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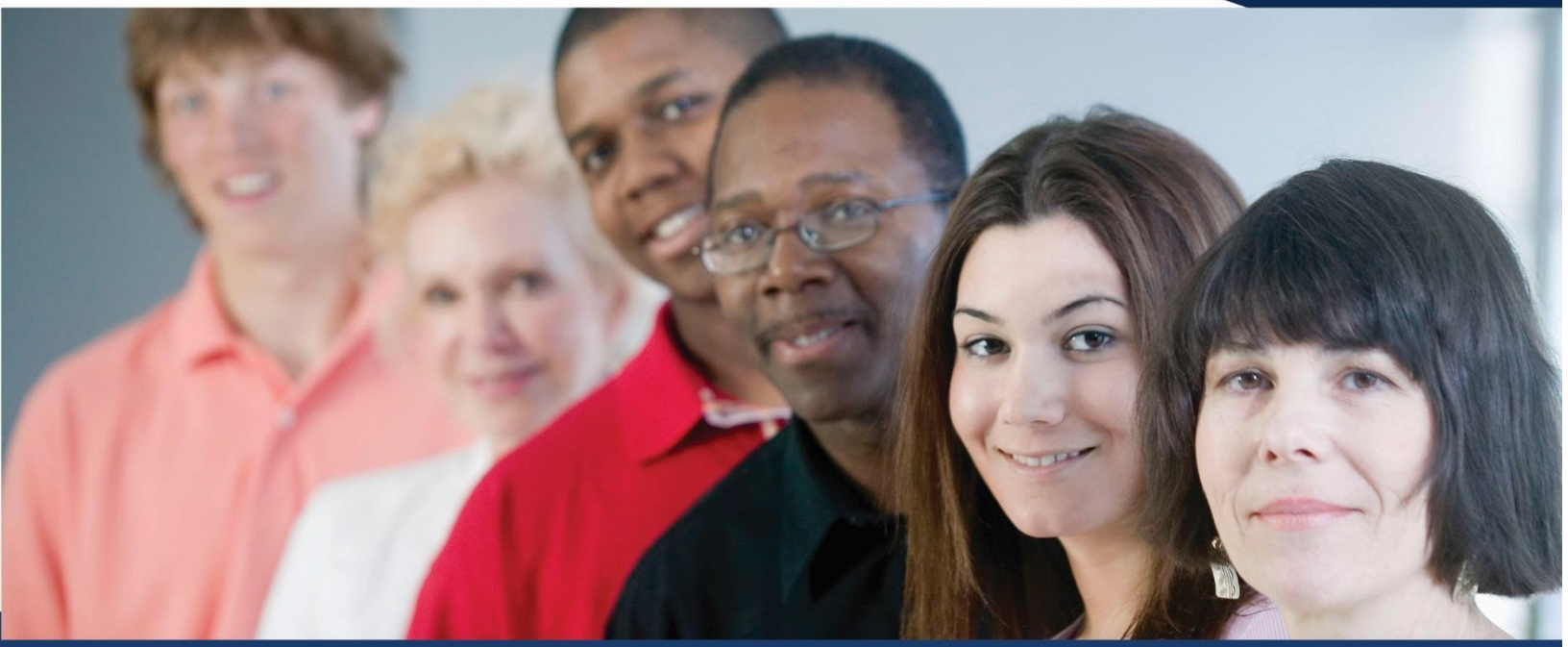

Cultural Competence Plan Update

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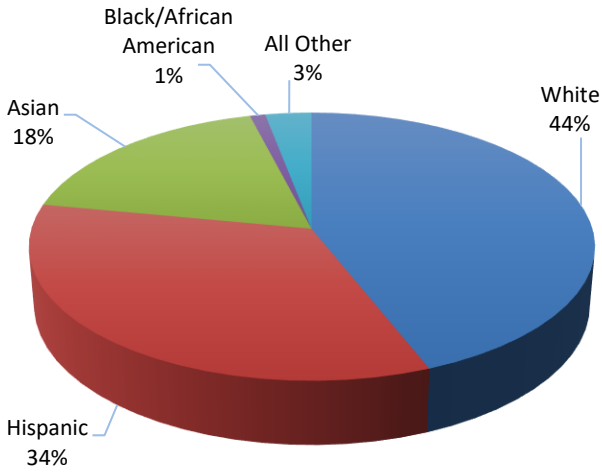
Introduction

Orange County's approximately 3.2 million residents enjoy a nearly perfect climate in which parks and beaches provide abundant opportunities for outdoor activities. Orange County is the home of exciting professional sports, a wide range of tourist attractions and quality venues for visual and performing arts. There is also a thriving business economy and a well-educated work force. The County of Orange Health Care Agency (HCA) is a regional service provider and planning agency whose core businesses include public safety, public health, environmental protection, regional planning, public assistance, social services and aviation.

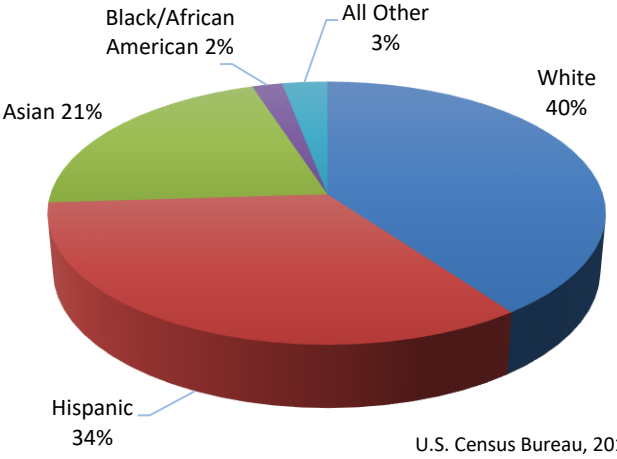
Orange County is the third most populous county in California, the sixth most populous in the US, and more populous than 21 US states. The demographics of Orange County have been rapidly changing in recent years. Based on data provided by the US Census Bureau, the population of the county increased by 5.8% between 2010 and 2018 (3,101,232 vs. 3,185,968, respectively). However, the non-White population had an overall larger growth, compared to the White/Caucasian population. During this period, the Hispanic population increased by 5.8%, the Asian population increased by 23.4% and the African American/Black population increased by 111.6% while the White/Caucasian population had a negative growth of 3.7%. Additionally, more than 900,000 (30%) of Orange County residents were born outside of the US (Census, 2013-2017).

Orange County Race/Ethnicity - 2010



U.S. Census Bureau, 2010

Orange County Race/Ethnicity - 2018



U.S. Census Bureau, 2018

1.1 Comparison of Orange County Race/Ethnicity Population, U.S. Census Bureau (2010 vs. 2018)

	White	*Hispanic*	*Asian*	*Black/African American*	*All Other*	*Total*
2010 Census	1,324,502	1,023,479	541,842	30,102	90,307	3,010,232
2018 Census	1,274,387	1,083,229	669,053	63,719	95,579	3,185,968
% Change	-3.78%	5.84%	23.48%	111.68%	5.84%	5.84%

Cultural competence is the ability to understand, appreciate, and interact with persons from cultures and/or belief systems other than one's own. As providers of mental health and substance use disorder (SUD) services, being culturally competent means being able to effectively deliver behavioral health services that meet the social, cultural and linguistic needs of consumers.

The Orange County Health Care Agency (OCHCA) believes in the importance of being culturally competent and develops and implements its Cultural Competence Program to assure that services provided reflect the cultural and linguistic needs of the individuals served by OCHCA, to identify any gaps or disparities in service provision, and to implement action steps to improve provision of services and consumer outcomes.

OCHCA believes that a culturally competent organization provides services that are culturally sensitive and responsive to diverse populations. OCHCA ensures standards of care are consistent with the philosophy that services provided are respectful of individuality, cultural diversity and imbedded into every facet of the department. OCHCA ensures that services are provided in a welcoming environment and by staff that is culturally competent and linguistically proficient to meet the needs of the population served.

We strive to ensure that our Behavioral Health Services (BHS) are keeping up with the fast changing demographics of our county and that our services are culturally and linguistically appropriate to the needs of the diverse communities that we serve.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

County Mental Health System Commitment to Cultural Competence

Policies, Procedures or Practices

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.

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

Behavioral Health Policy	Policy Details
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.
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.
BHS Policy 02.01.03.	Distribution of Translated Materials, requiring the availability of culturally and linguistically appropriate written information in the County's threshold languages to assist consumers in accessing specialty mental health services.
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.
BHS Policy 02.01.05.	Field Testing of Written Materials, requiring that written materials be field tested to ensure comprehension of the information provided.
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.

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.
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.
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.

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 Behavioral Health Services provider contracts. Although the language varies for specific contracts, below are some relevant examples.

- The contract for Mental Health Services Act (MHSA) Community Services and Supports (CSS) -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."
- 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."
- 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."

- For the Prevention and Early Intervention (P&I) contracts, language capability is a condition of employment and a specific program need to meet program goals. Specific contract language is used such as, "Contractor shall make every reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e. the unserved and underserved. In the staffing section of P&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."

BHS documents to be available at site visits:

The information below outlines Orange County's commitment to providing culturally and linguistically appropriate behavioral health services. These documents are used throughout our system, by both County- and Contract-operated programs.

- Behavioral Health Services Mission Statement: The mission of BHS 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
- 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
- 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 HCA's goals and strategic directions.

- 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.

County Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System

Community Outreach, Engagement and Involvement Efforts

- 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.

- The OC Links Information and Referral line provides telephone and online support for anyone seeking information or linkage to any of the Health Care Agency's Behavioral Health Services County or contracted programs. 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 bilingual OC Link's staff. Trained Navigators provide information, referral, and linkage directly to programs that meet the needs of callers, including multi-cultural and bilingual 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 www.ochealthinfo.com/oclinks.

- BHS provides Outreach and Engagement through 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 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.

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.

- 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.
- Written description of the cultural and linguistic competence responsibilities of the designated CC/ESM.
- 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 Community Services and Supports (CSS), PEI and Innovations programs and services.

- Responsibilities of the MDP Coordinator/ESM include, but are not limited to, the following:
  - Participate in the Cultural Competence plan and development and coordination of the Cultural Competence Committee.
  - 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).
  - 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 Department of Mental Health (DMH).
  - Develop, coordinate and facilitate the implementation of the state Department of Mental Health's required Cultural Competency Plan.
  - 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.
  - 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.
  - Maintain an on-going relationship with community organizations, planning agencies, and the community at large.
  - The CC/ESM is a supervisor in Behavioral Health Training Services (BHTS).
  - The CC/ESM oversees the Multicultural Development Program (MDP) which aims to promote health equity by enhancing culturally and linguistically appropriate, responsive and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides and coordinates language services and cultural trainings. Additionally it addresses mental health needs of the deaf and hard of hearing community through consultation and training. Clinical trainings and education facilitated 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 and Intersex population, Recovery: The Promise of Hope, Recovery Based Treatment Planning, 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.

Identify Budget Resources Targeted for Culturally and Linguistically Competent Activities

The County shall include evidence of a budget dedicated to culturally and linguistically competent activities

- HCA BHS currently has two positions dedicated to interpretation and translation services in Vietnamese and Spanish for the Multicultural Development Program (MDP). Both positions are currently vacant and being recruited through the BHS Human Resources department. MDP BHTS has additional bilingual staff who assist with translation and interpretation services in Farsi, Arabic, Korean and Vietnamese 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.

Discussion of Funding Allocations

- Interpreter and translation services: Outside interpretation and translation service providers that HCA BHS currently contracts with include: Language Line for interpretation (telephonic and onsite) and translation services; and Western Interpreting Network (WIN) for American Sign Language (ASL) services.

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

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	1,622,237	50.4%
Female	1,594,573	49.6%
Total Population	***3,216,810***	
Ethnicity	*Population*	*Percent*
White/Caucasian	1,346,680	41.9%
Hispanic/Latino	1,136,003	35.3%
Asian/Pacific Islander	596,202	18.5%
Black/African American	48,783	1.5%
Native American	6,818	0.2%
Multi Race/Other	82,324	2.6%
Total Population	***3,216,810***	
Age	*Population*	*Percent*
0-5 years	229,009	7.1%
6-17 years	495,118	15.4%
18-59 years	1,820,241	56.6%
60+ years	672,442	20.9%
Total Population	***3,216,810***	

Source: Department of Finance Population Statistics (2018)

2.2 OC Youth Population (0-17)

Youth Gender	*Population*	*Percent of Total Population*
Male	368,033	11.4%
Female	356,094	11.1%
Youth Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	226,163	7.0%
Hispanic/Latino	332,153	10.3%
Asian/Pacific Islander	122,065	3.8%
Black/African American	9,665	0.3%
Native American	1,300	-*
Multi Race/Other	32,781	1.0%
Youth Age	*Population*	*Percent of Total Population*
0-5 years	229,009	7.1%
6-11 years	241,162	7.5%
12-17 years	253,956	7.9%
Total Youth Population	***724,127***	***22.5%***

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

Source: Department of Finance Population Statistics (2018)

2.3 OC Adult Population (18+)

Adult Gender	*Population*	*Percent of Total Population*
Male	1,226,540	38.1%
Female	1,266,143	39.4%
Adult Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	1,120,517	34.8%
Hispanic/Latino	803,850	25.0%
Asian/Pacific Islander	474,137	14.7%
Black/African American	39,118	1.2%
Native American	5,518	0.2%
Multi Race/Other	49,543	1.5%
Adult Age (18+)	*Population*	*Percent of Total Population*
18-20 years	146,095	4.6%
21-24 years	190,842	6.0%
25-34 years	390,991	12.2%
35-44 years	411,721	12.9%
45-54 years	460,383	14.4%
55-64 years	409,797	12.8%
65+ years	482,854	15.1%
Total Adult Population	***2,492,683***	***77.9%***

Source: Department of Finance Population Statistics (2018)

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, on the following page). The US 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 Population Language Spoken at Home

	Population	*Percent*
English	1,622,972	54.0%
Spanish	762,003	25.4%
Asian/Pacific Islander Languages	459,456	15.3%
Other Indo-European Languages	129,646	4.3%
All Other Language	29,126	1.0%
Total	**3,003,203**	100%

Source: American Community Survey 1-year Estimates (2017). Retrieved from Census Reporter Profile Page for Orange County, CA

https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_17_1YR_S1601&prodType=table

Medi-Cal population service needs (Use current CALEQRO data if available)

The County shall include the following in the CCPR:

B. Summarize Medi-Cal population and client utilization data by race, ethnicity, age, gender and language as published in most recent CALEQRO 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 was 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 CALEQRO report for calendar year 2018 (Table 2.5). However, because the CALEQRO report did not provide estimates broken out by primary language, data from the 2018 California Medi-Cal Eligibility Data System (MEDS) and the Orange County Electronic Health Record System are provided in this report to examine penetration rates by primary language (Table 2.6).

The male and female populations were fairly evenly represented in Orange County's population. However, there was a higher proportion of female, as compared to males who were eligible for Medi-Cal services (54.1% versus 45.9%). Measureable differences were found between the County and Medi-Cal eligible populations when comparing results across ages. As expected, roughly half of the County's eligible population was between 18 to 59 years of age (49.1%). Residents under the age of 5 and over 60 were less likely to be Medi-Cal eligible (10.8% and 15.3%, respectively). Differences among residents of various racial and ethnic backgrounds were also identified. While roughly 41.9% of the population indicated they were of White/Caucasian decent, very few of these participants were eligible for services (16.8%). The highest proportion of Medi-Cal eligible residents were either Hispanic or Latino (48.7%) followed by Asian and Pacific Islanders (18.8%). Additionally, the most common language spoken at home among Orange County residents was English (54.0%), 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 with an approved service, the following groups were underrepresented: 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. On average, 18.8% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.6% were approved for services. Additionally, the number of Native American residents who were Medi-Cal eligible and had an approved service was extremely low during 2018 (0.2% and 0.4%, respectively). Residents over 60 years of age comprised 15.3% of the Medi-Cal eligible population, yet only 5.3% had an approved service. There was 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 18.3% were served. Similarly, those who spoke an Asian or Pacific Islander language made up 11.3% of the population and less than 1% had an approved service (0.9%).

Penetration Rates

Data provided by Behavioral Health Concepts, Inc. during the MHP's FY 2017-18 review demonstrated that the State-wide penetration rate was 4.5%. In Table 2.5, CALEQRO calculated Orange County's penetration rate as being below the State average at 2.9%. 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 CALEQRO 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 CALEQRO at 3.1% (Table 2.6).

Based on Table 2.5 and below, the penetration rate was higher than the CALEQRO average for residents who identified as Male, White/Caucasian, Black/African American, Native American, Multi-Race/Other, youth between the ages of 6 and 17 or adults between 18-59 years old. Additionally, those who spoke English as their primary language were similar to the HCA average (Table 2.6).

