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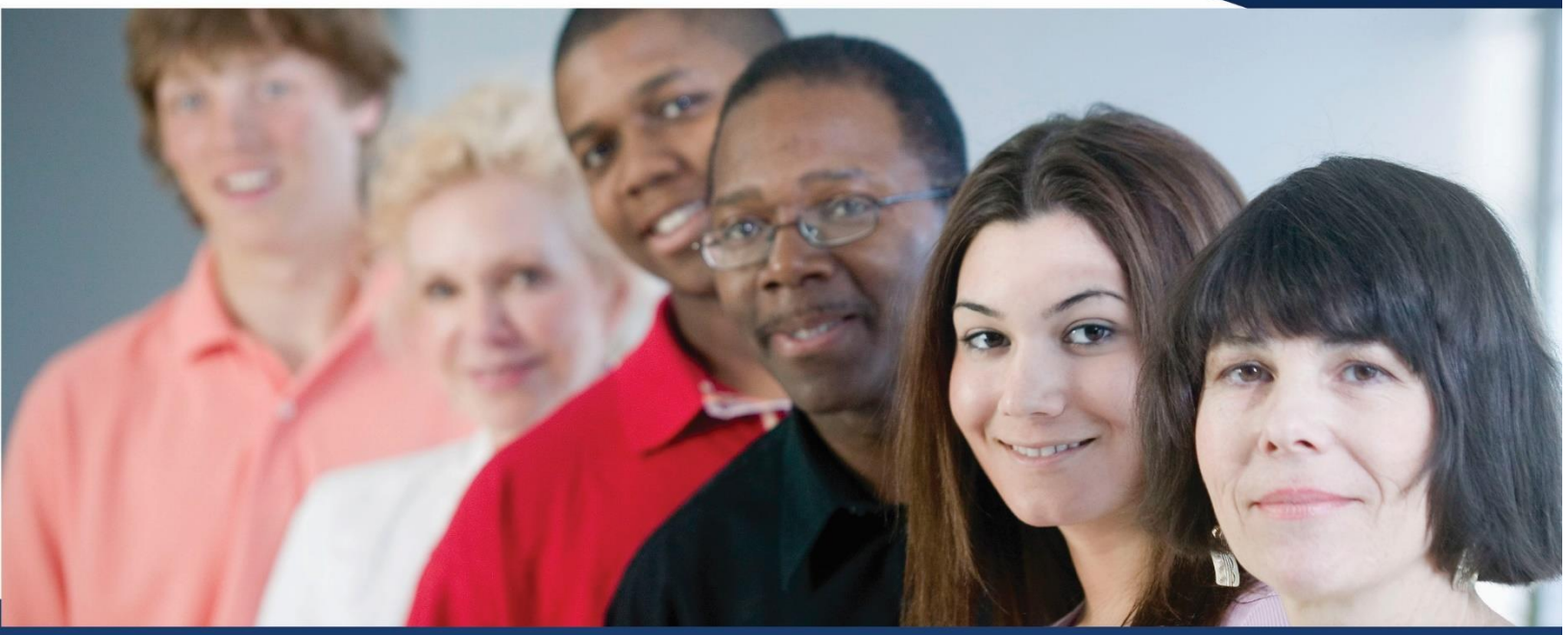

Cultural Competence Plan Update

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CHECKLIST FOR THE 2018 CULTURAL COMPETENCY PLAN: REQUIRED CRITERIA

Criterion 1:	Commitment to Cultural Competence
Criterion 2:	Updated Assessment of Service Needs
Criterion 3:	Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities
Criterion 4:	Client/Family Member/Community Committee: Integration of the Committee Within the County Mental Health System
Criterion 5:	Cultural Competent Training Activities
Criterion 6:	Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff
Criterion 7:	Language Capacity
Criterion 8:	Adaptation of Services

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:
    i. 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.
    ii. 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.
    iii. 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.
    iv. 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.
    v. BHS Policy 02.01.05 – Field Testing of Written Materials, requiring that written materials be field tested to ensure comprehension of the information provided.
    vi. 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.
    vii. 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.
    viii. 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.
    ix. 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 e v e r y 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 Statement of Philosophy:
   Partnering with our clients and the community, we value:
   i. Excellence in all we do
   ii. Integrity in how we do it
   iii. 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:
   i. HCA has also identified two internal business strategies focused on our greatest asset, our employees.
   ii. Encourage excellence by ensuring a healthy work environment that values employees.
   iii. 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.

a. 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, , 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

b. The OC Links Information and Referral 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 Link's 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 and their website address is https://cms.ocgov.com/gov/health/bhs/about/nit/oclinks/ .

c. 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:
    a. Participate in the Cultural Competence plan and development of the Cultural Competence Committee and sub-committees.
    b. 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).
    c. 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.
    d. Develop, coordinate and facilitate the implementation of the state Department of Mental Health's required Cultural Competency Plan.
    e. 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.
    f. 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.
    g. 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 Services (CYPBH) unit. The CC/ESM is an administrator under the WET Program management. In July 2018, the Workforce Education and Training (WET) program's name was changed to Behavioral Health Training Services (BHTS) in order to better define the services to a broader audience

F. The CC/ESM oversees 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:

   a. Developing, coordinating, and facilitating the implementation of a culturally responsive and inclusive plan for Orange County.
   b. Developing, implementing, and ensuring the accuracy of verbal interpretation and written translation services and materials in all threshold languages.
   c. Planning and organizing cultural diversity events at an organizational and community level, and
   d. 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 culture and linguistically competent activities.

   a. HCA/BHS currently has two employees dedicated to interpreter and translation services in the Multicultural Development Program (MDP). The languages are Vietnamese and Spanish. The bilingual English/Spanish speaking position is currently vacant. MDP/BHTS has additional bilingual staff who assist with translation and interpretation services in Farsi, Arabic and Korean 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:
    a. Interpreter and translation services:
        i. Outside interpretation and translation service providers that HCA/BHS currently contracts with include Language Line for interpretation and translation services and Western Interpreting Network (WIN) 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	1,588,642	49.6%
Female	1,612,106	50.4%
Total Population	***3,200,748***	
Ethnicity	*Population*	*Percent*
White/Caucasian	1,332,760	41.6%
Hispanic or Latino	1,118,467	34.9%
Asian and Pacific Islander	612,757	19.1%
Black/African American	49,390	1.5%
Native American	6,574	0.2%
Multi Race/Other	80,800	2.5%
Total Population	***3,200,748***	
Age	*Population*	*Percent*
0-5 years	229,908	7.2%
6-17 years	499,008	15.6%
18-59 years	1,821,478	56.9%
60+ years	650,354	20.3%
Total Population	***3,200,748***	

Source: Department of Finance Population Statistics (2017)

2.2 OC Youth Population (0-17)

Youth Gender	*Population*	*Percent of Total Population*
Male	374,205	11.7%
Female	354,711	11.1%
Youth Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	216,742	6.8%
Hispanic/Latino	346,661	10.8%
Asian, Pacific Islander	122,078	3.8%
Black/ African American	9,297	0.3%
Native American	1,143	*
Multi Race / Other	32,995	1.0%
Youth Age	*Population*	*Percent of Total Population*
00 to 04 years	190,790	6.0%
05 to 11 years	281,705	8.8%
12 to 17 years	256,421	8.0%
Total Youth Population	***728,916***	***22.8%***

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

Source: Department of Finance Population Statistics (2017)

2.3 OC Adult Population (18+)

Adult Gender	*Population*	*Percent of Total Population*
Male	1,214,437	37.3%
Female	1,257,395	37.6%
Adult Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	1,116,018	35.1%
Hispanic/Latino	771,806	17.7%
Asian, Pacific Islander	490,679	14.6%
Black / African American	40,093	1.9%
Native American	5,431	0.5%
Multi Race / Other	47,805	5.1%
Adult Age (18+)	*Population*	*Percent of Total Population*
18-19 years	96,543	3.0%
20-24 years	242,043	7.6%
25-34 years	392,769	12.3%
35-44 years	410,055	12.8%
45-54 years	462,822	14.5%
55-64 years	400,446	12.5%
65+ years	467,154	14.6%
Total Adult Population	***2,471,832***	***77.2%***

Source: Department of Finance Population Statistics (2017)

As of 2017, roughly 46% of Orange County citizens were non-English speakers, which is higher than the national average of 21.5% in 2015 (see Table 2.4). The U.S. Census Bureau indicated that a quarter (25%) of residents spoke Spanish at home, while 15% spoke an Asian or Pacific Islander language, and 5% spoke another language.

2.4 OC Language Population[1]

	Population	*Percent*
English	1,622,972	54%
Spanish	762,003	25%
Asian/Pacific Islander Languages	459,456	15%
Other Indo-European Languages	129,646	4%
All Other Language	29,126	1%
Total	***3,003,239***	

[1] *The source used in the 2017 Cultural Competency Plan Update was not used given that no new data had been provided (2015 Data USA http://datausa.io/profile/geo/orange-county-ca/#intro).*
Source: U.S. Census Bureau (2017). American Community Survey 1-year Estimates. Retrieved from Census Reporter Profile Page for Orange County, CA

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).

County and Medi-Cal Eligible Population

Data were extracted for the number of Medi-Cal eligible residents per month and those who received a service by gender, race/ethnicity, and age from the most recent CAEQRO report for calendar year 2017 (Table 2.5). However, because the CAEQRO report did not provide estimates for language, data from the California Medi-Cal Eligibility Data System (MEDS) and the Orange County Electronic Health Record System are provided in this report (Table 2.6).

