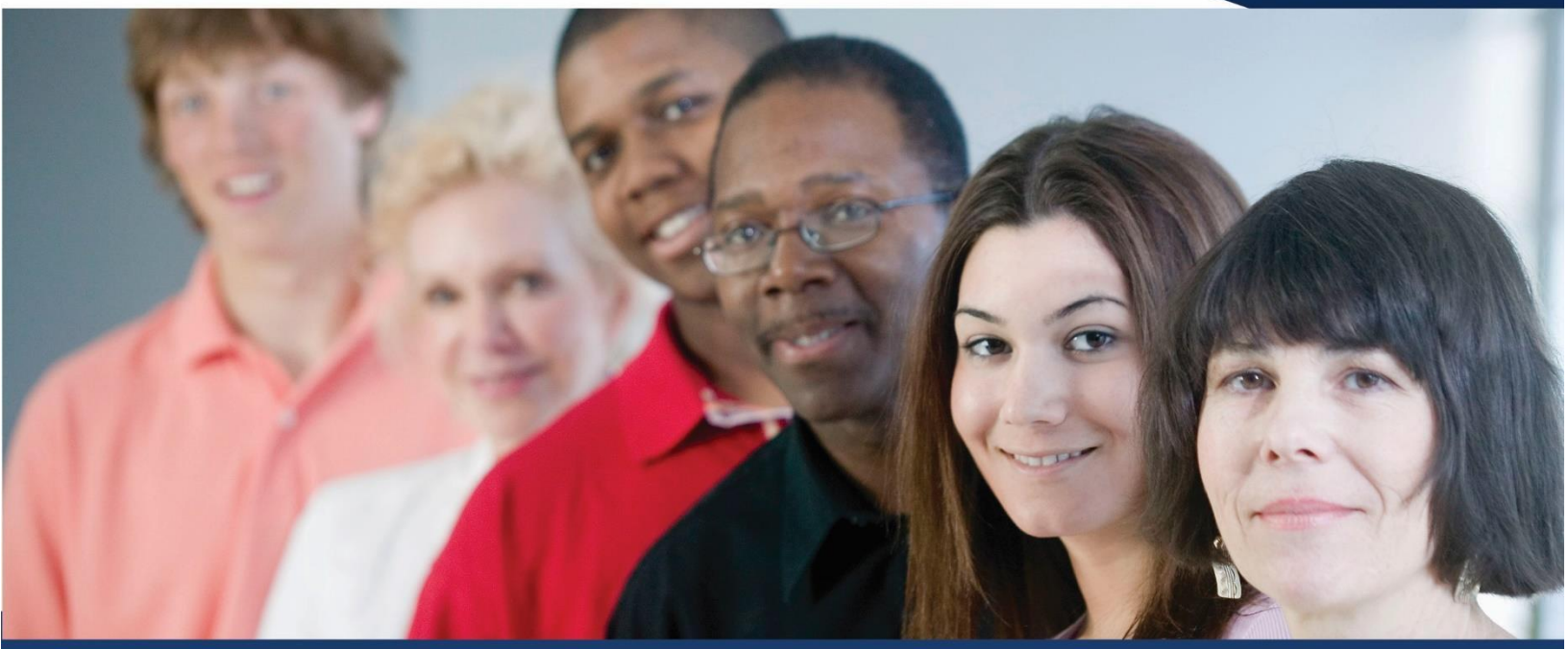

2020 Cultural Competence Plan Update

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Director's Message

Dear Colleagues and Partners:

This past year of 2020 may be remembered as one of the most challenging years in this nation's history. From the maelstrom of a global pandemic, to a bitterly divisive Presidential election, to an attack on the Capitol and uprisings in many cities throughout the country, the United States has been shaken to its foundations by problems, both internal and external. Certainly, the tragic killing of George Floyd, and many others over the years sparked unrest, but hopefully also caused a renewed commitment to rectify the unjust treatment of all ethnic and cultural minorities throughout the country.

Now, more than ever, we as an agency need to pay attention to our own cultural awareness and sensitivity, not only as staff members, but in how we reach to, and interact with the community-at-large. As we do our work, it is incumbent that we do so from a health equity perspective – addressing longstanding inequalities in service delivery and outcomes based on race, ethnicity, and culture.

While adapting and adjusting to address the Public Health Emergency resulting from the Coronavirus pandemic, we have attempted to deliver behavioral health services that meet the social, cultural, and linguistic needs of our consumers, especially through increased access and outreach. During this past year:

- We quickly re-invented ourselves to operate on a tele-health platform with multiple tele-health kits being placed at 21 different worksites. This was done to minimize service disruption to the greatest possible extent.
- We secured CARES Act funding to stand-up several programs to address the growing health disparities with ethnic and minority populations. Programs included targeted outreach into the ethnic minority populations, older adults, and Veterans in Orange County to provide COVID related support and resources.
- We reviewed the findings of the OC Equity Report and explored ways to operationalize the suggested goals in order to meet the needs of a diverse and disparate community.
- We created the office of Population and Health Equity whose sole mission is to guide the agency in better meeting the needs of our communities.
- We reorganized the Cultural Competence Committee into the Behavioral Health Equity Committee. The model for this plan was also taken from SAMHSA, and now institutes a much closer working relationship with the community by establishing consultative bodies within the committee structure. This change will allow a greater reliance on cultural humility by developing public-private partnerships with the community that can actively bring change and increased equity to the provision of behavioral health services and a reduction of mental health stigma in our communities.

Based upon these goals and guiding principles, we offer our 2020 Cultural Competence Plan Update. The plan remains grounded in the philosophy of SAMHSA's Recovery Model and seeks to reach out to the community in close collaboration, to assist in building a more resilient and hopeful Orange County in the coming years. HCA continues to believe that individuals with mental illnesses or addictions can recover and be members of a thriving community. Therefore, it is our hope that this Cultural Competence Plan Update will help move Behavioral Health Services further along the journey toward increased mental health equity for those whom we serve.

Jeffrey A. Nagel, Ph.D.
Behavioral Health Director

Introduction

The history of Orange County is one of significant racial, ethnic, cultural, and linguistic diversity. From the beginning of human habitation, a yet unknown people occupied these plains, hills, valleys, and mountains. They hunted, fished, and gathered plants and seeds for both food and medicinal purposes. Later, Shoshonean-speaking people arrived, becoming the progenitors of those whom we know today as the Juañeno and Gabrielino people.

Beginning in 1769, Spain, which had laid claim to Alta California some 200 years earlier, began to send Catholic missionaries and Spanish soldiers to colonize the area, establishing a chain of missions and forts that would become essential to understanding California history. Father Juñipero Serra founded Mission San Juan Capistrano on November 1, 1776 amidst grazing cattle, sheep, and horses of the southern coastal plain, thus beginning an extended period of European settlement in what is today Orange County.

In 1821, Alta California passed into the hands of the newly independent Mexican government. Land grants of up to 44,000 acres were granted to Mexican citizens who agreed to improve the land, creating vast ranchos for livestock raising, which quickly became the major source of capital for the local economy.

The Gold Rush of 1849 brought thousands of immigrants to California, including Orange County. An estimated 40,400 Chinese immigrants arrived in California to work both in the Gold Rush as well as helping to build the Transcontinental Railroad. In 1857, German immigrants from San Francisco purchased portions of land in the Rancho San Juan Cajon de Santa Ana to begin the wine industry. The first of the German colonists began arriving in 1859, calling their new home, “Anaheim” meaning “home on the Santa Ana.”

All through the latter part of the 19th century, immigrants continued to arrive, creating thriving farming communities which including winemaking, raising wheat and other cereal crops as well as a burgeoning citrus fruit industry. In 1889, Orange County had reached financial independence and was granted County status by the new state capitol at Sacramento.

The twentieth century saw rapid growth as more and more agricultural land was converted to high tech industries including aerospace, bio-medical, and manufacturing. To keep pace with this rapid growth, new housing developments were created and soon the quiet towns of Santa Ana, Garden Grove, Anaheim, and cities to the south, began to fill in with housing to support the growing business and industrial base of the northern cities. By the end of the 20th Century, Orange County had become a widely diverse ethnic and cultural landscape.

Sadly, World War II brought a dark stain on Orange County’s history. In 1942, Huntington Beach became the epicenter of a facility that interviewed Japanese nationals and Japanese Americans in preparation for sending them to internment camps elsewhere in the United States. The facility, the site of a Japanese Presbyterian Church, served as FBI interview offices, where many of Orange County’s early Japanese pioneering families were questioned about their loyalty to the United States. Even the Masuda family, whose son, Kazuo, a staff sergeant in the U.S. Army killed in Italy in 1944, were taken from their homes and sent to Arkansas where they spent the next three years in detention. Kazuo Masuda was posthumously awarded the Distinguished

Service Cross, the second highest award bestowed by the U.S. Army, for redirecting the attention of enemy soldiers so that his men could escape to safety. His bravery was highlighted in a speech by President Ronald Reagan at the signing of the Civil Liberties Act of 1988, which awarded restitution to Japanese Americans who had been interned during the war years. Sergeant Masuda's act of bravery is a fitting reminder of the need for all Americans to honor the ethnic and cultural diversity that has contributed to strengthening this country.

The Health Care Agency (OCHCA) values cultural development and respects cultural diversity as a core principle of its mission. We work to develop and implement our 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 ensures that standards of care are consistently respectful of individuality, cultural diversity, and are imbedded into every division of Behavioral Health Services. We endeavor to provide services in a welcoming environment, by staff that are culturally competent and linguistically proficient to meet the needs of the population served. As Orange County demographics rapidly change, we continually review and update our cultural competence plan to continue the mission of the Orange County Health Care Agency in meeting the needs of our diverse community. The Agency's mission seeks to provide culturally competent mental health services as listed below.

Orange County Health Care Agency (OCHCA) Mission

OCHCA Mission Statement

Our mission is to prevent substance abuse and/or mental health crisis; 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/programs to help individuals achieve and maintain the highest quality of health and wellness.

VISION
Working together for a healthier tomorrow
MISSION
In partnership with the community, protect and promote the health and safety of individuals and families in Orange County through: • Assessment and planning • Prevention and education • Treatment and care
VALUES
Partnering with our clients and the community, we value: • ***Excellence*** in all we do • ***Integrity*** in how we do it • ***Service*** with respect and dignity

Agency Philosophy: Dedication to Recovery Principles

Use of SAMHSA's Recovery Model (SAMHSA.gov) in the Health Care Agency's Continuum of Care

To integrate all programs under one philosophical umbrella, the County of Orange Health Care Agency, Behavioral Health Services adheres to the Recovery Model as delineated by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA's model is holistic, strength-based, grounded in hope, and is geared toward reducing disparities by being responsive and respectful to the different cultural, ethnic, and linguistic needs of the population. SAMHSA defines "Recovery" in the following way:

"Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:

- **Health**—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
- **Home**—having a stable and safe place to live.
- **Purpose**—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
- **Community**—having relationships and social networks that provide support, friendship, love, and hope."

SAMHSA notes that recovery can occur via many pathways and is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Because setbacks are a natural part of life, resilience becomes a key component of recovery.

To reduce disparities among those served, recovery services and supports must be flexible. SAMHSA encourages the tailoring of individual programs to the needs of specific populations. They state that what may work for one population may not be effective for another. For example, the nature of social supports, peer mentors, and recovery coaching for adolescents is different than for adults and older adults. Supporting recovery requires that mental health and addiction services:

- Be responsive and respectful to the health beliefs, practices, and cultural and linguistic needs of diverse people and groups.
- Actively address diversity in the delivery of services.
- Seek to reduce health disparities in access and outcomes.

The Recovery philosophy provides an overarching ethical and philosophical framework for all activities within Behavioral Health Services (BHS). Its flexibility and dedication to resilience-based services are at the core of BHS activities, particularly considering our adoption of a Trauma-Informed Care emphasis, both in provision of treatment and in support of our work force.

Summary

Given Orange County's diverse cultural, ethnic and linguistic history, and its current status as an evolving multi-lingual, multi-cultural center of influence, the Orange County Health Care Agency is particularly positioned to create a significant impact on the delivery of behavioral health services to a diverse range of cultures and languages. Our mission, in concert with our updated Cultural Competence Plan will assist us in breaking down the stigma of mental health treatment, hopefully ensuring that our participants are treated with dignity, empathy and cultural competence. The following eight criteria will elaborate our commitment to this process; describe our updated cultural program and activities; review our progress during the year; and make recommendations for on-going improvements over the coming years.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

County Mental Health System Commitment to Cultural Competence

Introduction

The commitment to the principles of Cultural Competence, following the underlying philosophy of the Recovery movement as articulated by the Substance Abuse and Mental Health Services Act (SAMHSA) is described in the broad categories of Policies, Procedures and Practices; Program Oversight and Compliance; Community Engagement and Involvement Efforts; and current budgetary allotments which have been set aside for further expansion of our programs. The entire Cultural Competence Plan will attempt to discuss each of these constructs in detail to provide guidance to Behavioral Health Services in meeting the complex mental health needs of our communities in a culturally sensitive and skillful manner. Each section of this criterion will provide an overview of principles, practices, policies, documents, and official structures of Behavioral Health Services as currently conceived.