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

	County Population[1]		*Average Number of Medi-Cal Eligibles per Month*[2]		*Medi-Cal Beneficiaries who Received an Approved Service per Year*[2]		*Penetration Rate*
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,622,237	50.4%	407,064	45.9%	13,035	51.1%	3.2%
Female	1,594,573	49.6%	480,608	54.1%	12,470	48.9%	2.6%
Race/Ethnicity							
White/Caucasian	1,346,680	41.9%	149,136	16.8%	6,788	26.6%	4.6%
Hispanic/Latino	1,136,003	35.3%	431,892	48.7%	11,605	45.5%	2.7%
Asian/Pacific Islander	596,202	18.5%	166,916	18.8%	2,192	8.6%	1.3%
Black/African American	48,783	1.5%	14,666	1.7%	918	3.6%	6.3%
Native American	6,818	0.2%	1,414	0.2%	105	0.4%	7.4%
Multi Race/Other	82,324	2.6%	123,650	13.9%	3,897	15.3%	3.2%
Age							
0-5 years	229,009	7.1%	96,125	10.8%	892	3.5%	0.9%
6-17 years	495,118	15.4%	219,705	24.8%	10,838	42.5%	4.9%
18-59 years	1,820,241	56.6%	436,147	49.1%	12,431	48.7%	2.9%
60+ years	672,442	20.9%	135,696	15.3%	1,344	5.3%	1.0%
Total Population	***3,216,810***		***887,673***		***25,505***		***2.9%***

[1] *Source: Department of Finance Population Statistics (2018)*

[2] *Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '18, CALEQRO report 2018*

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	54.0%	478,621	54.1%	20,938	77.4%	4.4%
Spanish	762,003	25.4%	290,462	32.8%	4,948	18.3%	1.7%
Asian/Pacific Islander Languages	459,456	15.3%	99,847	11.3%	880	3.3%	0.9%
Other Indo-European Languages	129,646	4.3%	7,667	0.9%	174	0.6%	2.3%
All Other Language	29,126	1.0%	8,130	0.9%	124	0.5%	1.5%
Primary Language Total	***3,003,203***		***884,727***		***27,064***		***3.1%***

[3]*Source: American Community Survey 1-year Estimates (2017). 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 17/18), Electronic Health Record System (IRIS)*

200% of Poverty (minus Medi-Cal) Population and Service Needs

The County shall include the following in the CCPR:

C. 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	
Female	210,000
Male	248,000
Race/Ethnicity	
White/Caucasian	117,000
Hispanic/Latino	247,000
Asian/Pacific Islander	79,000
Black/African American	14,000
Native American	*
Multi Race/Other	*
Age	
0-5 years	18,000
6-17 years	33,000
18-59 years	318,000
60+ years	89,000

*Data unavailable for this population

Source: California Health Interview Survey (2017)

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	1,622,237	50.4%	491,000	53.4%
Females	1,594,573	49.6%	429,000	46.6%
Race/Ethnicity				
White/Caucasian	1,346,680	41.9%	181,000	19.7%
Hispanic/Latino	1,136,003	35.3%	505,000	55.0%
Asian/Pacific Islander	596,202	18.5%	187,000	20.4%
Black/African American	48,783	1.5%	45,000	4.9%
Native American	6,818	0.2%	*	*
Multi Race/Other	82,324	2.6%	*	*
Age				
0-5 years	229,009	7.1%	79,000	8.6%
6-17 years	495,118	15.4%	115,000	12.5%
18-59 years	1,820,241	56.6%	549,000	59.7%
60+ years	672,442	20.9%	176,000	19.2%

*Data unavailable for this population

[1] *Source: Department of Finance Population Statistics (2018)*

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

Orange County Demographics

Orange County is the third most populous county and second most densely populated county in California.	It is home to a little over 3 million (3,190,400) people (Census, v2017), up almost 6% from 2010.
The County's population is comprised of four major racial/ethnic groups.	■ Whites (41%), Hispanics (34%), Asian/Pacific Islanders (21%) and Blacks/African Americans (2%). ■ 30% of residents are born outside the US (Census, 2013-2017).
Currently, Orange County has five threshold languages (Spanish, Vietnamese, Korean, Farsi and Arabic).	According to Orange County's Healthier Together (2019), English is spoken at home by 54% of the population four years and older, followed by Spanish (26%) and Asian/Pacific Islander languages (14%).
22% of the County's population was under age 18 and 14% were 65 or older (Census, v2017).	The percentage of the population ages 65 and older is expected to increase over the next 20 years. As the percentage of seniors grows, the need for mental and physical health care is expected to rise.
Approximately 6% (120,558) of the civilian population 18 and older are veterans (Census, 2013-2017).	In one study of OC veterans (OC Veterans Initiative), half of post-9/11 veterans interviewed did not have full-time employment, 18% reported being homeless in the previous year, and nearly half screened positive for posttraumatic stress disorder (PTSD) and/or depression.
Orange County is home to an emerging Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning population.	The California Health Interview Survey estimates that 4.5% of Orange County residents identify as gay, lesbian, homosexual or bisexual (2017).
The county has a well-educated population, with 85% of residents ages 25 years and older having graduated from high school and 39% having earned a bachelor's degree or higher.	This is slightly higher than the state average of 82% having graduated high school and 32% having earned a bachelor's degree or higher (Census, 2013-2017).
Since 2007, Orange County has consistently had the highest Cost of Living Index compared to neighboring areas. Although Orange County's cost of living for groceries, utilities, transportation and miscellaneous items tends to rank in the middle among similar jurisdictions, high housing costs make Orange County a very expensive place to live.	■ $81,851: Median household income (2013-2017). ■ $1,693: Median Gross Rent (Census 2013-2017). ■ $620,500: Median House Price (Census 2013-2017). ■ 5.3%: Unemployment Rate (OC Healthier Together, 2019). ■ 11.5%: Individuals below Poverty Level (Census 2013-2017).

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).

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

Identify Unserved/Underserved/Inappropriately Served Target Populations

The target populations include, but are not limited to: ethnic and cultural minorities [e.g., Latino/Latina, 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 Transitional Age Youth (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 2019/2020.[1]

Identified Strategies/Objectives/Actions/Timelines:

Community Services and Supports (CSS) Plan

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

- 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.
- 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 health care practitioners that see those who have mental illness years before they walk through the doors of the county mental health system or other mental health providers in the community.
- 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 2019/2020. (2019). *Orange County Mental Health Services Act Office report FY 2019/2020*. Orange County, CA: Health Care Agency.

resources.

- 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.
- 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 degrees in Social Work and Marriage and Family Therapist programs. Classes are offered on county sites in the evening, making it more accessible to 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 bilingual staff who want to further their education and shift from a support staff position to a clinical staff position.

Programs of Assertive Community Treatment (PACT)

Programs of Assertive Community Treatment (PACT) offer an individualized treatment approach aimed at assisting individuals of all ages with their recovery from chronic and persistent mental illness. Orange County PACT programs are similar to the FSPs in that they utilize the evidence-based Assertive Community Treatment model to provide comprehensive, intensive outpatient services to persons with serious emotional disturbance or serious mental illness who may have a co-occurring substance use disorder and have experienced difficulty engaging with more traditional outpatient mental health services. The main differences are that the PACT programs are County-operated and do not have flexible funding, and their primary eligibility criteria target individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the past year. PACT's overarching goals include engaging individuals into voluntary treatment; helping them remain safely in the community and out of the hospital and criminal justice system; assisting them with reintegrating into the community through stable housing, education, and/or employment; and linking them to community-based support. Orange County currently offers four PACT programs organized around the needs specific to different age groups.

Children and Youth Behavioral Health (CYBH) PACT

CYBH PACT works with youth ages 14-21 who are at a developmental stage crucial for attaining the independence and skills needed to be successful throughout their lives. The program is intended to serve those who are socially isolated and/or have minimal support systems. Caregivers may not understand their children's mental health issues and/or may feel disconnected by the hierarchy between traditional treatment teams of "experts" (e.g., psychiatrists, therapists) and the people receiving services. Youth and their families are referred to the program by CYBH County and County-contracted programs. The program provides services in English and Spanish.

Adult/TAY PACT

This program serves Transitional Age Youth (TAY) and adults ages 18-59 who, in addition to the primary PACT criteria, may be homeless or at-risk of homelessness or may have had an out-of-state placement. The program also works with culturally and/or linguistically isolated groups such as Latinos, Vietnamese, Koreans, Iranians and the deaf and hard of hearing. Referrals are accepted from the community, psychiatric hospitals and jails. Participants are screened for appropriateness by the four regional Adult and Older Adult Behavioral Health (AOABH) outpatient clinics or the two Open Access sites and assigned to the PACT program that will best meet their needs. The program provides services in English, Spanish, Vietnamese, Farsi, Korean and Arabic.

Older Adult PACT

The Older Adult PACT serves individuals who are ages 60 and older and who, in addition to the primary eligibility criteria described above, may have visited local emergency departments repeatedly or have had to call 911 frequently due to behavioral health issues. The program accepts referrals from the community, psychiatric hospitals and jails, and uses a screening process similar to that used for TAY and adults. The program provides services in English, Spanish, Vietnamese, Farsi, Korean and Arabic

Services

The PACT programs provide an individualized treatment approach that offers intensive services provided by multidisciplinary teams out in the community. These teams are staffed with Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Life Coaches, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance use services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused CBT. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family participants, which can include family therapy, is provided for youth and their families.

In addition, PACT provides intensive case management. Team members offer peer and/or care-giver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community resources such as NAMI, Family Resource Centers and the Wellness Centers to help facilitate their recovery and maintain their gains after being discharged from the program.

Strategies to Promote Recovery/Resilience

Central to all of Orange County's intensive outpatient treatment programs is the emphasis placed on helping individuals move forward in their recovery. The PACT teams work with participants using a strengths-based model to customize their treatment plans. Team members strive to instill hope in the participants with whom they work, identify their and their families' strengths, maintain a non-judgmental stance, and have empathy for

their and their families' struggles. Mental Health Specialists share their lived experience, serve as positive models, and provide valuable support and information both to the participants and the other team members. The ultimate goal of the PACT programs is to help participants build positive relationships and social supports in the community so they can move forward in their recovery and manage their behavioral health care needs outside of the public mental health setting.

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals often have difficulty linking to services for a variety of reasons. Some examples include homelessness and/or difficulty finding permanent housing; lack of food, transportation, childcare and/or social support; anxiety about their legal status and the possibility of being deported; difficulty navigating the very large mental health system; lack of open program space; stigma related to having a mental illness; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals.

To overcome these wide-ranging challenges, PACT Teams operate under the "Whatever It Takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or wherever participants are comfortable meeting in order to overcome barriers to access or engagement. The teams also carry smaller caseloads so individuals and their families can be seen more frequently and have their needs met in a timely manner. Moreover, many PACT therapists are bilingual (see grids) and able to communicate with monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

The TAY, Adult and Older Adult programs also offer a stream-lined referral and linkage process to (1) allow direct referrals into TAY PACT, and/or to (2) include more detailed and frequent follow-up with individuals who miss appointments or do not access treatment. As a result of these changes, individuals are linked to services more quickly and feel supported through the process. In addition, some clinicians are specifically assigned to engaging individuals who are referred from hospitals, homeless shelters like The Courtyard and the MHSA housing projects.

CYBH PACT, the newest program implemented June 2017, has worked to increase timely access to its services by presenting to providers about PACT services and eligibility criteria. Once referred, CYBH PACT therapists have attended sessions with the referring therapist, psychiatrist, youth and parent in order to explain the program in greater detail and establish rapport with the youth and parent. Like the other PACTs, CYBH PACT staff also work with hospital staff, OC Probation officers and others involved with the youth and family to engage them in their program services.

PACT teams also recognize the importance of successfully linking program participants to community-based providers as they approach discharge from PACT. Clinicians attend appointments with individuals in the new setting to ensure a smooth transition and ease any anxiety they may feel over the change. Although this

transition can be difficult and may take several visits, program staff appreciate the value of this process in allowing individuals to continue moving forward on their recovery journeys.

Strategies to Reduce Stigma and Discrimination

In addition to providing valuable direct services and supports to PACT participants, Mental Health Specialists also serve as inspirational role models, which can be powerful in reducing stigma among the people and families served. In addition, all clinicians and peer workers are trained yearly in cultural competency. The training provides an overview of how to incorporate culturally responsive approaches in their interactions with participants. 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 judgment as it relates to stereotyping, micro aggression and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond mainstream American culture. In addition, many PACT staff are bilingual and bicultural. Thus, through training and/or experience, PACT staff understand the heightened stigma and misconceptions about mental health that can exist in underserved ethnic communities, and draw upon this information to facilitate engagement with participants, establish rapport and reduce stigma and discrimination.

Outcomes

A total of 45 children/youth 178 TAY, 887 adults and 89 older adults were served in the PACT programs during FY 2017-18. One child/youth, 141 TAY, 928 adults and 103 older adults were served in the PACT programs during FY 2016-17. Using the same method and approach as the FSPs, the PACT programs performance are evaluated through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP. The outcomes presented below are for TAY, adults and older adults. CYBH PACT will present outcomes in future Plan updates when the data systems to report on these outcomes have been completed.

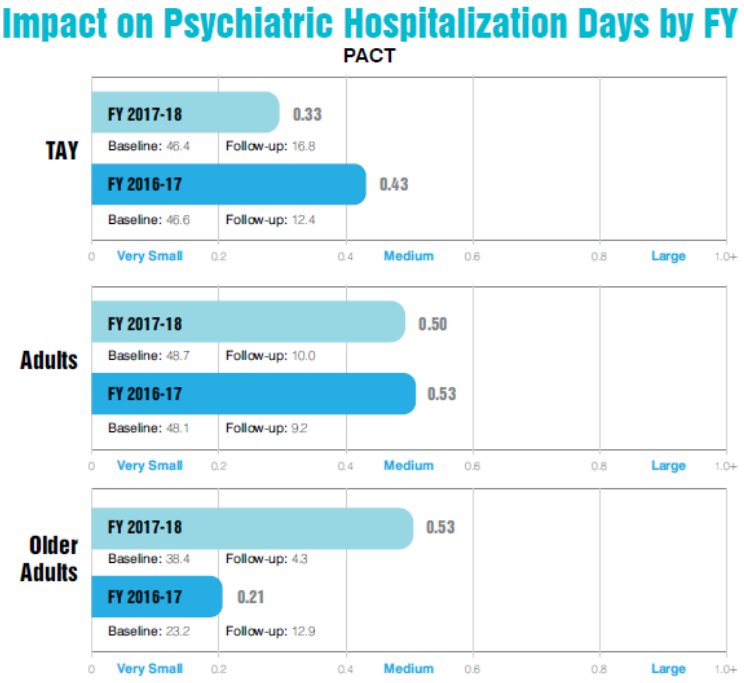
Psychiatric hospitalizations: Compared to the 12 months prior to enrolling in PACT, the TAY/Adult and Older Adult programs had a small to moderate impact on the average number of days spent psychiatrically hospitalized. The smallest effect observed was among older adults in FY 2016-17, which was likely attributable to the fact that several older adults remained hospitalized during that time, 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 was unable to be located.[1]

Homelessness: PACT also had a moderate impact on decreasing homelessness for all three age groups in FY 2016-17 and for adults in FY 2017-18, as well as a large impact on homelessness for TAY and older adults in FY 2017-18.[2] It should be noted that the number of TAY and older adults affected by homelessness prior to or after enrolling in PACT was much smaller than the number of adults

affected, thus the differences in impact observed in FY 2017-18 may reflect unique characteristics of the individuals served that year rather than a change in effectiveness of the TAY and Older Adult programs. HCA will continue to monitor outcomes over time.

Incarcerations: Compared to the year prior to enrollment, the PACT programs had a moderate impact on incarceration across both fiscal years, with TAY PACT demonstrating a moderate-to-large impact during FY 2017-18.[3] Due to the small number of TAY served in FY 2017-18, however, it is unclear if this observed increase in impact reflects a shift in overall program effectiveness, the unique characteristics of the TAY served in FY 2017-18, or some other factor. HCA will continue to monitor the trends in incarceration for PACT participants.

Employment: Across both fiscal years, TAY and Adult PACT programs did not impact employment, with TAY and adults only increasing their average days employed by about one to one-and-a-half weeks.[4] As with the FSPs, PACT programs continue to struggle with making inroads on this functional domain.

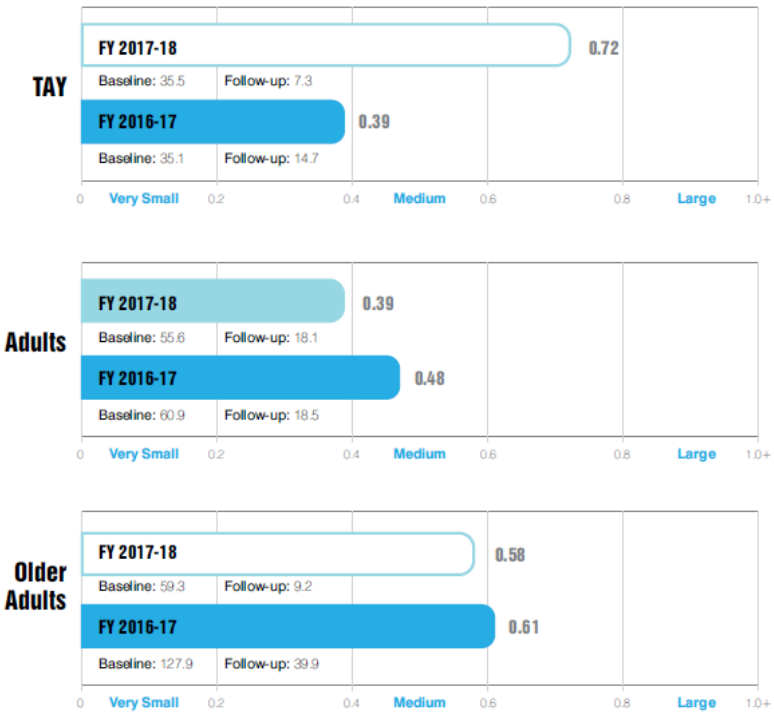


Impact on Unsheltered Homeless Days by FY

PACT

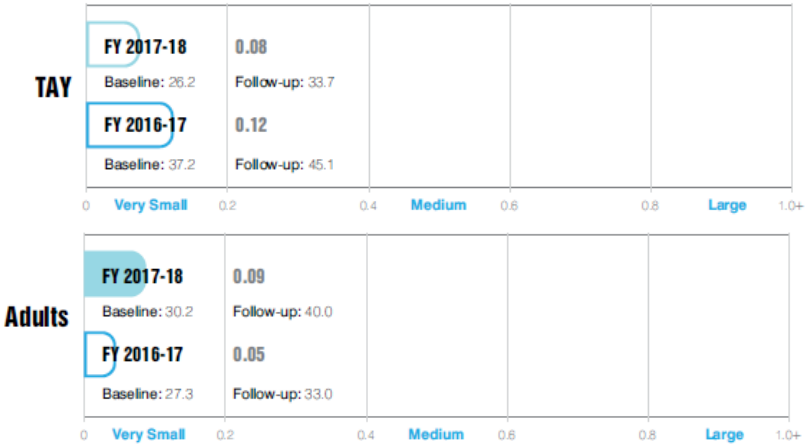
Impact on Incarceration Days by FY

PACT - FY 2017-18



Impact on Employment Days by FY

PACT



Reference Notes

1 Psychiatric Hospitalization Days:

TAY:

FY 2017-18: Prior M=46.4, SD=62.8; Since M=16.8, SD=61.1; t(82)=2.97, p<.01, Cohen's d=0.33