The male and female populations were fairly represented in Orange County's population. There was a higher proportion of female, as compared to males who were eligible for Medi-Cal services (55.0% versus 46.8%). Measureable differences were also found between the County and Medi-Cal eligible populations when comparing results across ages, especially for those under 18 years of age and between the ages of 18 to 64. As expected, more than half of the County's eligible population was between 18 to 59 years of age (50.2%). Differences among residents of various racial and ethnic backgrounds were also identified. While roughly 42% of the population indicated they were of White/Caucasian decent, very few of these participants were eligible for services (17.5%). The highest proportion of Medi-Cal eligible residents were either Hispanic or Latino (49.9%) followed by Asian and Pacific Islanders (19.2%). Additionally, the most common language spoken at home among Orange County residents was English, and these participants were most likely to be eligible (54.1%). Spanish was the second highest primary language in the county at

32.8%.

Medi-Cal Eligible to Beneficiaries being Served

Based on the number of Medi-Cal eligible residents and the number of beneficiaries who were served, the following groups were underrepresented: Females, Hispanic/Latinos, Asian and Pacific Islanders, Native Americans, youth 5 years of age and under, adults over the age of 60, and residents who spoke a language other than English. Residents over 60 years of age comprised 15% of the Medi-Cal population, yet only 5.5% were served. There is also a noticeable difference for those who speak a language other than English at home. Spanish speakers comprised almost one-third of the Medi-Cal population (32.8%), but only 17.3% were served. Similarly, those who spoke an Asian or Pacific Islander language made up 11.3% of the population and less than 5% were served (3.1%).

Penetration Rates

According to data provided by Behavioral Health Concepts, Inc. during the MHP's FY 2017-18 review, the State-wide penetration rate was 4.5%. In Table 2.5, CAEQRO calculated Orange County's penetration rate as being below the State average at 2.8%. This number was calculated based on the number of Medi-Cal beneficiaries who received an approved service within a calendar year divided by the average number of Medi-Cal eligible in the County per month. Since EQRO did not provide penetration rates for primary language, rates were calculated based on the total number of Medi-Cal beneficiaries served divided by the total number of residents who were eligible in a given year. Using this methodology, the Orange County penetration rate was slightly higher than CAEQRO at 3.0% (Table 2.6).

Based on Table 2.5 and below, the penetration rate was higher than the CAEQRO State-wide average for the residents who identified as Black/African American, Native American, Multi-Race/Other, or youth between the ages of 6 and 17. Additionally, those who spoke English as their primary language were similar to the HCA average (Table 2.6). Groups higher than or similar to the local average included males, White/Caucasians, Hispanic or Latino residents, as well as individuals ages 18 to 59. Residents under age 5, over the age of 60, and those who spoke an Asian or Pacific Islander language had the lowest penetration rates, with less than 1% being served.

2.5 Medi-Cal Penetration Rates by Gender, Race/Ethnicity, and Age

	County Population[1]		*Number of Medi-Cal Eligibles*[2]		*Medi-Cal Beneficiaries who Received an Approved Service*[2]		*Penetration Rate*
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,588,642	49.6%	417,762	46.8%	12,951	51.3%	3.1%
Female	1,612,106	50.4%	490,769	55.0%	12,306	48.7%	2.5%
Race/Ethnicity							
White/Caucasian	1,332,760	41.6%	156,049	17.5%	6,016	23.8%	3.9%
Hispanic or Latino	1,118,467	34.9%	445,387	49.9%	10,198	40.4%	2.3%
Asian and Pacific Islander	612,757	19.1%	171,163	19.2%	727	2.9%	1.2%
Black/African American	49,390	1.5%	15,021	1.7%	2,095	8.3%	4.8%
Native American	6,574	0.2%	1,445	0.2%	77	0.3%	5.3%
Multi Race/Other	80,800	2.5%	119,433	13.4%	6,144	24.3%	5.1%
Age							
0-5 years	229,908	7.2%	100,961	11.3%	921	3.6%	0.9%
6-17 years	499,008	15.6%	226,509	25.4%	10,300	40.8%	4.6%
18-59 years	1,821,478	56.9%	447,669	50.2%	12,648	50.1%	2.8%
60+ years	650,354	20.3%	133,358	15.0%	1,388	5.5%	1.0%
Total Population	***3,200,748***		***908,497***		***25,257***		***2.8%***

2.6 Medi-Cal Penetration Rates by Primary Language

	County Population[3]		*Number of Medi-Cal Eligibles*[4]		*Medi-Cal Beneficiaries Served*[5]		*Penetration Rate*
	N	*%*	*N*	*%*	*N*	*%*	*%*
Primary Language							
English	1,622,972	50.7%	478,621	54.1%	21,160	78.6%	4.4%
Spanish	762,003	23.8%	290,462	32.8%	4,653	17.3%	1.6%
Asian/Pacific Islander Languages	459,456	14.4%	99,847	11.3%	837	3.1%	0.8%
Other Indo-European Languages	129,646	4.1%	7,667	0.9%	167	0.6%	2.2%
All Other Language	29,162	0.9%	8,130	0.9%	103	0.4%	1.3%
Primary Language Total	***3,003,239***		***884,727***		***26,920***		***3.0%***

[1] *Source: Department of Finance Population Statistics (2017)*

[2] *Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange COunty MHP Calendar year '17, CA EQRO report 2018*

[3] *Source: U.S. Census Bureau (2017). American Community Survey 1-year Estimates. Retrieved from Census Reporter Profile Page for Orange County, CA*

[4] *Source: CA Medi-Cal Eligibility Data System (MEDS) Extract, May 2018*

[5] *Source: Orange County Health Care Agency (FY 16/17), Electronic Health Record System (IRIS)*

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).

2.7 Poverty Estimate for Population Living at or Below 200% FPL (minus Medi-Cal)

Gender	*Total Number*
Female	210,000
Male	248,000
Race/Ethnicity	*Total Number*
White/Caucasian	117,000
Hispanic/Latino	247,000
Asian/Pacific Islander	79,000
Black/African-American	14,000
Native American	*
Multi Race/Other	*
Age	*Total Number*
Under 18	51,000
18+	407,000

*For 2017, data unavailable for this population from the California Health Interview Survey.

Source: California Health Interview Survey (2017)

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).

2.8 Population Assessment

	County Wide Estimated Total Population[1]		County Wide Estimated Population Living at or Below 200% FPL[2]	
	N	%	N	%
Gender				
Males	1,588,642	49.6%	491,000	53.4%
Females	1,612,106	50.4%	429,000	46.6%
Race/Ethnicity				
White/Caucasian	1,332,760	41.6%	181,000	19.7%
Hispanic/Latino	1,118,467	34.9%	505,000	55.0%
Asian/Pacific Islander	612,757	19.1%	187,000	20.4%
Black/African American	49,390	1.5%	45,000	4.9%
Native American	6,574	0.2%	*	*
Multi Race/Other	80,800	2.5%	*	*
Age				
Under 18	728,916	23.0%	194,000	21.1%
18-64	2,004,678	11.0%	613,000	66.8%
65 and over	467,154	49.0%	111,000	12.1%

* For 2017, data unavailable for this population from the California Health Interview Survey.

[1] *Source: Department of Finance Population Statistics (2017)*

[2] *Source: California Health Interview Survey (2017)*

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

I. Identify 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. Outcome results for the following programs were extracted from the Orange County Mental Health Services Act (MHSA) Plan Update FY 2018/2019.[1]

II. Identified Strategies/Objectives/Actions/Timelines:

CCS Plan

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

[1] Orange County Mental Health Services Act (MHSA) Plan Update FY 2018/2019. (2018). *Orange County Mental Health Services Act Office report FY 2018/2019*. Orange County, CA: Health Care Agency.

resources.

d. 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. BHTS and MDP provide language training to culturally competent staff.

e. 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 (PACT)

The Program for Assertive Community Treatment (PACT) teams in Orange County target high risk underserved mentally ill Transitional Age Youth (TAY), mentally ill adults and older adults. Ethnic populations include the monolingual Latinos, Vietnamese, Korean and Iranian adults, as well as the linguistically isolated, which includes the Deaf and Hard of Hearing. 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. 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 use and family therapy. In addition, supportive services such as money management and linkage are offered.

TAY PACT: The target population for the Transitional Age Youth PACT program is diverse and includes chronically mentally ill TAY, ages 18 to 26. 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.

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 and 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 one child/youth, 141 TAY, 928 adults and 103 older adults were served in the PACTs during FY 2016-17. Using the same method and approach as the FSPs, these programs evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. Because CYBH PACT was not implemented until June 2017, outcomes are not yet available for this program.

Psychiatric hospitalizations: TAY and adults experienced a moderate decrease in the average number of days spent psychiatrically hospitalized during FY 2016-17 compared to the 12 months prior to enrolling in PACT. While the statistical analysis[1] for older adults indicates that their days spent hospitalized essentially

did not change, this is likely due to the fact that a number of older adults remained hospitalized despite being ready for discharge to a lower level of care because a placement option appropriate for their complex medical, physical or Activities of Daily Living needs could not be located.

