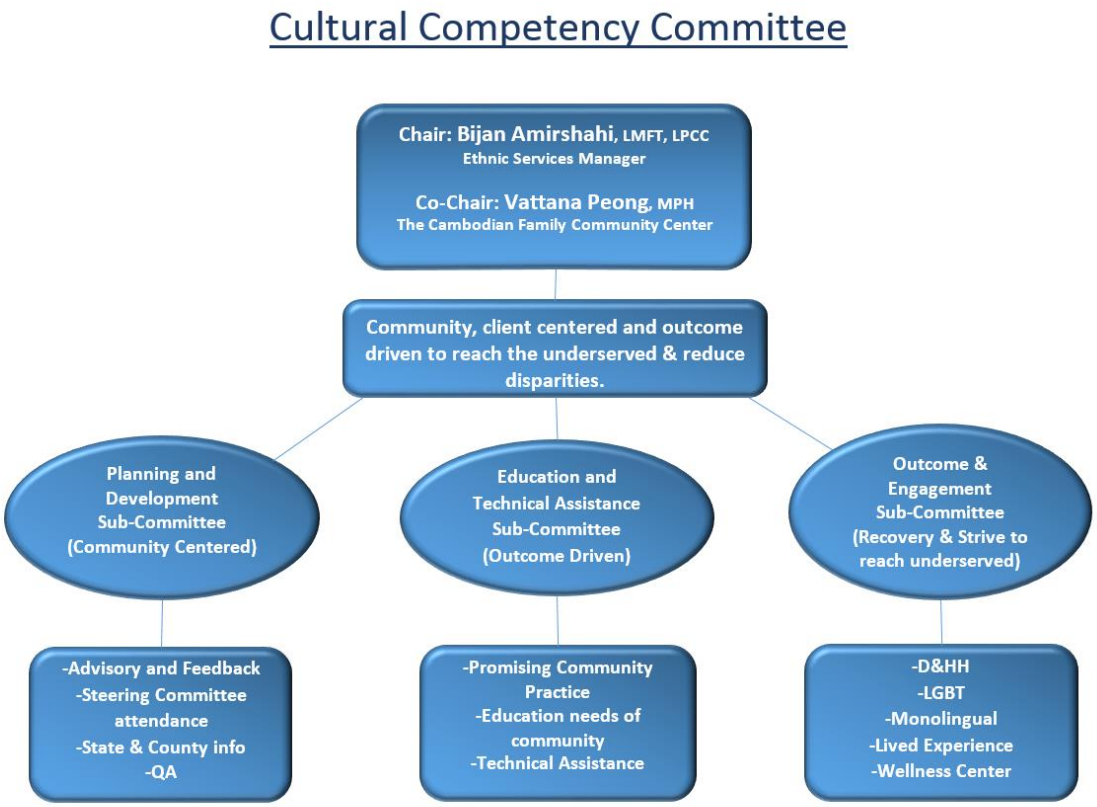
- Caregiver of Mental Health Consumer
- Substance Use
- Veterans
- Older Adults (age 60 or over)
- Hispanic/Latino Community
- African-American Community
- Native American Community

- Consumer
- Family member
- Client of County-contracted clinic
- Incarcerated
- Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning/Queer
- Transitional Age Youth (18-25)
- Deaf and Hard of Hearing Community
- Asian/Pacific Islander Community

d) The CAAC committee membership was limited to 15. Five of the volunteers/advocates are Spanish speakers and two of them have Vietnamese as their primary language. Others are welcome to attend the meetings. Currently, CAAC provides diverse perspectives representing the groups listed above, including perspective of African-American. Orange County's population is about 2% African-American.

2. Cultural Competence Committee

Recognizing the need for a dedicated (separate) Cultural Competence Committee, HCA/BHS formed the Cultural Competence Committee (CCC) in 2016, which includes members from the community and county that also represent or serve persons from the diverse ethnic and cultural groups in Orange County. The Cultural Competence Committee's overarching goal is to increase cultural awareness, sensitivity and responsiveness in the OC-BHS response to the needs of diverse cultural populations to foster hope, wellness, resilience and recovery in our communities. The CCC began meeting on a monthly basis in May 2016, and has developed several CCC Sub-Committees that include Planning and Development, Education and Technical Support, Outreach and Engagement, and Advocacy for Deaf and Hard of Hearing.