FY 2016-17: Prior M=46.6, SD=63.1; Since M=12.4, SD=49.4; t(92)=4.12, p<0.001, Cohen's d=0.43

Adults:

FY 2017-18: Prior M=48.7, SD=77.8; Since M=10.0, SD=35.7; t(659)=11.86, p<.001, Cohen's d=0.50

FY 2016-17: Prior M=48.1, SD=76.2; Since M=9.2, SD=27.7; t(687)=12.59, p<0.001, Cohen's d=0.53

Older Adults:

FY 2017-18: Prior M=38.4, SD=74.8; Since M=4.3, SD=17.3; t(69)=3.73, p<.001, Cohen's d=0.53

FY 2016-17: Prior M=23.2, SD=43.5; Since M=12.9, SD=28.5; t(52)=1.64, p=0.11, Cohen's d=0.21

2 Homeless Days:

TAY:

FY 2017-18: Prior M=73.2, SD=59.2; Since M=19.9, SD=42.7; t(16)=3.36, p<.01, Cohen's d=0.83

FY 2016-17: Prior M=57.6, SD=61.2; Since M=15.2, SD=43.3; t(17)=3.37, p<0.01, Cohen's d=0.57

Adults:

FY 2017-18: Prior M=152.6, SD=136.1; Since M=65.8, SD=104.7; t(227)=7.62, p<.001, Cohen's d=0.51

FY 2016-17: Prior M=142.5, SD=126.0; Since M=65.3, SD=104.2; t(242)=7.97, p<0.001, Cohen's d=0.47

Older Adults:

FY 2017-18: Prior M=187.0, SD=141.5; Since M=49.6, SD=102.3; t(33)=4.96, p<.001, Cohen's d=0.86

FY 2016-17: Prior M=167.8, SD=145.8; Since M=71.8, SD=108.1; t(30)=2.81, p=<0.01, Cohen's d=0.54

3 Incarceration Days:

TAY:

FY 2017-18: Prior M=35.5, SD=36.0; Since M=7.3, SD=15.2; t(19)=3.02, p=.07, Cohen's d=0.72

FY 2016-17: Prior M=35.1, SD=31.9; Since M=14.7, SD=43.2; t(29)=2.48, p<0.05, Cohen's d=0.39

Adults:

FY 2017-18: Prior M=55.6, SD=83.9; Since M=18.1, SD=50.3; t(200)=5.38, p<.001, Cohen's d=0.39

FY 2016-17: Prior M=60.9, SD=85.5; Since M=18.5, SD=40.2; t(216)=6.38, p<0.001, Cohen's d=0.48

Older Adults:

FY 2017-18: Prior M=59.3, SD=85.1; Since M=9.2, SD=22.7; t(12)=1.93, p=.08, Cohen's d=0.58

FY 2016-17: Prior M=127.9, SD=110.7; Since M=39.9, SD=95.7; t(10)=3.24, p<0.01, Cohen's d=0.61

4 Employment Days:

TAY:

FY 2017-18: Prior M=26.2, SD=72.9; Since M=33.7, SD=82.7; t(90)=-0.73, p=.47, Cohen's d=-0.08

FY 2016-17: Prior M=37.2, SD=87.1; Since M=45.1, SD=92.7; t(92)=-0.68, p=0.50, Cohen's d=-0.12

Adults:

FY 2017-18: Prior M=30.2, SD=81.0; Since M=40.0, SD=93.6; t(718)=-2.41, p<.05, Cohen's d=-0.09

FY 2016-17: Prior M=27.3, SD=77.5; Since M=33.0, SD=83.5; t(753)=-1.55, p=0.12, Cohen's d=-0.05

Crisis Assessment Teams/Psychiatric Emergency Response Teams

Target Population and Program Characteristics

The Crisis Assessment Teams (CAT) provide mobile crisis assessment and response throughout Orange County for individuals of all ages 24 hours a day, 7 days a week, 365 days a year. There are currently 27 children's CAT clinicians and 45 TAY/Adult clinicians who respond to calls from anyone in the community and dispatch to anywhere in Orange County. The TAY/Adult team hired 5 out of 8 of the expansion positions this year. The Children's CAT program provides services in English, Spanish and Vietnamese.

Psychiatric Emergency Response Teams (PERT) are specialized units comprised of behavioral health clinicians from the TAY/Adult CAT who ride along with police officers. PERT clinicians partner with 16 agencies across Orange County, including the Orange County Sheriff's Department and police departments in the cities of Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Seal Beach, Tustin and Westminster during shifts designated by each participating department. The TAY and Adult CAT/PERT program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Khmer, Tagalog and Mandarin.

Services

CAT is a multi-disciplinary program that provides prompt response anywhere in the county, when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training to conduct evaluations and risk assessments that are geared to the individual's age and developmental level and involve interviews with collateral sources such as parents, guardians, family members, law enforcement, emergency department staff and school personnel. Clinicians link individuals to an appropriate level of care to ensure their safety, which may involve initiating an involuntary hospitalization. They also conduct follow-up contacts with individuals and/or their parents/guardians to provide information and referrals and to encourage linkage to on-going behavioral health services that may help reduce the need for future crisis interventions.

PERT clinicians have established strong partnerships with numerous local law enforcement agencies throughout Orange County. They ride along with police officers on designated shifts and promptly respond to calls involving individuals with behavioral health needs. During these calls clinicians conduct risk assessments, initiate involuntary hospitalizations as necessary and provide appropriate care and linkages to resources in a dignified manner. In addition to assisting individuals in accessing needed behavioral health services, PERT educates police on behavioral health issues and provides officers with tools that allow them to assist individuals living with behavioral health issues more effectively.

Strategies to Promote Recovery/Resilience

During the assessment, clinicians work with the individual in crisis and/or their family members to identify previously successful coping strategies, as well as any available supports and resources. Clinicians also work to make timely referrals and linkages to facilitate recovery and prevent the need for future crisis services.

Strategies to Improve Timely Access to Services for Underserved Populations

The Children's and TAY/Adult teams serve all of County of Orange and strive to improve timely access to their services in a number of ways. First, the teams advertise their services on the Internet and at community events and accept referrals 24/7 from anyone in the community through a toll-free number. In an effort to encourage utilization by underserved populations, CAT clinicians also conduct trainings and outreach throughout the county to increase recognition of the signs of behavioral health crisis and address any associated misperceptions about mental health. The teams also provide a mobile response to overcome any transportation barriers on the part of the people they serve and strive to arrive within one hour of receiving the referral and within 30 minutes from the time the clinician dispatches. Finally, the teams have bilingual/bicultural staff with the capacity to provide services in many languages (see grids). In addition to working with those in crisis, bilingual/bicultural clinicians work with family members to provide information and culturally appropriate referrals to ensure that individuals and their families receive services in a timely manner.

Both teams have noted a steady increase in calls over the past several years, particularly as homelessness has persisted and passage of AB 2246 required all school districts to have a suicide prevention response in place for students in grades 7 through 12. With requests for services coming from families, hospitals, schools, caregivers, law enforcement, social services, treatment providers and the general community at ever increasing rates, CAT and PERT continue to expand their teams to provide better geographic coverage across Orange County and maintain a timely response. Nevertheless, it has proved challenging to keep up with demand, particularly for Children's CAT.

Strategies to Reduce Stigma and Discrimination

CAT/PERT continues to place priority on hiring bilingual and bicultural staff. Staff also attend cultural diversity workshops so that they may conduct evaluations in a sensitive manner and offer culturally appropriate service referrals. In addition, PERT provides law enforcement with information and tools to help officers more effectively assist individuals who are experiencing a behavioral health crisis. The success of these law enforcement/behavioral health partnerships has resulted in a more compassionate response in the community.

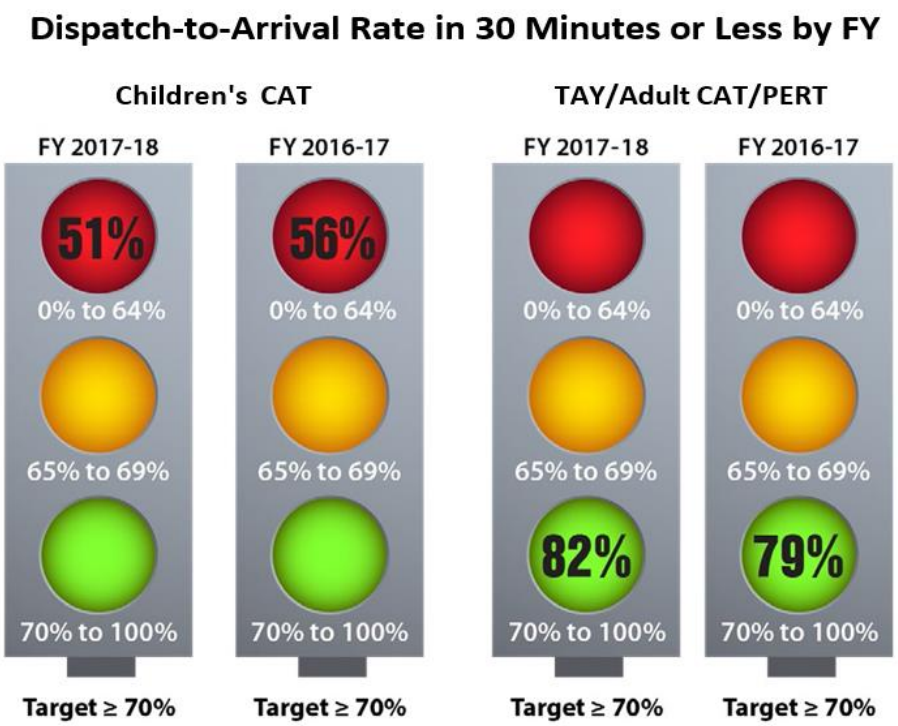
Outcomes

The Children's team conducted 3,786 evaluations in FY 2017-18 and 3,039 evaluations in FY 2016-17. The TAY/Adult team conducted 4,553 evaluations in FY 2017-18 and 4,568 evaluations in FY 2016-17.

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. TAY/Adult CAT/PERT met its goal with a dispatch-to-arrival rate of 82% in FY 2017-18 and 79% in FY 2016-17. Although the Children's team missed its target over the past two years with a 51% and 56% response rate in FY 2017-18 and FY 2016-17, respectively, in both years the average dispatch-to-arrival time was still close to target (i.e., 34 minutes in FY 2017-18, 32 minutes in FY 2016-17).

The Children's CAT team has identified potential factors contributing to why the response time has fallen short of the goal. The program receives a majority of calls in the late afternoon and early evening hours when school ends for the day and parents are arriving home. This coincides with high peak traffic times on local freeways resulting in longer drives. The team is currently examining the number of calls from areas that are farthest from the office location to identify ways to address response time, especially during high traffic times. Additionally, while the program is centrally located in Orange County, staff must walk to an off-site parking lot to get to their cars, thereby increasing response time by approximately 5 minutes. With the program moving to a new location with on-site parking in March 2019, HCA will monitor whether this change helps improve dispatch-to-arrival times.

In addition to dispatch-to-arrival times, the teams examine the rate at which individuals are psychiatrically hospitalized as a way of monitoring the severity of the presenting problems experienced by the individuals served and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals continued to be hospitalized less than half the time (40% and 44% in FY 2017-18 and FY 2016-17, respectively, for children; 45% and 48% in FY 2017-18 and FY 2016-17, respectively, for TAY/adults). The program has continued to note a larger number of individuals living 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 level of care needs, thereby limiting placement options.



Supported Employment (CSS)

Target Population and Program Characteristics

The Supported Employment (SE) program serves Orange County residents 18 and older who are living with severe and persistent mental illness, may have a co-occurring substance use disorder and require job assistance to obtain competitive or volunteer employment. Participants are referred to the program from County and County-contracted Outpatient and Recovery programs, FSPs and select PEI and Innovation programs. Participants must be engaged in behavioral health services during their entire enrollment in the program and have an assigned plan coordinator or personal services coordinator who will collaborate with the SE team to assist with behavioral issues that may arise while participating in the program. The program provides services in Spanish, Vietnamese, Farsi and Korean.

Services

The Supported Employment program Individual Employment Plans are developed by the employment team with the participant and use the evidence-based Individual Placement & Support employment model to provide services such as volunteer or competitive job placement, ongoing work-based vocational assessment, benefits planning, individualized program planning, time-unlimited job coaching, counseling and peer support services.

Employment Specialists (ES) and Peer Support Specialists (PSS) work together as an Employment Team. The ES assists participants with employment preparation including, but not limited to, locating job leads, assisting with application submissions and assessments, interviewing, image consultation and transportation issues. The ES also provides one-on-one job support, either by telephone or at the participant's workplace, to ensure successful job retention. The PSS are individuals with lived experience with behavioral health and substance use challenges, and who possess skills learned in formal training, and/or professional roles, to deliver services in a behavioral health setting to promote mind-body recovery and resiliency. PSS work with participants in developing job skills, and assist the ES in helping the participant identify areas of need for development, and may use techniques such as role modeling, field mentoring, mutual support, and others that foster independence and promote recovery. For those who may not yet be ready for competitive employment, the program offers volunteer opportunities at places of business around the county as a way for them to gain work-related skills and confidence.

Strategies to Increase Recovery/Resilience

Securing meaningful employment represents a significant step toward recovery and re-integration into the community. Staff strives to build working relationships with prospective employers, educate employers to understand mental illness and combat stigma, and serves as the main liaison between the employers and program participants. The ES maintains ongoing, open communication with participant treatment teams to promote positive work outcomes. The PSS provide training and support to participants using the principles of hope, equality, respect, personal responsibility and self-determination. While it is sometimes a concern among the target population that they might lose their benefits such as SSI/SSDI if they become employed, they also recognize that this may be a final step to gaining full independence from the 'system.'

Strategies to Improve Timely Access to Services for Underserved Populations

The SE program engages in a number of activities to encourage timely access to its services. First, SE staff regularly present at County and County-contracted clinics to encourage referrals to the program. From the day the participant enrolls, the program strives to foster an environment of empathy and hope, which contributes to their ongoing program participation. ES and PSS staff provide person-centered supports in line with the evidence-based model of Individual Placement & Support so that they can support participants in finding and keeping a good job in a supportive work environment. The team is highly mobile and can meet individuals in their communities to provide supported services. The employment team also collaborates with the referring treatment provider to discuss the participant's progress, success stories and/ or any significant behavior that prompts need for clinical interventions. In addition, services are provided in English, Spanish, Vietnamese, Korean, Farsi and American Sign Language.

Strategies to Reduce Stigma and Discrimination

Helping participants find and maintain good jobs in the community is, in and of itself, an act of reducing stigma and discrimination. More and more program participants are requesting assistance in disclosing their barriers to employers. This opens up ample opportunity for staff to have a supportive on-site presence that fosters collaboration and education between the participants and their employers and co-workers. The program promotes participants' successes in maintaining employment and highlights welcoming employers who provide individuals with mental health challenges the opportunity to meaningfully integrate into the communities via competitive employment. This effort is carried out through media exposure via news publication, newsletters and presentations of success stories at community meetings.

Outcomes

The program served 474 participants in FY 2017-18, which included 334 new enrollments. In FY 2016-17, 405 participants were served, which included 290 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. A total of 128 of the 263 (49%) job placements in FY 2017-18 and 118 of the 203 (58%) job placements in FY 2016-17 resulted in a successful graduation from the program after achieving the employment milestone. This is most likely due to changes in staffing structure; only one program manager instead of two managing the two regions. There was also rapid staffing turnover at both north and south.

Transportation (CSS)

Target Population and Program Characteristics

The Transportation program serves adults ages 18 and older who need transportation assistance to and from necessary County behavioral health and/or primary care appointments, as well as behavioral health supportive services. Individuals are referred to the program by their BHS treatment provider, following an assessment of their transportation needs and their history of missing their scheduled appointments due to transportation issues.

Services

Individuals are provided curb-to-curb service or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance and the driver will pick them up at their specified location, take them to their appointment, pick them up after the appointment and take them back to their destination of origin. Individuals also have the option to stop and get their prescriptions filled as necessary.

Strategies to Promote Recovery/Resilience

A survey on transportation needs conducted at the four large County adult outpatient clinics (Santa Ana, Anaheim, Westminster and Mission Viejo) indicated that over 40% of missed clinic appointments was a direct result of transportation issues. These issues included, but were not limited to, lack of a car or money for gas or a bus, inability to navigate the public transportation system, the time it takes to use public transportation system, anxiety surrounding using public transportation or riding with others and reliance on others to get rides to and from appointments. By providing reliable pick-up and drop-off at their requested destinations, it is anticipated that participants will be better able to engage in treatment consistently, thus allowing them to pursue their recovery.

Strategies to Improve Timely Access to Services for Underserved Populations

The program facilitates timely access to needed behavioral health and medical services for participants with significant transportation-related barriers to care by providing them with the means to attend these appointments.

Strategies to Reduce Stigma and Discrimination

By offering free transportation, the program makes behavioral health and medical treatment equally accessible to individuals in need of care regardless of their socioeconomic means.

Outcomes

The contract began July 12, 2018, with the first ride taking place on July 12, 2018. Outcomes will be reported in future plans.

Supportive Services for Residents in Permanent Supportive Housing (CSS)

Target Population and Program Characteristics

This new program will serve adults ages 18 and older who are living with serious mental illness, residing in permanent supportive housing in Orange County but lacking supportive services, thus placing them at-risk of losing their housing. Eligible participants will be referred from County outpatient clinics and programs, as well as private providers. The program will also serve underserved individuals, including those who have not successfully engaged in behavioral health services.

Services

The primary goal of this program is to assist participants with maintaining their housing by providing integrated and multi-disciplinary intensive case management services to those who do not have access to on-site housing support. The program will assess individual needs, assist individuals with housing sustainability and, when needed, link individuals to appropriate community resources and supports. The program is currently a three-year pilot project and is new to the FY 2019-20 MHSA Plan. Program services will be developed and described in more detail in future Plans.

Wellness Centers (CSS)

Target Population and Program Characteristics

Orange County funds three Wellness Centers through CSS that serve adults 18 and older who are living with a serious and persistent mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on, their recovery which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The centers serve a diverse member base and provides services in Spanish, Vietnamese, Farsi, Korean and Arabic. Wellness Center West, in particular, has a unique, dual track program that provides groups, classes and activities in English and monolingual threshold languages that 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.