Psychiatric Hospitalization Days PACT FY 2016-17	TAY	Adults	Older Adults
	73%↓	81%↓	44%↓
	Before: 46.6 After: 12.4	Before: 48.1 After: 9.2	Before: 23.2 After: 12.9

Homelessness: PACT participants also experienced moderate reductions in the average number of days they spent homeless during FY 2016-17 compared to the 12 months prior to enrolling in the program.[2]

Unsheltered Homeless Days PACT FY 2016-17	TAY	Adults	Older Adults
	74%↓	54%↓	57%↓
	Before: 57.6 After: 15.2	Before: 142.5 After: 65.3	Before: 167.8 After: 71.8

Incarcerations: Compared to the year prior to enrollment, adults and older adults reported moderate decreases and TAY reported small decreases in the average number of days spent incarcerated during FY 2016-17.[3]

Incarceration Days PACT FY 2016-17	TAY	Adults	Older Adults
	58%↓	70%↓	69%↓
	Before: 35.1 After: 14.7	Before: 142.5 After: 65.3	Before: 167.8 After: 71.8

Employment: Similar to the FSPs, TAY and adults served in PACT did not experience meaningful gains in employment, with TAY only increasing their days employed by an average of one week and adults by an average of six days during FY 2016-17. [4]

Employment Days PACT FY 2016-17	TAY	Adults
	22%↑	21%↑
	Before: 37.2 After: 45.1	Before: 27.3 After: 33.0

Reference Notes

[1] *Psychiatric Hospitalization Days:*
TAY: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t (92) = 4.12, p<0.001, Cohen's d=.43
Adults: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t (687) = 12.59, p<0.001, Cohen's d=.53
Older Adults: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t (52) = 1.64, p=0.11, Cohen's d=.21

[2] *Homeless Days:*
TAY: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t (17) = 3.37, p<0.01, Cohen's d=.57
Adults: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t (242) = 7.97, p<0.001, Cohen's d=.47
Older Adults: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t (30) = 2.81, p=0.009, Cohen's d=.54

[3] *Incarceration Days:*
TAY: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t (29) = 2.48, p<0.05, Cohen's d=.39
Adults: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t (216) = 6.38, p<0.001, Cohen's d=.48
Older Adults: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t (10) = 3.24, p<0.01, Cohen's d=.61

[4] *Employment Days:*
TAY: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t (92) = -0.68, p=0.50, Cohen's d=-.12
Adults: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t (753) =-1.55, p=0.12, Cohen's d=-.05

Crisis Assessment Team (CAT)

The Crisis Assessment and Psychiatric Emergency and Response Teams provide mobile field services to individuals in behavioral health crises. The Crisis Assessment Team (CAT) provides 24-hour mobile response services to any adult experiencing a behavioral health crisis. Staff members receive calls to provide crisis intervention to individuals living with mental health issues from law enforcement officers in the field, social services agencies, and concerned family members. CAT conducts risk assessments, initiates voluntary or involuntary hospitalizations when necessary, provides resources and linkage, and conducts follow-up contacts for individuals assessed. The primary languages that are served include English, Spanish, Vietnamese, Korean, Cambodian, Arabic and Tagalog.

Children's CAT: 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, a CAT member will 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.

Transitional Age Youth (TAY) CAT: The Crisis Assessment Team has a Transitional Age Youth (TAY) component that provides specialized services to adults from 18-25 years of age. The TAY 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 behavioral health crisis. In response to behavioral health emergencies, staff members provides crisis intervention, assessments for lower levels of care, evaluations for involuntary hospitalizations when necessary, and assistance for law enforcement, fire department, and social service agencies. Bilingual/bi-cultural staff members work with family members to provide information, referrals, and community support services.

This program currently has three staff members that have expertise and additional training in working with

the TAY population.

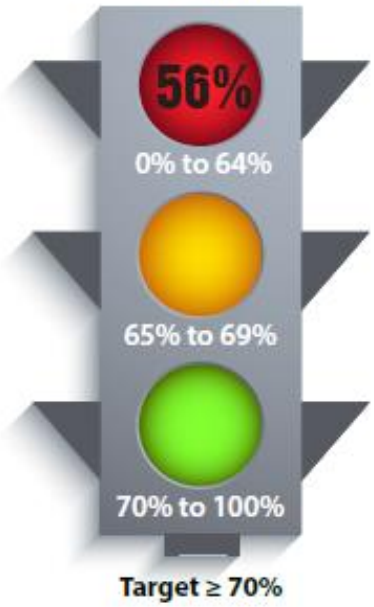
The Psychiatric Evaluation and Response Team (PERT) is a specialized unit designed to create a behavioral health and law enforcement response team. Staff members on our Psychiatric Emergency and Response Team (PERT) are behavioral health clinicians who ride along with assigned law enforcement officers to address behavioral health related calls in the assigned city. PERT conducts risk assessments, initiates involuntary hospitalizations when necessary, and provides resources and education. The program also provides outreach and follow-up services to ensure linkage to ongoing services.

While the primary purpose of the partnership is to assist individuals in need in accessing Behavioral Health Services, the PERT team also provides education to law enforcement officers regarding behavioral health conditions and provides them with the tools necessary to more effectively assist individuals who are living with behavioral health disorders.

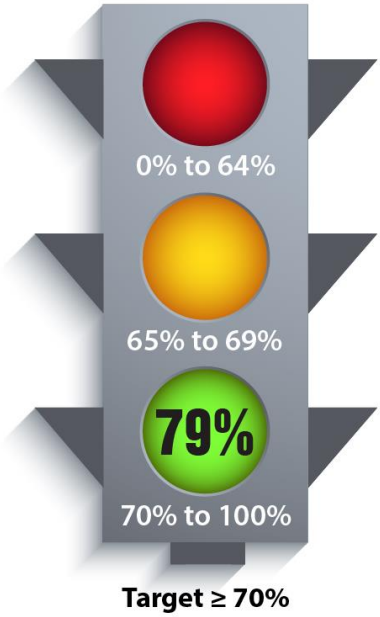
Outcomes: In FY 2016-17, the Children's team conducted 3,039 evaluations, and the TAY/Adult team conducted 4,568 evaluations. The program is evaluated by the timeliness with which CAT is able to respond to calls, with the goal that the dispatch-to-arrival time is 30 minutes or less at least 70% of the time. The Children's team missed its target with a 56% response rate, although the average dispatch to arrival time was 32.3 minutes. TAY/Adult CAT/PERT met its goal with a dispatch-to-arrival rate of 79%.

The 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 44% for children and 48% for TAY/adults. The program has noted a growing number of individuals 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 placement options.

Dispatch-to-Arrival in 30 minutes or Less
Children's CAT
FY 2016-17



Dispatch-to-Arrival in 30 minutes or Less
TAY/Adult CAT/PERT
FY 2016-17



Supported Employment

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 405 new participants in FY 2016-17, which included 291 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 2016-17, 118 of the 203 (58%) job placements resulted in a successful graduation from the program after achieving the employment milestone.

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

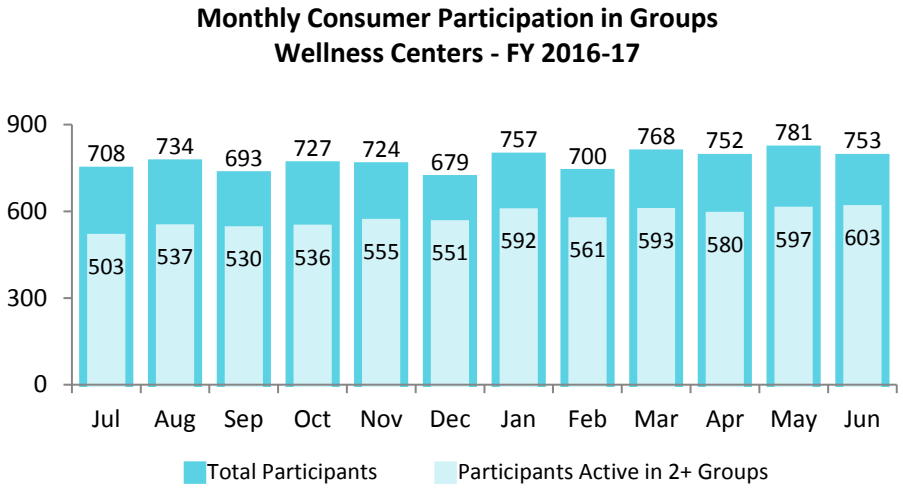
achieve his or her vision of recovery while providing acceptance, dignity and social inclusion. The programs are member-driven, and utilize staff with a history of participating in mental health services, and are committed to providing peer-to-peer promotion and community integration of emotional, physical, 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.

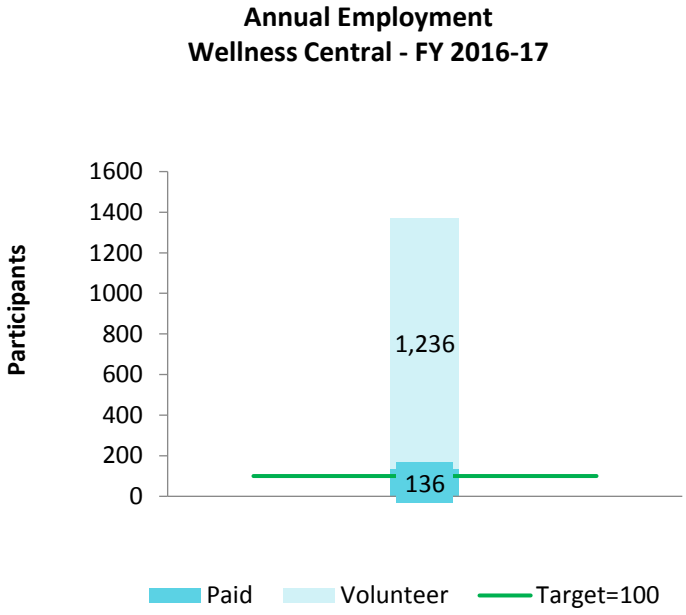
Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings and recreational activities. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer 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.