Policies, Procedures or Practices

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

*1.1 Behavioral Health Services Policies and Procedures (Update 2020)***

Behavioral Health Policy	Policy Details
BHS Policy 02.01.01.	All of Behavior Health Services (BHS) County and County Contracted providers shall be culturally competent.
BHS Policy 02.01.02.	All Behavioral Health Service (BHS) consumers shall have access to linguistically appropriate services.
BHS Policy 02.01.03.	Behavioral Health Services (BHS) is committed to providing consumers with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.
BHS Policy 02.01.04.	All beneficiaries receiving behavioral health services from the County of Orange Health Care Agency (HCA) Behavioral Health Services (BHS) will receive and/or have access to a copy of the appropriate Provider Directory.
BHS Policy 02.01.05.	Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension. Written materials include, but are not limited to: • MHP Consumer Handbook • MHP Provider List • General Correspondence • Beneficiary grievance and fair hearing materials • Confidentiality and release of private health information • MHP orientation materials

	• SMHS education materials
BHS Policy 02.01.06.	It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.
BHS Policy 02.06.02.	Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.
BHS Policy 03.01.03.	BHS trainings that address cultural issues shall be of the highest possible quality. Toward this end, the Multicultural Development Program shall provide review, feedback and consultation on all trainings that address cultural issues prior to the training date.

Program Oversight and Compliance

BHS utilizes policies and procedures to provide oversight and governance for workforce expectations, client care, and to establish strategic goals. The following is a brief sample of policies and procedures, strategic plans, and documents that establish accountability. BHS continues to develop strategic plans as needs arise and reviews its governance policies regularly.

1.2 Program Oversight and Compliance Supporting Documents

Title	Description	Source
BHS Policies and Procedures	List of policies and procedures for operations and client care	https://www.ochealthinfo.com/bhs/pnp
Addressing Opioid Crisis In Orange County	Relevant strategic plan for BHS	https://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=106463
HCA Organizational Chart	Leadership within organization	https://cms.ocgov.com/civicax/filebank/blobdload.aspx?BlobID=23167
Compliance Orientation, Education and Training	HCA Human Resources policies	https://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=50206
Informing Materials for Mental Health Plan Consumers	Accountability policies and procedures	https://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=50869
Medi-Cal Consumer Rights Under the Orange County Mental Health Plan	Client care and rights	https://www.ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=50869

**Copies of all of the Policies and Procedures listed above can be found in Appendix I.

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. 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 Behavioral 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 Behavioral 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.
- The current ESM has been in office since September 2017 and holds the position of both Service Chief II of the Multicultural Development Program (MDP) and Ethnic Services Manager (ESM)
- Responsibilities of the MDP Coordinator/ESM include, but are not limited to, the following:
  - Participate in the Cultural Competence plan 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 to the needs of the populations served 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 reviews and approves all staff trainings for culturally competent content.
  - 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. 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). The Mental Health Specialist position dedicated to interpretation and translation services in Vietnamese is currently vacant and being recruited through the BHS Human Resources department. Within the Behavioral Health Training Services (BHTS) team, MDP access to additional bilingual staff who assist with translation and interpretation services in Spanish, Farsi, Arabic, Korean and Vietnamese as part of their job responsibilities. Additionally, there are more than 400 BHS bilingual staff who are able to provide interpreter services at either their assigned service site or as needed. In total the MDP program is budgeted for $617,000.

Discussion of Funding Allocations

Interpreter and translation services: Outside interpretation and translation service providers that HCA BHS contracted with during FY 18/19 were Language Line for interpretation (telephonic and onsite) and translation services; and Western Interpreting Network (WIN) for American Sign Language (ASL) services. These services are budgeted based on utilization rates and estimates for each year. A contract agency-wide with a vendor is budgeted for up to $200,000. During FY 18/19, BHS spent $$66,605 on document translation and interpretation services. For American Sign Language services, a contract with a vendor is budgeted for up to $300,000 for HCA.

Summary

Given the above referenced information showing current Policies and Procedures, compliance practices, community engagement and budgetary allotments, the Health Care Agency actively continues its commitment to our stakeholders to provide high quality services delivered in a culturally and linguistically sensitive manner. The following section, Criterion 2, further develops this commitment by revealing areas of strength and weakness identified over the past 12 months, based upon the demographic data within the section. Behavioral Health Services continues to look both outward and inward in a comprehensive self-assessment to measure our progress in light of state-wide mandates and the inherent desire to build up the community by reducing mental health stigma and creating partnerships within the community to further build trust in our services.

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

Introduction

To better understand the mission of Orange County Health Care Agency, Behavioral Health Services (BHS), it is necessary to explore Orange County's past and current demographics. Orange County is the third most populous county in California, the sixth most populous in the US, and more populous than 21 US states. Based on data provided by the Department of Finance, the population of the county increased by 7% between 2010 and 2019 (3,010,323 vs. 3,220,987, respectively). The diverse population of Orange County speaks a variety of languages as well. Currently, Orange County provides services in 6 threshold languages to meet Medi-Cal standards. Though not as diverse as Los Angeles County, with at 12 identified languages [(1)], the breakdown of languages spoken in Orange County provides opportunities for BHS to partner with different communities to provide education about behavioral health, recovery, and to bring services to these communities.

Orange County is a complex, multi-cultural society consisting of many different ethnicities, cultures, and languages. Each of these groups brings a different set of intersecting needs, strengths, values, and abilities to the County. The following sections provide a view of the current demographic statistics in some detail.

General Population

To make informed decisions about what services and resources are necessary in Orange County during the year 2020, the Multicultural Development Program examined the County's 2019 population projections. This allows Health Care Agency management to identify the cultural and linguistic needs of specific target populations, which is critical to the development and provision of effective behavioral health services. Data for tables 2.1 through 2.3 on the following pages were pulled from the Department of Finance population projections (2019).

2.1 Total Population of Orange County, California

Gender	*Population*	*Percent*
Male	1,597,031	49.6%
Female	1,623,956	50.4%
Total Population	***3,220,987***	
Ethnicity	*Population*	*Percent*
White/Caucasian	1,298,223	40.3%
Hispanic/Latino	1,131,628	35.1%
Asian/Pacific Islander	696,226	21.6%
Black/African American	56,319	1.7%
Native American	7,717	0.2%
Multi Race/Other	30,874	1.0%
Total Population	***3,220,987***	
Age	*Population*	*Percent*
0-5 years	230,673	7.2%
6-17 years	486,330	15.1%
18-59 years	1,810,547	56.3%
60+ years	693,437	21.6%
Total Population	***3,220,987***	

Source: Department of Finance Population Statistics (2019)

Of the 3,220,987 residents in Orange County, 78% (n=2,503,984) were over the age of 18 and 22.3% (n=717,003) were between the ages of 0-17. A breakdown of the demographics for each of these groups can be found in tables 2.2 and 2.3 on the following page.

2.2 Youth Population (0-17) of Orange County, California

Youth Gender	*Population*	*Percent of Total Population*
Male	367,820	11.4%
Female	349,183	10.8%
Youth Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	224,468	7.0%
Hispanic/Latino	321,274	10.0%
Asian/Pacific Islander	138,351	4.3%
Black/African American	10,078	0.3%
Native American	1,486	-*
Multi Race/Other	21,346	0.7%
Youth Age	*Population*	*Percent of Total Population*
0-5 years	230,673	7.2%
6-11 years	238,254	7.4%
12-17 years	248,076	7.7%
Total Youth Population	***717,003***	***22.3%***

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

Source: Department of Finance Population Statistics (2019)

2.3 Adult Population (18+) of Orange County, California

Adult Gender	*Population*	*Percent of Total Population*
Male	1,229,211	38.2%
Female	1,274,773	39.6%
Adult Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	1,073,755	33.3%
Hispanic/Latino	810,354	25.2%
Asian/Pacific Islander	557,875	17.3%
Black/African American	46,241	1.4%
Native American	6,231	0.2%
Multi Race/Other	9,528	0.3%
Adult Age (18+)	*Population*	*Percent of Total Population*
18-20 years	152,276	4.7%
21-24 years	191,397	5.9%
25-34 years	405,259	12.6%
35-44 years	414,633	12.9%
45-54 years	430,042	13.4%
55-64 years	410,938	12.8%
65+ years	499,439	15.5%
Total Adult Population	***2,503,984***	***77.7%***

Source: Department of Finance Population Statistics (2019)

As of 2018, roughly 45% of Orange County citizens were non-English speakers. This percentage is similar to the California State average (45%), but more than double the National average of 22% (US Census Bureau 1-year Estimates, 2018; see Table 2.4). The US Census Bureau indicated that a quarter (25%) of Orange County residents spoke Spanish at home, while 15% spoke an Asian or Pacific Islander language, and 5% spoke another language at home.

2.4 Language Spoken at Home, Orange County, California

	Children 5-17		*Adults 18+*		*Total*	
	Population	*Percent*	*Population*	*Percent*	*Population*	*Percent*
English Only	289,631	57%	1,345,660	54%	1,635,291	55%
Spanish	152,479	30%	591,089	24%	743,568	25%
Asian/Pacific-Islander Languages	51,841	10%	403,733	16%	455,574	15%
Other Indo-Islander Languages	12,406	2%	116,571	5%	128,977	4%
All Other Languages	5,005	1%	30,129	1%	35,134	1%
Total	***511,362***	100%	***2,487,182***	100%	***2,998,544***	100%

Source: U.S. Census Bureau (2018). Age by Language Spoken at Home for the Population 5 Years and Over American Community Survey 1-year estimates. Retrieved from <https://censusreporter.org/profiles/05000US06059-orange-county-ca/>

Orange County Populations in Need of Services

Medi-Cal Eligible Population for Mental Health Services

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).

In 2019, males and females were equally represented in Orange County. Yet, female residents were more likely to be eligible for Medi-Cal services, as compared to males (54.2% versus 45.8%). Measurable age differences were identified when comparing the County population projections with Medi-Cal eligible populations. As expected, roughly half of the County's Medi-Cal eligible population was between 18 to 59 years of age (49%). Residents under the age of 5 and over 60 were less likely to be Medi-Cal eligible (10.3% and 16.1%, respectively). Racial and ethnic differences were also found among Orange County residents. Ethnic minorities were among the residents most likely to be considered Medi-Cal eligible, with the majority being either Hispanic or Latino (48.4%) or Asian and Pacific Islanders (19.5%). While 40.3% of the County's population was White/Caucasian decent in 2019, very few were eligible for services (16.6%). Additionally, the most common language spoken at home among Orange County residents was English (54.5%). These residents were most likely to be eligible (54.5%), while one-third of Med-Cal eligible residents were Spanish speaking (32.1%).

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
- Black/African Americans
- Native American s
- Youth 5 years of age and under
- Adults over the age of 60
- Residents who spoke a language other than English

On average, 19.5% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.6% received an approved service. Additionally, the number of Native American residents who were Medi-Cal eligible and had an approved service was extremely low during 2019 (0.2% and 0.4%, respectively). Residents over 60 years of age comprised 16.1% of the Medi-Cal eligible population, yet only 5.4% 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 (32.1%), but only 16.8% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 11.6% of the Medi-Cal population and only 3.3% had an approved service.

Penetration Rates

Data provided by Behavioral Health Concepts; Inc. during the Mental Health Plan's FY 2018-19 review demonstrated that the State-wide penetration rate was 4.9%.