Services

Wellness Centers are grounded in the Recovery Model and provide a support system of peers to assist members in maintaining their stability while continuing to progress in their personal growth and development. The programs are culturally and linguistically appropriate while focusing on personalized socialization, relationship building, assistance with maintaining benefits, setting educational and employment goals, and giving back to the community via volunteer opportunities.

Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. 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 member's family, friends or significant others.

The Wellness Centers utilize Member Advisory Boards (MABs) composed of members who develop or modify programming and evaluate the successes or failures of groups, activities and classes. They also use a community town hall model and member Satisfaction and Quality of Life surveys to make decisions about programming and activities.

Strategies to Promote Recovery/Resilience

All three of the Wellness Centers provide a safe and nurturing environment for each individual to achieve their vision of recovery while providing acceptance, dignity and social inclusion. Programs are member-driven, 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.

Strategies to Increase Timely Access to Services for Underserved Populations

Many members have experienced isolation for years and have had limited exposure to the community in which they live. Housing, transportation and difficulties associated with homelessness and symptoms of mental illness also prevent members from joining in Wellness Center activities. To help address these barriers, staff at the Wellness Centers share their lived experience with members and connect with them on a more personal level. They serve as role models to members, provide encouragement and hope that recovery is possible, and share that participating in the groups, classes and/or activities could help them develop confidence and skills to assist them on their own recovery journey.

The Wellness Centers are supportive programs that complement clinical programs, and many members are referred by their treatment teams to assist with their recovery. To encourage on-going referrals, center flyers and monthly Wellness Center activity calendars are distributed to all County and County-contracted programs. In addition, the Wellness Centers frequently perform outreach activities by staffing booths at behavioral health and other community events, and by presenting to community partners that may work with individuals who could benefit from Wellness Center programming.

Strategies to Reduce Stigma and Discrimination

All three Wellness Centers provide a warm, welcoming and accepting environment, and serve all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members, and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. The Wellness Centers also offer a variety of groups such as Diversity Plus and the LGBTIQ group that are specifically designed for the widely diverse membership.

Utilizing peer staff with lived experience with behavioral health issues is key to operating programs of this nature as these staff can relate on a much deeper level with members because they have often walked in their shoes. Peer staff are from a variety of cultures, ethnicities and backgrounds, and have the ability to serve members from all threshold languages.

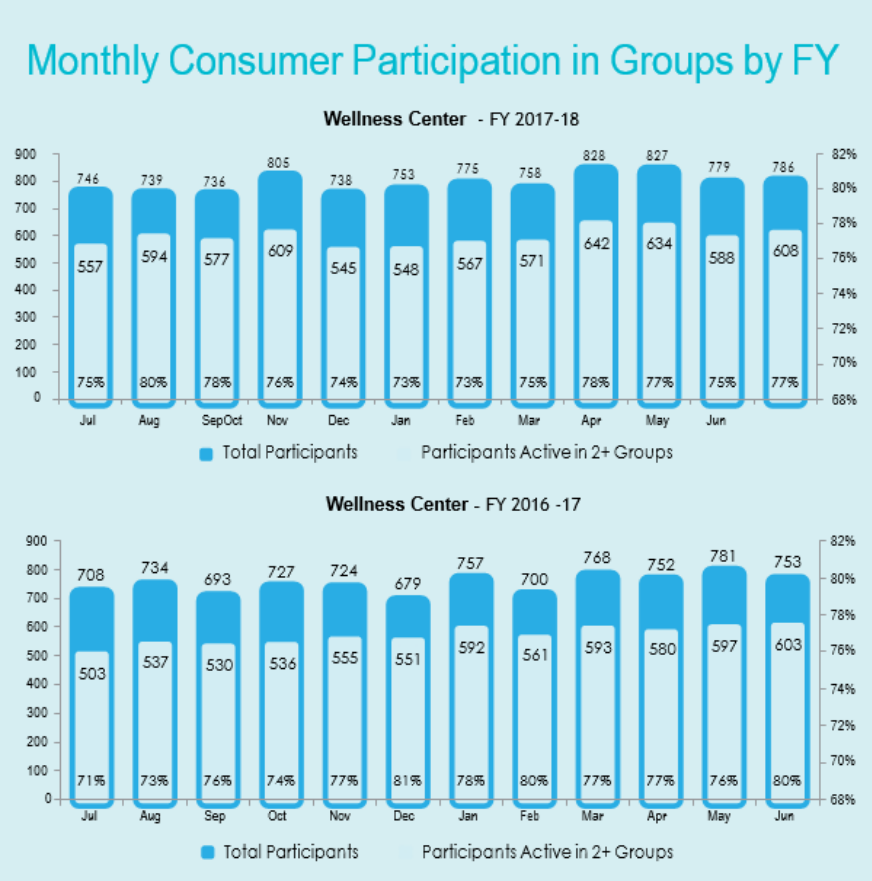
Employment preparation offered by the centers help members focus on their experience, skills and what they have to offer, rather than focusing on their illness. Socialization activities held in the community help to develop confidence in members that they, too, can participate in everything their communities have to offer, which helps to reduce isolation and fear. Members often meet up on their own in the community after these

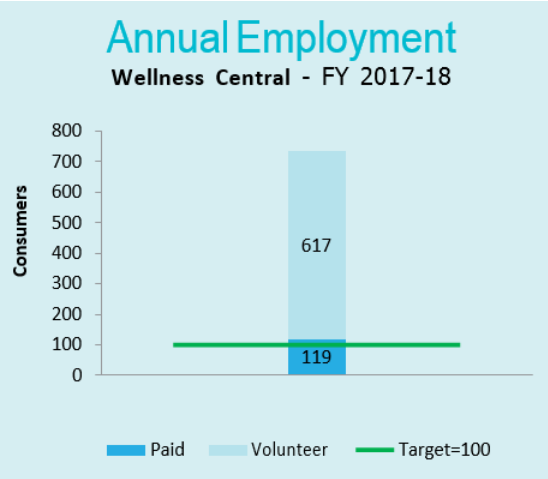
socialization activities.

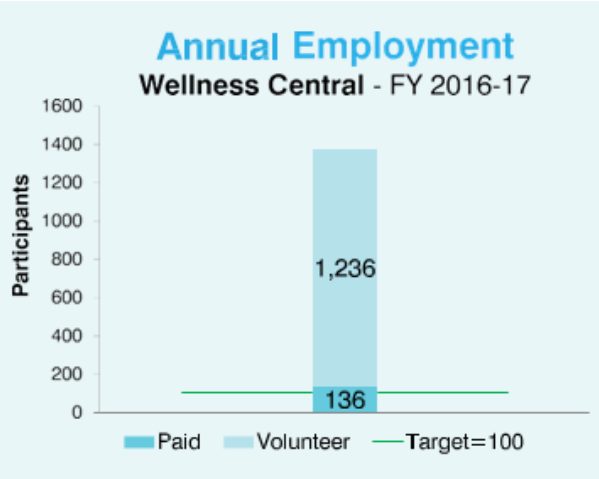
Outcomes

The Wellness Centers served a total of 2,412 adults in FY 2017-18 and 2,424 in FY 2016-17. The program assesses 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 with 76% of members participating in two or more groups/activities each month during FY 2017-18. This is comparable to FY 2016-17 in which 77% of members participated in two or more groups/activities each month. 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 2017-18, 2,026 (84%) adults participated in community integration activities and in FY 2016-17, 2,038 (84%) adults participated.

The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 146 and 141 adults enrolled in education classes in FY 2017-18 and FY 2016-17, respectively. Thus, school enrollment 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, 736 adults in FY 2017-18 and 1,372 adults in FY 2016-17 were involved in employment, largely due to the large proportion in volunteer positions (see graphs). The programs will continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.







Peer Mentoring (CSS)

Target Population and Program Characteristics

The Peer Mentoring program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring disorder, and would benefit from the supportive services from a peer. This CSS program consists of three unique tracks:

- Track 1 serves participants in County-operated and County-contracted outpatient programs (i.e., Clinics, FSPs) who are referred by their therapist or personal service coordinator for assistance with re-integration into their community following a recent psychiatric hospitalization or multiple Emergency Department visits and with short-term treatment goals such as daily living skills/life skills development, vocational and educational opportunities, social development and adaptation, improved family functioning, and identification of community resources.
  Peer mentoring services expanded in FY 2018-19 to children and adults who are receiving services in the County outpatient clinics as well as their families. Additional details will be provided in future Plans as the services are more fully developed.
- Track 2, which was originally funded through the Senate Bill 82 Triage Grant and will now be continued with MHSA CSS funds, serves participants being discharged from the County Crisis Stabilization Unit (CSU) or Royale Therapeutic Residential Center (RTRC) and require assistance linking to ongoing behavioral health or community services.
- Track 3, developed as part of the County's Whole Person Care plan, serves participants who are living with serious mental illness, are homeless or at-risk of homelessness and are Medi-Cal beneficiaries. Participants are referred to this Peer Mentoring track by the BHS Outreach and Engagement team and Housing Navigators from contracted providers after they have been placed in housing (see Whole Person Care in the Special Projects section).

Services

Services are customized depending on the individuals' needs and the track in which they are participating. The program provides services in Spanish, Vietnamese, Farsi and Korean.

In Track One, peers, youth mentors and/or parent partners work with participants on achieving short-term treatment goals that are part of a larger, overall treatment plan established by their treatment providers. The goals generally take 60 days or less to achieve and may include, but are not limited to, learning to use and navigate the public transportation system; obtaining identification cards or driver's licenses; assisting with housing applications; increasing socialization activities such as attending groups or activities at the Wellness Centers; helping with the transition from inpatient care back into community living; assisting with stabilizing a person who has experienced multiple Emergency Department visits; coordinating crisis management; providing skills building workshops; facilitating referrals and linkages to needed resources; helping to identify the personal needs of participants; and/or facilitating or assisting with groups.

In Track Two, the peer navigator receive a warm hand-off from licensed Crisis Stabilization Unit staff or RTRC staff. After establishing a relationship with the participant, the peer navigator works to enroll the participant in the Peer Mentoring program and matches them with a peer mentor who will link them to necessary follow-up behavioral health or medical appointments. Peers also work with participants on accessing community-based services such as food pantries or emergency overnight shelters as needed. Peer mentors share their lived experience, which often provides the encouragement a participant needs to engage in

ongoing services following a crisis. Peers work to link participants to services within 30 days of engagement. Longer time periods are often associated with the inability to make or maintain contact with the participant after the engagement period, as many are homeless, don't have telephones and/or may stay at different locations on a nightly basis.

In Track Three, peers help Whole Person Care participants sustain their housing placements for longer than six months. Peer Mentors will provide supportive and tenancy-sustaining services that may include landlord negotiations, housekeeping, food shopping and preparation, financial management, medication management, transportation, medical care, arranging utilities, phone, insurance and access to community supports and services.

Strategies to Promote Recovery/Resilience

The principles of the Recovery Model are embedded in the program and peers focus on a participant's strengths and foster their sense of empowerment, hope and resilience while on their recovery journey. Across all tracks, the Peer Mentoring programs strive to improve participant's well-being and resourcefulness, thus allowing them to re-integrate successfully into their communities.

Strategies to Increase Timely Access to Services for Underserved Populations

The Peer Mentoring program has proactively built relationships with leadership at County Clinics and County-contracted outpatient clinics by conducting presentations to inform staff of the referral process, and services provided, and to share success stories. Sharing data on linkage rates and successful goal completion as a result of using Peer Mentoring services has had a large influence on increasing referrals to the program.

Some individuals receiving Peer Mentoring services have children and/or work. While they understand the benefits of working with a peer, finding the time to meet is perceived as adding another responsibility and, at times, can cause some reluctance to engage in services. Peer mentors educate the individual's family members or significant support persons about the recovery model and the benefits of participating in follow-up services so that they may encourage their loved one to access those necessary services.

Homelessness is another factor that can affect program access as Peer Mentors can lose touch with individuals who do not have a stable residence or telephone to remind them about their appointments or responsibilities. During initial contact with the participant, peer staff makes significant effort to learn about where a participant may be staying and how to contact them in order to minimize losing contact with them once their initial meeting has ended.

Strategies to Reduce Stigma and Discrimination

The core values of the Peer Mentoring program draw upon cultural strengths and provide services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. Cultural competence is an essential part of the program development, recruitment and hiring of

staff. In addition, Peer Mentors encourage participants and other staff working with the participants to use recovery language. They normalize seeking mental health treatment by sharing their own lived experiences and by discussing how any other individual would seek treatment for a physical illness. Peers also demonstrate empathy, caring and concern to bolster participants' self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, a doctor, etc.

Outcomes

Of the 457 adults and older adults enrolled in Track 1 during FY 2017-18, 385 individuals (84%) successfully completed their goals with assistance from their peer mentor. 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. For both FY 2017-18 and FY 2016-17, 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 339 adults and older adults enrolled in Track 2 during FY 2017-18, 203 individuals (60%) were successfully linked to their follow-up behavioral health and/or medical appointments. 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.

Track 3 is the newest of the peer mentor tracks. Of the 33 adults and older adults enrolled in Track 3 during FY 2017-18, 22 individuals (67%) successfully completed their housing goals with assistance from their peer mentor.

Recovery Open Access (CSS)

Target Population and Program Characteristics

Recovery Open Access serves individuals ages 18 and older living with serious and persistent mental illness and a possible co-occurring disorder who are in need of urgent outpatient behavioral health services. The target population includes adults who are being discharged from psychiatric hospitals, released from jail or are currently enrolled in outpatient BHS services and have an urgent medication need that cannot wait until their next scheduled appointment. These individuals are at-risk of further hospitalization or incarceration if not linked to behavioral health services quickly.

Services

Recovery Open Access serves two key functions: (1) it links adults with serious and persistent illness to on-going, appropriate behavioral health services and (2) it provides access to short-term integrated behavioral health services (i.e., brief assessments, case management, crisis counseling and intervention services, SUD services, temporary medication support) while an individual is waiting to be linked to their (first) appointment. In order to decrease the risk of re-hospitalization or recidivism, staff try to see participants within 24 hours of the time of discharge from the hospital or jail and to keep them engaged in

services until they link to on-going care. The program provides services in Spanish, Vietnamese and Khmer.

Strategies to Promote Recovery/Resilience

By providing timely access to needed care, including mediation support, Recovery Open Access allows individuals to move forward in their recovery instead of hitting roadblocks to their care.

Strategies to Increase Timely Access to Services for Underserved Populations

Individuals in the program face issues related to transportation, difficulty navigating the behavioral health system, management of their symptoms, and/or degree of insight into their mental health issues. As described above, Recovery Open Access improves access to care by expediting urgent care needs and by facilitating quicker and smoother linkages to behavioral health treatment for those discharging from inpatient and jail settings. Recovery Open Access has made significant progress linking individuals to ongoing care within 30 days of discharge, making 1,014 linkages in FY 2017-18 compared to 591 linkages made in FY 2016-17.

Strategies to Reduce Stigma and Discrimination

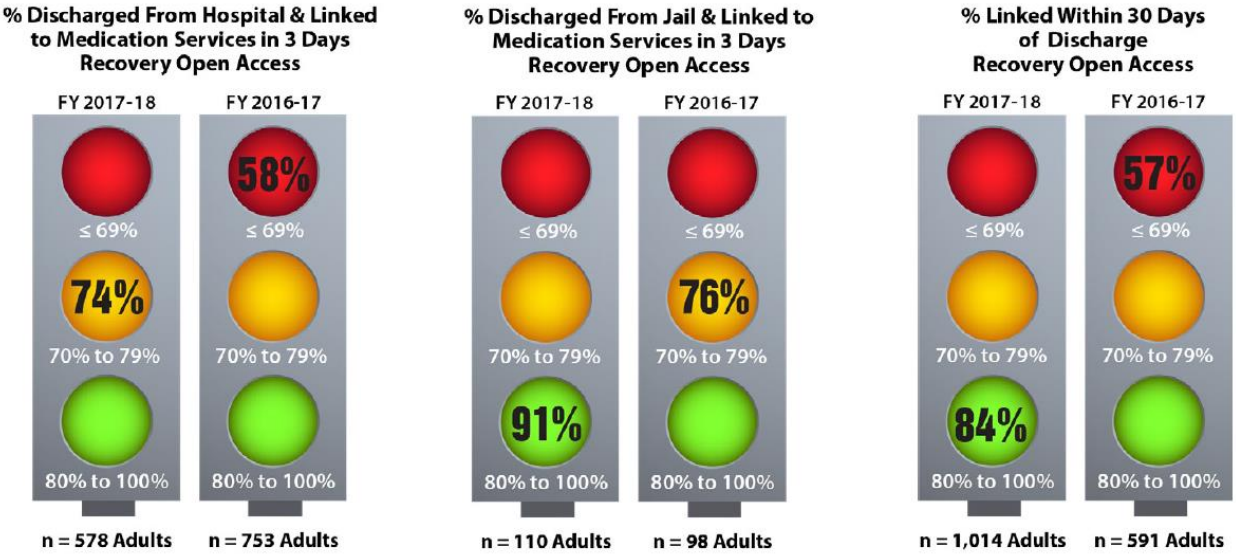
All clinicians and peer workers are trained yearly in cultural competency, which reviews the concepts of culture, race, ethnicity, diversity, stigma and self-stigma. The training also demonstrates the influence of unconscious thought on a person's judgment as it relates to stereotyping and racism. Through this training and their on-going supervision, Recovery Open Access clinicians are provided strategies to recognize diversity, embrace the uniqueness of cultures beyond mainstream American culture and incorporate a culturally responsive approach in their service planning, service delivery and interactions with program participants.

Outcomes

Recovery Open Access served 1,762 adults in FY 2017-18, up from 1,357 adults served in FY 2016-17. Performance of the program was measured by whether the program met or exceeded the following targets:

- 80% of adults discharged from a hospital and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of adults discharged from jail and admitted to Recovery Open Access are linked to medication services within 3 business days
- 80% of all adults admitted to Recovery Open Access are linked to ongoing care within 30 days

The program made considerable progress toward meeting its targets in FY 2017-18 after not meeting any of its goals in FY 2016-17. Program expectations for scheduling appointments with the Open Access psychiatrist, receiving medication and receiving on-going care were clarified with staff at the end of FY 2016-17, which greatly improved the timeliness with which staff achieved all three linkage goals in FY 2017-18.