Outcomes: The Wellness Centers served a total of 2,424 adults during FY 2016-17. They 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, 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 71% in July to 80-81% in December, February, and June). 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 2016-17, 2,028 (84%) 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. One hundred and forty one adults enrolled in education classes during FY 2016-17. 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 classes. In contrast, 1,372 adults (56% of total served) were involved in employment during FY 2016-17, largely due to the numbers in volunteer positions (see graph). The programs will continue their efforts to engage members in employment and work toward increasing the number who obtain paid positions.



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 below.

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 from Royale Therapeutic Residential Center in Santa Ana, 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 services were implemented in 2017, and are a component of the Department of Health Care Services' Whole Person Care (WPC) Grant. The overarching goal of the WPC project is the coordination of physical 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 focuses 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 Housing Navigators at Collette's

Children's Home, as well as 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, Collette's and/or 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 are 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 130 on an annual basis.

Outcomes: Of the 352 adults and older adults served in Track 1 during FY 2016-17, 248 individuals (70%) successfully completed their goals with assistance from their Peer Mentor. The most common types of goals for which individuals were referred included learning to navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; and increasing socialization activities.

Of the 403 adults and older adults served in Track 2 during FY 2016-17, 216 individuals (54%) were successfully linked to their follow-up behavioral health and/or medical appointments

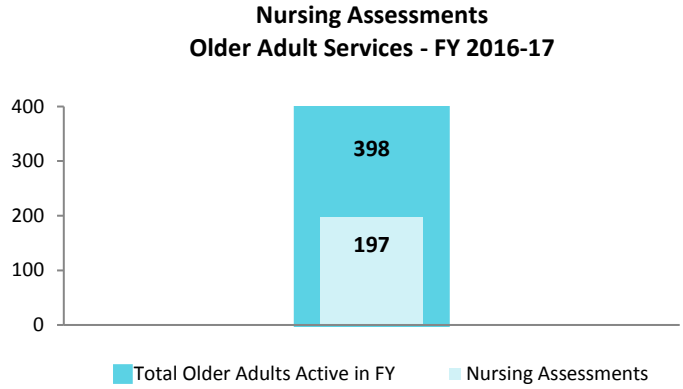
Older Adult Recovery Program

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.

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 2016-17, the program served 398 older adults, 263 of whom were new admissions. One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary care, which is quantified as the number of nursing assessments completed. Of those served, half (n=197) had a nursing assessment completed during FY 2016-17.



Integrated Community Services

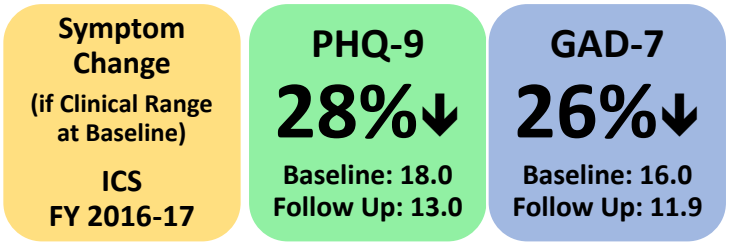
The Integrated Community Services (ICS) project is a collaboration between County Behavioral Health Services and contracted community medical clinics that provide access to integrated medical and mental health services to County and community participants. The ICS model creates one health home for participants,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

There are two components to the ICS project: ICS County Home and ICS Community Home. On the County side, Primary Care Physicians, Registered Nurses, and Peer Specialists are placed in three behavioral health clinics: Santa Ana, Westminster, and Anaheim. The ICS County home provides primary medical care services to transitional age youth (TAY), adults and older adults. Participants must be

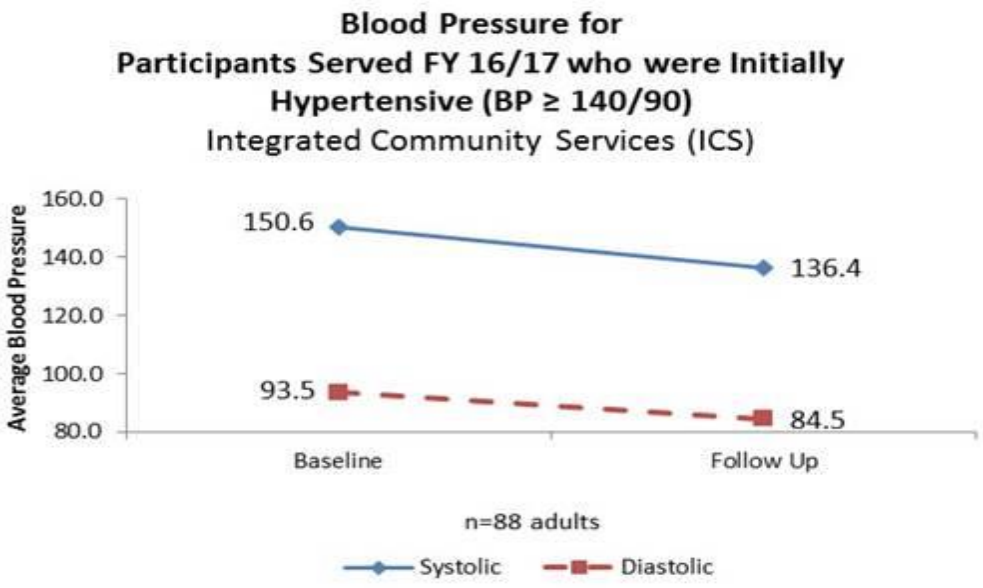
residents of Orange County, Medi-Cal eligible or enrolled, or have third party coverage. Project participants must also have a chronic health condition and be currently enrolled in behavioral health services at an Orange County Behavioral Health Clinic in Santa Ana, Westminster or Anaheim. Within the community side, County 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: A total of 467 adults participated in ICS during FY 2016-17. ICS monitored both mental health symptoms and physical health markers to assess program impact. Adults who scored in the clinical range on measures of depression (PHQ-9) and anxiety (GAD-7) at baseline (i.e., score $\geq$ 10), reported a moderate decrease in symptoms at the most recent follow up.[1] More specifically, average depression scores decreased from the moderately severe range to the moderate range and average anxiety scores decreased from the severe range to the moderate range.[1]



In addition to mental health assessments, ICS maintains continual tracking of adults' health outcomes (biometrics) such as blood pressure. Adults with two or more measurements who fit criteria for high blood pressure or hypertension at baseline (i.e., ≥ 140/90) demonstrated moderate decreases of about 10% both in their systolic and diastolic blood pressure while enrolled in ICS.[2]



Reference Notes

[1] PHQ-9: Prior M=18.0, SD=5.0; Since M=13.0, SD=6.9; t (104) = 7.23, p<.001, Cohen's d=.59
GAD-7: Prior M=16.0, SD=3.5; Since M=11.9, SD=6.3; t (82) = 6.61, p<.001, Cohen's d=.60
[2] Systolic: Prior M=150.6, SD=18.4; Since M=136.4, SD=23.9; t (87) = 4.87, p<.001, Cohen's d=.47
Diastolic: Prior M=93.5, SD=8.9; Since M=84.5, SD=14.5; t (87) = 5.29, p<.001, Cohen's d=.54

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 use 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.

To improve access to its services, the Courtyard outreach team is available 7 days a week and operates during evening hours. The staff is bilingual/bicultural and a language translation service is available when needed. In addition, the team is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals into services. Since The Courtyard Outreach team went live in December 2016, it has made 5,130 outreach contacts, 826 referrals and 278 linkages to services.

Workforce Education and Training (WET) Plan

In July 2018, BHS agreed to re-name the WET department to Behavioral Health Training Services, which helps to define the services to a broader audience. However, the initiatives and strategic plans for reducing disparities remain a part of the 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, Transgender, questioning and Intersex 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 Behavioral Health Training Services (BHTS) 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 BHTS component.

The Orange County Health Care Agency Behavioral Health Training Services (BHTS) contracted with the Golden West College Regional Criminal Justice Training Center since the inception of the Crisis Intervention Training (CIT) for Law Enforcement program in 2008. In FY 2016-17, 15 CIT classes were taught to a total of 372 Orange County law enforcement officers. The CIT 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 adds 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:

Name of Training	Level	Hours
CIT I	Basic	16
CIT II	Intermediate	8
CIT III	Advanced	16
Certificate of Completion:		40

The Certificate of Completion certifies that the participant received 40 hours of specialized training in Crisis Intervention. CIT III was first taught in November 2017. In November 2018, CIT IV was added to include training for dispatchers.

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. An example of such trainings is 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 BHTS program also supports trainings by community partners by providing continuing education credits. Some of these partners have been Mental Health Association, National Association of Mental Illness of 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 2016-17, there were 378 individuals who attended nine trainings provided by 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

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 2016-17, REI provided 187 total trainings to 750 active students. Of the 223 newly enrolled students, 54% identified themselves as living with a behavioral health condition, 30% identified themselves as family members of those living with a behavioral health condition and 16% identified as both.

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 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 BHTS 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 2016-17, tuition incentives were provided to 20 staff, three of whom were undergraduates and 17 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 2016-17, a total of eight psychiatrists participated in the Loan Repayment Program.

Outcomes: In Spring 2018, a survey was conducted with all staff who had participated in FIP since its inception. This survey was sent out to roughly 114 staff who previously participated in FIP, and a total of 27 staff responded to this survey (24% response rate). Of those who responded, the majority of participants self-identified as female (70%) and were between the ages of 26-59 (93%). Participants also indicated their ethnic background as being either Mexican or other Latino (42%), Caucasian/White (15%), Vietnamese (12%), or Multi-Ethnic (12%). Participants were also asked about their employment and educational goals. After completing FIP, those surveyed were more likely to be promoted and/or earn advanced degrees (e.g., Bachelor's or Master's).