In Table 2.5, CALEQRO calculated Orange County's penetration rate as being below the State average at 3.0%. 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. CALEQRO did not provide penetration rates for primary language, thus rates were calculated dividing the total number of Medi-Cal beneficiaries served by the total number of residents who were eligible. Using this methodology, the penetration rate calculated for residents who identified their primary language and this rate was slightly higher than CALEQRO at 3.5% (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-year-old. Additionally, those who spoke English as their primary language were higher than 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*[2]
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,597,031	49.6%	390,031	45.8%	12,919	51.0%	3.3%
Female	1,623,956	50.4%	461,977	54.2%	12,402	49.0%	2.7%
Race/Ethnicity							
White/Caucasian	1,298,223	40.3%	141,718	16.6%	6,660	26.3%	4.7%
Hispanic/Latino	1,131,628	35.1%	411,977	48.4%	11,809	46.6%	2.9%
Asian/Pacific Islander	696,226	21.6%	165,926	19.5%	2,170	8.6%	1.3%
Black/African American	56,319	1.7%	14,336	1.7%	921	3.6%	6.4%
Native American	7,717	0.2%	1,418	0.2%	106	0.4%	7.5%
Multi Race/Other	30,874	1.0%	116,363	13.7%	3,655	14.4%	3.1%
Age							
0-5 years	230,673	7.2%	88,100	10.3%	895	3.5%	1.0%
6-17 years	486,330	15.1%	209,327	24.6%	10,812	42.7%	5.2%
18-59 years	1,810,547	56.2%	417,346	49.0%	12,248	48.4%	2.9%
60+ years	693,437	21.5%	137,237	16.1%	1,366	5.4%	1.0%
Total Population	***3,220,987***		***852,008***		***25,321***		***3.0%***

[1] *Source: Department of Finance Population Statistics (2019)*

[2] *Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '19, CA EQRO report 2019*

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	1,635,291	54.5%	465,244	54.5%	23,940	88.5%	5.1%
Spanish	743,568	24.8%	274,188	32.1%	4,560	16.8%	1.7%
Asian/Pacific Islander Languages	455,574	15.2%	98,709	11.6%	901	3.3%	0.9%
Other Indo-European Languages	128,977	4.3%	7,687	0.9%	169	0.6%	2.2%
All Other Language	35,134	1.2%	8,042	0.9%	136	0.5%	1.7%
Primary Language Total	***2,998,544***		***853,870***		***29,706***		***3.5%***

[3]Source: U.S. Census Bureau (2018). Age by Language Spoken at Home for the Population 5 Years and Over American Community Survey 1-year estimates. Retrieved from <https://censusreporter.org>

[4] Source: CA Medi-Cal Eligibility Data System (MEDS) Extract, May 2019

[5] Source: Orange County Health Care Agency (FY 18/19), Electronic Health Record System (IRIS)

Drug Medi-Cal Organized Delivery System (DMC-ODS) Eligible Population

Data was extracted for the number of Drug 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 fiscal year 2019-20 (Table 2.7). However, because the CALEQRO report did not provide estimates broken out by primary language, this data was not included in this analysis.

In 2019-20, female residents were more likely to be eligible for Drug Medi-Cal services, as compared to males (55.8% versus 44.2%). Measurable age differences were identified when comparing the County population projections with Medi-Cal eligible populations. More than half of the County's Medi-Cal eligible population was between 18 to 64 years of age (69.3%). Residents between the ages of 12-17 and over 65 were less likely to be Medi-Cal eligible (16.1% and 14.6%, respectively). Racial and ethnic differences were also found among Orange County residents. Some ethnic minority groups were among the residents most likely to be considered Medi-Cal eligible, with the majority being either Hispanic or Latino (44.1%) or Multi-Racial/Other (14.2%). Additionally, White/Caucasian residents made up 18.1% of the Drug Medi-Cal eligible population in Orange County. Overall, these trends are similar to the statistics reported for Mental Health Plan Medi-Cal eligible residents.

DMC-ODS 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:

- Female
- Asian and Pacific Islanders
- Black/African Americans
- Native Americans
- Youth between the ages of 12-17 years
- Adults over the age of 60

On average, 55.8% of Female residents were eligible for Medi-Cal services, yet only 37.1% received an approved service. With regard to age disparities, youth between the ages of 12-17 were 16.1% of the Drug Medi-Cal eligible population, but only 5.0% received services. Residents over 60 years of age comprised 14.6% of the Medi-Cal eligible population, and only 7.0% had an approved service.

It should be noted that ethnic minorities such as Asian/Pacific Islander, Black/African American, and Native American made up the smallest proportion of Drug Medi-Cal eligible residents. While these groups were less likely to be considered eligible for services, they were also less likely to receive an approved service compared to other groups.

Penetration Rates

Data provided by Behavioral Health Concepts, Inc. for FY 2019-20 demonstrated that the State-wide penetration rate was 0.8%.

In Table 2.7, CALEQRO calculated Orange County's penetration rate as being slightly below the State average at 0.7%. The penetration rates were higher than the CALEQRO County-wide average for residents who identified as Male, White/Caucasian, Black/African American, Native American, Multi-Race/Other, residents between the ages of 18-64 year-old.

2.7 DMC-ODS Penetration Rates by Gender, Race/Ethnicity, and Age

	County Population[1]		*Average Number of DMC-ODS Eligibles per Month*[2]		*DMC-ODS Beneficiaries who Received an Approved Service per Year*[2]		*Penetration Rate*[2]
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,597,031	49.6%	293,899	44.2%	3,057	62.9%	1.0%
Female	1,623,956	50.4%	370,940	55.8%	1,803	37.1%	0.5%
Race/Ethnicity							
White/Caucasian	1,298,223	40.3%	120,202	18.1%	2,107	43.4%	1.8%
Hispanic/Latino	1,131,628	35.1%	293,251	44.1%	1,677	34.5%	0.6%
Asian/Pacific Islander	696,226	21.6%	14,442	2.2%	166	3.4%	0.1%
Black/African American	56,319	1.7%	11,351	1.7%	111	2.3%	1.0%
Native American	7,717	0.2%	1,235	0.2%	37	0.8%	3.0%
Multi Race/Other	30,874	1.0%	94,360	14.2%	762	15.7%	0.8%
Age[3]							
12-17 years	248,076	9.0%	107,193	16.1%	245	5.0%	0.2%
18-64 years	2,004,545	72.8%	460,787	69.3%	4,277	88.0%	0.9%
65+ years	499,439	18.1%	96,859	14.6%	338	7.0%	0.4%
Total Population	***3,220,987***		***664,839***		***4,860***		***0.7%***

[1] *Source: Department of Finance Population Statistics (2019)*

[3] *Residents ages 0-11 years were not included in the analysis of penetration rates.*

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

Federal Poverty Line (FLP) data was extracted from the California Health Interview Survey (CHIS, 2018). In total, 297,000 non-Medi-Cal beneficiaries who lived in Orange County were living at or below the 200% FPL in 2018 (see Table 2.8). The majority of these residents were either female, Hispanic/Latino, or between the ages of 18-59 years old.

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

Gender	*Number*
Female	167,000
Male	130,000
Race/Ethnicity	*Number*
White/Caucasian	97,000
Hispanic/Latino	138,000
Asian/Pacific Islander	57,000
Black/African-American	3,000
Native American	*
Multi Race/Other	2,000
Age	*Number*
0-5 years	0
6-17 years	14,000
18-59 years	208,000
60+ years	75,000
Total	***297,000***

*Data unavailable for this population

Source: California Health Interview Survey (2018)

Table 2.9, on the following page, compares Orange County's total population with the total number of residents living at or below the 200% FPL. Results indicate that one-third of Orange County residents are living at or below the 200% FPL (998,000 compared to 3,220,987). Similar to the results looking at the Orange County population, minus Medi-Cal, the majority of these residents were either female, Hispanic/Latino, or between the ages of 18-59 years old.

2.9 Population Assessment

	County Wide Estimated Total Population[1]		*County Wide Estimated Population Living at or Below 200% FPL*[2]	
	N	*%*	*N*	*%*
Gender				
Males	1,597,031	49.6%	451,000	45.2%
Females	1,623,956	50.4%	547,000	54.8%
Race/Ethnicity				
White/Caucasian	1,298,223	40.3%	251,000	25.2%
Hispanic/Latino	1,131,628	35.1%	433,000	43.4%
Asian/Pacific Islander	696,226	21.6%	286,000	28.7%
Black/African American	56,319	1.7%	8,000	0.8%
Native American	7,717	0.2%	*	*
Multi Race/Other	30,874	1.0%	19,000	1.9%
Age				
0-5 years	230,673	7.2%	85,000	8.5%
6-17 years	486,330	15.1%	180,000	18.0%
18-59 years	1,810,547	56.3%	522,000	52.3%
60+ years	693,437	21.6%	212,000	21.2%
Total	***3,220,987***		***998,000***	

*Data unavailable for this population

[1] *Source: Department of Finance Population Statistics (2019)*

[2] *Source: California Health Interview Survey (2018)*

MHSA Community Services and Supports Population Assessment[1]

Orange County At-A-Glance

The tables below were pulled from the most recent Mental Health Services Act (MHSA) annual update (2020). Information presented discusses Orange County Population statistics, actual and proposed budgets for MHSA funded programs (e.g., CSS and PEI), and estimated demographics of clients served by age, gender, and race/ethnicity.

POPULATION: 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 (3,185,968) people (Census, v2018), up almost 7% from 2010.
ETHNIC/RACIAL DIVERSITY: The County's population is comprised of four major racial/ethnic groups.	Whites (41%), Hispanics (34%), Asian/Pacific Islanders (20%) and Blacks/African Americans (2%). 30% of residents are born outside the US (Census, v2018 5-yr estimates 2014-2018).
LANGUAGES SPOKEN: Currently, Orange County has six threshold languages (Spanish, Vietnamese, Korean, Farsi, Arabic, and Mandarin Chinese).	According to Orange County's Healthier Together (2019), English is spoken at home by 53.2% of the population four years and older, followed by Spanish (26%) and Asian/Pacific Islander languages (14%).
AGE GROUPS: 22.5% of the County's population was under age 18 and 15% were 65 or older (Census, v2018).	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.
VETERANS: Approximately 5% (112,264) of the civilian population 18 and older are veterans (Census, 2018 5-yr estimates 2014-2018).	In one study of OC veterans, 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 (OC Veterans Initiative).
LGBTIQ: Orange County is home to an emerging Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning population.	Approximately 4% of Orange County residents identify as gay, lesbian, homosexual or bisexual, and 24% of teenagers report they are not gender conforming (CA, Health Interview Survey, 2018).
EDUCATION LEVEL: The county has a well-educated population, with 85% of residents ages 25 years and older having graduated from high school and 40% having earned a bachelor's degree or higher .	This is slightly higher than the state average of 84% having graduated high school and 34% having earned a bachelor's degree or higher (Census, 2018 5-yr estimates 2014-2018).

[1] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2020-2021 thru 2022-2023. Published Spring 2020. [ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=96051]

COST OF LIVING: 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.	$85,851: Median household income $1,777: Median Gross Rent $652,900 Median House Price 5.1%: Unemployment Rate 11.5% Individuals below Poverty Level (Census, 5-yr estimates 2014-2018).

CSS/PEI Budgets[2]

FY2020-21 – 2022-2023 Component Budget			Projected Unduplicated # to Be Served by Component		
Fiscal Year	**CSS**	**PEI**	**Fiscal Year**	**CSS**	**PEI**
Actual FY 2019-20 Budget	$174,195,419	$43,490,187	FY 2019-20	55,503	195,333
Proposed FY 2020-21 Budget	$155,088,175	$47,061,483	FY 2020-21	61,623	216,898
Proposed FY 2021-22 Budget	$164,627,171	$49,286,926	FY 2021-22	68,242	204,483
Proposed FY 2022-23 Budget	$165,320,336	$40,988,101	FY 2022-23	73,066	173,459

Projected Numbers to be Served[3]

Estimated Proportion of Clients to be Served by Component and Demographic Characteristic								
Age Group	**CSS**	**PEI**	**Gender**	**CSS**	**PEI**	**Race/Ethnicity**	**CSS**	**PEI**
0-15 years	9%	47%	Female	42%	54%	African American/Black	7%	3%
16-25 years	16%	18%	Male	56%	42%	American Indian/Alaskan Native	1%	3%
26-59 years	63%	25%	Transgender	2%	1%	Asian/ Pacific Islander	10%	14%
60+ years	12%	10	Genderqueer	0%	0%	Caucasian/White	42%	23%
			Questioning/Unsure	0%	0%	Hispanic/Latino	34%	47%
			Other	0%	2%	Middle Eastern/North African	1%	1%
						Other	5%	9%

[2] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2020-2021 thru 2022-2023. Published Spring 2020. [ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=96051]
[3] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2020-2021 thru 2022-2023. Published Spring 2020. [ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=96051]

Prevention and Early Intervention (PEI) Plan: Identifying PEI Priority Populations

Between October and November 2019, the MHSA Office distributed a Community Feedback Survey to Orange County community members regarding the five priority populations they believe have the greatest need for or disparities in receiving different types of behavioral health services. The service types were based on the different types of behavioral health programs provided by the MHSA funded County sites, and the priority populations were identified by the MHSA office. A paper version of the survey was distributed at community events and BHS programs. Electronic surveys were distributed to 1,320 stakeholders on the MHSA, Be Well, and BHS Contract Provider distribution lists. Although the electronic survey was originally set to close on October 25, 2019, it remained open for an additional two weeks. This was done so that participants at the Community Engagement Meetings, who had not had a chance to complete it, had the opportunity to do so.