The above figure is the Cultural Competency Committee (CCC) Organizational Chart. The following is CCC's accomplishments summary for FY 2016-2017:

a) Since its inception May 2016 through the end of 2017, CCC held 17 meetings.
b) More than 25 organizations/contract providers/county departments and programs were represented at CCC meetings. The membership roster is shown in the table below.
c) Three Sub-Committees were established to address specific needs of the CCC:
   - Planning and Development

- Education and Technical Assistance
- Outreach & Engagement

d) Members developed vision and mission statements.
e) A co-chair from a community-based organization was selected.
f) Several presentations were made for the members covering the following programs/subjects:
   - OC Links (OC Behavioral Health Information & Referrals)
   - Adult & Older Adult Behavioral Health Services
   - Children and Youth Behavioral Health Services
   - Prevention and Early Intervention Services
   - Mental Health Association Wellness Center West program and services
   - "I Speak" or "Language Accommodation Request" card
   - Cultural Competency Summit XX.
   - Proposition 47, Proposition 64, Dismissal of Criminal Cases, and the New Leaf Program: reducing felonies to misdemeanors
   - Older Adult Behavioral Services
   - Orange County's History and Diversity through the Looking Glass
   - County BHS Veterans Services

g) CCC members represented at MHSA Steering Committee meetings.
h) Members participated in end of the year holiday celebration by sharing ethnic food and stories in 2016 and 2017.
i) Increased awareness of cultural practices/traditions among CCC members/organizations. Information about the Iranian and Cambodian New Year celebrations were presented to the members.
j) Increased CCC members' involvement in field testing and developing mandatory annual training.
k) CCC member represented at Spiritual Advisory Board
l) CLAS – Cultural and Linguistically Appropriate Services (CLAS) Standards were reviewed.

3. Community Quality Improvement Committee (CQIC)

The Community Quality Improvement Committee (CQIC) is the quality improvement committee that meets the requirements of the Department of Healthcare Services (DHCS). It includes managers, consumers, MH providers, and others as determined by the committee. It deals with all mental health programs, including MHSA programs and contract programs.

4. Community Quality Improvement Committee – Advisory Group (CQIC-AG)

a. The Community Quality Improvement Committee – Advisory Group (CQIC-AG) is an advisory body comprised of consumers, family members, and caregivers. County staff members from various departments provide support to this committee as needed.

b. The mission of the CQIC-AG is to advise the Community Quality Improvement Committee (CQIC) on issues related to delivery of publicly funded mental health services in Orange County. The CQIC-AG focuses on the quality, accessibility, and cultural competence of the county services provided. Moreover, the CQIC-AG is interested in ensuring that county services are client-driven, consumer and family focused, recovery and resiliency-focused, and cost-effective. The CQIC-AG may initiate and work on any number of quality improvement projects and serves as an advisory body to the CQIC.

5. Community Planning Process

All MHSA Plans are developed through a comprehensive, inclusive community planning process. In addition to the roles of the MHSA CAAC and the MHSA Steering Committee, community input is obtained through a variety of means, including focus groups, key informant interviews, advisory subcommittees, and surveys. The planning processes for each component included representatives from all major stakeholder and ethnic/cultural groups that were most impacted by the particular component. In addition to planning processes for MHSA components, separate planning groups were formed to advise HCA on particular projects. For example, both program organizational structure and the building which will house the services were designed through consumer and family-member work groups.

a. The MHSA Steering Committee reflects Orange County's ethnic and linguistic diversity. Interpreters are available for members who do not speak English. Members are selected to represent a wide variety of community stakeholders,

including but not limited to, law enforcement, social services, housing, Medi-Cal, Mental Health Board, community-based services providers, NAMI, education, substance abuse treatment, the County's major ethnic communities (Latino, Vietnamese, Korean, Arab, Iranian), consumers in each age category, family members, Orange County Regional Center, veterans, cities, faith-based organizations, deaf and hard of hearing community, LGBTIQ community, Hospital Association, Mental Health the Association, OC Psychiatric Society, OC Indian Center, and the courts.

b. The MHSA Steering Committee operates on a consensus model. The Health Care Agency makes the decisions on MHSA budget items and expenditures. The Steering Committee provides HCA with critical feedback necessary to make funding and program decisions.

6. Community-Based Service Providers

HCA has conducted outreach in the community to bring ethnic-specific providers into the system of care. A coalition of three Asian-American organizations provides Outreach and Full Service Partnerships to children and TAY, such as the Orange County Asian Pacific Islander Community Alliance (OCAPICA). HCA has also worked closely with a coalition of seven multi-ethnic providers (Multi-Ethnic Collaborative of Community agencies -MECCA) to develop joint projects. MECCA's focus is to reduce ethnic disproportionality and disparity in mental health and social services.