Older Adult Services (CSS)

Target Population and Program Characteristics

Older Adult Services (OAS) serves individuals age 60 years and older who are living with serious and persistent mental illness (SPMI), have multiple functional impairments and may also have a co-occurring substance use disorder. Many of the older adults served in this program are homebound due to physical, mental, financial or other impairments. They are diverse and come from African American, Latino, Vietnamese, Korean and Iranian communities. OAS accepts referrals from all sources.

Services

OAS provides case management, referral and linkages to various community resources, vocational and educational support, substance use services, nursing services, crisis intervention, medication monitoring, therapy services (individual, group, and family), and psycho-education for participants, family members and caregivers. Evidence-based practices such as Cognitive Behavioral Therapy, Motivational Interviewing, EMDR, DBT, problem solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care are used. The program provides services in English, Spanish, Vietnamese, Farsi, Korean, Arabic, Amharic and Mandarin.

Strategies to Promote Recovery/Resilience

All services are highly individualized and provided with the aim of increasing access to community and medical services, maintaining independence and decreasing isolation. The goals are accomplished by providing services that focus on reducing symptoms and increasing skills to cope with life stressors.

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation is a huge barrier for the older adult population. Many lack the financial resources to own a private vehicle or use taxi services. Some rely on family and caregivers for transportation and are dependent on their availability. Others lack the physical and cognitive capacity to manage public transportation. By making all of its

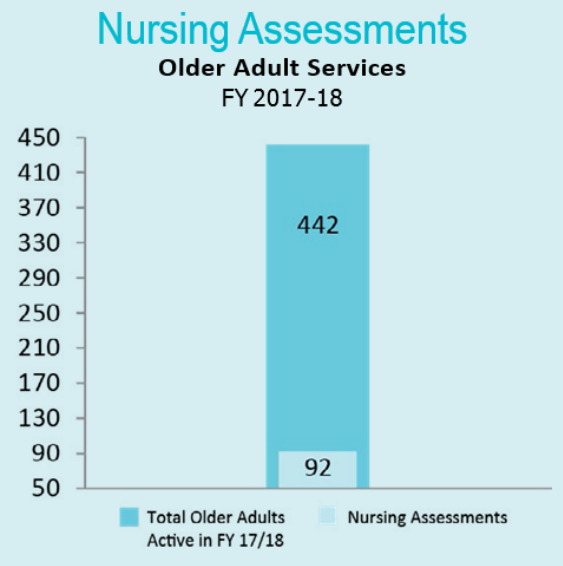
services available to participants out in the community, if needed, OAS recovery has greatly improved access to services for older adults living with SPMI in Orange County. In addition, program staff provides services in many languages (see grid) through staff who are bicultural/bilingual. Language line translation is also available to provide services in any language not spoken by program staff in order to reduce delays in accessing the program due to language barriers. Staff also dedicates a considerable amount of time providing transportation to participants to assist them in accessing community-based providers for other needs not met directly by OAS (i.e., medical appointments, government offices, senior centers).

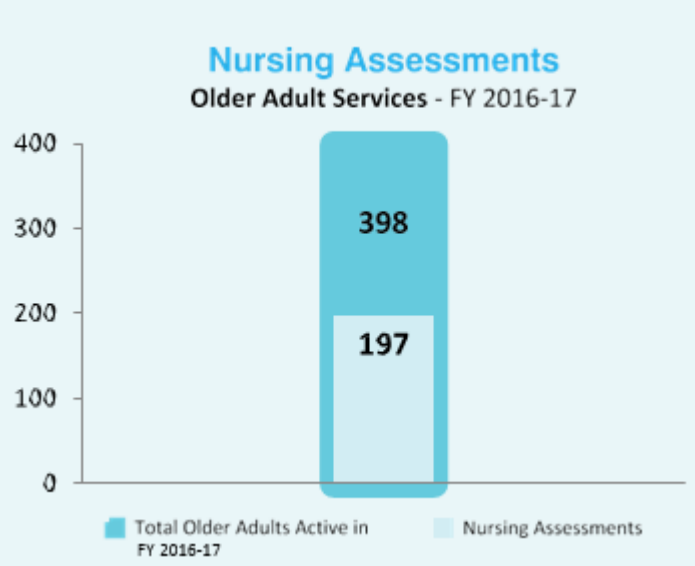
Strategies to Reduce Stigma and Discrimination

Older adults may hesitate to access OAS due to stigma related to being an older adult. For example, they may fear losing their independence or being removed from their homes, forced to take medications and/or forced to live in a nursing home due to their age. They may also feel shame due to their belief that, as adults, they should not need anyone's help to live their lives. OAS staff are trained and encouraged to take whatever time is needed to develop trust with participants in order to facilitate engagement into services. Older adults enjoy sharing their life stories and staff taking time to listen is an important engagement tool. OAS also collaborates with Social Services Senior Santa program to provide necessities to older adults such as household items, clothing and hygiene items, which can serve as a strong contributor to engagement. In addition, the OAS SHOPP program is dedicated to conducting outreach and engagement with individuals referred to OAS, where it can take several friendly home visits before an older adult engages in OAS services.

Outcomes

In FY 2017-18, the program served 443 older adults, 298 of whom were new admissions. 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 the total adults served during FY 2017-18, 21%, had a nursing assessment completed. In contrast, during FY 2016-17, approximately half (49%) had a completed nursing assessment. This reduction is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. Staff has not yet returned to their normal work location and employees are currently spread out over multiple offices until repairs can be completed, which has affected program operations and service delivery.





Integrated Community Services (CSS)

Target Population and Program Characteristics

Integrated Community Services (ICS) serves individuals ages 18 and older who have chronic primary care and mental health needs. The program, which was originally an Innovation project continued with CSS funding due to its demonstrated success, has two components: ICS County Home and ICS Community Home. On the ICS County Home side, primary care physicians (PCPs), registered nurses (RNs), and medical care coordinators are placed in behavioral health clinics. On the ICS Community Home side, County therapists and psychiatrists work with mental health caseworkers within contracted and subcontracted primary care sites. This collaboration with community medical clinics and County mental health programs is a health care model that bridges the gaps in service for the underserved low-income community. The program serves adults who are Medi-Cal enrolled or eligible, or have third party coverage. Individuals are referred to this program by County behavioral health providers, community organizations and contracted community clinics.

Services

In addition to the medical care provided by the PCPs and RNs, ICS behavioral health staff conducts a number of psychoeducational support groups on topics such as nutrition, diet, chronic diseases, depression, anxiety, exercise and other physical and mental health care subjects. ICS clinicians also provide therapy, counseling, crisis assessment and intervention and utilize evidence-based and best practices such as Motivational Interviewing, Seeking Safety and Cognitive Behavioral Therapy. The program provides services in English, Spanish, Vietnamese and Korean.

Mental Health Workers also provide case management and help facilitate program participant's linkage to community organizations that provide a range of services (i.e., prescription eyeglasses, free clinic, Serve the People, housing assistance, 211 of Orange County, etc.). They help participants navigate the system of care and share their lived experience to help participants gain insight and make positive choices about their health care and behavioral health needs.

Strategies to Promote Recovery/Resilience

ICS' integrated, multi-disciplinary teams promote recovery and resilience by providing coordinated care and enabling adults to better navigate different systems of care within their communities. ICS support groups have also helped raise awareness and provide participants with information they need to make better decisions about their lifestyles that impact their overall health. These groups also serve as a safe place for participants to ask questions and get accurate information about physical and mental health care. By decreasing mental health symptoms and addressing and improving physical health problems, program participants are expected to increase their life expectancy and live a better quality of life. Peer support and role modeling also play a key role in promoting resilience in these participants.

Strategies to Improve Timely Access to Services for Underserved Populations

Transportation poses an issue to program access as many participants do not have the means to get to the clinics. Although ICS staff have the ability to do community outreach, follow through from participants can pose a challenge. The program attempts to address these barriers by teaching participants how to use public transportation, providing bus passes and placing reminder calls about the date and time of upcoming appointments. In addition, ICS staff are bicultural/bilingual in a number of languages (see grid) and have access to a language- line in order to reduce difficulties engaging in services due to language barriers.

Strategies to Reduce Stigma and Discrimination

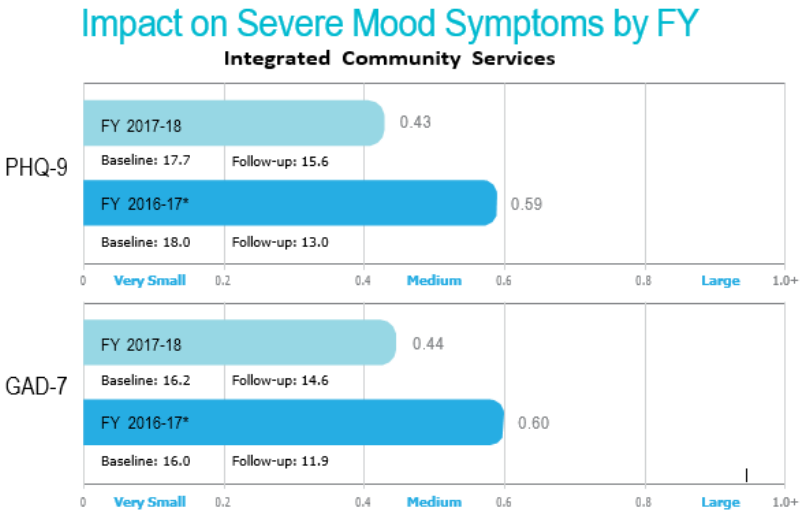
ICS provides services to a large number of people in the Asian communities where stigma continues to be associated with mental illness and, as a result, many participants tend to keep issues within the family and not seek needed services. Staff work to reduce stigma by educating participants and their family members about mental illness as a brain disease and beginning engagement into services by focusing on somatic symptoms.

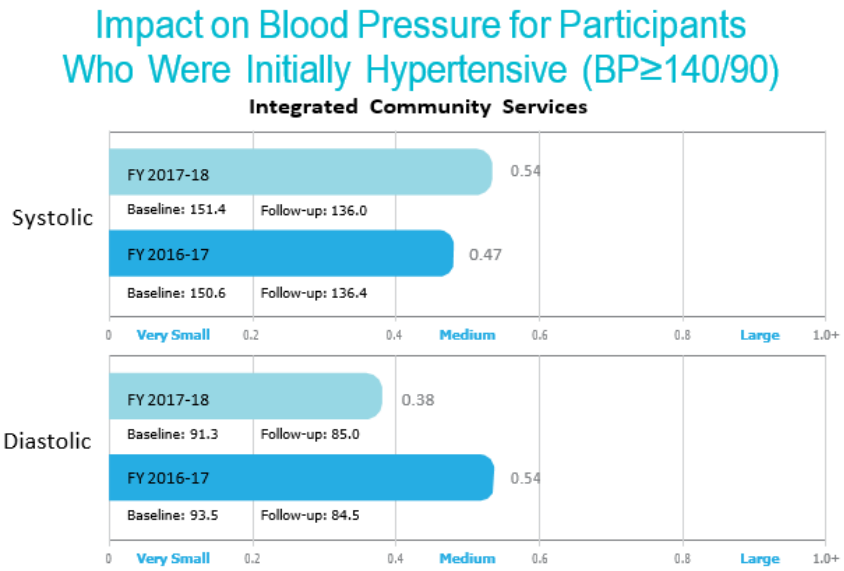
Outcomes

The program served a total of 500 adults in FY 2017-18, and 467 adults in the year prior (February 2016 - June 2017*). ICS monitored both mental health symptoms and physical health markers to assess program impact.

Across both fiscal years, adults with severe depression and/or anxiety at baseline, as measured by the PHQ-9 and GAD-7, experienced medium reductions in their symptoms.[1]

In addition, adults who met criteria for hypertension at baseline (i.e., ≥ 140/90) generally demonstrated moderate decreases both in their systolic and diastolic blood pressure, although the decrease in diastolic blood pressure was somewhat reduced in FY 2017-18.[2]





Reference Notes

[1] PHQ-9:

FY 2017-18: Prior M=17.7, SD=5.0; Since M=15.6, SD=6.1; t (135) = 4.97, p<.001, Cohen's d=.43

FY 2016-17: 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:

FY 2017-18: Prior M=16.2, SD=3.6; Since M=14.6, SD=5.0; t (112) = 4.40, p<.001, Cohen's d=.44

FY 2016-17: 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:

FY 2017-18: Prior M=151.4, SD=15.7; Since M=136.0, SD=24.9; t (66) = 4.30, p<.001, Cohen's d=.54

FY 2016-17: 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:

FY 2017-18: Prior M=91.3, SD=9.2; Since M=85.0, SD=15.6; t (66) = 3.00, p<.01, Cohen's d=.38

FY 2016-17: Prior M=93.5, SD=8.9; Since M=84.5, SD=14.5; t (87) = 5.29, p<.001, Cohen's d=.54

The Multi-Service Center Courtyard Program (CSS)

Target Population and Program Characteristics

The Multi-Service Center (MSC) Courtyard program serves residents ages 18 years or older who are living at the Courtyard homeless shelter in Santa Ana and have a serious and persistent mental illness and/or co-occurring substance use disorder. The mobile outreach team from the Multi-Service Center operates at the Courtyard

shelter seven days a week to link individuals to mental health and/or substance use services, including detoxification.

Services

Courtyard outreach workers assess residents' strengths and resources to determine their level of psychosocial impairment, substance use, physical health problems, support network, adequacy of living arrangements, financial status, employment status and basic needs. In coordination with BHS O&E staff operating at The Courtyard during traditional business hours, MSC outreach workers facilitate linkage to the most appropriate services for each individual (i.e., case management, outpatient mental health, medical appointments, housing, employment, SSI/SSDI and other services such as obtaining identification or other personal documents, etc.). The team can transport, or facilitate the transportation of, residents to those services as needed. The program provides services in Spanish, Vietnamese, Farsi and Korean.

Strategies to Increase Timely Access to Services for Underserved Populations

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. In FY 2017-18, the Courtyard Outreach made 8,194 contacts, 786 referrals and 577 linkages. In FY 2016-17, the program made 7,431 contacts, 896 referrals and 642 linkages.

Strategies to Reduce Stigma and Discrimination

Outreach workers often have lived experience and are knowledgeable about the field of chronic homelessness, mental health and substance use. They recognize that each person's diverse experiences, values and beliefs impact how they will access services. Using the principles of recovery, they are trained to identify the underlying conditions associated with homelessness and address them in a judgment-free manner. The staff also upholds cultural values that protect against discrimination and harassment on the basis of race, ethnicity, religion, sexual orientation, national origin, age, physical disability, medical condition, marital status or any other characteristic that may result in exclusion.

Challenges, Barriers and Solutions in Progress

The MSC Courtyard program strives to build stronger partnerships with the collaborative agencies and community groups focused on integrating the residents at the Courtyard into permanent housing. Communication among community partners is not only necessary but ideal to meet the immediate needs of the residents. The program has an on-site Outreach Lead to act as the liaison with these other agencies. The Lead also provides additional support to the team by attending meetings with the collaborative and ensuring that outcomes data are collected properly and presented in a timely manner.

Community Impact

The Courtyard mobile outreach team collaborates with a variety of human services and non-profit providers to help residents meet basic needs and obtain access to behavioral health services, housing, employment, public benefits and personal identification documents. By partnering with the collaborative agencies and the Courtyard residents, the Courtyard mobile outreach team is part of a shared goal to help break the cycle of homelessness among those living with serious mental illness.

Workforce Education and Training (WET)

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 covers 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 Latina/o, 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 Hard of Hearing and have limited English or other written language reading skills. In FY 2017-18, WET also provided two Mental Health First Aid (MHFA) trainings in Spanish to 29 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 BHTS 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 2017-18, there were 230 individuals who attended six trainings provided by consumer and family member presenters with lived-experience.

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 2017-18, REI provided 156 total trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% 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 2017-18, tuition incentives were provided to 22 staff, three of whom were undergraduates and 19 of whom were master's 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 2017-18, a total of six psychiatrists participated in the Loan Repayment Program.

Prevention and Early Intervention (PEI)

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

Community Counseling and Supportive Services (PEI)

Target Population and Program Characteristics

The target population for Community Counseling and Supportive Services (CCSS) includes Orange County residents of all age groups who have, or are at-risk of developing, a mild to moderate behavioral health condition and have limited or no access to behavioral health services. The majority of enrolled participants are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. The program is designed to treat the early symptoms of depression, anxiety, alcohol and/or drug use, violence and Post Traumatic Stress Disorder (PTSD). The early onset of mental illness is determined through referrals and screening. Participants are referred to the program by family resource centers, medical offices and emergency departments within the local community. The program also receives referrals from County-operated and County-contracted programs.

Services

CCSS provides face-to-face individual counseling and groups (i.e., psychoeducational, skill building and insight oriented), case management, and referral and linkage to community services. Psychiatric medication support and behavioral health nurse wellness evaluations are also provided for participants. Clinicians utilize evidence-based practices such as Eye Movement Desensitization Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants. The program provides services in English, Spanish, Vietnamese, Korean, Arabic and ASL.

Strategies to Promote Recovery/ Resilience

Clinicians use various strategies such as mindfulness practices, strengths-based approaches and motivational interviewing to reinforce and strengthen resilience in participants. Enrolled participants are engaged in individualized care planning to promote positive change. The clinic promotes recovery by creating an open, warm and safe place to receive care and individualized services.

Strategies to Improve Timely Access to Underserved Populations

Program participants experience barriers to engaging in services such as lack of childcare or transportation, an inability to take time off work to make counseling appointments during business hours, conflicting family priorities, financial burden, substance use, lack of a support system and mental health

stigma. To overcome these barriers, program staff participate in various outreach events in Orange County and through community presentations to de-stigmatize and break down barriers to mental health services. The program also offers evening hours, onsite childcare and bus vouchers for those without reliable means of transportation. In addition, the program provides bilingual/bicultural staff in the threshold languages to work with non-English speaking participants. The program also partners with community agencies to provide services to highly marginalized populations such as the Middle Eastern and North African refugee and the Deaf and Hard of Hearing communities via "satellite" locations to improve timely access to services. Finally, in FY 2018-19, the program has co-located a clinician with the Sheriff's School Mobile Assessment Resource Team (SMART) to provide comprehensive assessment of identified students at-risk.