12 Service Types
Behavioral Health System Navigation
Outreach & Engagement
Early Intervention
Outpatient Treatment
Crisis Services
Residential Treatment (non-emergency)
Supportive Services
Peer Support
Stigma and Discrimination Reduction
Mental Health & Well-Being Promotion
Violence & Bullying Prevention
Suicide Prevention

MHSA Priority Populations	
Children (0-15 years)	Students at Risk of School Failure
Youth (16-25 years)	Veterans
Adult (26-59 years)	Criminal Justice Involved
Older Adults (60+ years)	Mental Health with Substance Use
Foster Youth	Mental Health with Medical Conditions
Parent/Families	Racial/Ethnic Groups
LGBTQ	Monolingual/Limited English
Homeless	Other

The MHSA Office collected responses from a total of 1,136 paper and electronic surveys. Sixty-one percent of respondents identified as consumers and/or family members, all stakeholder groups required by the MHSA were represented among the respondents. Additionally, 16% of respondents were adolescents or

Transitional Age Youth (TAY), whose previous participation in community planning had been low to non-existent. In addition, the racial and ethnic diversity of the survey respondents were representative of Orange County diverse population as a whole.

Respondents identified three age groups and two specialized populations as being among the top five groups with unmet need:

- **Youth** (16-25) in 12 of the 12 service types
- **Adults** (26-59 years) in 10 of the 12 service types
- **Children** (0-15 years) in 8 of the 12 service types
- **Individuals Living with Co-Occurring Mental Health and Substance Use Disorders** in 7 of the 12 service types
- **Homeless Individuals** in 7 of the 12 service types

Summary

Response to Current Inequities in Health Care Distribution

The Orange County Health Care Agency's vision is "working together for a healthier tomorrow"; its mission is to be "in partnership with the community, protect and promote the health and safety of individuals and families in Orange County through: assessment and planning, prevention and education, and treatment and care".

To realize this vision and deliver on its mission equitably for all of the county's residents, the Agency must offer services and supports that are reflective and responsive for all people, regardless of ethnicity and race, age or gender, and socioeconomic status. While HCA has a variety of means to progress towards achieving this equity in its impact on health, data tells us that significant inequity in health status remains.

Based on the complexity and scope of the challenge to achieve equity and to assure steady progress towards better health for all, HCA has developed an Office of Populations Health and Equity that will support all divisions and programs within the agency to improve their ability to drive toward equitable access, service delivery and health and safety outcomes.

Background

The OC Healthier Together initiative helps explain why achieving health equity remains so challenging. In their March 2019 "Forces of Change Assessment"[4], it identifies trends, events, or factors that affect the community's health – many of which present challenges toward achieving health equity. Some of these are:

- Economic Disparity. Wages are stagnant for lower income workers, student debt burden is at a crisis level at an individual and societal, there is increased disparity between upper and lower incomes. This leads to inability to access nutritious foods, safe and adequate housing, health care and may increase violence/crimes and increased stressors.
- Health Care (including Pharmaceuticals) Costs. Continued increases in health care costs are placing greater burdens on businesses and individuals. This dynamic leads to businesses leaving, people choosing high deductibles/copays and not accessing care.
- Health Care Financing Structures. Reimbursements by public and private insurance is low and claims processing is extremely burdensome. These burdens cause there to be an inadequate number of

[4] http://www.ochealthiertogether.org/content/sites/ochca/HIP_Agenda_and_Highlights/Forces_of_Change_Assessment_2019-12-13_FINAL_rev.pdf

providers accepting insurance, preferential treatment based on personal resources, and systems still incentivizing illness/disease treatment rather than prevention.

These challenges disproportionately impact vulnerable and at-risk populations negatively and are at the root of the above health inequities. To mitigate their impacts and realize optimal health and safety for those most impacted, HCA's services and supports must increasingly become systematic countermeasures to them.

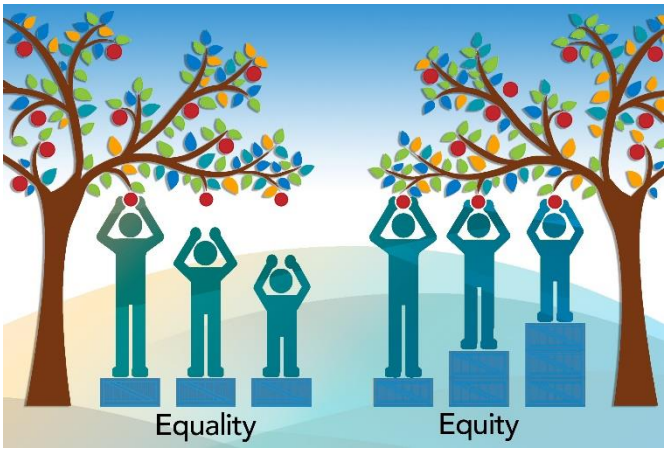
This dynamic is informed by looking at three variables in Orange County and within the Health Care Agency: *diversity*, *equity,* and *inclusion*.

Diversity: Orange County is home to approximately 3.2 million residents. 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 7.0% between 2010 and 2019. As demonstrated in the table below, the non-White population had the largest overall growth, compared to the White/Caucasian population.

	White	Hispanic	Asian	Black/African American	All Other	Total
Population (2010 Census)	1,328,499	1,012,973	540,834	44,000	83,926	3,010,232
Breakdown by Ethnic Background	44%	34%	18%	1%	3%	100%
Population (2019 Census)	1,298,223	1,131,628	696,226	56,319	38,591	3,220,987
Breakdown by Ethnic Background	40%	35%	22%	2%	1%	100%
% Change - 2010 vs. 2019	-2.28%	11.71%	28.73%	28.00%	-54.02%	7.00%

Comparison of Orange County Race/Ethnicity Population, Department of Finance Population Projections (2010 vs. 2019)

To serve such a diverse populous, we need systems that are designed to be responsive to different groups and individual's cultures.



Equity: Given the great diversity of the Orange County population, HCA is challenged to provide services and support that are equitable and responsive to the needs of the different communities we serve. It is important to acknowledge that in order for the unserved and underserved populations to receive equitable health care services and achieve recovery outcomes and consumer satisfaction comparable to the rest of the population, we need to be prepared to do more for certain individuals and populations. It has to become part of the DNA of HCA that one size (service) fits all is no longer applicable in the diverse environment we live in. In order to accomplish the goal of providing equitable health care services to the communities in OC, we have to ensure that among these responses, our services are culturally and linguistically appropriate to the needs of the populations we serve.

The service utilization breakdown by race/ethnicity also shows the disproportionate use of service by different communities.

HCA Client Utilization Fiscal Year 2018-19 compared to 2019 Population Estimates

Service Recipient*	Total[1]		Population 2019[2]	
	Number	*Percentage*	*Number*	*Percentage*
American Indian	144	0.34%	unavailable	unavailable
African American	1,766	4.11%	56,319	2%
Asian	3,414	7.95%	696,226	22%
White/Caucasian	13,102	30.52%	1,298,223	40%
Latino/Hispanic	20,511	47.78%	1,131,628	35%
Pacific Islander	204	0.48%	unavailable	unavailable
Other	769	1.79%	38,591	1%
Unknown	3,018	7.03%	unavailable	unavailable
Total	***42,928***	***100.00%***	**3,220,987**	**100%**

**17 participants did not identify their race/ethnicity or Hispanic origin*

[1] Source: Orange County Health Care Agency (FY 18/19), Electronic Health Record System (IRIS)

[2] Source: Department of Finance Population Statistics (2019)

Such differences in access by ethnicity suggest that there may be bias in the way the system is designed and services are marketed and delivered. While not intentional, services (and communicaiton of them) are not currently designed to serve all populations; in surveying community members and listening to our participants, we have learned the following barriers to accessing care:

- Program designs, including services like intake, care processes, and health education, are not sufficiently responsive to cultural needs of underserved groups.
- Lack of knowledge about our programs among underserved communities.
- A lack of trust in government organizations; and,
- We do not regularly check-in to determine the need for services and match what the programs' offer, and so services will go under-utilized (as the utilization rate data indicated above).

Inclusion Inclusion is both an indicator and a means of achieving equity and responding to the needs of diverse populations. Inclusion is relevant both internally with staff awareness and cultural sensitivity, as well as externally, in terms of development and maintenance of community partnerships with key stakeholders. Level of inclusion is directly related to our ablity to shape and drive system change.

Staff may know very little about the different cultures from which their co-workers, supervisors, leaders, etc. come. There is a lack of awareness, knowledge among staff of each other's culture, which may lead to a reduction in the ability of staff to work as a team and promote cooperation within shared workflows.

In 2019, the USC Dornsife Program for Environmental and Regional Equity prepared "An Equity Profile of Orange County."[5] Based on a thorough study of the socioeconomic and health conditions of different ethnic and cultural communities, the report identified "Ten (plus one) steps to equity for Orange County." Of the ten, the Office of Population Health and Equity intends to initially focus on the following activities:

[5] https://www.ocgrantmakers.org/wp-content/uploads/2019/03/EP_Summary-Orange_County_15_final.pdf

1. **Embed and operationalize a prevention-oriented approach to advance health equity**. Emerging strategies intended to improve the collective health of Orange County's residents must include a more intentional focus on upstream prevention. This means explicitly tackling the social determinants of health and well-being, rather than primarily engaging in efforts that emphasize increased availability and coordination of clinical services and treatment. To eliminate health disparities and create a landscape that fosters health and wellness, Orange County should take a comprehensive approach with strategies that bridge social, physical, and economic factors through new policies, stronger systems, and improved organizational practices.

2. **Build civic health among underrepresented voices**. The region's health is tied to its civic health. Increasing community engagement among racial/ethnic groups that have been historically underrepresented in decision-making brings in the voices of those who are often most impacted by policy change. Supporting non-profit organizations and other trusted local institutions who are most attune to the needs and concerns of the community can ensure policies are truly addressing equity.

3. **Build a culture in which racial equity is discussed and is a shared goal**. Discussing issues of race and racism can be uncomfortable, but this is a necessary step in working towards equity. To improve optimal health outcomes for all, Orange County should acknowledge the history that led to today's racialized gaps, develop partnerships that center on the perspectives of vulnerable populations, and keep an eye towards mitigating future inequities. Rooting the conversation in data can help business leaders, funders, government officials, and community-based organizations create a sustained dialogue around race and racial equity.

4. **Support in developing a regional equity strategy, indicators of progress, and a data system for measuring progress.** Looking forward, Orange County is poised to support in developing a county-wide strategy that centers environmental, social, and economic equity practices. The region's relative prosperity means that it can pursue a bold strategy that addresses inequities in order to set the stage for decades of equitable growth. Developing an ongoing system for tracking progress over time can help to keep equity as a county-wide goal. What is not measured will not be achieved—yet measurement and data alone are not enough.

The Office of Populations Health and Equity will support recovery-focused care by working towards reducing mental health stigma, the inculcation of hope in the client and their family, and helping the client navigate our behavioral health services to live life full of hope and dignity and well-being. In that light, much of the above referenced activity will also be focused around providing education to the community about recovery principles, while being sensitive to the underlying philosophies, religious beliefs, and cultural determinants of these groups. The following section, Criterion 3, will provide the road map to our service provision.

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

Introduction

This section provides a detailed review of BHS programs, highlighting their status for the reporting period. Each program presented its outcomes, and areas of cultural intersection were noted where possible. Material will be highlighted to provide a greater focus on gender, culture, ethnicity and specific outcomes in those programs.

Changes to Criterion 3 for 2020 include the addition of program data and summary information from our Substance Use Prevention, Education and Disorders programs. This addition of this program further clarifies the work of BHS in reaching marginalized communities, such as the homeless, for whom substance use disorders are endemic.

Identify Unserved/Underserved/Inappropriately Served Target Populations

The target populations for each of the programs listed in this criterion include, but are not limited to: ethnic and cultural minorities [e.g., Latino/Latina, Black/African American, 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.[6]

Identified Strategies/Objectives/Actions/Timelines

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals often have the 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; lack of open program space; stigma related to having 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, some programs, like the PACT programs, have adopted the "Whatever It Takes" model to engage individuals in treatment. They provide person-centered, recovery-based interventions primarily in the home or whenever participants are comfortable meeting 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

[6] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2020-2021 thru 2022-2023. Published Spring 2020. ochealthinfo.com/civicax/filebank/blobdload.aspx?BlobID=96051

bilingual (see grids) and able to communicate with the monolingual individuals and family members in their preferred language, thus facilitating their engagement in services.

Strategies to Reduce Stigma and Discrimination

One of the core principles of the Recovery Movement is the commitment to reducing stigma and discrimination. Given the stigmatizing nature of behavioral health disorders, BHS has implemented a Peer Specialists program to assist in normalizing our participant's experience. The Peer Specialists all have lived experience of behavioral health issues. They serve as inspirational role models, which can be powerful in reducing stigma among the people and families served. They normalize the experience, act as coaches and mentors, and assist the participant in deriving the most benefit from the County services possible.