B. Cultural Competence Committee Roster listing member affiliation if any.

Name	Organization/Agency	Email	Phone #
Adelekan, Patricia	Los Amigos	iehof2015@gmail.com	714-628-9844
Ahn, Ellen	Korean Community	eahn@kcsinc.org	714-527-6561
Brimbuela, Lucy	BMD ResCare	Lbrimbuela@bmdrescare.co m	714-401-8418
Burney, Lenora	HCA BHS CYBH CAT	LBurney@ochca.com	714-834-2159

Calvet, Helene	HCA Public Health	hcalvet@ochca.com	714-834-3122
Caou, Ross	OC Intelligence Assessment Center	RossCaou@ociac.ca.gov	714-981-0707
Chai, Jane	HCA Public Health	jchai@ochca.com	714-834-7776
Chiu, Irene	OCAPICA	ichiu@ocapica.org	562-219-1590
Choeng, Sophia	Cambodian Family	sophiac@cambodianfamily.org	714-571-1966
Clark, Leon	New Spirit Baptist Church	LWCandAJC@sbcglobal.net	714-543-4746
Cohen, Sylvia	Mental Health Association	cohen@mhaoc.com	
Daniels, Danielle	HCA BHS	Ddaniels@ochca.com	714-834-5481
DeWindt, Kevin	HCA BHS Adult & Older Adult Services	Kdewindt@ochca.com	714-855-4115
Domingo, Michelle	BMD ResCare	mdomingo@bmdrescare.co m	714-401-8418
Eftekharzadeh, Sohail	Pathways	sohail.eftekharzadeh@pathways.org	714-361-4860
Gharadjedaghi, Ehsan	Norooz Clinic Foundation	drehsan@att.net	949-510-1321
Foo, Mary Ann	OCAPICA	mafoo@ocapica.org	
Fowler , Christopher	LTC (CA) CSMR	cfowler110@cox.net	949-677-3515
Francisca , Leal	Latino Health Access	fleal@latinohealthaccess.or g	714-542-7792
Fung , Annie	Cal State Fullerton	toanniefung@hotmail.com	626-428-8313
Gallardo, Miguel	MECCA	dr.mgallardo@gmail.com	949-215-1696
Garfias, Marcy	HCA BHS CYBH	mgarfias@ochca.com	714-834-3543

Granado, Joaquin	HCA BHS OC ACCEPT	jgranado@ochca.com	714-517-6100
Hale, Mary	Health Care Agency	Mhale@ochca.com	714-834-6032
Hanifzai, Wali	Access California	wali@accesscal.org	(714) 917-0440
Helmy, Deana	HCA BHS WET	dhelmy@ochca.com	714-667-5602
Hill , Michael	Public Defender	michael.hill@pubdef.ocgov. com	714-834-2144
Hillenbrand, Leslie	NAMI OC	Lhillenbrand@namioc.org	714-393-0742
Hoang, Paul	HCA BHS CAT	phoang@ochca.com	866-830-6011
Hogan, Mikel	Cal State U. Fullerton	mhogan@fullerton.edu	
Horner , David	HCA BHS AQIS	Dhorner@ochca.com	714-834-6232
Huynh, Luann	Community Member	adhuynh56@yahoo.com	
Ishikawa, Sharon	HCA BHS MHSA	sishikawa@ochca.com	714-834-6587
Ibarra , Nan	NAMI	Nibarra@namioc.org	
Jabbar, Fathima	HCA BHS CAT	fjabbar@ochca.com	866-830-6011
Kazner, Charlene	Pacific Islander Health Partnership	sevenkaz@aol.com	
Lane, Nedenia	Public Guardian	NLANE@OCHCA.COM	714-567-7660
Lee , Ye	OCAPICA	ylee@ocapica.org	714-636-9095
Lent, Debbie	Health Care Agency	Dlent@ochca.com	714-834-5035
Li, Annie	Chinese Community Center	annie.occcs@yahoo.com	949-375-4959