For participants exiting the program, CCSS provides referrals to appropriate community services and resources in order to promote and sustain recovery. The program provided 298 referrals and 156 linkages in FY 2017-18 and 328 referrals and 157 linkages in FY 2016-17. The program primarily makes referrals and linkages to behavioral health services, legal services and advocacy, and health care benefits.

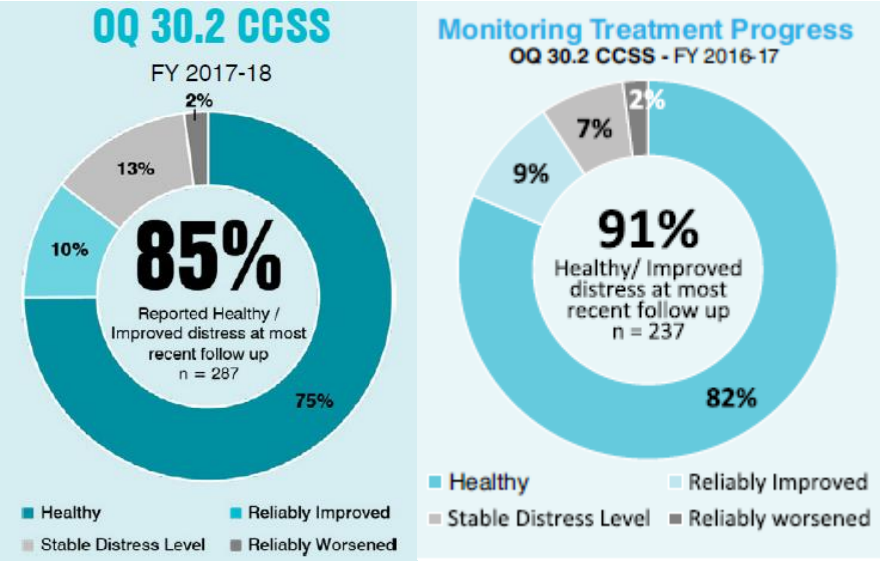
Strategies to Reduce Stigma and Discrimination

CCSS serves all eligible Orange County residents regardless of citizenship status. The program employs bilingual and bicultural staff to provide services in a culturally sensitive manner. As mentioned above, it has also partnered with community agencies that work with unserved populations who might be reluctant or unwilling to seek out treatment at a behavioral health clinic but will engage in services in non-behavioral health settings.

Outcomes

CCSS served a total of 492 participants during FY 2017-18 (29 children, 87 TAY, 357 adults and 19 older adults) and 467 participants in FY 2016-17 (34 children, 73 TAY, 344 adults and 16 older adults). Individuals completed an age-appropriate form of the OQ 30.2 at intake, every three months of program participation and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. This measure reflects cultural competence as it is available in all threshold languages and contains a wide range of symptoms, including somatic symptoms, which may be experienced and/ or reported by people from different cultural backgrounds.

Of the 492 participants who were served in FY 2017-18, 287 completed the OQ 30.2 at intake and at least one follow-up. In FY 2016-17, 237 of the 467 individuals served had completed both a baseline and follow-up assessment. Across both fiscal years, the overwhelming majority reported mental health distress levels that were either in the healthy/non-distressed range (FY 2017-18: 75%; FY 2016-17: 82%) or were reliably improved (FY 2017- 18: 10%; FY 2016-17: 9%) at the most recent follow-up. Thus, CCSS services were associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with a meaningful reduction in suffering among those who had reported clinically elevated distress levels upon entering the program.



College Veterans Program – Early Intervention Services (PEI)

Target Population and Program Characteristics

The College Veterans Program – Early Intervention Services provides services to military veterans and their family members who are enrolled at local college campuses. Participants served in this program tend to be between the ages of 22-57 years and, due to unique issues and challenges related to the transition from active military duty to civilian and student life, are at-risk of developing mental health conditions and/or of experiencing school failure. Student veterans are self-referred or referred by campus staff or faculty to this PEI program, which was established to meet a need identified by community stakeholders during the MHSA community planning process.

Services

The College Veterans Program places counselors who understand military culture in Orange County community colleges to help veterans navigate available support services and resources. Services include behavioral health screening and assessment to determine whether further evaluation and/or referrals to behavioral health services are needed, individualized case management, brief counseling, and referrals and linkages to appropriate community resources. Services are provided using evidence-based and best practices such as motivational interviewing. Through this program, participants also have access to appointments with a Behavioral Health Services clinician who is a veteran and can understand the unique issues and challenges faced by veterans transitioning to civilian and student life. These services are provided with the goal of helping them succeed at college by reducing their school failure or dropout rates and by reintegrating them into the community and their families. The program provides services in English.

Strategies to Promote Recovery/Resilience

College Veteran Program utilizes a master's level clinician who is also military-connected with lived experience. Utilizing a person-centered and strength-based approach, the interventions work to

address barriers to recovery or access to care and promote resiliency through encouraging healthy choices and positive coping mechanisms. The clinician is located on-site at the assigned campuses and is purposefully incorporated into the student health center or veteran resource center.

Strategies to Increase Timely Access to Services for Underserved Populations

Many participants have limited resources, such as limited or lack of transportation, housing, financial stability or support, adequate employment and/or daycare. Some participants, particularly with their military-connected background, may also hold cultural beliefs that deter them from asking for help. To address these barriers, the program is co-located on campus because there is far less stigma associated with school settings compared to mental health settings.

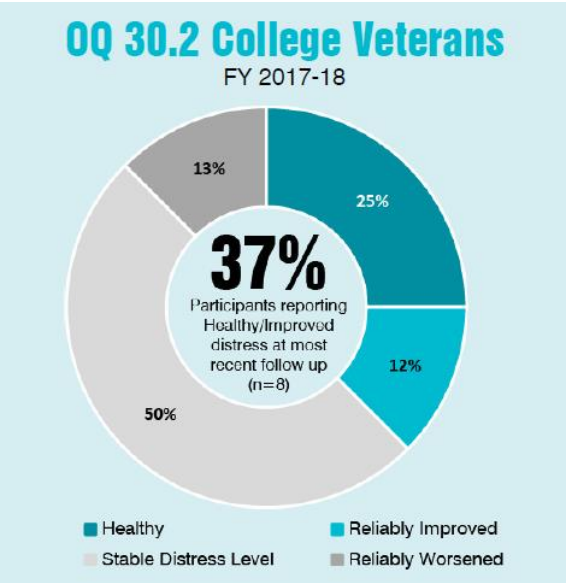
Clinicians also provide referrals to community-based services and supports as participant needs are identified. Once a referral is made, the clinician follows up with the participant to ensure they attended the first appointment. If a linkage did not occur, the clinician engages the veteran in discussions about the appropriateness of and their desire for change. Participants most frequently connected with transportation services; food and nutrition assistance; housing resources and advocacy; employment services and resources; adult education services; legal services and advocacy; behavioral health crisis response; behavioral health outpatient services; financial services; PEI programs; health care services; health education, disease prevention, wellness, and physical fitness; special needs and disability services; and veteran entitlement programs.

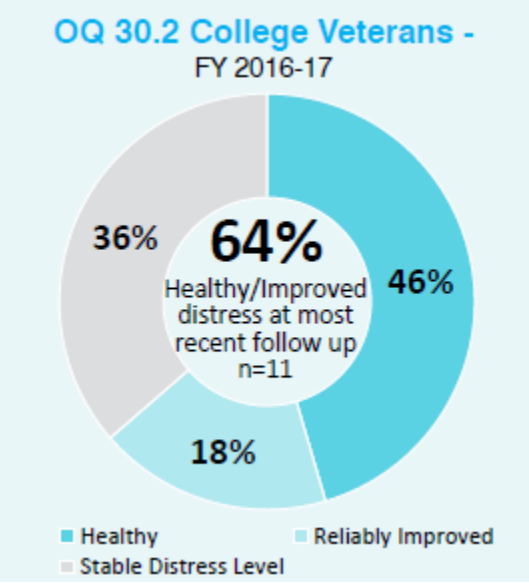
Strategies to Reduce Stigma and Discrimination

The program is staffed by military service members or veterans who can address the unique needs of student veterans, including the stigma associated with seeking behavioral health services and how those services might impact Veterans Administration (VA) benefits or be reported to the VA. The on-campus clinician provides frequent education to staff and faculty about ways to engage military-connected students with a culturally competent approach.

Outcomes

The College Veterans program served a total of 14 participants in FY 2017-18 and 27 participants in FY 2016-17. The program intended to administer the OQ 30.2 at intake, every three months and at discharge, and compare scores to the measure's clinical benchmarks. Due to implementation issues the measure was only administered at intake and discharge and paired measures were only available for 8 individuals in FY 2017-18 and 11 individuals in FY 2016-17. Among these, 37% in FY 2017-18 and 64% in FY 2016-17 reported healthy or reliably improved levels of distress at the time of discharge. While the findings demonstrate that the program prevented symptoms of mental distress from becoming severe and disabling for this small subset of participants, it is unclear whether this pattern of results is generalizable to the larger population of student-veterans served. Thus, the program is engaging in a two-fold process regarding its performance outcomes. First, it is working to improve its completion rate of the outcome measure and, second, it is working with program staff on how to utilize the OQ as a tool that can help inform clinical care.





OCACCEPT(PEI)

Target Population and Program Characteristics

OC ACCEPT provides community-based behavioral health and supportive services to individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ) and to the important people in their lives. OC ACCEPT 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. Referrals to the program are completed via telephone or walk-in. Self-referrals are preferred but other providers or family members may refer as well.

Services

OC ACCEPT provides a wide range of services to the Orange County community. Highly trained, skilled clinicians provide program participants with individual and/or family counseling using evidence-based therapeutic interventions such as cognitive behavioral treatment, motivational interviewing and other techniques. Peer specialists facilitate discussion groups; promote health and wellness activities; provide social, educational and vocational support; and offer targeted case management to help individuals access needed resources or meet other goal-specific needs.

In addition, OC ACCEPT raises awareness and reduces stigma by providing education about the LGBTIQ population to other mental health providers and the general community. The program provides services in English and Spanish.

Strategies to Promote Recovery/Resilience

OC ACCEPT works from a strengths-based approach that incorporates recovery principles by using motivational interviewing, working with participants to develop client-centered and individualized care plans and focusing on

participants' strengths.

Strategies to Improve Timely Access to Services for Underserved Populations

Factors such as stigma or lack of family support may inhibit individuals, particularly youth, from seeking services on their own. Limited transportation can also serve as barrier. To help address these challenges, the clinic is centrally located in Orange County, near major freeways and streets with access to public transportation. To increase access to care for those who are isolated, services can also be provided in the community.

In addition, for participants with additional needs and/or who are exiting the program, staff works to link them to community support.

Strategies for Reducing Stigma and Discrimination

OC ACCEPT provides educational and program promotion presentations to the community, including other behavioral health providers, school staff/faculty, public health staff, social services staff and other community members. The focus of these presentations is to educate the community about the needs, challenges and issues faced by the LGBTIQ population, as well as to reduce stigma and discrimination through raising awareness of the various barriers and issues this population faces. In FY 2017-18, OC ACCEPT participated in 54 community events and/or promotions that reached 1,499 attendees and provided 15 community education presentations/trainings to 393 attendees. In FY 2016-17 the program provided education, support and technical assistance to more than 1,880 community members through its collaborations with Orange County agencies and community groups such as the Wellness Center, The Center OC, Public Health, and local high schools and colleges.

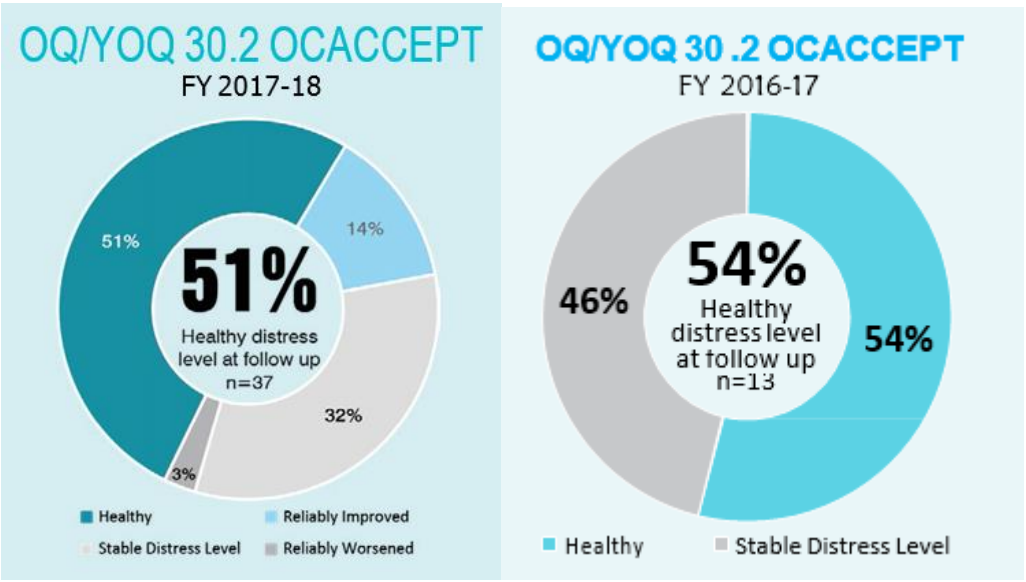
Outcomes

One hundred and twenty-one participants were served by OC ACCEPT during both FY 2017-18 and FY 2016-17. 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, 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 then to compare scores to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

In FY 2017-18, 37 of the 121 participants served, completed both the baseline and follow-up measure. Of the 37 with paired assessments, about half reported feeling healthy or reliably improved distress levels at follow-up, and another third reported stable distress levels. Similar patterns were observed In FY 2016-17 (54% healthy and 46% stably distressed at follow-up), although the program experienced challenges with implementation that year, particularly at follow-up, and only 13 of the 121 participants served had completed more than one valid assessment.

In addition, the program had enrolled participants experiencing severe and persistent mental illness at the time these measures were collected, which may account for the larger proportion of participants reporting stable functioning (as opposed to healthy and/or reliably improved

functioning) relative to other early intervention outpatient programs. As the intent of OC ACCEPT is to serve those who are experiencing mild to moderate mental health symptoms, the program has since implemented procedures to identify those with greater needs and refer them to the appropriate level of care. Thus, while OC ACCEPT has demonstrated some success at preventing symptoms of mental illness from becoming severe and disabling among the few who have completed measures, the conclusiveness 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:

- 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
- Make a change to an existing practice in the field of mental health, including but not limited to application to a different population
- 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 these projects is provided below. Additional project descriptions and outcomes are

available in the FY 2019-20 MHSA Annual Plan Update.

Strong Families-Strong Children: Behavioral Health Services for Military Families (INN to PEI)

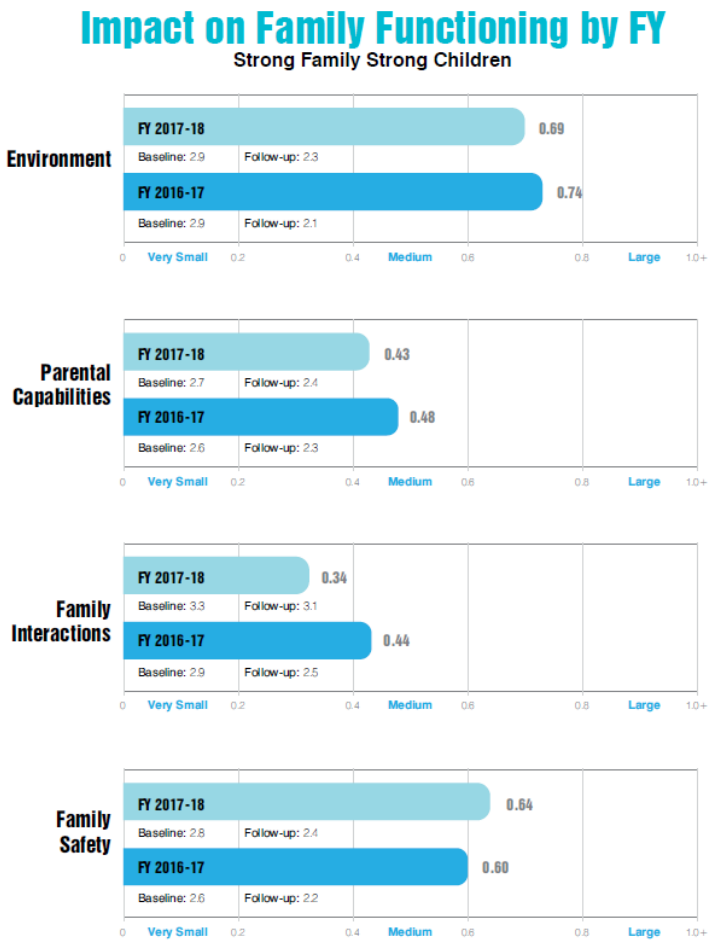
Behavioral Health Services for Military Families serves all members in the military family, including veterans, service members, spouses, partners and children. The project utilizes trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns 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. The program provides services in Spanish.