Participants were asked several career-oriented questions to better understand how FIP helped them advance in their jobs. The vast majority felt that FIP helped them to advance in their careers (93%). FIP was also perceived by the majority of staff as a very or extremely helpful tool to help them achieve their educational goals (93%) and to better provide bilingual/bicultural services (82%). Additionally, almost all staff would recommend this program to someone they know (96%).

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. The PEI plans serve a diverse community in Orange County that includes individuals from all threshold languages groups and many other underserved communities in Orange County. These programs are served by staff who are multicultural and multilingual in the threshold languages as well as other languages. These programs outreach and 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):

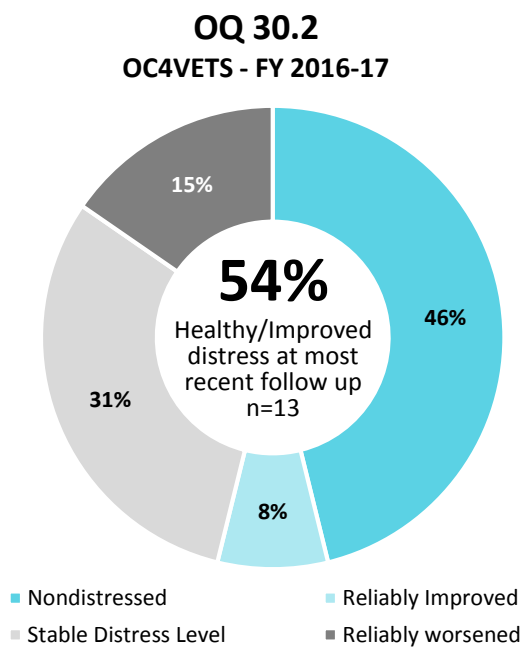
- Disparities in Access to Mental Health Services
- Underserved Cultural Populations
- Statewide Projects for Stigma Reduction

OC4Vets

OC4Vets is a Behavioral Health Services program that is co-located at the Orange County Community Resources Veterans Service Office (VSO). The program's main goal is to engage Veterans, service-members or their family members who are in need of behavioral health services.

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 program 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 Master-level clinicians, peer navigators who are Veterans, and supportive services staff with expertise in housing and employment resources. OC4Vets offers a fluid and clinically-informed setting for behavioral health screening and assessment, short-term counseling, case management, employment and housing supportive services, and, referral and linkage to community resources.

Outcomes: OC4Vets served a total of 172 participants during FY 2016-17. OC4Vets experienced administration issues with the OQ® 30.2 and paired measures were only available for 13 individuals. A little over half reported healthy or reliably improved levels of distress at the time of discharge and nearly one-third reported stable distress. Because two Veterans (15%) reported significantly greater distress at the time of discharge, the program is working to implement strategies on how to identify and work with individuals in need of greater support and/or a higher level of care in a timely and effective manner. The program is also working with staff to improve its outcome measure completion rate so that it can determine whether these results are unique to this particular subsample or whether this pattern is reflective of the overall Veteran population served by OC4Vets.



OC ACCEPT

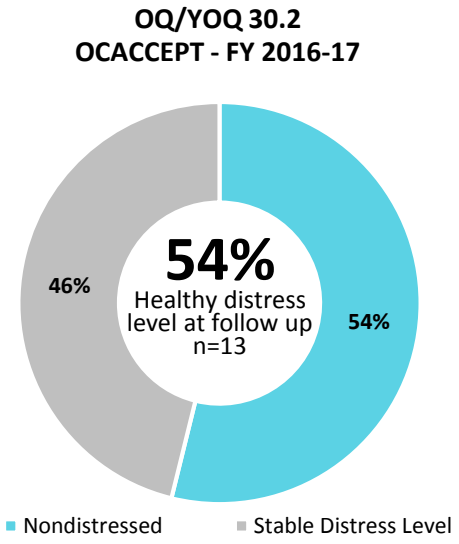
OC ACCEPT (Acceptance through Compassionate Care, Empowerment, and Positive Transformation) provides community-based mental health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and the important people 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 2016-17, 121 participants were served by OC ACCEPT (20 youth under age 18 and 101 adults 18 and older). The program aims to measure reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth and OQ® 30.2 for adults). The goal was for participants to complete the form at intake, every three months of program participation and at program exit, and the difference between intake (baseline) and the most recent

follow-up scores would be used to determine whether there was a significant reduction in prolonged suffering.

In FY 2016-17, the program experienced challenges with implementing the OQ®/YOQ®, particularly at follow-up, and only 3 out of 20 youth and 10 out of 121 adults completed more than one valid assessment. Of the 13 with paired assessments, slightly more than half reported feeling non-distressed at follow-up and the remaining reported stable distress levels. Thus, while OC ACCEPT services were associated with preventing symptoms of mental illness from becoming severe and disabling among the few who completed measures, the generalizability of the program's effectiveness should be regarded as tentative until additional data are available for analysis.



Innovation Plan

Innovation projects are time-limited, pilot programs designed to evaluate the effectiveness of new or changed practices in mental health. Projects contribute to learning in one or more of the following ways:

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

As part of the MHSA General Standards and MHSA Innovation Regulations, Cultural Competence is a required element in the planning, implementation and evaluation of an Innovation project. As such,

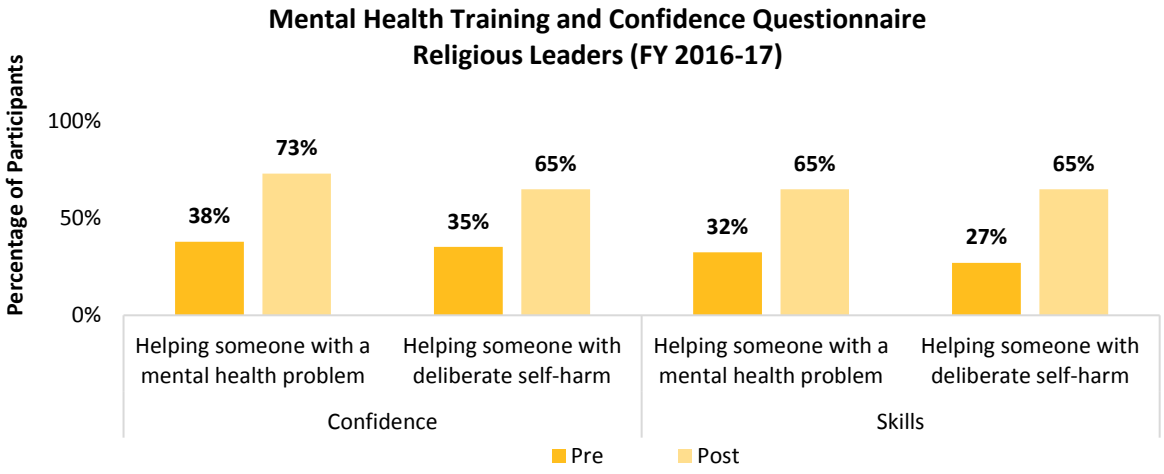
all projects take into account inclusion of diverse target populations and communities; equal access to services; and outreach and engagement of diverse racial/ethnic, cultural and linguistic populations.

Orange County currently has six Innovation projects that serve specific ethnic or cultural groups. A description of two of these projects is provided below. Additional project descriptions and outcomes are available in the FY 2018/2019 MHSA Annual Plan Update.

Religious Leaders Behavioral Health Training Services

The Religious Leaders Behavioral Health Training Services project is designed for religious leaders and community members of all faiths in Orange County. The project utilizes a train-the-trainer model to provide basic behavioral health skills training to religious leaders. Project staff conduct outreach at various religious establishments located throughout Orange County to recruit and enroll religious leaders into an 8-hour train-the-trainer course. Trained religious leaders, in turn, provide a 4-hour basic behavioral health skills training to their congregants and community members. Training content for the religious leaders and community members includes culturally competent information and open discussion about the impact of culture and religious beliefs on mental illness and recovery; the cultural impact of stigma; cultural barriers to accessing treatment; cultural variations in defining mental health; and spirituality as a protective factor to address stigma and the effect on their community. All trainings are provided in a group setting and offered at various locations throughout Orange County

Outcomes: Religious leaders were asked to complete the Mental Health Training and Confidence Questionnaire before and after receiving the 8-hour training. The questionnaire asked participants to rate the degree to which they felt comfortable and had the skills to help someone with a mental health problem or with thoughts/behaviors of self-harm. The training appeared to be effective in increasing comfort and skill with assisting those experiencing mental health symptoms: while only about one-third of the participants rated themselves as high in confidence and/or skills prior to receiving the training, about two-thirds rated themselves as high in these areas after receiving the training (n = 37).