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 concept 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.

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 many opportunities for staff to have a supportive on-site presence that fosters collaboration and education between the participants and their employers and co-workers. Our contract agencies who provide work re-entry promote participants' successes in maintaining employment and develops relationships with welcoming employers who provide individuals with mental health challenges the opportunity to 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.

- To meet these goals, Behavioral Health Services programs are designed with these principles in mind. The following sections will detail the various programs currently administered in our BHS system of care:

  - 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 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 administered by Drug Medi-Cal-ODS

The County Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan provides substance use disorder (SUD) treatment services for all eligible Medi-Cal beneficiaries who reside in Orange County. We began offering DMC-ODS services on July 1, 2018.

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

The DMC-ODS offers beneficiaries a full range of SUD treatment services when they are medically necessary. The County Plan requires treatment placement decisions to follow the criteria established by the **American Society of Addiction Medicine (ASAM)**.

Beneficiaries can access DMC-ODS services by calling the Beneficiary Access Line at (800) 723-8641, 24 hours a day, 7 days per week. For more information about the ODS plan, anyone can call Member Services at (855) 625-4657, Monday through Friday between 8:00 AM and 6:00 PM. Medi-Cal beneficiaries are eligible for these services if they are medically necessary.

Youth under age 21 and pregnant or parenting women are eligible for additional services.

For more information about DMC-ODS, visit www.ochealthinfo.com/dmc-ods.

Levels of treatment for Substance Use Disorders (Adults and Youth)

Outpatient Drug Free (ODF)	Program consists of up to nine hours per week for adults and less than six hours a week for adolescents when determined to be medically necessary. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.
Intensive Outpatient Treatment (IOT)	Program consists of a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents when determined to be medically. Services can be provided by a certified counselor in any appropriate setting in the community.
Residential Treatment	**Treatment** is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services when determined as medically necessary. Residential services require prior authorization by the County Plan. Each authorization for residential services can be for a maximum of 90 days for adults and 30 days for youth. **Only two authorizations for residential services are allowed in a one-year-period.**
Recovery Services	This program important for recovery and wellness. The treatment community helps beneficiaries be empowered and prepared to manage their health and health care.
Withdrawal Management	These services are offered in residential, non-institutional, non-medical withdrawal management programs that utilize a social model detox system, for a maximum of seven (7) days to help beneficiaries during the non-acute detoxification process. Acute withdrawal management services are available 24 hours a day, 7 days a week.
Narcotic Treatment Program/Opioid Treatment Program (NTP/OTP)	Services are available to adults 18 year of age and older, seven (7) days per week and are provided by licensed NTP facilities. You must be a resident of Orange County to receive NTP services at Orange County NTP sites. Occasional courtesy dosing of beneficiaries from other counties occurs on a case by case basis. Beneficiaries should contact the NTP to determine the steps needed to obtain an occasional dose outside of their county of residence.

Medication Assisted Treatment (MAT)	**MAT** is the use of prescription medications, in combination with counseling and behavioral therapies. MAT services can occur in conjunction with any of the ASAM levels of care that are covered under the plan.

Services for Youth

Youth under 21 years of age may receive additional medically necessary services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT services include screening, vision, dental, hearing and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered for adults.

Services for Pregnant and Parenting Women

In addition to the standard benefits, pregnant women can receive residential services through the last day of the month that the 60th day after delivery occurs. Services include additional support, including childcare and counseling focused on the parent-child relationship.

Substance Use Disorders (SUD) Prevention Programs (Children, Youth, and Adults)

Target Population

Primary prevention services are made available to youth, students, parents, adults, families, health professionals, school staff and business members throughout the county. Youth-centered prevention serves those ages eight to 18 years of age. This includes youth enrolled in traditional and non-traditional schools, those participating in after school programming, youth from faith-based organizations, youth residing in (low-income) apartment complexes, and those attending programs sponsored by youth/community serving agencies (i.e., Girl and Boy Scouts). Parents, care givers, and adult family members are provided services.

Although services are made available countywide, OCHCA uses a data driven approach to both maximize resources and create a greater impact. Thus, prevention programming is strategically focused in higher need communities and school districts.

Services

Orange County's primary prevention programs include a broad array of prevention strategies directed at those not identified to be in need of substance use disorder treatment. Services include, but are not limited to, providing education, disseminating information/materials, conducting presentations and trainings, implementing a collective impact framework, developing media campaigns and supporting youth-led prevention activities. Services are designed to promote safe and healthy communities.

Programs are delivered by County-led teams as well as by contracted providers. For example, one of its providers is the Orange County Department of Education, who administers the Friday Night Live Partnership (a program based on the principles of positive youth development), and a school-based education program, reaching youth, parents, and school staff.

Recognizing Orange County's diversity, the OCHCA uses a data driven approach and strives to understand unique community needs and disparities. To this end, prevention services are provided in different Orange County communities (e.g., beach cities), to diverse populations, and within different age and gender subpopulations.

Outcomes

The OCHCA led a year-long strategic planning process that included input from stakeholders from various sectors in the community and completed a comprehensive data assessment analysis. This process produced a five-year (2018-2023) alcohol and other drug prevention strategic plan. Four priority areas/goals were identified:

- Decrease underage drinking
- Reduce prescription drug abuse
- Decrease cannabis/marijuana use among youth
- Reduce AOD impaired driving collisions

Below are examples of outcomes achieved during FY 2018-2019 in support of the Plan's goals. Outcomes were measured using pre/post or post only surveys.

Table of Reported Outcomes

Target Population	Number Served	Intervention Type	Result
Youth	2,480	Education – Prescription Drug Prevention	82% reported confidence in their ability to walk away from drug use when pressured.
Adults/Parents	363	Education – Substance Use Prevention	72% reported willingness to regularly talk with youth about dangers of drugs and alcohol.
Adults/School staff	281	Education – Substance Use Prevention	90% of school staff reported increased knowledge about risk and protective factors for alcohol and other drug use.
Adults/Beverage Industry/Security	700	Education – Responsible Beverage Service Training	70 different alcohol retail establishments doing business in Orange County were successfully trained.
Adults	1,400	Education – Impaired Driving Prevention	94% reported increased knowledge about the dangers of impaired driving.
Adults	Unknown	Multi-Media Education Campaign - Opioid Awareness	Program began in February 2020 targeting older, non-Hispanic white males who live in coastal and South Orange County. Viewers were encouraged to visit site called: www.wrongforyou.com

Challenges/Barriers/Solutions in Progress

The classroom has been the main environment to reach youth. Due to Covid-19, exploration of virtual platforms and the many tools available to engage/involve youth during educational classes continues. In-person lessons are being reformatted to be virtually interactive, featuring on-line games and hands-on activities.

Community Impact

The OCHCA continues strong and productive partnerships with schools, community-based organizations, municipalities, hospitals, law enforcement, and alcohol establishment staff. Orange County residents tend to have comparable, and in many cases, much lower rates of alcohol and/or other drug use compared to national and state levels, with just a few exceptions. Although these data are overall favorable, the OCHCA continues to employ proactive and evidence-informed approaches to improve and sustain health behaviors among the residents of Orange County.

SUD Trends

According to the findings from the 2017-18 Orange County California Healthy Kids Survey, past 30 day alcohol and other drug (AOD) use rates by 11th graders has decreased since 2008, and are consistently lower than California rates. Past (30 day) marijuana/cannabis use and use of prescription medication to get "high" or for other than medical reasons have also been trending down among Orange County youth, according to survey data findings. Orange County's alcohol and/or drug collision rate is higher than that of California. Risk factors include a no/low perception of being caught while driving impaired as well as unclear social norms. At present, there is no data for 2018-2019 Healthy Kids Survey.

Navigation and Linkage to Treatment/Services (OC Links-PEI)

Target Population and Program Characteristics

OC Links is a Behavioral Health Services (BHS) Information and Referral Line that serves anyone seeking information or linkage to any of the BHS programs. Because the Navigators who staff the line are clinicians, they are able to work with callers experiencing any level of behavioral health issue. All clinicians are bi-lingual and staffing is based on call volume with the largest number of clinicians being English and Spanish speakers. Three out of the five languages are currently fully staffed, with job offers out to Korean and Arabic speaking clinicians.

FAST FACT: OC Links has responded to more than 80,000 calls since opening in the fall of 2013.

During the 2019-2020 reporting period, OC Links reported the following outcomes:

Category	Call Volume
Total Calls	13,292
English	11,684
Spanish	1,297
Vietnamese	116
Farsi	114
Korean	38
Arabic	3
Other languages	38

Prior to the onset of COVID-19, each year OC Links would facilitate or participate in a number of outreach events and programs to various cultural communities throughout Orange County. Staff members who were fluent in the represented language, provided County brochures and materials in that language. These materials included crisis phone numbers in all of the threshold languages of Orange County. These events were implemented in colleges and universities, high schools, resource fairs, community centers, cultural events and other venues.

Services

Serving as the single access point for the HCA BHS System of Care, OC Links provides telephone and internet, chat-based support for any Orange County resident seeking HCA Behavioral Health services. OC Links operates from 8 a.m. to 6 p.m., Monday through Friday. During these hours, callers may access navigation services through a toll-free phone number (855-OC-Links or 855-625-4657) or a Live Chat option available on the OC Links webpage (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).—OC Links attempts to refer to culturally appropriate agencies that will meet the linguistic, cultural and religious need of the particular client. OC Links tries to be the Behavioral Health Services experts on community resources and the cultural capacities of each agency.

Challenges, Barriers, and Solutions in Progress

Increasing community awareness about OC Links and the services available through the County is a constant challenge that must continually be addressed. In order to better educate the public about OC Links on an ongoing basis, a short video about the program was created and placed on the HCA website. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County BHS.

Community Impact

The program has responded to more than 80,000 participants since opening in the Fall of 2013. OC Links serves

Orange County residents by helping callers navigate a large and complex continuum of care and linking them to the County and/ or County-contracted services best suited to meet their behavioral health, linguistic and cultural needs.

BHS Outreach & Engagement (O&E)

Target Population and Program Characteristics

BHS Outreach and Engagement (O&E) provides field-based access and linkage to treatment and/or support services for those who are homeless or at risk of homelessness and who have had difficulty engaging in mental health services on their own. O&E staff identifies participants through street outreach and referrals from community members and/or providers.

Services

To promote awareness of, and increase referrals to its services, BHS O&E performs outreach at community events and locations likely to be frequented by individuals the program intends to serve and/or the providers that work with them in non-mental health capacities (i.e., street outreach, homeless service provider locations, etc.). All outreach services are focused on making referrals and ensuring linkages to ongoing behavioral health and support services by providing assistance with scheduling appointments, providing transportation to services, addressing barriers and offering ongoing follow-up.

Challenges, Barriers, and Solutions in Progress

Housing

Lack of affordable housing continues to be a barrier, especially for the homeless, and the program continues to collaborate with agencies to improve access to affordable housing opportunities. To address some participants' reluctance to provide personal information or enroll in engagement services, the programs have reached out to work with trusted community agencies/organizations. Through these partnerships, O&E staff has demonstrated the ability to follow through on commitments to address participants' needs and assisted individuals with accessing referrals, thereby building trust and rapport with participants. Once rapport and some success in linking to resources have been established, participants have been more receptive to engaging in ongoing services. BHS O&E has been called upon to engage individuals at homeless encampments across the county in partnership with cities and local law enforcement agencies many times over the past few years.

Cultural Competence Successes

After the large-scale riverbed engagement two years ago, the community saw the impact of the Outreach Team engaging and linking homeless individuals to treatment, shelter and services. Due to their cultural competence working with this population, many cities and police/sheriff departments have requested BHS O&E support for one-time and ongoing engagement projects in communities across the county. This has necessitated increases in staffing and working hours/days resulting in the program now being active seven days per week and expanding their daily hours until 8 p.m. on weekdays.

Community Impact

FAST FACT: Due to their cultural competence working with the homeless population, many cities and police/sheriff departments have requested BHS Outreach and Engagement support for one-time and ongoing engagement projects in communities across the county.

O&E is firmly rooted in Orange County with strong collaborations with various community based organizations, school districts, law enforcement, churches, physician groups, parent groups, housing providers, outreach teams, older adult programs, other behavioral health programs and other providers of basic needs. The program has reached homeless individuals of all ages from multiple cultures throughout Orange County and has helped them access needed behavioral health and supportive services, including housing. The homeless and provider community widely accepts O&E as a supportive program to help individuals, families and agencies seeking linkage to mental health and substance use programs. This impact has resulted in significant increases in daily calls to the Outreach (800) phone line, requests for community response and partnerships for city-based homeless encampment engagements and street outreach. Outreach has added ten additional staff positions to manage these requests.