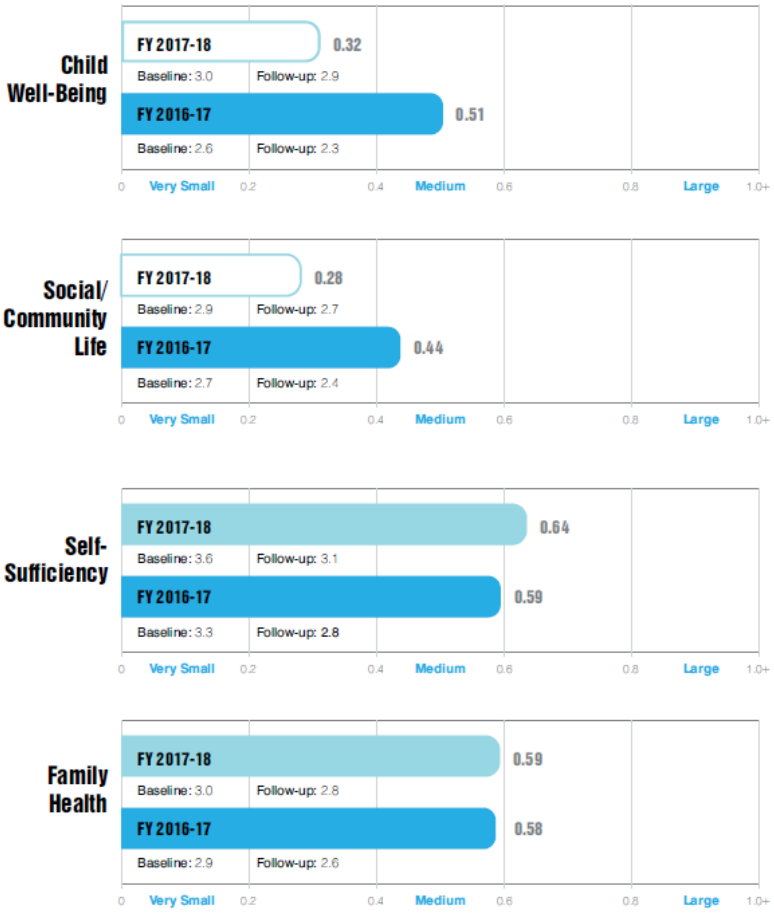
*This program transitioned from INN to PEI on July 1, 2019

Outcomes

Strong Families Strong Children (SFSC) served 49 families (n=323 individual family members) in FY 2017-18 and 40 families (n=288 individual family members) in FY 2016-17. The goals of the project were to improve family communication, functioning and overall well-being, which was assessed using the North Carolina Family Assessment Scale (NCFAS). The NCFAS assesses several domains of family functioning that are rated on a 6-point continuum, 0 (serious problem) to 6 (clear strength). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

Baseline and follow-up ratings on the NCFAS were provided for 40 families in FY 2017-18 and 49 families in FY 2016-17. Project services were associated with medium-to-large improvements in environment (e.g., housing stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health) in both fiscal years. Project services were associated with small-to-medium improvements parental capabilities (e.g., supervision of children), family interactions (e.g., relationship between caregivers) in social/community life and child well-being, with somewhat greater effects observed in these domains in FY 2016-17 compared to FY 2017-18. Taken together, these findings suggest that project services help families maintain and/or strengthen different aspects of family functioning, which can serve as an important protective factor for military families.


Impact on Family Functioning by FY
Strong Family Strong Children
Environment
FY 2017-18
0.69
Baseline: 2.9
Follow-up: 2.3
FY 2016-17
0.74
Baseline: 2.9
Follow-up: 2.1
Parental Capabilities
FY 2017-18
0.43
Baseline: 2.7
Follow-up: 2.4
FY 2016-17
0.48
Baseline: 2.6
Follow-up: 2.3
Family Interactions
FY 2017-18
0.34
Baseline: 3.3
Follow-up: 3.1
FY 2016-17
0.44
Baseline: 2.9
Follow-up: 2.5
Family Safety
FY 2017-18
0.64
Baseline: 2.8
Follow-up: 2.4
FY 2016-17
0.60
Baseline: 2.6
Follow-up: 2.2
0
Very Small
0.2
0.4
Medium
0.6
0.8
Large
1.0+



Continuum of Care for Veteran & Military Children and Families (INN)

The Continuum of Care for Veteran & Military Children and Families Innovation project provides behavioral health and peer support services to active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones. The project integrates military culture and services into Family Resource Centers (FRCs) located throughout Orange County to train non-veteran organizations on how to identify, screen and serve military connected families. It seeks to expand general service providers' knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population.

Services

The project is staffed with peer navigators who are co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military cultural awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project is also staffed with clinicians who, with the on-going support of peer navigators, provide counseling and trauma-informed care utilizing evidence-based practices.

This project was approved by the Mental Health Services Oversight and Accountability Commission on March

23, 2017. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to application to a different population. The project began services July 1, 2018. Innovation funds for this project will end June 30, 2022.

Strategies to Promote Recovery/Resilience

This project is staffed with peer navigators who have experience and knowledge of military culture. Peer navigators train FRC staff on military culture, thereby increasing military cultural awareness among non-veteran organizations. These efforts help promote recovery by building a stronger resource and support network to address the complex needs of veterans and their families.

Strategies to Increase Timely Access to Services for Underserved Populations

By providing services directly within the FRCs, project staff has the opportunity to connect with participants while they are seeking other services and provide them with timely access to needed behavioral health support and treatment, either directly or by linking them to community programs. The project also trains FRC staff on how best to meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population. More importantly, FRCs also serve as a new point of entry into behavioral health services, including supportive and treatment services, for military families. The support offered by a military-connected peer is expected to increase family members' access to needed services, especially behavioral health care, which they may be reluctant to seek on their own due to the stigma associated with mental illness. The project began on July 1, 2018. Referrals and linkages to County and/or community behavioral health services will be reported in future Plan updates.

Strategies to Reduce Stigma and Discrimination

This project is embedded in at-risk communities and brings veteran-specific services and support into an easily accessible, inviting and nonclinical setting. Military-connected families seeking FRC resources have the opportunity to access behavioral health services through a less stigmatizing point of entry. Peer navigators also connect with families by sharing their military backgrounds, which helps overcome fears of being misunderstood.

Outcomes

The project began July 1, 2018. Outcomes will be reported in future Plan updates.

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, 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 (LGBTIQ), 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. These services began in the last quarter of 2018 at Orange County Deaf Equal Access Foundation (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 counseling or psychoeducational groups. In this way, it is anticipated that more individuals will be aware of and able to access these important services.

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

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).

Community Action Advisory Committee

The MHSA Community Action Advisory Committee (CAAC) is a group of 15 individuals who are living with a mental health condition or who have a family member living with a mental health condition. The group meets on a monthly basis to discuss MHSA-related programs, review program outcomes and make recommendations to the MHSA Steering Committee on program/service needs and gaps from the consumer/family member perspective. A member of CAAC sits on the MHSA Steering Committee and provides updates on behalf of CAAC, related to community needs, funding ideas/requests, and any other issue related to consumers and family members.

Cultural Competence Committee

Recognizing the need for a dedicated (separate) Cultural Competence Committee, HCABHS 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 included 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 met three times in 2018 and worked on refining the vision and mission statements of CCC and developing smart goals for the 2018-19 fiscal year. The following is CCC's accomplishments summary for FY 2017-18:

- Since its inception May 2016 through October of 2019, CCC held 36 meetings (10 meetings in 2017-2018).
- More than 30 organizations/contract providers/county departments and programs were

represented at CCC meetings. Average number of attendees per meeting was 20. The membership roster is shown in the table below.

- Several presentations were made for/by the members covering the following topics:
    1. Lunar Year
    2. National Women's History Month
    3. Vernal Equinox -- Nowruz: Persian New Year
    4. Women's Equality Day
    5. Eid Al-Adha
    6. International Week of the Deaf
    7. Hispanic Heritage Month
    8. Indigenous/Columbus Day
    9. The Day of the Dead
    10. National Coming Out Day
    11. Martin Luther King Day
    12. Black History Month
    13. Cambodian New Year
    14. Asian American and Pacific Islander Heritage Month
    15. Cinque De Mayo
    16. Mental Health Matters Month
    17. Memorial Day
    18. National Minority Mental Health Awareness Month
- CCC members represented at MHSA Steering Committee meetings.
- CCC member represented at Spiritual Advisory Board meetings.
- Members participated in end of the year holiday celebration by sharing ethnic food and stories in 2016, 2017 and 2018.
- Increased awareness of cultural practices/traditions among CCC members/organizations through the 18 presentations listed above.
- Increased CCC members' involvement in field testing and developing mandatory annual training.
- CLAS – Cultural and Linguistically Appropriate Services (CLAS) Standards were reviewed.
- 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's members. The online training was launched on November 30, 2018 and within three months was completed by over 2,000 BHS staff and employees of contracted providers.
- 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.
- Cultural Competence Communication Partnership (CCCP) idea was developed at CCC,

presented to the agency management and taken on the road to several programs.

- Multilingual Afterhours Greeting project was developed at CCC and will be presented to the BHS's top management.

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

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

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.

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.

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.

- 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 use 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.

- 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.

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.

Cultural Competence Committee Roster – Member Affiliation, FY 2017-18

NAME	PROGRAM
1. Patricia Adelekan	Los Amigos
2. Gerry Aguirre	PRAS
3. Ellen Ahn	Korean Community Services
4. Karla Amezquita	MHSA
5. Bijan Amirshahi	MDP
6. Jennifer Belgarde	NAMI
7. Lucy Brimbuela	Palm Village
8. Lenora Burney	CAT
9. Helene Calvet	Public Health
10. Cyndi Cassil	OCVETS
11. Diane Chang	MDP
12. Irene Chiu	OCAPICA
13. Sophia Choeng	Cambodian Family
14. Leon Clark	New Spirit Baptist Church
15. Sylvia Cohen	Wellness Center
16. Danielle Daniels	HCA
17. Kevin DeWindt	AOABH
18. Francisca Leal	Latino Health Access
19. Annie Fung	CSUF
20. Miguel Gallardo	MECCA/Pepperdine University
21. Gonzalo Garcia	Santa Ana PD
22. Mary Hale	HCA

23. Michael Hill	Public Defender
24. Leslie Hillenbrand	NAMI OC
25. Paul Hoang	CAT
26. David Horner	AQIS
27. Nan Ibarra	NAMI
28. Ruben Ibarra	Santa Ana PD
29. Nedenia Lane	Public Guardian
30. Ye Lee	OCAPICA
31. Debbie Lent	HCA
32. Annie Li	Chinese Community Center
33. Annahita Mahdavi	Long Beach City College
34. Maryam Sayyedi	OMID/CSUF
35. Belinda McCleese	MDP
36. Jeff Nagel	HCA/MHSA
37. Tricia Nguyen	VNCOC
38. Vanessa Pearson	VietCare
39. Vattana Peong	Cambodian Family
40. Minh ha Pham	WET
41. Lorna Pham	LSP Consulting
42. Kenneth Pickering	WET
43. Steve Pitman	Pitman Insurance Associate
44. Rosie Quiroz	MDP
45. Teresa Renteria	OCVETS
46. Tina Rocha	OCAPICA
47. Loreta Ruiz	Latino Health Access
48. Paul Russell	OCIAC
49. Kevin Smith	MDP
50. Renee Thomas	OCDEAF
51. Anette Tran	PRAS
52. Pierre Tran	MDP
53. Candace Trevino	SSA
54. Ana Tutila	CAAC
55. Crystal Valencia	OC ACCEPT
56. Illiana Welty	MECCA
57. Brittany Whetsell	WET
58. Brenda Wilson Codispoti	SSA
59. Desbah Yazzie	Latino Health Access
60. Elizabeth Zayas	OC Links
61. Natalie Nguyen	AOABH

62. Mikel Hogan	CSUF
63. Deana Helmy	WET

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.

The County Mental Health Plan shall encourage all Staff and Contractors to Receive Cultural Competence Trainings

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.

Cultural competence must be embedded into all trainings requiring Continuing Education (CE) 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.

Annual Cultural Competence Training

Cultural Competence trainings are 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.

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

Table 5.1 below is a chart that provides information on the culturally competent trainings provided during FY 2017-18.

5.1 Name of Cultural Competency Trainings, FY 2017-18

	Count of Training Title	*Number of Attendees*	*Combined Training Hours*	*Combined CEs Given*
Cultural Competence Training for Staff & the Community	7	563	26.8	24
Bio-Spiritual Focusing: Listening to the Wisdom of the Body	1	51	3.15	3
Caring for Gender Nonconforming and Transgender Youth	1	149	6.5	6
Clinical Considerations when Working with Patients and Families from the Sikh Faith	1	21	2	2
Mindful Listening	1	87	3.15	3
Role of Forgiveness in Psychotherapy	1	68	2	2
Spirituality in Therapy: A Developmental Model	1	49	2	2
Veteran Conference	1	138	8	6
Mental Health Training for Law Enforcement[2]	26	400	1	1
Crisis Intervention Training I (CIT)	12	302	0	0
Crisis Intervention Training II (CIT)	7	49	0	0
Crisis Intervention Training III (CIT)	2	15	0	0
Working with Sign Language Interpreters	3	31	1	1
Working Effectively in Behavioral Health Setting with Sign Language Interpreters	2	3	0	0
Training on Evidence-Based Practices	48	1,351	2,895.9	54
CBT and Relapse Prevention Strategies (SARC)	1	55	7.5	0
Dialectical Behavior Therapy	1	249	19.5	18
EMDR 5-Hour Consultation	1	7	5	0
EMDR Monthly Consultation	2	11	1.15	0
Mental Health First Aid (Adult and Youth)	19	351	2,808	0
Motivational Interviewing (SARC)	1	72	7.5	0
Non-Violent Crisis Intervention (AOABH)	3	36	7.15	6
Non-Violent Crisis Intervention (CYBH)	10	185	7.15	6
Non-Violent Crisis Intervention (Half Day - AOABH)	3	38	3.15	3

[2] CIT is a series based training. In order to gain certification, participants must complete 16 hours of CIT I, 8 hours of CIT II, and 16 hours of CIT III which totals to 40 hours.

SBIRT (SARC)	1	17	4.15	0
Seeking Safety	2	82	6.5	6
Substance Use Disorders 101 (SARC)	1	77	3.15	0
Trauma Focused - Cognitive Behavioral Therapy	2	90	14	13
Treating Trauma and Substance Use: A Mindfulness-Based Multi-Modal Approach	1	81	2	2
Training Provided by Consumers & Family Members for Staff, Consumers/Family Members and the Community	6	230	20.5	18.5
NAMI	4	80	17	15
Recovery: The Promise of Hope	2	150	3.5	3.5
Workforce Education &Training Coordination	102	2,556	95.5	37
5150 - LPS Initial Certification Training	5	162	8	5
5585 - Designation Training & Certification	3	88	7.5	4.5
Active Shooter	2	194	2	0
ASAM A	1	65	5	0
ASAM B	1	46	5	0
ASAM C	2	70	5	0
Clinical Supervision	2	148	7.5	6
Continuum of Care	1	34	6	4.5
Housing & Placement	4	163	28	0
Law & Ethics	2	272	7.5	6
Meeting of the Minds	1	101	8	5
Patient's Rights Respect & Dignity	1	15	0	0
Raising Awareness About First Episode of Psychosis	4	45	2	2
Rights for Individuals in Inpatient Mental Health Facilities	29	563	1	1
Rights for Individuals in Outpatient Mental Health Facilities	19	226	1	1
Vicarious Trauma	25	364	2	2
Total	*189*	*5,100*	*3,039.7*	*134.5*

5.2 Cultural Competency Training Attendance by Participant's Professional Role, FY 17-18

Attendance by function*	Total Number	Percentage
County Administrator/Manager	373	9.4%
County Direct Service Provider	1,495	37.7%
County Support Staff	346	8.7%
Community-Based Administrator/Manager	369	9.3%
Community-Based Direct Service Provider	951	24.0%
Community-Based Support Staff	430	10.8%
Total	***3,964***	***100.0%***

*Some attendees reported multiple professional roles

5.3 Cultural Competency Training Attendance by Participant's Personal Role, FY 17-18

Attendance by function*	Total Number	Percentage
Consumers	541	12.5%
Parents	623	14.4%
Family Members	698	16.1%
Community Members	1,056	24.3%
Caregivers	612	14.1%
Teachers	107	2.5%
Students	196	4.5%
Youth	35	0.8%
Others	473	10.9%
Total	***4,341***	***100.0%***

*Some attendees reported multiple personal 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, LGBTIQ, SES, Elderly, Deaf and Hard of Hearing, disabilities, etc.)
   vi. Mental Health Interpreter training
   vii. Training staff in the use of mental health interpreters

Counties Must have a Process for the Incorporation of Client Culture/Family Member Culture Training Throughout the Mental Health System

Descriptions of some culturally competence trainings offered during FY 2017-18 are included in the table below.