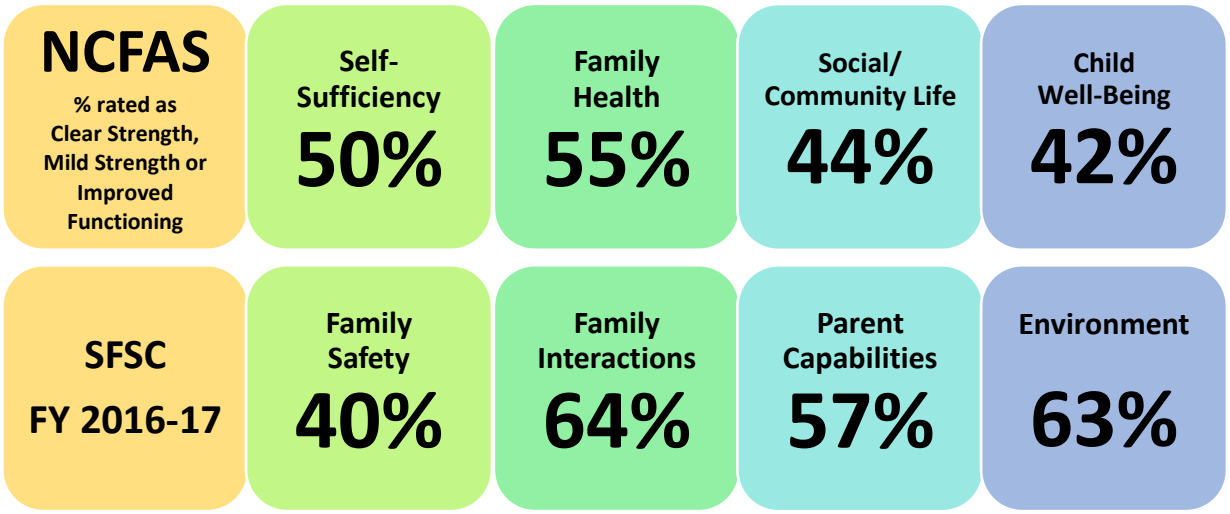
In addition, religious leaders completed the Knowledge, Attitudes, and Beliefs about Mental Illness Questionnaire before and after receiving the training. After noting unexpected increases in a few items that suggested the training actually promoted misconceptions surrounding mental illness, staff discovered that these unanticipated results almost exclusively occurred among individuals who reported that they had limited English proficiency and/or their preferred language was not English. Thus, staff are reviewing the forms to determine if the quality of the translations are driving these results, and/or whether there are issues related to the training itself. These findings will be addressed in the project's final report.

Behavioral Health Services for Military Families

Behavioral Health Services for Military Families serves all members in the military family, including veterans, service members, spouses, partners and children. The project utilizes trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family, such as post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), substance use and other conditions. Clinicians provide short-term individual and family therapy to address the impact of traumatic events and experiences on children and family members. Peer navigators provide one-on-one peer support, case management, and referrals and linkages to community resources. Additional project services include outreach and engagement, and screening and assessment to encourage appropriate referrals to and enrollment in program services; workshops and educational support groups for families; and counseling using the Families Overcoming Under Stress (FOCUS) program, which is an evidence-based practice derived from research on military-related risk and protective factors that aims to improve parent-child well-being and family functioning

Outcomes: In FY 2016-17, 277 families were served in the Strong Families-Strong Children (SFSC) project. The goals of the project are to improve family communication, functioning and overall well-

being, which was evaluated using the North Carolina Family Assessment Scale (NCFAS). Project staff provided ratings at intake and discharge (n=96) which were scored according to whether families demonstrated strengths (i.e., mild, clear), adequate functioning, or needs (i.e., mild, moderate, severe) in each of the domains. The project's success in helping families maintain or improve these protective factors was evaluated by the proportion of families that exhibited strengths or improvement in each domain.



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 (LGBTQI), 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 and hard of hearing community and has lived-experience within the culture, provides behavioral health services such as psychosocial assessment and individual counseling to deaf and hard of hearing residents of Orange County. The services became available in November of 2017 and are provided at the Behavioral Health Services Prevention and Intervention Program Community Counseling and Supportive Services (CCSS) in Orange, which is a central location within the County. T hese services began in the last quarter of 2018 at OCDEAF, 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. Between the two centers on average 6-8 clients receive the respective services per week. In this way, it is anticipated that more individuals will be aware of and able to access these important service.

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 to Address Cultural and Linguistic Issues and has Participation from Cultural Groups, which 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).

a. Community Action Advisory Committee

i. 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.

ii. 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.

iii. 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

iv. 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

b. 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 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. In the second half of 2018 the sub-committees merged to form a steering committee. The steering committee has met three times and worked on refining the vision and mission statements of CCC and developing smart goals for the 2018-2019 fiscal year.

The following is CCC's accomplishments summary for FY 2017-2018:

i. Since its inception May 2016 through the end of 2018, CCC held 28 meetings.
ii. More than 30 organizations/contract providers/county departments and programs were represented at CCC meetings. The membership roster is shown in the table below.
iii. Several presentations were made for the members covering the following topics:
    1. Lunar Year
    2. Black History Month
    3. National Women's History Month
    4. Vernal Equinox -- Nowruz: Persian New Year
    5. National Mental Health Awareness Month
    6. National Minority Mental Health Awareness Month
    7. Women's Equality Day
    8. Eid Al-Adha
    9. International Week of the Deaf
    10. Hispanic Heritage Month
    11. Indigenous / Columbus Day
    12. The day of the Dead
    13. National Coming Out Day
iv. CCC members represented at MHSA Steering Committee meetings.
v. Members participated in end of the year holiday celebration by sharing ethnic food and stories in 2016, 2017 and 2018.
vi. Increased awareness of cultural practices/traditions among CCC members/organizations through the 13 presentations listed above.
vii. Increased CCC members' involvement in field testing and developing mandatory annual training.
viii. CCC member represented at Spiritual Advisory Board
ix. CLAS – Cultural and Linguistically Appropriate Services (CLAS) Standards were reviewed.
x. The online 2018-2019 Cultural Competency Training benefited from feedback and cooperation from CCC members including four video clips on culture that were presented by one of CCC members. The online training was launched on November 30, 2018 and as of December 17, 2018 a total

of 932 people have completed the training.

xi. The idea of Culture Corner, a video series about different cultures intended to help clinicians and staff better understand and connect with the participants we serve and enhance the quality of behavioral health services was generated from the CCC meetings and the first video was launched in September 2018.

b. 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 reviews all mental health programs, including MHSA programs and contract programs

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

i. 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.

ii. The mission of the CQIC-AG is to advise the Community Quality Improvement Committee (CQIC) on issues related to delivery of publicly funded behavioral 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.

d. 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.

i. 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.

ii. 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.

e. 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

Name	Organization/Agency
Adelekan, Patricia	Los Amigos
Afrasaibi, Elham	SSA
Aguirre, Gerry	Patient's Rights
Ahn, Ellen	Korean Community
Alabi, Jessica Ayo	Orange Coast College
Aminian, Asita	OC Links
Amirshahi, Bijan	BHTS/MDP
Austin, Jason	BHS NIT
Balcom, Heather	Prevention & Intervention

Batchhelder, Brian	OCVets
Benitez, Veronica	CEGU
Brack, Yvonne	CYBH
Brimbuela, Lucy	BMD ResCare
Burney, Lenora	HCA BHS CYBH CAT
Castro, Olivia	SSA
Caou, Ross	OC Intelligence Asses. Ctr.
Chai, Jane	HCA Public Health
Chang, Diane	BHTS
Chiu, Irene	OCAPICA
Choeng, Sophia	Cambodian Family
Clark, Leon	New Spirit Baptist Church
Cohen, Sylvia	Mental Health Association
Dang, Stella	BHTS
Daniels, Danielle	HCA BHS
DeWindt, Kevin	HCA BHS A&OA Services
Domingo, Michelle	BMD ResCare
Doroudian, Negar	BHS-CYP-Innovation Projects
Eftekharzadeh, Sohail	Pathways
Gharadjedaghi, Ehsan	Norooz Clinic Foundation
Foo, Mary Ann	OCAPICA
Fowler , Christopher	LTC (CA) CSMR
Francisca , Leal	Latino Health Access
Fung , Annie	Cal State Fullerton
Gallardo, Miguel	MECCA
Garcia, Gonzalo	Santa Ana PD
Garfias, Marcy	HCA BHS CYBH

Granado, Joaquin	HCA BHS OC ACCEPT
Gonzalez, Luis	HCA BHS OC ACCEPT
Hanifzai, Wali	Access California
Helmy, Deana	HCA BHS WET
Hill , Michael	Public Defender
Hillenbrand, Leslie	NAMI OC
Hoang, Paul	HCA BHS CAT
Hogan, Mikel	Cal State U. Fullerton
Huynh, Luann	Community Member
Ishikawa, Sharon	HCA BHS MHSA
Ibarra , Nan	NAMI
Jabbar, Fathima	HCA BHS CAT
Juhasz, Brigitte	CYBH
Kazner, Charlene	Pacific Islander Health
Keefe, Keunho	BHTS
Lane, Nedenia	Public Guardian
Lawrenz, Mark	HCA
Lee , Ye	OCAPICA
Lent, Debbie	Health Care Agency
Lembke, Phyllis	NAMI
Li, Annie	Chinese Community Center
Lopez, Susi	Latino Health Access
Mahdavi, Annahita	Long Beach City College
Marin, Maria	HCA BHS PACT
Martinez, Luis	HCA BHS MHSA
McCleese, Belinda	HCA BHS MDP
Merritt, Alex	BHTS

Morales, Patricia	OC links
Mullard, Michael	BHTS
Nagel , Jeff	HCA BHS MHSA
Nguyen, Natalie	HCA BHS AOABH
Nguyen, Tricia	VNCOC
O'Brien, Brett	HCA BHS CYBH
Pang, Jane	Pacific Islander Health
Peong , Vattana	Cambodian Family Center
Perez, Karla	HCA BHS MHSA
Pham, Lorna	Viet-Care
Pitman, Steve	Pitman Insurance Associate
Rao, Bhuvana	Health Care Agency
Read, Mary	Cal State Fullerton
Renteria, Teresa	BHTS
Rocha, Tina	OCAPICA
Ruiz, Loreta	Latino Health Access
Sadeq, Ahmad	SSA
Sayyedi, Maryam	OMID
Solorza, Linda	OCSD
Suh, Min	HCA BHS MHSA
Thornton, April	HCA BHS AOABH
Thomas, Renee	OCDEAF
To, Justin	Health Care Agency
Tran, Annette	HCA BHS Patients' Rights
Tran, Pierre	HCA BHS MDP
Trevino, Candace	SSA
Tutila, Ana	CAAC