Mahdavi, Annahita	Long Beach City College	amahdavi@lbcc.edu	949-933-7913
Marin, Maria	HCA BHS PACT	mmarin@ochca.com	714-447-7000
Martinez, Luis	HCA BHS MHSA	lmartinez@ochca.com	714-834-4602
McCleese, Belinda	HCA BHS MDP	BMcCleese@ochca.com	714-586-5914
Nagel , Jeff	HCA BHS MHSA	Jnagel@ochca.com	714-834-6587
Nguyen, Natalie	HCA BHS AOABH	nanguyen@ochca.com	714-972-3718
Nguyen, Tricia	VNCOC	ttnguyen@thevncoc.org	714-640-3411
O'Brien, Brett	HCA BHS CYBH	bobrien@ochca,com	714-834-2011
Pang, Jane	Pacific Islander Health Partnership	kaalasplace@yahoo.com	
Peong , Vattana	The Cambodian Family Center	VattanaP@Cambodianfamily.org	714-571-1966
Perez, Karla	HCA BHS MHSA	Kamezquita@ochca.com	714-834-3105
Pham, Lorna	Viet-Care	lorna.pham@viet-care.org	
Pitman, Steve	Pitman Insurance Associate	stevepitman1@gmail.com	800-498-1866
Quiroz, Rosie	HCA BHS MDP	rquiroz@ochca.com	714-667-5614
Rao, Bhuvana	Health Care Agency	brao@ochca.com	714-834-2077
Read, Mary	Cal State Fullerton	mread@fullerton.edu	657-278-2167
Renteria, Teresa	HCA BHS OC Links	Trenteria@ochca.com	714-834-6838
Rocha, Tina	OCAPICA	trocha@ocapica.org	714-636-9095

Ruiz, Loreta	Latino Health Access	Lruiz@latinohealthaccess.o rg	714-542-7792
Sadeq, Ahmad	SSA	Ahmad.Sadeq@ssa.ocgov.com	
Sayyedi, Maryam	OMID	msayyedi@omidinstitute.org	949-502-4721
Solorza, Linda	OCSD	lsolarza@ocsd.org	714-647-7026
Suh, Min	HCA BHS MHSA	msuh@ochca.com	714-834-3105
Thornton, April	HCA BHS AOABH	athornton@ochca.com	714-834-4606
Thomas, Renee	OCDEAF	rthomas@ocdeaf.org	714-503-0689
To, Justin	Health Care Agency	jto@ochca.com	
Tran, Annette	HCA BHS Patients' Rights Advocacy	anntran@ochca.com	714-834-5839
Tran, Pierre	HCA BHS MDP	pitran@ochca.com	714-667-5610
Trevino, Candace	SSA	candace.trevino@ssa.ocgov. com	714-435-4650
Tutila, Ana	CAAC	aruchaana@yahoo.com	714-583-2576
Ullman, Hanhthuc	Health Care Agency	hullman@ochca.com	714-896-7566
Valencia, Crystal	OCACCEPT	cvalencia@ochca.com	714-517-6100
Weckerly, Christina	HCA BHS CYBH	CWeckerly@ochca.com	(714) 834-8348
Welty, Iliana	MECCA	iLiana@ocmecca.org	714-202-4753
Wilson Codispoti, Brenda	SSA	brenda.wilsoncodispoti@ssa.ocgov.com	714-435-4646

CRITERION 5: TRAINING ACTIVITIES

Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer.

I. The County Mental Health Plan shall encourage all staff and contractors to receive cultural competence trainings.

A. BHS county and contracted staff are expected to take the required annual cultural competence training. The BHS Director will inform all staff of the requirement for Annual Cultural Competence training, and Certifications provided from the required training will be monitored by BHS Program Managers for both county and contract employees to ensure that 100% of staff have taken the training.

B. Cultural competence must be embedded into all trainings requiring Continuing Education units, as described in the description, objectives, listed references, and training contents. Trainers are expected to incorporate cultural references in all training topics, bulletin notices and learning objectives relative to the topic. Skills building and education are conducted to address cultural competence and reduce stigma and discrimination within the behavioral health system, to prepare/develop and maintain a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members with valuable lived-experience.

II. Annual cultural competence trainings

A. Cultural competence trainings were provided for staff and stakeholders on a variety of topics:

Name of Cultural Competency Trainings in FY 15-16	Number of Attendees	Combined Training Hours	Combined CEUs Given
A Guide to Working with Vietnamese American Families	159	6	6
ASL How to Beat the Holiday Blues	14	1.5	0
Integrating Spiritual Components to Psychological Treatment	61	2	2
Let Us Talk About It (Mental Health Awareness)	18	2	0
Mental Health Interpreter Training	35	21	21
Principles of Working with Interpreters	15	8	7
Psychotherapy with Latter Day Saints	48	2	2
Spirituality Trainings	144	4	4
Spirituality Conference	182	8.5	5.25
Understanding Client Cultures	129	6	6
What is Mental Illness	5	1.5	0
Working Effectively with Sign Language Interpreters in BH Setting	53	4	4
Working with Sign Language Interpreters	84	8	8
Online Cultural Competency Training	2373	1	1
Total:	3320	75.5	66.25