Training Title	Description	Presenter(s) Name
Culturally Sensitive Clinical Supervision: Ensuring Competence in Our Diverse World Date: 08/29/17	In this six-hour course, participants will receive core knowledge of culturally sensitive clinical supervisory practices and learn how to incorporate multicultural competence when dealing with legal/ethical issues in supervision. Supervision issues including boundaries and workplace professionalism will be discussed from a standpoint that honors diversity, along with suggestions for how to incorporate culturally sensitive approaches to supervising peer mentors/peers with lived behavioral health experience.	Mary M. Read, Ph.D., LMFT
Culturally Sensitive Clinical Supervision: Ensuring Competence in Our Diverse World Date: 04/11/18	In this six-hour course, participants will receive core knowledge of culturally sensitive clinical supervisory practices and learn how to incorporate multicultural competence when dealing with legal/ethical issues in supervision. Supervision issues including boundaries and workplace professionalism will be discussed from a standpoint that honors diversity, along with suggestions for how to incorporate culturally sensitive approaches to supervising peer mentors/peers with lived behavioral health experience.	Mary M. Read, Ph.D., LMFT
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.	Bijan Amirshahi, LMFT, LPCC

	Strategies are also provided to recognize diversity and embrace uniqueness of other cultures beyond the mainstream American culture.	
Legal and Ethical Considerations Date: 11/07/17	This six-hour training focuses on client-therapist situations that exemplify various complex ethical dilemmas such as (1) risk management specific to cultural competency, (2) self-awareness and working with diversity, (3) dealing with dangerous clients (Tarasoff and its progeny), and (4) working with families and minors with emphasis on diversity.	Pamela Harmell, Ph.D.
Law & Ethics: Client Welfare, Therapist Responsibility Date: 05/22/18	This workshop addresses therapist's responsibility to ensuring patient welfare in all aspects of practice. Participants will learn to deal with ethical dilemmas such as (1) Domestic Violence, assessment and detection, legal issues related to child abuse, custody issues and teens, (2) When therapist values conflict with patient values (highlighting two precedent setting legal cases), (3) Suicide assessment (now required by the Board of Psychology including the opioid crisis and suicide), (44) Current ethical standard of care in the world of technology, Skype, FaceTime, texting, social media and HIPAA compliance, (5) Subpoenas and court orders. Literature updates, along with relevant Codes of Ethics and current expert opinion will be included in all areas of discussion. This program reviews current research findings and knowledge that inform the practice of ethical and legal practice.	Pamela Harmell, Ph.D.
Meeting of the Minds "Without Mental	Bring together the full spectrum of the mental health community of Orange County; Raise awareness, enhance skills,	Keynote Speaker: Paxton Dickerson

Health, There is NO Health" Date: 05/30/18	increases cultural sensitivity and reduce stigma; Share information, strengthen existing relationships, network and develop new alliances; Improve patient care and quality of life for persons impacted by mental illness.	OCHCA presenters: Gerry Aguirre Patricia Hikida Teri Williams Lance Lindgren Della Lisi Kerr OC Public Guardian: Nathan Obbards Elvira Dodd
Recovery: The Promise of Hope Date: 09/28/17	In two parts, this training will address issues related to the process of recovery from mental illness and substance use. In the first half, recovery will be defined, and guiding principles and the risk factors affecting recovery will be discussed in depth including brief video clip interviews with five individuals in the process of recovery. In the second half, the same five individuals with "Lived Experience" will share their stories of recovery with the audience, following by a question and answer session.	Bijan Amirshahi, LMFT, LPCC
Recovery: The Promise of Hope Date: 11/29/17	In two parts, this training will address issues related to the process of recovery from mental illness and substance use. In the first half, recovery will be defined, and guiding principles and the risk factors affecting recovery will be discussed in depth including brief video clip interviews with five individuals in the process of recovery. In the second half, the same five individuals with "Lived Experience" will share their stories of recovery with the audience, following by a question and answer session.	Bijan Amirshahi, LMFT, LPCC
Treating Trauma and Substance Use: A Mindfulness-Based Multi-Modal Approach Date: 07/25/17	This two-hour training will explore how chemical dependence treatment has come a long way over the centuries, particularly since the advent of Alcoholics Anonymous over 80 years ago. For the past 2,600 years, the evolving therapeutic applications and practices of Buddhist Mindfulness has contributed to the psychological and spiritual relief of millions of people. In the past 30+ years, the understanding and	Dr. Stephen Dansiger, Psy.D., MFT

	treatment of trauma-related disorders and difficulties have progressed, particularly through the development of Eye Movement Desensitization Reprocessing therapy and other modalities. This workshop will explore the link between traumatic experiences, regardless of whether Post Traumatic Stress Disorder is present, and the challenges associated with substance use and dependence. SAMSHA (2014) and others have indicated the need for chemical dependent treatment to follow the principles of trauma informed care. This workshop will present a template for integrating all of this knowledge and practice into a design for chemical dependence treatment.	
Clinical Considerations when Working with Patients and Families from the Sikh Faith Date: 09/26/17	This is a two-hour training for clinicians, supervisors, and community partners and will include a discussion of the history, basic beliefs and practices of the Sikh community. Spiritual beliefs, core values and lifestyle of Sikhs and the implication on medical treatment will be covered. Some examples of the challenges identified for clinicians/consumers will be discussed. Clinicians will be exposed to the realities and misconceptions about the Sikh religion and identity so that treatment can move forward in a way that is useful for clients and authentic clinicians.	Dr. Jasjit Singh, M.D.
Communicating Effectively with Deaf & Hard of Hearing Date: 11/07/17 (CIT I) Ongoing (CIT II) Ongoing	In this course participants will have an opportunity to learn the significance of the impact of mental health issues upon the Deaf and Hard of Hearing population, describe a few auxiliary aids/services for the target population required by ADA, identify different ways to communicate effectively with the target population, and explain the four steps that can help to approach the target population. The goal is to provide the guidelines on how to identify the target population's communication needs and to have effective communication with them.	Belinda McCleese, LMFT

Exploring the Role of Forgiveness in Psychotherapy Date: 10/24/17	This two-hour training for County clinicians, supervisors and community partners will explore the role of forgiveness in psychotherapy. The training will define aspects of self-forgiveness and forgiveness of others, as well as address various cultural aspects of forgiveness. The training will also include a review of the current research on the effects of forgiveness therapy interventions on mental and physical health, and provide evidence-based practices and clinical implications of forgiveness interventions.	Anindita Gunguly, Ph.D. Mark MacMillin, Psy.D.
Mindful Listening: Foundations in Mindfulness for Ourselves, Work and Client Interactions Date: 11/01/17	This three-hour experiential training for County clinicians, supervisors, and community partners will address the particular practice of Mindful Listening for use with clients. The training will include and introduction to Mindfulness – the practice of being in the present with intention and nonjudgement. Research showing the benefits of mindfulness practice for both clinicians and clients will be presented. Mindful Listening tools will be covered, along with opportunities to practice. Finally, this training will discuss ways mindfulness practice might be further integrated into personal life, work life, and professional life with clients in ways that are useful for clients and authentic for clinicians.	Gail Stearns, M.Div., Ph.D.
Spirituality in Therapy: A Developmental Model Date: 01/31/18	This two-hour training will provide a brief overview of literature on the role of spirituality in therapy, introduce a developmentally based psychotherapy model where spirituality may enhance therapy process, and explore whether or not spirituality should become part of the therapeutic process. The training will also provide an opportunity for the participants to assess their own spirituality from a developmental perspective. Finally, participants will review a case vignette and discuss the client's spirituality and its role in	Maryam Sayyedi, Ph.D.

	the therapy process.	
Caring for Gender Nonconforming and Transgender Youth Date: 12/11/17	Gender dysphoria is best understood as the ongoing distress about the incongruence between one's assigned sex and one's internal gender identity. This ongoing distress frequently results in impairment of function. To help alleviate this distress, many transgender youth require physical changes to their bodies to bring them into closer alignment with their internal gender identity. Unfortunately, access to competent mental health and medical care for those youth desiring physical gender transition is still extremely rare and often inadequate in most places around the United States. This 6-hour training will provide clinically relevant information about the medical and mental health care needs for gender non-conforming youth and transgender adolescents and young adults and the impact gender dysphoria has on the psychosocial well-being of youth and young adults. While primarily didactic in presentation, this training will also include case studies and experiential activities.	Johanna Olson-Kennedy, MD Susan Landon, LMFT Aydin Olson-Kennedy, ACSW
Veteran's Conference Date: 09/20/17	The Community Behavioral Health Summit provides an opportunity to engage in active dialogue on how we can address the needs of our Veterans and their families and also seek collaborative support for those needs. We intend to accomplish this goal by discussing ways we work together in order to help our Veterans and their families build resiliency. Our end goal is to promote a seamless continuity of care for our Veterans and their families both in and out of the VA. Topics of discussion will include Veteran suicides, supporting military families, adjustment issues for returning Veterans, accessing care at the VA (including information on the Clay	Speakers: Kathleen West, MPH, DrPH Dylan Bender, MA, LMFT Marshall Thomas, Ed.D. OCHCA: Della Lisi Kerr

	Hunt Act and care for OTH discharges), and more. This year's summit will include keynote speakers and breakout sessions.	
Working Effectively in BH with Sign Language Interpreters (Ongoing)	In this course participants will have an opportunity to learn the primary role of interpreter, gain understanding of the possible negative impact of the use of family member(s) as interpreter upon the therapeutic procedure and gain awareness of the importance of clinician briefing with interpreter before and after sessions. Additionally, the participants will learn the four different interpersonal dynamics between clinician, client and interpreter: and the impact of the use of interpreter upon family dynamics. The goal is to provide the guidelines on how to work effectively with sign language interpreters in the mental health setting.	Belinda McCleese, LMFT
Working with Sign Language Interpreters (Ongoing)	In this course participants will have an opportunity to learn the significance of the impact of mental health issues upon the deaf and hard of hearing population, gain understanding of the four different definitions of deafness, and gain exposure to the relationship with Americans with Disability Acts and providing qualified sign language interpreters. The goal is to provide the 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

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 by the Office of Statewide Health Planning and Development (OSHPD) for the Workforce Education and Training (WET) component. The results submitted to the Office of Statewide Health Planning and 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 September 2019, was a collaborative effort between the County's Behavioral Health Training Services (BHTS) department 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.

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 Mental Health Workers, General Psychiatrists, Psychiatric Mental Health Nurse Practitioners, Executive Management Staff, and Mental Health Specialists.

6.1 Number of PMHS Employees and Vacancies, September 2019

	N
Total Number of Current PMHS Employees	1,282
Total Number of PMHS Vacancies	202
Total Number of Current PMHS Direct Service Filled Positions[1]	616
Total Number of Current PMHS Direct Service Vacancies	105

[1] The total number of current PMHS direct service filled positions does not include Executive and Management staff (see table 6.2, *n* = 35). The numbers presented in this table are reflective of only staff who provide direct services to the community. If Executive and Management staff were included, a total of 651 BHS positions would be filled.

6.2 Currently Filled and Vacant BHS Positions, September 2019[1]

	Number of Positions Filled	*Number of Vacancies*	*Total Number of Positions*
Licensed Clinical Social Worker	382	56.5	438.5
Mental Health Specialist	79	13	92
Licensed Clinical Psychologist	57	6	63
Executive and Management Staff	35	7	42
Mental Health Worker	16	16	32
Psychiatrist - Child and Adolescent	25.5	2	27.5
Psychiatrist - Geriatric	23	2	25
Psychiatric Mental Health Clinical Nurse Specialist	18	3.5	21.5
Psychiatric Mental Health Nurse Practitioner	14	5	19
Psychiatrist - General	1.5	1	2.5
Total	***651***	***112***	***763***

[1] Position classifications not currently used in Orange County include Case Manager, Licensed Marriage and Family Therapist, Licensed Professional Clinical Counselor, Licensed Psychiatric Technician, Occupational Therapist, Physician Assistant, Substance Abuse/AOD/SUD Counselor.

Positions Designated for Consumers or Family Members

There is a need in Orange County to fill vacancies in our peer specialist workforce, also known as Mental Health Workers, who provide services. As of September 2019, 50% 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	16
Number of Vacancies	16
Total Peer Positions Available	32

Language Proficiency

There are five threshold languages in Orange County. These are, Spanish, Vietnamese, Farsi, Korean and Arabic. As of September 2019, all employees in Orange County's BHS system spoke English (*n* = 1,282). Of the 627 BHS staff who spoke a language other than English, 79.3% of the workforce were able to provide services in Spanish, 13.9% in Vietnamese, 2.6% in Korean, and 1.9% in Farsi. (Table 6.4.) However, there is a need for more staff who speak Arabic, which is another threshold language in Orange County. As of September 2019, only three BHS staff members spoke this language (0.5%). Additionally, to better understand the staff who could provide bilingual services to those in the community, an analysis of job classification by language was conducted. Staff mostly likely to indicate they could provide bilingual services included Behavioral Health Clinicians, Office Specialists, Mental Health Specialists, Office Assistants and Office Technicians.

*6.4 Languages Spoken by BHS Staff, September 2019**

	Frequency	Valid Percent
Spanish	497	79.3%
Vietnamese	87	13.9%
Korean	16	2.6%
Farsi	12	1.9%
Other Languages	14	2.2%
Multiple Languages	1	0.2%
Total	***627***	***100.0%***

**Languages with fewer than 10 bilingual staff included American Sign Language, Arabic, Cambodian, Cantonese, Chinese, French, Hindi (Urdu), Japanese, Mandarin, Romanian, Russian, Tagalog.*

6.5 Number of Bilingual Staff, by Position, September 2019

	Spanish	*Vietnamese*	*Korean*	*Farsi*	*Multiple Languages*	*Other Languages*	*Total*
Behavioral Health Clinician I-II	154	32	12	4	0	6	208
Office Specialist	103	10	0	2	0	1	116
Mental Health Specialist	52	16	1	0	0	3	72
Office Assistant	41	1	0	0	0	0	42
Office Technician	31	4	0	0	0	1	36
Clinical Psychologist I-II	15	2	1	2	0	0	20
HCA Service Chief I-II	13	4	0	1	0	1	19
Information Processing Technician	18	0	0	0	1	0	19
Mental Health Worker I-II	16	1	0	0	0	0	17
Office Supervisor B-D	13	0	0	0	0	0	13
Staff Specialist	12	1	0	0	0	0	13
Staff Assistant	7	5	0	0	0	0	12
Psychiatrist	3	4	1	1	0	0	9
Information Processing Specialist	5	1	0	0	0	1	7
Community Worker II	6	0	0	0	0	0	6
HCA Program Supervisor I-II	4	0	0	2	0	0	6
Administrative Manager I-III	2	3	0	0	0	0	5
Behavioral Health Nurse	1	2	0	0	0	1	4
Health Program Specialist	0	1	1	0	0	0	2
Research Analyst IV	1	0	0	0	0	0	1
Total	***497***	***87***	***16***	***12***	***1***	***14***	***627***

CRITERION 7: LANGUAGE CAPACITY

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

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 to 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.

Interpreter Services for Persons who have Limited English Proficiency (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 either by phone or through live-chat at www.ochealthinfo.com/oclinks.
- A 24-hour Crisis Assessment Team (CAT) toll–free number (866-830-6011) that individuals can call if they believe they have a mental health crisis.
- A Suicide Prevention Hotline phone number: 1-877-727-4747 (1 877-7CRISIS). This hotline is available in our threshold languages.
- The NAMI Warmline 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 Warmline 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.

For *over-the-Phone Interpretation Services* participants can call 1 (844) 898-7557. During this call, they should indicate the language services needed in, input a 4 digit unit number, and provide the caller's name and telephone number.

For *on-site (in-person) requests*, participants complete the Onsite Interpreter Request Form and email it to: onsiterequests@fluentLS.com.

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

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 7.5 reflect the interpretation and translation services utilized during FY 2017-18. During this fiscal year, in-house interpretation and translation services were provided by the Multi-Cultural Development Program. Interpretation services were also provided by Language Line, a contracted program with HCA. Additionally, American Sign Language services were contracted through an external program called Western Interpreting Network (WIN).

Between July 1, 2017 and October 30, 2017, interpretation services were provided by Interpreters Unlimited. Starting in November of 2017, Language Line began providing over the phone interpretation services to several behavioral health programs across Orange County. In FY 2017-18, these programs facilitated 2,026 calls, which accumulated to roughly 529 hours of telephone interpretations (see Table 7.1). Additionally, the majority of phone interpretation services provided during FY 2018-19 were in Spanish, followed by Vietnamese, Mandarin, Korean and Arabic. In FY 2017-18, out of the 1,280 total calls, roughly 87% were made in one of those languages.

7.1 Total Number of Telephone Interpretation Services Provided by Month, FY 17-18

	Number of Calls	Minutes on Call	Facilitated Hours
July-17	120	1,576	26
August-17	150	2,687	45
September-17	118	1,707	28
October-17	124	2,113	35
November-17	156	2,375	40
December-17	162	2,107	35
January-18	131	1,916	32
February-18	182	2,760	46
March-18	249	3,824	64
April-18	203	3,240	54
May-18	212	3,586	60
June-18	219	3,850	64
Total	*2,026*	*31,741*	*529*

Source: Language Line and Interpreters Unlimited (FY 2017-18).

7.2 Top Five Over the Phone Translation Requests, FY 17-18

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	677	10,090	168
Vietnamese	222	3,757	63
Mandarin	114	2,170	36
Korean	58	1,091	18
Arabic	52	663	11
Total	***1,123***	***17,771***	***296***

Source: Language Line

Health Care Agency departments that most often requested language translation services included, MHSA Community Supportive Services (Children and Adults), MHSA Prevention and Early Intervention Services, Correctional Mental Health, and Children Youth Behavioral Health Services (see Table 7.3).

7.3 Behavioral Health Programs to Request Interpretation Services, FY 17-18

	Number of Calls	Minutes on Call	Facilitated Hours
MHSA - Community Supportive Services - Adults	431	6,251	104
MHSA - Community Supportive Services - Children	175	3,614	60
MHSA - Prevention and Early Intervention	101	1,214	20
Correctional Mental Health	72	922	15
Children and Youth Services	57	931	16
Adult Mental Health Services - Outpatient/Crisis	31	699	12
Alcohol and Drug Use Services	13	111	2
Behavioral Health Services Administration	3	50	1
Adult Mental Health Services - Inpatient/Housing	2	28	0.47
MHSA - BHTS (WET), Innovation, Capital, Info Tech	1	1	0.02
Total	***886***	***13,821***	***230***

Source: Language Line

Staff from the Multi-Cultural Development Program also provide in-person interpretation services (see Table 7.4). Similar to Language Line findings, in-person translation services were also provided, primarily in Spanish and Vietnamese. In FY 2017-18, there were 176 requests for ASL interpretation services and a total of 407 hours were billed by various HCA programs.

7.4 Hours Billed for In-Person Interpretation

	Number of Interpretations	Facilitated Hours
Spanish[1]	31	51
Vietnamese[1]	34	65
American Sign Language[2]	176	407
Total	***241***	***523***

[1] *WET Interpretations Log Database, FY 17-18*
[2] *Western Interpreting Network, FY 17-18*

The Multi-Cultural Development Program also helps with creation and review of document translations (see Table 7.5). This could include PowerPoint presentations, brochures, and surveys that are used across BHS. During FY 2017-18, document translation requests were primarily made for Vietnamese, Spanish, Farsi and Arabic. This accounted for 85% of the total number of document translation requests.

7.5 Document Translation Requests by Threshold Language, FY 2017-18

	Total Number	Percent
Vietnamese	65	30%
Spanish	50	23%
Farsi	35	16%
Arabic	34	16%
Korean	30	14%
Other	2	1%
Grand Total	***216***	100%

Source: WET Interpretations Log Database, FY 17-18

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:

- 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.
- 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.
- 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.

- 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

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:

- "Services shall be active in supporting and implementing the program's philosophy and its individualized, strength- based, culturally/linguistically competent and Consumer-centered approach."
- "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 Consumer's worldview and belief systems and to enhance the therapeutic relationship, intervention and outcome. Consideration to how Consumer's identify in terms of race, ethnicity, sexual orientation and spirituality shall be considered when developing and providing services."
- 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."