Ullman, Hanhthuc	Health Care Agency
Valencia, Crystal	OCACCEPT
Weckerly, Christina	HCA BHS CYBH
Welty, Iliana	MECCA
Whetsell, Brittany	BHTS
Wilson Codispoti, Brenda	SSA

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 Training

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

5.1 Name of Cultural Competency Trainings, FY 16-17

	Number of Attendees	*Combined Training Hours*	*Combined CEUs Given*
Ancestral Wisdom Teachings and Applications in Work with Latinos	85	3	3
Clinical Considerations when Working with Members of the Baha'i Faith	22	2	2
Communicating Effectively w/ Deaf & Hard of Hearing[1]	27	1	0
Culturally Sensitive Clinical Supervision: Ensuring Competence in Our Diverse World	133	7	6
"Faithful" Felons: Incarceration and Spirituality	62	2	2
Mental Health Interpreter Training Project	31	28	28
Military Culture	77	3	3
Online Cultural Competency Training (Ongoing)	453	1	1
Spiritual Resilience, Healing & the Brain	50	2	2
Spirituality and Religion throughout Treatment	52	2	2
Vicarious Trauma Spiritual Beliefs and Hope	73	2	2
Understanding Client Culture & Journeys (Online & In-person)	134	5	5
Working Effectively in BH with Sign Language Interpreters (Ongoing)	111	1	1
Working with Sign Language Interpreters (Ongoing)	45	1	1
Total	***1,355***	***60***	***58***

[1] No CEUs were given for this training as it was a CIT II (Intermediate) training

*5.2 Cultural Competency Training Attendance by Participants' Role**

	Total Number	*Percent*
County Administrator/Manager	128	4.7%
County Direct Service Provider	371	13.6%
County Support Staff	244	8.9%
Community-Based Administrator/Manager	124	4.5%
Community-Based Direct Service Provider	217	7.9%
Community-Based Support Staff	284	10.4%
Consumers	141	5.2%
Parents	150	5.5%
Family Members	178	6.5%
Community Member	349	12.8%
Caregiver	124	4.5%
Teacher	33	1.2%
Student	141	5.2%
Youth	11	0.4%
Other	235	8.6%
Total	***2,730***	***100.0%***

*Some attendees reported duplicated roles

B. Annual cultural competence training topics shall include, but not be limited to the following:
   i. Communicating with and interviewing diverse individuals and families
   ii. Multicultural knowledge
   iii. Cultural Sensitivity and awareness
   iv. Cultural formulation including diagnosis and treatment planning
   v. Social/Cultural diversity (Diverse groups, LGBTQ, SES, Elderly, Deaf and Hard of Hearing, disabilities, etc.)
   vi. Mental Health Interpreter training
   vii. 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 offered during FY 2016-17 are included in the table below.

Training Title	Description	Presenter(s) Name
Ancestral Wisdom Teachings and Applications in Work with Latinos	This training highlight cultural, spiritual and health principles stemming from native and ancestral teachings which are still present and being used today within the Latino Community. The origins, theoretical/practicing principles of health/wellness representative of the Latino Community, current applications and use of alternative health professionals (Curanderos, Hierberos, and others) will be discussed. Clinicians will be exposed to common presenting illnesses and symptoms within the Latino community and will learn effective, culturally based methods to address these concerns in the clinical work with Latino population.	Jorge Padilla, Psy.D.
Clinical Considerations when Working with	This training covers an overview of the Baha'i Faith and basic	Fereshteh Bethel, Ph.D.

Members of the Baha'i Faith	components that may be of significance when working with its members in a clinical context. The importance of assessment at intake will be addressed to better indicate whether the inclusion of spirituality in psychotherapy is necessary, and if so, how to contextually apply spiritual treatment in a manner that benefits the client while maintaining the authenticity of the clinician. Differences between spirituality and religion will be explored, as well as the recent research on the value of incorporating integrated ethical strategies to psychological treatment.	
Communicating Effectively w/ Deaf & Hard of Hearing	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 McCleese, LMFT Kevin Dewindt, RAS
Culturally Sensitive Clinical Supervision: Ensuring Competence in Our Diverse World	In this six-hour course, participants will receive core knowledge of culturally sensitive clinical supervisory practices and learn how to incorporate multicultural	Mary M. Read, Ph.D., LMFT

	competence when dealing with legal/ethical issues in supervision. Supervision issues including boundaries and workplace professionalism will be discussed from a standpoint honoring diversity, along with suggestions for how to incorporate culturally sensitive approaches to supervising peer mentors/peers with lived behavioral health experience.	
"Faithful" Felons: Incarceration and Spirituality	This two-hour training addresses the background of spiritual programs available in CA prisons, as well as the factors that drive some inmates to explore and participate in such programs. The effectiveness of these programs and the relationship between spirituality and recidivism will be explored. Common terminology, phrases, and potential warning signs relevant to various spiritual practices will be discussed. Emphasis will be placed on the factors that reduce recidivism and support positive reintegration, with special attention given to how clinicians can support the reintegration of the formerly incarcerated and help them reach their treatment goals.	Dr. Maryloyola Yettke, D.Min
Mental Health Interpreter Training Project	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.	Lidia Gamulin, LCSW

	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.	
Military Culture	This three-hour training is designed to help providers understand US military culture and the challenges that military members would experience with deployment, traumatic brain injury, grief, post-traumatic stresses, increase risk of substance use as coping mechanism, risk of homelessness and suicide. The impact on their children and families will also be discussed.	Leah McGowan, LCSW, MAJ, MS, CAARNG(US) Michael Franc, Psy.D., NFG, NG, CAARNG(US) Brenda J. Threatt (CPT), Lead Chaplain CSMR Sothern Detachment, Los Alamitos JATB
Online Cultural Competency Training (Ongoing)	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity and diversity as well as stigma and self-stigma are discussed. The training also demonstrates the influence of unconscious thought on our judgement as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace uniqueness of other cultures beyond the mainstream American culture.	Bijan Amirshahi, LMFT, LPCC

Spiritual Resilience, Healing & the Brain	This training emphasizes the importance of how a patient's spiritual beliefs can heal the mind, body, and spirit. This experiential training advances a novel paradigm of healing in which spirituality and science converge to integrate the emerging research from "social brain" theory and contemplative neuroscience within the context of spiritual resiliency and self-identity with ancient teachings from the various spiritual tradition. The ultimate intention of this training is to equip health practitioners with an increased recognition and deeper appreciation as to how their client's spiritual identity and faith can positively affect the health and healing journey. The most recent research in brain science and how to apply as experiential tools and techniques in the context of therapy will also be discussed.	Jay Kumar, Ph.D.
Spirituality and Religion throughout Treatment	This intermediate-level training will assist clinicians in understanding the differences and similarities between spirituality and religion, and evaluate their own core spiritual values and practices (i.e. their search for meaning and transcendence). Three helpful tools will be provided to help clinicians understand their own and their patient's spiritual history.	David Chenot, Ph.D. Michael Millard, Ph.D.
Vicarious Trauma Spiritual Beliefs and	Vicarious trauma is what happens to a caregiver's neurological (or	Patricia Wenskunas, Founder and CEO,

Hope	cognitive), physical, psychological, emotional and spiritual health when listening to traumatic stories day after day or responding to a traumatic situation while having to control his/her reaction(s). This training explores how faith, religion, and/or spiritual beliefs can change and improve family, career, life, self, and relationships.	Crime Stoppers, Inc.
Understanding Client Culture & Journeys (Online & In-person)	This training defines Client Culture, explains the concept of lived experience, recovery philosophy, stigma and self-stigma toward mental health and substance use issues. Culturally competent communication skills required in working with behavioral health clients/consumers will be discussed. The experiential component of the training provides powerful personal stories narrated from the perspectives of three clients/consumers and a family member. Their values, beliefs, and resilience – molded in part by personal experiences with mental illness and substance use, the behavioral health system and their own ethnic cultures -will be explored. The last part of the training will be conducted in a Q & A format with participating clients/consumers on a panel.	Bijan Amirshahi, LMFT, LPCC
Working Effectively in BH with Sign Language Interpreters (Ongoing)	This training provides guidelines on how to work effectively with sign language interpreters in the mental health setting.	Belinda McCleese, LMFT

Working with Sign Language Interpreters (Ongoing)	This training provides guidelines on how to work with sign language interpreters properly and to have effective communication with the target population.	Belinda McCleese, 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

The initial assessment of Orange County's mental health workforce was conducted in 2012, and included all areas of Behavioral Health Services (BHS). A follow-up assessment was conducted in 2018 to examine the fiscal year 2016-17 workforce. This was done as part of the Mental Health Services Act (MHSA) needs assessment that was submitted to the Office of Statewide Health Planning and Development (OSHPD) for the Workforce Education and Training (WET) component. The results are summarized below.