The Courtyard Program (CSS)

Target Population and Program Characteristics

The Courtyard Outreach program serves residents ages 18 years or older who are living at The Courtyard homeless shelter in Santa Ana and have a serious 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, Courtyard 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 additional services such as obtaining identification or other personal documents, etc.). These services seek to meet the needs of the client's cultural and linguistic needs.

FAST FACT: The number of contacts at the Courtyard has increased by 38% and the number of referrals has increased by 31% respectively from FY 2016-17 to 2018-19. However, the number of linkages has decreased. Program staff and administrators are currently reviewing the data to ascertain the reason for this trend.

The team can transport, or facilitate the transportation of, residents to those services as needed. As can be seen in the table below, the number of contacts has increased by 38% and the number of referrals has increased by 31% from FY 2016-17 to FY 2018-19. This upward trend is most likely a result of stable staffing. Although the number of contacts and referrals have increased in recent years, the number of linkages has decreased. Program staff is currently evaluating the reasons behind this trend.

Program		Linkage Metrics			
		# Contacts	# Referrals	# Linkages	Types of Linkages
Courtyard Outreach	FY 16-17	7,431	896	642	Basic needs; Education; MHA Multi-Service Center; Information and Referral Sources; Employment Services and Resources; Legal Services and Advocacy
	FY 17-17	8,194	786	577	
	FY 18-19	10,262	1,172	555	

Challenges, Barriers, and Solutions in Progress

The Courtyard Outreach 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 outreach team collaborates with a variety of human services and nonprofit 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 shares in the goal of helping break the cycle of homelessness among those living with serious mental illness.

CHS Jail to Community Re-Entry (CSS)

Target Population and Program Characteristics

The Correctional Health Services (CHS) Jail to Community Re-Entry Program (JCRP) is a collaboration between BHS and CHS that serves adults ages 18 and older who are living with mental illness and detained in a County jail.

FAST FACT: This CSS-funded program was developed in response to the high rates of recidivism observed among inmates living with mental illness and aims to decrease rates of returning to jail by providing access and linkage to needed behavioral health services and supports.

Services

This program uses a comprehensive approach to discharge planning and re-entry linkage services for inmates with mental illness at all five County jail facilities. Discharge planning services are conducted while individuals are still in custody and include thorough risk assessments, comprehensive individualized case management, and evidence based re-entry groups such as Moral Reconation Therapy (MRT) aimed at identifying possible barriers to successful re-entry and developing tailored discharge plans.

Outcomes

The program was still ramping up in FY 2018-19 and outcomes will be reported in future Plan Updates.

FAST FACT: CHS is a multi-disciplinary program working in collaboration with other County agencies and community stakeholders. They cooperate with other agencies to identify gaps in service delivery and to solidify linkages with external stakeholders to for a smooth transition from jail to community.

Challenges, Barriers, and Solutions in Progress

The JCRP program is faced with the challenge of finding appropriate placement options for the number of inmates living with serious mental illness who discharge from County jail facilities. In addition, although transportation is a determining factor in solidifying linkages with external stakeholders for a smooth transition from jail to community, at this time only a few programs provide transportation services for inmates leaving the facility and JCRP does not currently have the capability to provide transportation internally. There is also a challenge linking inmates who are at OCJ for only a short period of time (0-7 days) to services since many community programs require a substantial amount of time for their referral process. JCRP has been working with Open Access North/South and Opportunity Knocks to close this gap in services, and clinicians are now able to make appointments for Opportunity Knocks up until the day before an inmate's release and for Open Access on the same day of their release. Going forward, the program hopes to expand this option for "last minute" referral and linkage to other programs in the county. Finally, JCRP staff have established a weekly re-entry planning meeting with OCSD, Probation and other ancillary agencies to review case plans and discuss the urgent needs of inmates prior to their release. This process serves to address any unmet needs of the inmates prior to release.

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 accessing 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 mental illness to ongoing, 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 ongoing care.

Outcomes

Performance of the program was measured by whether the program met or exceeded the following targets:

- 80% of adults discharged from a hospital and referred for medication are linked to Open Access medication services within 3 business days
- 80% of adults discharged from a jail and referred for medication are linked to Open Access medication services within 3 business days
- 80% of adults referred by Open Access to ongoing care are linked within 30 days.

Total Individuals Served		
FY 2016-17	**FY 2017-18**	**FY 2018-19**
1,357	1,762	1,852

The program continued to meet its targets in FY 2018-19 after staff expectations around scheduling appointments with the Open Access psychiatrist, receiving medication and receiving ongoing care were clarified at the end of FY 2016-17. Additional staff has resulted in smaller caseloads, and this has allowed staff to more closely monitor linkages and follow-up on missed appointments. These improvements, in addition to the implementation of a Performance Improvement Project (PIP) in October 2018 that focused on linking hospitalized clients to Open Access and outpatient services, may have contributed in the upward trend in linkages since 2016-17.

Target	FY 2016-17		FY 2017-18		FY 2018-19	
Referred to Open Access Medication Services	**By Hospital**	**By Jail**	**By Hospital**	**By Jail**	**By Hospital**	**By Jail**
# Referred for Medication by Discharge Location	**753**	**98**	**578**	**110**	**585**	**72**
% Linked Within 3 Business Days	**58%**	**76%**	**74%**	**91%**	**82%**	**89%**
Referred by Open Access to Ongoing Care						
# Referred to Ongoing Care	**591**		**1,014**		**962**	
% Linked Within 30 Days	**57%**		**84%**		**95%**	

Challenges, Barriers, and Solutions in Progress

Since relocating the Open Access South site from Mission Viejo to Costa Mesa, the work load across the north and south locations has become more balanced. In addition, a peer is now employed at Open Access south to assist participants with linking to their appointments at the outpatient clinics and aligning the south site with the peer support already provided at the north site. As part of a PIP for the Mental Health Plan, Open Access will have an intake counselor provide on-site intake assessments at local hospitals for those participants who have been previously hospitalized multiple times but did not attend their intake appointments at Open Access following discharge from the hospital.

Community Impact

Recovery Open Access has provided services to more than 4,861 individuals since its inception through the end of FY 2018-19. The program collaborates with a variety of community partners including: hospitals, jails,

homeless shelters, substance use programs, community health clinics, mental health clinics, OC Probation and Orange County Social Services Agency (SSA) to help individuals receive needed behavioral health care.

Crisis Prevention and Support Services (CSS)

Mobile Crisis Assessment Team (CSS)

Target Population and Program Characteristics

The mobile Crisis Assessment Team (CAT) program serves individuals of all ages who are experiencing a behavioral health crisis. Clinicians respond to calls from anyone in the community 24 hours a day, 7 days a week year-round and dispatch to locations throughout Orange County other than inpatient psychiatric or skilled nursing facilities which are staffed to conduct such evaluations.

Services

This multi-disciplinary program provides prompt response in the county when an individual is experiencing a behavioral health crisis. Clinicians receive specialized training and are designated to conduct evaluations and risk assessments that are geared to the individual's age and developmental level.

Outcomes

The program is evaluated by the timeliness with which the teams are able to respond to calls, with the goal of a dispatch-to-arrival time that is 30 minutes or less at least 70% of the time. While the TAY/Adult/Older Adult team continues to meet this goal, the Children's team has missed the target over the past three years, with a decreasing rate each year (the average response time still tends to be approximately 35 minutes).

One notable factor contributing to the delayed response time of the Children's team is that a majority of their calls come in the late afternoon and early evening hours during peak traffic times. The team is continuing to examine the number of calls from areas that are farthest from the office location to identify ways to improve response times, as this is aligned with one of the Three-Year Plan strategic priorities (Suicide Prevention).

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 (44%, 40% and 42% in FYs 2016-17 through 2018-19 for children; 48%, 45% and 46% in FYs 2016-17 through 2018-19 for TAY, adults and older adults).

Age Group	FY 2016-17		FY 2017-18		FY 2018-19	
	Evaluations Completed	Dispatch-to-Arrival Rate	Evaluations Completed	Dispatch-to-Arrival Rate	Evaluations Completed	Dispatch-to-Arrival Rate
0-17 years	3,039	56%	3,786	51%	4,037	47%
18 years & older	4,568	79%	4,553	82%	4,869	84%

Challenges, Barriers, and Solutions in Progress

While the increasing calls from law enforcement, schools and the community are ultimately a reflection of the program's positive impact in Orange County, this growing demand nevertheless poses challenges. As PERT continues to expand, the TAY/Adult/Older Adult team experiences decreased staffing due to the transition of CAT staff to the new PERTs. To accommodate increasing call volume, both the Children's and TAY/Adult/Older Adult teams have increased the number of positions, however hiring remains difficult due to the inherent challenges in staffing a 24/7 program. Hiring bilingual staff is also difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. The HCA is working to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift. To address the increase in volume during daytime hours, CAT has also been supported by Lanterman Petris Short (LPS)-designated clinicians from County-operated outpatient clinics and, for the Adult team, clinicians from the Program for Assertive Community Treatment. While the Children's team has continued to evaluate the impact of call location on response time, current staffing shortages have prevented the team from stationing a clinician in a high-volume or remote location. During high volume call times, all staff are generally in the field on evaluations and being dispatched from one field location to the next. Increased staffing to support the continually increasing call volume will allow the consideration of other dispatch locations throughout Orange County. The Children's team has been supported by LPS-designated clinicians in the County-operated Children and Youth Behavioral Health regional outpatient clinics to address the increasing volume of crisis assessments during daytime hours and at school locations.

FAST FACT: Hiring bilingual staff is also difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. HCA is working to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift.

Community Impact

Since their inception in January 2003 through June 2019, the mobile crisis teams have responded to calls for more than 28,500 children under age 18 and 48,000 adults ages 18 and older. The teams have been successful in safely linking individuals who are experiencing behavioral health crises to appropriate levels of care that are less restrictive or costly and more recovery-oriented than inpatient psychiatric hospitalization, hospital emergency department visits and incarceration. Feedback from law enforcement about having clinicians out in the field with officers has also been overwhelmingly positive, helping to incorporate a more compassionate response when law enforcement interacts with individuals experiencing behavioral health crises.

Crisis Stabilization Units (PEI)

Target Population and Program Characteristics

In the prior MHSA Three-Year Plan, stakeholders identified a need to expand Crisis Stabilization Unit (CSU) capacity. The MHSA CSUs will provide the community with a 24-hour, 7-day a week, year-round service for individuals who are experiencing a behavioral health crisis requiring emergent stabilization that cannot wait until a regularly scheduled appointment. One of the contracted programs will serve Orange County residents ages 13 and older, the majority of whom may be on a 72-hour civil detention for psychiatric evaluation due to danger to self, others or grave disability resulting from a behavioral health disorder (i.e., Welfare and Institutions Code 5150/5585).

Services

Services, which are not to exceed 23 hours and 59 minutes, will include psychiatric evaluation, basic medical services, individual and group therapy as appropriate, nursing assessment, collateral services with significant others, individual and family education, medication services, crisis intervention, peer mentor services, referral, linkage and follow up services and transfer to inpatient level of care as appropriate. Services will also include substance use disorder treatment for individuals who have co-occurring substance use disorders.

In-Home Crisis Stabilization (CSS)

Target Population and Program Characteristics

The In-Home Crisis Stabilization (IHCS) program operates a 24-hour, 7-day a week, year-round service which consists of family stabilization teams that provide short-term, intensive in-home services to individuals who have been assessed to be at imminent risk of psychiatric hospitalization or out-of-home placement but are capable of remaining safely in the community and out of the hospital with appropriate support. The teams include clinicians and peers with lived experience, with one set of teams serving youth under age 18 and another serving TAY, adults and older adults ages 18 and older. Individuals are referred by County behavioral health clinicians and emergency department personnel.

FAST FACT: More than 3,700 children have received in-home support since services began in 2006 and more than 200 adults have received support since services began in 2018.

Outcomes

The goal of IHCS is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. Both teams continue to be successful in meeting this goal.

Age Group	FY 2016-17		FY 2017-18		FY 2018-19	
	Admissions	Hospitalization Rate	Admissions	Hospitalization Rate	Admissions	Hospitalization Rate
0-17 years	423	13%	672	7%	748	8%
18 years & older	-	-	-	-	211	10%

Challenges, Barriers, and Solutions in Progress

The Children's team has seen continuous growth in referrals since program inception, and works to stay within a three-week timeframe to address crisis events for children and youth. Due to the increased numbers of clients, the program has seen delays in the ability to link clients to ongoing services by the end of the three week period. To address this, the program has been increasing focus on the discharge process and working to link the children and their families as early as possible during the treatment period. Linking children with private insurance has been increasingly challenging for the Children's team. The program has worked to address this by increasing outreach to private insurance providers to educate and increase collaboration for linkages to covered outpatient or other appropriate services.