Attendance by function*	Headcount	Percent of Total Attendees
County Administrator/Manager	398	12%
County Direct Service Provider	1,926	58%
County Support Staff	996	30%
Community-Based Administrator/Manager	564	17%
Community-Based Direct Service Provider	1,428	43%
Community-Based Support Staff	1,428	43%
Consumers	697	21%
Parents	697	21%
Family Members	996	30%
Community Member	1,693	51%
Caregiver	465	14%
Teacher	166	5%
Student	498	15%

*Some attendees reported duplicated roles

B. Annual cultural competence training topics shall include, but not be limited to the following:

1. Communicating with and interviewing diverse individuals and families
2. Multicultural knowledge
3. Cultural Sensitivity and awareness

4. Cultural formulation including diagnosis and treatment planning
5. Social/Cultural diversity (Diverse groups, LGBTQ, SES, Elderly, Deaf and Hard of Hearing, disabilities, etc.)
6. Mental Health Interpreter training
7. Training staff in the use of mental health interpreters

Cultural Competence training is comprised of many topics, including those related to Lesbian, Gay, Bisexual and Transgender individuals, co-occurring disorders in the Asian/Pacific Islander community, and interpreter certification training. Effective culturally competent training and education was developed for clinicians, service providers and the community about the Latino, Vietnamese, Korean, Iranian and Arabic cultures; cultural competence courses for nurses; development of education and training that address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County; and support for staff to translate materials into the threshold languages so that monolingual consumers/family members or community members can participate in services. This training effort also includes learning opportunities as well as training materials for persons who are deaf and have limited English or other written language reading skills.

III. Counties must have a process for the incorporation of Client Culture/Family Member Culture Training throughout the mental health system.

Descriptions of some cultural competence trainings in FY 2015-2016:

Training Title	Description	Presenter(s) Name
A Guide in Working with Vietnamese American Families	This training highlights the Vietnamese family systems perspectives by detailing their world view, cultural values and belief systems, concept of self, spiritual diversities as well as family characteristics in terms of socialization, parenting styles, roles and rules, relationship dynamics, communication patterns, and coping mechanisms.	Minh-Ha Pham, Psy. D.

ASL How to Beat the Holiday Blues	Identify the symptoms of depression and anxiety that may rise during the holiday season. Use new tools for preventing or reducing these symptoms during this stressful time. Find resources and a support system when needed.	Belinda McCleese, LMFT
Deaf /Hard of Hearing Consumers with Mental Illness and Substance Abuse/Dependency	In this one-hour training, Rehabilitation Counselors for the deaf will have an opportunity to learn the significance of the mental health issues and substance abuse/dependency in the Deaf and Hard of Hearing population, develop awareness of possible areas of relevant issues for intake interview, gain understanding the importance of collaboration services, and gain exposure to the role of Mental Health Professional/Registered Addiction Specialist in Individual Plan for Employment (IPE) development.	Belinda Mcleese, LMFT Kevin Dewindt, RAS
Integrating Spiritual Components to Psychological Treatment	This two-hour training for County clinicians, supervisors, and community partners will include a discussion around the importance of assessing and incorporating spirituality into psychological treatment.	Elizabeth Powell, Psy.D.
Let Us Talk About It (Mental Health Awareness)	Mental Health Workshop for the Deaf and Hard of Hearing with topics ranging from: What is Mental Health Illness? How to Overcome Stigma. Types of Mental Health Challenge and Symptoms. When & Where to find Professional Help.	Belinda Mcleese, LMFT

Mental Health Interpreter Training	This is a 3-day, 21-hour intensive training that expands the skills of bilingual staff who typically have no formal interpreter training, but who use their cultural and linguistic skills to interpret within their agencies. Interpreters learn basic knowledge around interpreter roles, models of interpreting, professional ethics, consumer rights, mental health terms, diagnosis and unique challenges for interpreters in mental health settings. This interactive training is experiential and provides participants with the opportunity to practice didactic materials immediately after receiving them.	Lidia Gamulin, LCSW
Online Cultural Competency Training	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients.	Bijan Amirshahi, LMFT, LPCC
Principles of Working with Interpreters - Mental Health Interpreter 1.22.16	The purpose of the training is to support mental health providers working within communities where concentrated numbers of monolingual or non-English speaking (LEP) clients receive services.	Lidia Gamulin, LCSW
Psychotherapy with Latter Day Saints	This is a two-hour training for County clinicians, supervisors, and community partners and will include a discussion of the basic beliefs and practices of the Latter Day Saints (LDS) community.	Todd Huisken, LMFT
Spirituality	This two-hour training designed for County clinicians, contractors, faith-based leaders and community partners will include a discussion of spiritual damage, moral injury, trauma and spiritual healing.	Nathan Graeser, MSW
Spirituality Conference	A full day conference on “Spiritual Damage and Healing”. There are two keynote speakers and four breakout sessions on Spirituality and Healing, Spiritual Approach to Substance Use Treatment, Refugees Mental Health, and Applying the Victim.	Gail Searns, Ph. D. Jay Kumar, Ph. D.