Methodology:

During the initial 2012 workforce needs assessment, an electronic survey was disseminated to better understand the cultural and linguistic characteristics that made up Orange County's mental health workforce. This follow-up assessment, conducted in 2018, was a collaborative effort between the County's Behavioral Health Training Services (BHTS) department, Financial Services, and Human Resources. The summary statistics provided below primarily include County employees and do not represent the total number of county contracted agencies or individual county contractors. Results from BHS were compiled together to obtain results across various job classifications, racial and ethnic backgrounds, and primary languages. This assessment included an evaluation of currently filled and vacant positions by job titles, number of positions designated for consumers and family members and occupied by consumers or family members, and the capability of staff (based on bilingual pay status) in providing services in a threshold language (Spanish, Vietnamese, Farsi, Korean and Arabic). 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 County-operated BHS programs, there is a need to fill vacant positions among PHMS employees who provide direct and non-direct services in order to meet the needs of the current clientele (Table 6.1). Based on the most recent needs assessment, roughly 84% of the needed positions are currently filled. Among the county staff, the greatest need was among Psychiatric Mental Health Nurse Practitioner; Psychiatrists for children, adolescents, and geriatrics; Mental Health Workers; and Licensed Clinical Social Workers.

6.1 Number of PMHS Employees and Vacancies

	Total Number
Total Number of Current PMHS Employees	1,071
Total Number of PMHS Vacancies	140
Total Number of Current PMHS Direct Service Filled Positions	618
Total Number of Current PMHS Direct Service Vacancies	100

6.2 Currently Filled and Vacant BHS Positions[1]

	Number of Positions Filled	*Number of Vacancies*	*Substitute Profession Titles*
Case Manager	0	0	Mental Health Specialist or MHW series
Executive and Management Staff	30	1	
Licensed Clinical Psychologist	53	7	
Licensed Clinical Social Worker	234	40	
Licensed Marriage and Family Therapist	117	9	
Licensed Professional Clinical Counselor	0	0	MFT or CSW positions
Mental Health Specialist	109	17	
Mental Health Worker I,II,III	20	4	
Psychiatric Mental Health Clinical Nurse Specialist	36	4	Behavioral Health Nurse
Psychiatric Mental Health Nurse Practitioner	13	6	Comprehensive Care Nurse II
Psychiatrist - Child and Adolescent	14	4	
Psychiatrist - General	3	0	
Psychiatrist - Geriatric	19	9	
Substance Abuse/AOD/SUD Counselor	0	0	Mental Health Specialist or MHW series

[1] Position classifications not currently used in Orange County include Licensed Psychiatric Technician, Occupational Therapist, and Physician Assistant

B. Positions designated for individuals for consumers or family members

There is a need in Orange County to fill vacancies in our peer specialist workforce who provide services. As of fiscal year 2016-17, 60% of peer specialist positions were unfilled

(Table 6.3). While there are vacancies to be filled, Orange County employs peer specialists in an effort to provide services to those who can be difficult to reach. Employing peers helps the agency align treatment goals the principles of recovery, recovery resulting in greater orientation that benefits the agency and the individuals who are served. The agency is able to provide individuals with greater quality of care and support to successfully meet recovery goals with peers providing a great deal of "on the ground" assistance in linking clients to resources and other services, advocacy, and social support. Peers enhance the level of treatment provided by other professionals, leading to less inpatient and crisis services, greater engagement in treatment, decreased symptoms, increased development of coping skills and life satisfaction, and diversification of the mental health workforce. This could lead to major cost-savings for the County's mental health system in the future. Additionally, the presence of peers can help create a recovery environment, altering negative attitudes and reducing stigma while instilling hope and helping those around them to start "believing in recovery."

While there are several benefits to having peer specialists as part of the mental health workforce, Orange County has experienced some difficulty establishing peers in services. The lack of a job classification with opportunities for advancement for peers and low wages are a challenge in recruiting and retaining a peer workforce. Currently the agency does not have a designated classification for peers with any upward mobility (e.g., peer leaders, peer supervisors, or other senior peer positions). Also, integration of peers into the system has created role confusions among staff, as some of those who work with and supervise peers still struggle with understanding the peer role and how to utilize their skills. Professional stigma still exists and could also be seen as one of the challenges for great integration of peers in to the mental health system. Finally, the lack of state recognized peer training and certification serves as a barrier for peer integration and recognition of peer specialists as a valid profession, despite it being an evidence-based practice.

6.3 Number of Peer Specialists Providing Services

	Total Number
Number Employed	20
Number of Vacancies	30
Total Peer Positions Available	50

C. Language proficiency

There are five threshold languages in Orange County. These include, Spanish, Vietnamese, Farsi, Korean and Arabic. During FY 2016-17 all employees in Orange County's BHS system

spoke English (*n* = 1,071). Of the 530 BHS staff who spoke a primary language other than English, 69% of the workforce in fiscal year 2016-17 were able to provide services in Spanish, 18% in Vietnamese, 5% in Farsi and Arabic, and 3% in Korean (Table 6.4). Among those, 202 staff indicated they were bilingual speaking (Table 6.5). The majority of staff were bilingual in Korean, Vietnamese, and Spanish. Other languages BHS could provide services included Arabic, Cambodian, Chinese (Mandarin and Cantonese), Farsi, and Tagalog. Staff mostly likely to indicate they could provide bilingual services included Clinical Social Workers, Marriage and Family Therapists, Mental Health Specialists, and Office Assistants.

6.4 Primary Languages Spoken by BHS Staff

	Number of Direct Service Staff	
	N	*%*
Spanish	364	69%
Hmong/Vietnamese	95	18%
Chinese (Mandarin and Cantonese)	10	2%
Russian	1	*
Korean	18	3%
Tagalog	13	2%
American Sign Language	2	*
Arabic and Farsi	27	5%
Total	***530***	***100%***

*Statistically unstable.

6.5 Number of Bilingual Staff, by Position

	Korean	*Spanish*	*Vietnamese*
Behavioral Health Nurse	0	1	2
Clinical Psychologist	0	6	2
Clinical Social Worker	4	22	7
Community Worker	0	4	0
Comprehensive Care Nurse	1	0	0
Contract Employee	0	1	0
Data Entry Technician	0	0	1
Deputy Public Guardian	0	3	0
HCA Program Supervisor	0	0	0
HCA Service Chief	0	9	2
Information Processing Specialist	0	0	0
Information Processing Technician	0	2	0
IT Systems Technician	0	1	0
Marriage and Family Therapist	3	25	4
Mental Health Specialist	1	26	4
Mental Health Worker	1	5	1
Nurse Practitioner	0	1	0
Nursing Assistant	0	0	0
Office Assistant	0	3	1
Office Specialist	0	28	1
Office Technician	0	5	0
Psychiatrist	1	1	0
Sr. Deputy Public Guardian	0	0	0
Staff Assistant	0	0	2
Staff Specialist	0	1	0
Supervising Comprehensive Care Nurse	0	0	1
Total	***11***	***144***	***28***

*Languages with fewer than 10 bilingual staff included Arabic, Cambodian, Cantonese, Chinese, Farsi, Mandarin, and Tagalog

This assessment also included an evaluation of the racial and ethnic backgrounds of mental health staff. The majority of staff were either Caucasian/White or Middle Eastern, Hispanic/Latino, or Asian (Table 6.6).

6.6 Number of Staff in BHS During FY 2016-17, by Race/Ethnicity

	Total Number	*Percent*
Caucasian/White[1]	414	39%
Hispanic/Latino	404	38%
Middle Eastern[1]	414	39%
Asian	166	16%
African American/Black	49	5%
Other/Unknown	38	4%
Total	***1,071***	***100%***

[1] Data for Caucasian/White and Middle Eastern are collapsed under the same category, "White/Caucasian," in Orange County's data tracking system

CRITERION 7: LANGUAGE CAPACITY

I. Offer Language Assistance to Individuals who have Limited English Proficiency (LEP) 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

C. 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 LEP

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:

- OC LINKS Information and Referral (1-855-OC-LINKS/625-4657) for individuals to call or online chat to access any of the over 200 behavioral health programs available through the Health Care Agency's Behavioral Health system. Individuals 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-Phone Interpretation Services:

Call: 1 (844) 898-7557

- Indicate: language needed
- Input: 4 digit unit number
- Provide: caller's name and telephone number

On-site (in-person) Requests:
Complete the Onsite Interpreter Request Form and email it to: onsiterequests@fluentLS.com

Written Documents Requests:
Email all requests 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 a l s o 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.

III. 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 tables 7.1 through 7.2 reflect the interpretation and translation services utilized during FY 2016-17. The majority of in-person interpretation services provided during FY 2016-17 were in Spanish, followed by Vietnamese, Farsi, and Arabic.[2] Similarly, document translations requests were also provided, primarily in Spanish, Vietnamese, Arabic, and Farsi.

In FY 2016-2017, there were 163 requests for ASL interpretation services and a total of 30,684 minutes were billed by various HCA Programs.

7.1 Hours Billed for In-Person Interpretation

	Number of Interpretations Conducted	*Facilitated Hours*
Spanish	65	139:45
Vietnamese	28	83:30
Farsi	1	2:00
Arabic	1	2:00
Total	***95***	***227:15***

Source: WET Interpretations Log Database, FY 16-17

7.2 Document Translation Request by Threshold Language, FY 2016-17

	2016	*2017*	*Total Number*
Arabic	31	51	82
Chinese	7	2	9
Farsi	31	41	72
Korean	23	30	53
Spanish	51	63	114
Translation to English	*	4	4
Vietnamese	54	54	108
Total	***197***	***245***	***442***

** No data was provided.*

Source: WET Cultural Competency Trainings Database, FY 16-17

[2] In FY 2017-18, a new contract was established for over the phone interpretation services. Given this shift in services, FY 2016-17 data for over the phone translations is unavailable.

IV. 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:

   a. 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."

ochealth CARE AGENCY

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