Community Impact

More than 3,700 children have received in-home support since services began in 2006 and more than 200 adults have received support since services began in 2018. The program collaborates with referring agencies, behavioral health programs, schools and emergency departments, and will collaborate with the crisis stabilization units (CSUs) once established.

Crisis Residential Services (CSS)

Target Population and Program Characteristics

The Crisis Residential Services provides highly structured, voluntary services in a residential setting for individuals experiencing a behavioral health crisis. Individuals ages 12 and older can be referred to the program if they have been evaluated for psychiatric hospitalization, can safely be referred to a less restrictive, lower level of care and they and/or their family are experiencing considerable distress. The program is voluntary and serves anyone in Orange County who meets eligibility requirements. Individuals must be referred by hospitals (for the Children's sites), County CAT/PERTs or County or County-contracted Specialty Mental Health Plan programs (i.e., the program does not accept walk-ins, self-referrals). CRS has a number of sites throughout the county and different sites are tailored to meet the needs of different age groups: Children between the ages of 12 and 17 receive services at three sites (i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, although children can remain in treatment for up to six weeks if needed. Additional Children's sites will be added to comply with State-mandated Continuum of Care (COC) Children's Crisis Residential Program (CCRP) services. TAY between the ages of 18-25 receive services at a site with six beds in Costa Mesa. Services generally last for three weeks, although youth can remain in treatment for up to six weeks if needed. Because many TAY admitted to the program have experienced multiple trauma characterized by violence, are homeless or at risk of homelessness, have co-occurring substance use issues and/or receive little family support, some may receive less intensive residential services for several months to allow for greater stabilization and prevent the

recurrence of behavioral health crises. Adults/Older Adults ages 18 and older receive services at three sites (Orange (15 beds), Mission Viejo (6 beds), Anaheim (6 beds)) with a total of 27 beds. Stays last an average of 7 to 14 days.

The Orange site at the 401 S. Tustin campus has 4 ADA beds available. The Anaheim site is in the process of being converted into a Silver Treehouse that will exclusively serve adults ages 60 and over. Construction has started at the site and a temporary wall has been established to renovate the location with a larger non-ambulatory bedroom and ADA-accessible bathroom, while still being accessible to the community. A new exterior door providing a direct exit from the new ADA bedroom will be provided. The office and medication room will be relocated to a smaller existing bedroom. ADA accessible ramps will be provided on both exits from the house. All 6 beds will be available to the age group 60 years and over and 2 beds will be ADA compliant to serve individuals who are not ambulatory. The HCA hopes to provide this service by the end of FY 2019-20.

Services

The residences emulate home-like environments in which intensive and structured psychosocial, trauma-informed, recovery services are offered. Depending on the individual's age and their or their family's needs, services can include crisis intervention; individual, group and family counseling/therapy; group education and rehabilitation; assistance with self-administration of medications; training in skills of daily living; case management; development of a Wellness Recovery Action Plan (WRAP); prevention education; recreational activities; activities to build social skills; parent education and skill-building; mindfulness training; and nursing assessments. The evidence-based and best practices most commonly used include cognitive behavior therapy, Dialectical Behavioral Therapy (DBT) and trauma-informed care. Programs also provide substance use disorders education and treatment services for people who have co-occurring disorders. To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other on-going behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual; etc.). Children also have the option to participate in a weekly graduate drop-in group.

Outcomes

The goal of the program is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. The program met this goal with hospitalization rates ranging from 12% to 19% across all fiscal years and age groups.

Age Group	FY 2016-17		FY 2017-18		FY 2018-19	
	Admissions	Hospitalization Rate	Admissions	Hospitalization Rate	Admissions	Hospitalization Rate
Children, 0-17 years	243	14%	277	13%	288	12%
TAY, 18-25 years	68	12%	75	13%	69	16%
Adult/Older Adults, 18-99+ years	426	See note*	626	See note*	821	19%

** In prior years, hospitalization rates were tracked by a different target (i.e., less than 5% within 48 hours of discharge) and was shifted to be consistent with the target used by the Children's sites in this Three-Year Plan. This previous target was also reached across the three FYs reported above (i.e., 0-1%).*

In addition, Adult Services tracks the percentage of individuals who are able to be safely referred to a less restrictive level of care such as an outpatient clinic, Full Service Partnership or private psychiatrist/therapist. The target goal established by management is a 90% referral rate to a lower level of care, which was exceeded in FYs 2016-17 through 2018-19 (i.e., 98%, 93% and 95%, respectively).

Challenges, Barriers, and Solutions in Progress

An ongoing, primary challenge has been the increased demand for Crisis Residential Services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and, as mentioned above, anticipates the introduction of a Silver Treehouse that will exclusively address the needs of older adults in crisis starting by the end of FY 2019-20. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care, and children periodically showed an increased demand for services throughout the past calendar year and, at times, either had to be placed on a waitlist or diverted to other crisis services such as in-home crisis. The HCA is examining these trends to determine projected need for Children's Crisis Residential Services over the course of the next three year period. As part of this, the HCA is considering how the new State requirement for a CCRP level of care and facility type will affect the children's crisis residential needs moving forward to ensure a sufficient number of beds are available for youth determined to need this level of care.

Community Impact

Since inception, the program has assisted more than 1,700 children, 1,600 TAY, and 4,000 adults/older adults with intensive services provided in a therapeutic, home-like environment. The program reduces admissions to local emergency departments and provides a strengths-based, recovery-oriented alternative to psychiatric hospitals for those experiencing a behavioral health crisis.

FAST FACT: HCA has recognized a service gap in the needs of older adults in crisis. Because of this, HCA anticipates developing a Silver Tree House, a crisis residential treatment center designed to meet the needs of older adults in crisis. It is expected to be developed by the end of FY 2019-20.

Outpatient Treatment

Community Counseling and Supporting Services (CCSS) – All Ages

Target Population and Program Characteristics

Beginning in FY 2020-21, the Community Counseling and Supportive Services (CCSS) will merge with OC ACCEPT to serve Orange County residents of all age groups who have, or are at risk of developing, a mild to moderate behavioral health condition and 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. With the merging of OC ACCEPT, CCSS has also expanded capacity to provide specialized expertise working with individuals struggling with and/or identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives. CCSS is designed to address the early symptoms of depression, anxiety, alcohol and/or drug use, suicidal thoughts, violence and Post Traumatic Stress Disorder (PTSD) that may be experienced by all participants, as well as the confusion, isolation, grief and loss, high-risk behaviors, self-esteem challenges, victimization by bullying, trauma, homelessness and lack of familial support frequently experienced by individuals specifically identifying as LGBTIQ. The early onset of mental illness is determined through the referral screening process, and participants are referred to the program by family resource centers, medical offices, community-based organizations, County-operated and County-contracted programs, and self-referral.

Services

CCSS provides face-to-face individual and collateral counseling, groups (i.e., psychoeducational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services. Clinicians utilize evidence-based practices such as Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants. In addition, 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. Services are tailored to meet the age, developmental and cultural needs of each participant.

Outcomes

Participants completed the age appropriate 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 118 Three-Year Program and Expenditure Plan FYs 2020-2023 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. The program aims to measure reductions in, or prevention of, prolonged suffering through an age-appropriate form of the

FAST FACT: In FY 2018-19, CCSS provided 24 community outreach and education programs and trained 719 attendees. The overall goal was to raise awareness and reduce stigma over behavioral health issues in the LGBTIQ community. CCSS now has a satellite office in Mission Viejo clinic to increase its outreach to the LGBTIQ community.

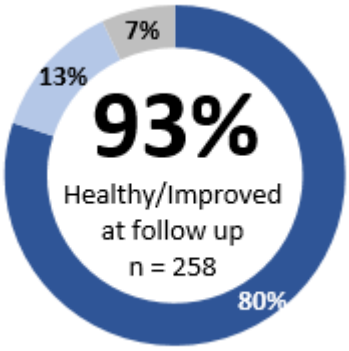
OQ® (YOQ® 30.2 for youth, OQ® 30.2 for adults). The goal was for participants to complete the form at intake, every three months of program participation and at program exit, and then to compare scores to the measure's clinical benchmarks to determine program effectiveness at improving symptoms.

		FY 2016-17	FY 2017-18	FY 2018-19
General Unit (original CCSS)	Total Served	467	492	422
	Baseline + 1 Follow-up OQ Completed	237	287	258
LGBTIQ Unit (OC ACCEPT)	Total Served	121	121	79*
	Baseline + 1 Follow-up OQ Completed	13	37	40

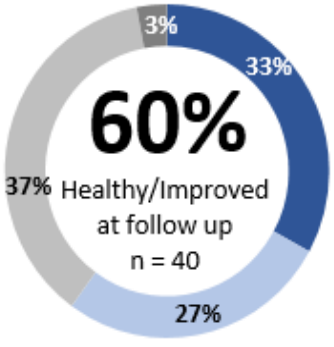
* The decline in the number of clients served in FY 2018-29 was due to changes in program eligibility requirements implemented that year.

Across all three fiscal years, the overwhelming majority of individuals served in the CCSS general unit and a little over half served in the LGBTIQ unit reported mental health distress levels that were either in the healthy/non-distressed range or were reliably improved at the most recent follow-up. Within the LGBTIQ unit, over one-third to nearly one-half if individuals reported stable (i.e., non-worsening) levels of distress. 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 enrolling, particularly within the general unit.

With regard to what appears to be differential symptom improvement between the general and LGBTIQ units, it should be noted that across the three years reported here, the LGBTIQ unit enrolled participants experiencing severe and persistent mental illness whereas the general unit referred these individuals to other programs. This difference in enrollment and referral practice may account for the larger proportion of LGBTIQ participants reporting stable functioning (as opposed to healthy and/or reliably improved functioning) relative to the other CCSS participants and other early intervention outpatient programs. As the intent of the program is to serve those who are experiencing mild to moderate mental health symptoms, the LGBTIQ unit implemented procedures during FY 2018-19 to identify those with greater needs and refer them to the appropriate level of care. Thus, while the program has demonstrated some success at preventing symptoms of mental illness from becoming severe and disabling among the few LGBTIQ participants who completed measures, the conclusiveness of the program's effectiveness should be regarded as tentative until additional data are available following these changes in enrollment practices.



CCSS General: FY 2018-19



CCSS LGBTQ+: FY 2018-19

Challenges, Barriers and Solutions in Progress

Beginning FY 2017-18, both units of the expanded CCSS program have implemented a new Intake Coordinator role to assist with better identifying individuals eligible for services and referring others to a more appropriate resource. Subsequently, the program has been more effective in screening and triaging referred participants to the most appropriate level of care, as well as tracking the number of screenings conducted for individuals who are ultimately referred and linked to other services. Improved screening processes have resulted in fewer individuals enrolling into the general unit compared to prior years, and the program is continuing to outreach and create new partnerships so that they may reach and serve greater numbers of eligible participants. In contrast, client enrollment in the LGBTIQ unit increased during FY 2018-19. This unit had been challenged with not having a full-time program supervisor located on-site after services transitioned to PEI from Innovation in March 2016. In addition to implementing the dedicated Intake Coordinator position, a full-time program supervisor was hired in November 2018. Since then, several changes have taken place to improve program operations, including staff training, outreach to new referral sources, clarification of eligibility criteria, and outcomes data collection. Although a psychiatrist was hired in FY 2016-17 to provide medication support services, in FY 2019-20 it was determined that these services could be discontinued as there was not high demand for them. In the event that an individual requests, or a clinician identifies an individual might benefit from, medication support services, the clinician will work closely with the participant to link them to their primary care provider or a community psychiatrist.

Community Impact

CCSS collaborates with community-based organizations to provide culturally responsive services to the Arabic-speaking, deaf-and-hard-of-hearing and LGBTIQ communities. Since inception, the expanded program has provided services to more than 2,100 individuals, 431 of whom were part of its LGBTIQ service. Additionally, in FY 2018-19, 1,029 individuals (of 1,124 referred to the program), were screened by the Intake Coordinator. The Intake Coordinator position has reinforced the program's ability to accurately identify and enroll participants into services that fall within the mild to moderate spectrum. Conversely, participants presenting with higher severity symptoms are referred and linked to the appropriate level of care that addresses their specific need in a timely manner. The expanded program has also provided valuable education and resources to various unserved and underserved populations with mental health needs in order to promote awareness of and encourage use of its services. In this FY, the program provided 24 community educations presentations and trainings to over 719 attendees, raising awareness and reducing stigma about the LGBTIQ population. To better serve those residing in south Orange County, CCSS has identified a satellite office in Mission Viejo and is currently enrolling participants at its new site.

School-Based Mental Health Services (PEI)

Target Population and Program Characteristics

The School-Based Mental Health Services (SBMHS) program provides school-based, early intervention services for individual students in grades 6 through 8 who are experiencing mild to moderate depression, anxiety and/or substance use problems. Students are referred by school staff and screened by program clinicians to determine early-onset of mental illness and program eligibility.