Understanding Client Culture and Journeys	This training defines Client Culture, explains the concept of lived experience, recovery philosophy, stigma and self-stigma toward mental health and substance abuse issues.	Bijan Amirshahi, LMFT, LPCC
What is Mental Illness?	Explain the definition of a Mental Disorder or Mental Illness. Identify some symptoms of four different Mental Disorders: (Depression, Anxiety, Bipolar Disorder and Schizophrenia)	Belinda Mcleese, LMFT
Working Effectively with Sign Language Interpreters in Behavioral Health Setting	This training provides guidelines on how to work effectively with sign language interpreters in the mental health setting.	Belinda Mcleese, LMFT
Working with Sign Language Interpreters	This training provides guidelines on how to work with sign language interpreters properly and to have effective communication with the target population.	Belinda Mcleese, LMFT
Working with Sign Language Interpreters for Crisis Intervention Training for Law Enforcement Personnel	In this one-hour training, police officers will have an opportunity to learn the significance of mental health issues upon the Deaf and Hard of Hearing population, gain understanding of four different definitions of deafness, and gain exposure to the relationship with Americans with Disability Act and providing qualified sign language interpreters.	Belinda Mcleese, LMFT

CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

I. Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations.

Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to the Office of Statewide Health Planning and Development (OSHPD) for the Workforce Education and Training (WET) component.

Workforce Needs Assessment

Methodology:

An electronic survey was conducted in 2012 within all areas of Behavioral Health Services (BHS). Survey participants included County employees, employees in county contract agencies and individual county contractors. Results from each division were compiled together to obtain results for all BHS. The survey asked for budgeted and currently filled positions by job titles, number of estimated personnel needed to meet current client caseload, number of positions designated for consumers and family members and occupied by consumers or family members (self-reported), and the capability of staff (based on bilingual pay status) in providing services in a threshold language (Spanish, Vietnamese, Farsi and Korean).

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

A. Needs by occupational category

Across BHS, direct service staff and non-direct service staff categories have the most need for additional staff to meet the needs of current clientele (Tables 2 & 3). Among the direct service staff, the greatest need were in the areas of licensed clinical Social Workers, Licensed Substance Abuse Specialists, Mental Health Workers, Life Coaches and Employment Specialists/Job Coaches based on the most recent needs assessment, 86% of the needed positions are currently filled. The current workforce for the directors or service chief category appears to be in line with the number needed to meet the current needs (Table 1). ADAS, AMHS and COE all have over 90% of their total needed positions currently filled while only 65% in P&I and 85% in CYS. Among the divisions, P&I and CYS have the

greatest need for additional staff in the direct service and non-direct service categories (Table 2). For both P&I and CYS, the number of full time equivalents (FTEs) budgeted, however, is less than the number of FTEs actually needed to meet current client needs (Table 4).

B. Positions designated for individuals for consumers or family members

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

C. Language proficiency

There are five threshold languages in Orange County. These include, Spanish, Vietnamese, Farsi, Korean and Arabic. Across all BHS, 30% of the current workforce is able to provide services in Spanish, 8% in Vietnamese, 2% in Farsi and 2% in Korean (Table 4). Among the program directors/service chiefs, a similar rate (13% in Spanish, 2% in Vietnamese, 1% in Farsi and 2% in Korean) of language proficiency was observed (Table1). Among the non-direct and direct service staff categories, the threshold languages are similarly represented with about 30% in Spanish, 6% in Vietnamese, and less than 3% in Farsi and Korean languages (Tables 2 and 3).

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

In addition, data was analyzed on the number of clients in our Integrated Records Information System (IRIS) during FY 11/12 who had requested services in one of the threshold languages. These data show that across BHS, 16% requested services in Spanish, 3% in Vietnamese, 0.5% in Farsi and 0.5% in Korean. Among the divisions, P&I had the highest percentage of its clients requesting services in

Spanish (63%), followed by CYS (24%), WET (11%), AMHS (10%) and ADAS (9%). The number of clients requesting Vietnamese language was highest in AMHS (6%). The number of clients requesting Farsi or Korean languages remained consistent (less than 1% except for Korean, which was 3%, in WET) across all divisions (Table 5). Comparison of these numbers to the current language proficiency of our workforce might suggest that our current workforce is over- represented in Spanish and is well-represented in other threshold languages. It is expected that in the near future, Chinese will become a threshold language in Orange County, but that remains to be seen.

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

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

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

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

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

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

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

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

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

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

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

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

Table 5. Fiscal Year 11/12 Clients with Requested Primary Languages in IRIS by Division

Table 5. Fiscal Year 11/12 Clients with Requested Primary Languages in IRIS by Division							
Division	Farsi	Korean	Spanish	Vietnamese	Total Requested Languages By Division	Total All Other Languages In Divisions	Total Division Clients
ADAS	8	8	593	33	642	5,686	6,328
% ADAS to All Clients in ADAS	0.13%	0.13%	9.37%	0.52%	10.15%	89.85%	100.00%
AMHS IP/Res	3	23	88	84	198	1,306	1,504
% AMHS IP/Res to All Clients in AMHS IP/Res	0.20%	1.53%	5.85%	5.59%	13.16%	86.84%	100.00%
AMHS OP Oper	101	90	1,214	701	2,106	9,622	11,728
% AMHS OP Oper to All Clients in AMHS OP Oper	0.86%	0.77%	10.35%	5.98%	17.96%	82.04%	100.00%
CYS	29	20	3,516	90	3,772	10,897	14,669
% CYS to All Clients in CYS	0.20%	0.14%	23.97%	0.61%	25.71%	74.29%	100.00%
PEI	1	0	116	0	117	69	186
% PEI to All Client in PEI	0.54%	0.00%	62.37%	0.00%	62.90%	37.10%	100.00%
BOCE	0	6	23	57	86	128	214
% BOCE to All Clients in BOCE	0.00%	2.80%	10.75%	26.64%	40.19%	59.81%	100.00%
Total Languages	142	141	5,527	908	6,835	27,580	34,629
% Grand Total Languages to All Divisions	0.41%	0.41%	15.96%	2.62%	19.74%	79.64%	100.00%

Data source: Orange County MHSA Plan update FY 2015-2016

CRITERION 7: LANGUAGE CAPACITY

I. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

A. The County shall include Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.

B. Increase bilingual workforce capacity: Dedicated resources and strategies

HCA BHS is actively involved in developing a multi-cultural and bilingual work force in order to effectively serve the needs of the diverse ethnic and cultural community and effectively engaged unserved and underserved persons with mental illness and substance use disorders in Orange County. As a result, a great deal of emphasis has been placed in the proposed actions to create a tuition pilot program that will allow current support staff attend school and pursue mental health careers. BHS has also emphasized high school career pathways targeted to mostly Latino school districts, to encourage more Spanish-speaking students to consider mental health careers.

II. Interpreter services for persons who have Limited English Proficiency (LEP)

- Policies, procedures, and practices

Orange County has several phone lines that individuals may call to access support and services. All of these phone lines provide access in multiple languages. These include:

- OCLINKS Information and Referral Line (1-855-OC-LINKS/625-4657) for individuals to call for one point of contact to access any of the over 200 behavioral health programs available through the Health Care Agency's behavioral health system. Callers can speak with a clinical navigator in English, Spanish, Vietnamese, Farsi, Korean, and Arabic either by phone or through live-chat at www.ochealthinfo.com/oclinks.

- A 24-hour toll –free number (1-800-723-8641) that individuals can call if they believe they have a mental health issue.
- A Suicide Prevention Hotline phone number: 1-877-727-4747 (1 877-7CRISIS). This hotline is available in our threshold languages.
- A Warm Line that allows individuals to talk with a trained peer who is under the supervision of a licensed professional. That phone number is 1-877-910-9276 (1-877-910-WARM). The warm line also employs peers who speak our threshold and emerging languages.

The protocol used for implementing language access through the County's 24-hour phone line with state-wide access is provided below.

Over-the-telephone Interpretation Services-

Call: 1 (844) 898-7557

1) Indicate: language needed
2) Input: 4 digit unit number
3) Provide: caller's name, telephone number

On-site (in-person) requests-

Complete the Onsite Interpreter request form and email to: onsiterequests@FluentLS.com

Written documents requests-

Email to: translation@languageline.com

Or submit a request through the website at: https://www.languageline.com/translation-localization-request

- Training is provided to staff who need to access the 24-hour language phone line in order to as to meet the client's linguistic capability.
- All BHS staff have been required to learn how to use this language line provided by the county's contracted provider.

- In addition, a language poster has been placed in each of the BHS clinic waiting rooms to assist consumers and family members in asking for an interpreter in their own language. Clients are informed in writing in their primary language, of their rights to language assistance services at no cost.
- In the written materials provided to each client, it states that Orange County "is responsible to provide the people it serves with culturally and linguistically competent specialty mental health services. For example: non-English or limited English speaking persons have the right to receive services in their preferred language and the right to request an interpreter. If an interpreter is requested, one must be provided at no cost. People seeking services do not have to bring their own interpreters. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. Information is also available in alternative formats if someone cannot read or has visual challenges." The written materials are available in Spanish, Vietnamese, Farsi, Korean and Arabic as well as English.

B. Use of bilingual staff or interpreter services for people with LEP

Evidence that the county accommodates individuals with LEP by providing bilingual staff or interpreter services may be found in the County's contract for interpreter services. It is also found in the fact that such accommodation is described in the client handbook as a right of each client. In addition, it is mentioned in the section of the handbook on cultural competency. Furthermore, BHS has developed policies requiring that such assistance be provided.

The following tables reflect the interpreter and translation services utilized during 2015 – 2016.

Over the phone interpretation:

Language Requested	Minutes Billed	Language Requested	Minutes Billed
Spanish	8,287	Armenian	58
Vietnamese	2,208	Cantonese	53
Korean	1,435	Gujarati	49

Arabic	916	Akan	43
Mandarin	742	Punjabi	42
Bengali	380	Pashto	41
Farsi	363	Dari	40
Russian	270	Telugu	37
Haitian Creole	198	Hausa	35
Cambodian	187	Bangla	32
Somali	121	French	27
Polish	109	Samoan	21
Romanian	109	Indonesian	20
Wolof	89	Burmese	15
Japanese	72	Persian	12
Soninke	65	Urdu	11
Tagalog	63	Hmong	5
Twi	62	Karen	5
Grand Total:	**16,222**		

In-Person Interpretation:

Language	Minutes Billed
Arabic	275

Farsi	120
Hindi	285
Korean	100
Russian	115
Spanish	1,279
Vietnamese	645
Total	**2,819**

In FY 2015-2016, there was increase in utilization of ASL interpretation services from 164 to 292 requests compared to previous year. A total of 37,225 minutes were billed by various HCA Programs.

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

Bilingual staff and/or interpreter services are available at all BHS programs and services, as demonstrated by:

- Availability of interpreter and/or bilingual staff
- Evidence of the availability of interpreter and/or bilingual staff may be seen in county posters and flyers displayed in the behavioral health clinics. As previously mentioned, BHS policies and sections of the client handbook also support the existence of interpreter or bilingual services.
- Interpreter services are offered and provided to clients and the response to the offer is recorded
- BHS Policy # 02.01.04 was revised in November 2010 and requires that the offer of the Provider List to new clients must be documented in the Advisement Check list.
- Evidence that Staff that are linguistically proficient in threshold languages
- Bilingual staff in the five threshold languages are eligible to receive additional bilingual pay. In order to receive this additional pay, staff must be certified via testing by the Orange County Human Resources (HR) Department.
- Process to ensure that interpreters are trained and monitored for language competence

- Staff members may be tested to determine their proficiency in languages other than English. Qualified BHS staff employees are paid an additional forty (40) to ninety (90) cents per hour depending on their classification. To become qualified, employees must be certified as qualified by the HR Director. Tests coordinated by HR are administered to determine certification. This includes such specialized communication skills, such as sign language.

CRITERION 8: ADAPTATION OF SERVICES

I. Quality of Care: Contract Providers

The County shall provide evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

All BHS contractors are required to demonstrate a commitment to providing culturally competent services that will accommodate the language needs of the clients served. Contract language that demonstrates this includes:

A. "Services shall be active in supporting and implementing the program's philosophy and its individualized, strength-based, culturally/linguistically competent and Consumer-centered approach."

B. "PROGRAM PHILOSOPHIES – CONTRACTOR's program shall be guided by the following values, philosophies, and approaches to Recovery in the services provided:

1. Ensuring Cultural Considerations – CONTRACTOR shall tailor services to the Consumers' worldview and belief systems and to enhance the therapeutic relationship, intervention, and outcome. Consideration to how Consumers' identify in terms of race, ethnicity, sexual orientation, and spirituality shall be considered when developing and providing services.

C. Staffing: "CONTRACTOR shall include bilingual/bicultural services to meet the needs of threshold languages as determined by COUNTY. Whenever possible, bilingual/bicultural staff should be retained. Any clinical vacancies occurring at a time when bilingual and bicultural composition of the clinical staffing does not meet the above requirement must be filled with bilingual and bicultural staff . . ."

"CONTRACTOR shall make its best effort to provide services pursuant to the Agreement in a manner that is culturally and linguistically appropriate for the population(s) served."