Services

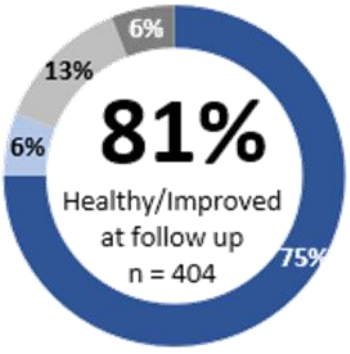
The program provides assessment, individual counseling, case management, and referral and linkage to community resources. It uses evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat and Seeking Safety, as well as Eye Movement Desensitization and Reprocessing (EMDR).

Outcomes

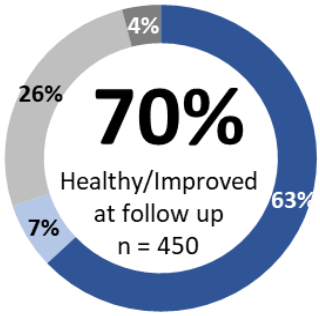
Program performance was evaluated through measures administered at intake, every three months and at discharge. The program assessed reductions in or prevention of prolonged suffering via the YOQ® 30.2 beginning in FY 2017-18.

		FY 2016-17	FY 2017-18	FY 2018-19
SB Mental Health Services	Total Served	623	612	672
	Baseline + 1 Follow-up OQ Completed	N/A	404	450

Results indicate that program services are associated with preventing symptoms of mental illness from becoming severe and disabling for the majority of students served across the past two years. The HCA has noted the shift in the proportion of youth reporting healthy versus stable distress levels in FY 2018-19 (63% vs 26%) compared to FY 2017-18 (75% vs 13%), and will explore possible factors underlying this change and monitor trends over time.



SB MHS: FY 2017-18



SB MHS: FY 2018-19

Challenges, Barriers and Solutions in Progress

In FY 2017-18, the program expanded services to a new district (n=2 schools) and the program has been working through a number of factors that have impacted its ability to fully scale up its direct services to students. First, the program experienced several staff vacancies that it was ultimately able to address through leveraging the clinicians in the SBMHS prevention track. In addition, services were delayed until appropriate office space was identified and the referral processes with the school were worked out. Finally, students' access to services and the number of students that could be seen in a day was limited due to a request that appointments not be scheduled during math and language arts classes whenever possible.

As mentioned above, clinicians from the SBMHS prevention track help addressed staffing shortages in the early intervention outpatient track when services were expanded to a new district. Since then, two additional

school districts have requested early intervention services and are in the process of establishing a Memorandum of Understanding with the HCA. To meet these requests, as well as future anticipated requests, the SBMHS prevention track will merge with the early intervention track beginning in FY 2020-21. This integration will allow the SBMHS program to accommodate schools' requests for increased clinical support by allowing all program clinicians to provide early intervention outpatient services when clinically indicated, while still continuing to provide prevention curriculum as an adjunct group service for students not enrolled in outpatient treatment. The program is also seeking Medi-Cal certification as a way to further expand staffing and increase capacity to serve additional students.

Community Impact

The combined Prevention/Early Intervention program has provided services to more than 14,750 students since its inception in August 2011. The program collaborates with nine school districts and has helped to fill an important and growing need for mental health services in schools.

First Onset of Psychiatric Illness (OC CREW; PEI)

Target Population and Program Characteristics

The First Onset of Psychiatric Illness program, also known as Orange County Center for Resiliency, Education and Wellness (OC CREW), serves youth ages 12 through 25 who are experiencing a first episode of psychotic illness with symptom onset within the past 24 months. The program also serves the families of eligible youth. To be eligible for services, the youths' symptoms cannot be caused by the effects of substance use, a known medical condition, depression, bipolar disorder or trauma. The program receives self-referrals and referrals from County-operated and County-contracted specialty mental health clinics and community providers.

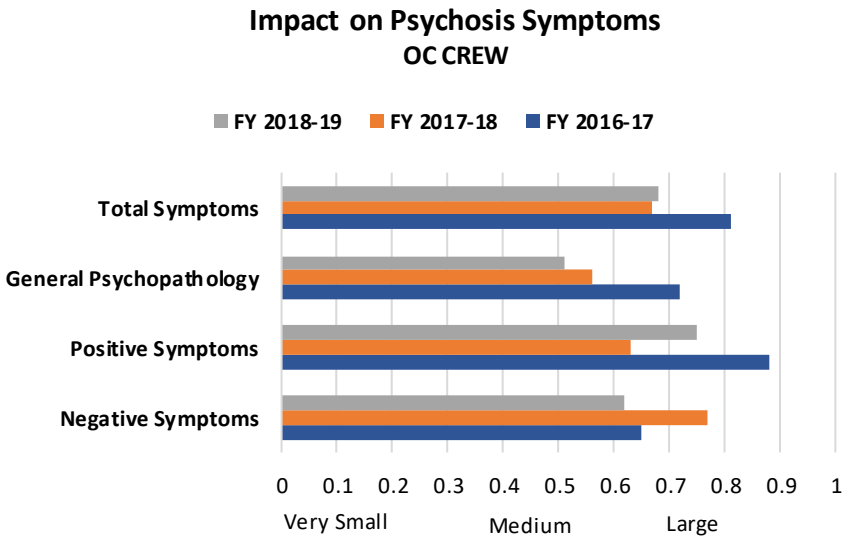
Services

OC CREW uses Early Detection and Intervention for the Prevention of Psychosis (EDIPP) and a Wellness Recovery Action Plan (WRAP) to guide service planning and delivery. The services offered include individual therapy, case management, psychiatric care, psychoeducation, vocational and educational support, social wellness activities, substance use services, and referral and linkage to community resources. In addition to collateral services and evidence-based practices, including Cognitive Behavioral Therapy, Assertive Community Treatment, Art Therapy, medication services and Multi-Family Groups (MFG), the program offers community and professional training on the First Onset of Psychosis.

Outcomes

OC CREW's purpose is to reduce prolonged suffering from untreated mental illness as assessed through ratings on the Positive and Negative Syndrome Scale (PANSS), which is a culturally sensitive assessment that has been tested and validated with diverse ethnic/racial and cultural groups. Psychiatrists provided ratings at intake, every six months and at program exit, and the difference between intake (baseline) and the most recent follow-up is used to determine whether there was a reduction of prolonged suffering. 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 youth served in the program. Medium to large reductions in symptoms were consistently observed across the three years, with slightly greater impact noted in FY 2016-17 than in FYs 2018-19 and 2017-18. Taken together, these findings suggest that OC CREW reduces prolonged suffering from untreated mental illness and helps prevent first episode psychosis from becoming severe, persistent and disabling.

		FY 2016-17	FY 2017-18	FY 2018-19
OC CREW	Total Served	82	91	73
	Baseline + 1 Follow-up PANSS Completed	51	51	54



Challenges, Barriers and Solutions in Progress

The primary barrier faced by program participants is financial, which affects their ability to access reliable transportation, childcare and many other daily basic needs that, in turn, affect their ability to access program services. OC CREW addresses this by providing transportation and childcare when needed. Additional operational challenges occurring during this reporting period include several vacancies in key staff roles (i.e., program supervisor, psychiatrist, clinicians, and mental health specialist). These existing vacancies affected the program's ability to enroll new participants. To address this challenge, staff from different programs who have the necessary skill set have been identified to provide much needed cross coverage. This will allow existing enrolled participants to continue to receive the appropriate level of care needed since external

program staff will provide clinical case management and group facilitation, thus freeing up existing clinicians to screen and enroll new participants. As part of its participation in a statewide Innovation project, OC CREW consulted with the Early Psychosis Learning Health Care Network (EPLHCN), a network of experts that utilizes data to improve early psychosis care, and moved from the PANSS, a psychometric completed by the psychiatrist, to the Brief Psychiatric Rating Scale (BPRS), a brief psychometric completed by the clinician. This will allow the psychiatrist to provide more direct client care and, as a result, increase the ability to enroll new participants to the program. Also, the program is seeking Medi-Cal certification to expand staffing and increase capacity to serve additional participants.

Community Impact

The program has provided services to more than 580 participants since its inception in the Spring of 2011. By providing field-based services, the program is able to reach, serve and impact individuals who are reluctant to seek behavioral health treatment for fear of being stigmatized, have limited resources to access clinic-based care, or experience functional limitations due to their mental health symptoms. During this FY, OC CREW joined the Early Psychosis Learning Health Care Network (EPLHCN, see next page) which is an Innovation project that seeks to support collaboration between Early Psychosis programs at the state and national level to identify ways in which we can improve care and make a greater impact on the community served.

OC Parent Wellness Program (PEI)

Target Population and Program Characteristics

Beginning in FY 2020-21, the Orange County Parent Wellness Program will be re-organized and include Stress Free Families and Connect the Tots. The expanded OC Parent Wellness Program will specialize in serving at-risk and stressed families with children under age 18. This includes pregnant females and partners affected by the pregnancy or birth of a child within the past 12 months, families that have been reported to Child Protective Services (CPS) for allegations of child abuse or neglect, or families with a young child between the ages of 0 and 8 years who are exhibiting mild to moderate behavioral health symptoms that may negatively impact their readiness for school. Referrals come from a variety of sources including self-referrals, hospitals, schools, behavioral health outpatient facilities, and the Social Services Agency (SSA). Eligibility criteria for families referred by SSA is that the most recent child abuse and/or neglect allegation(s) was found to be inconclusive, unfounded or unsubstantiated.

Services

The expanded OC Parent Wellness Program provides early intervention outpatient treatment that includes screening and needs assessment, clinical case management, individual counseling, parent education, psychoeducational support groups, wellness activities, referral and linkage to community resources, and community outreach and education. The counseling approaches used by clinicians include Cognitive Behavioral Therapy (CBT), Eye Movement Desensitization and Reprocessing (EMDR) and art therapy, when indicated. The program also utilizes the evidenced-based curriculum, Triple P (Positive Parenting Program), with staff having been recently trained in providing more intensive Triple P parent education to better meet the needs of the families served. Clinicians also receive specialized training on additional evidence-based curricula (i.e., Mothers and Babies, Understanding Childhood Trauma), to ensure they follow the fidelity of

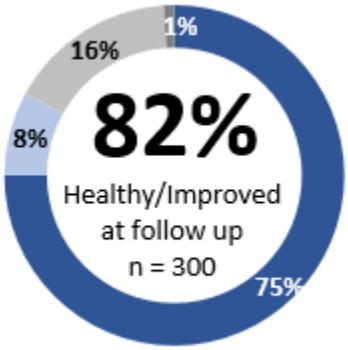
these models and remain current on best practices when working with trauma-exposed individuals.

Outcomes

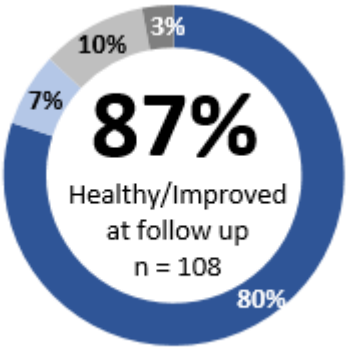
The program measures reductions in or prevention of prolonged suffering through an age-appropriate form of the OQ® or the PROMIS PGH-7 and PARCA-SE. Participants completed the identified measure at intake, every three months and program exit. OQ® scores were compared to the measure's clinical benchmarks, and change in PROMIS/PARCA-SE scores were analyzed and reported by effect size, to determine program effectiveness.

		FY 2016-17	FY 2017-18	FY 2018-19
Pregnant or New Parents *(former OC PWP)*	Total Served	617	506	539
	Age Breakdown	*< 18=76 ≥ 18+ = 541*	*< 18=45 ≥ 18+ = 461*	*< 18=34 ≥ 18+ = 541*
	Baseline + 1 Follow-up Y/OQ Completed	179	310	300
Parents Referred by CPS/SSA *(former SFF)*	Total Parents/Caregivers Served	117	148	147
	Total Children in the Home	*147*	*342*	*189*
	Baseline + 1 Follow-up Y/OQ Completed	*52*	*104*	*108*
At-Risk Children *(former CTT)*	Total Served			
	Baseline + 1 Follow-up PGH-7 Completed	-	38	31
	Baseline + 1 Follow-up PARCA Completed	215	204	156

Across the three fiscal years, anywhere from 75% through 90% of enrolled parents who were expecting, had a child within the past year, or had been referred by CPS/SSA reported healthy or reliably improved levels of distress, as measured by the OQ®, since starting services. Thus, services were associated with preventing symptoms of mental illness from becoming severe and disabling for the overwhelming majority of parents served. For the parents who report a significant worsening in their distress, program staff have been streamlining procedures to quickly identify these individuals earlier in the course of treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists.

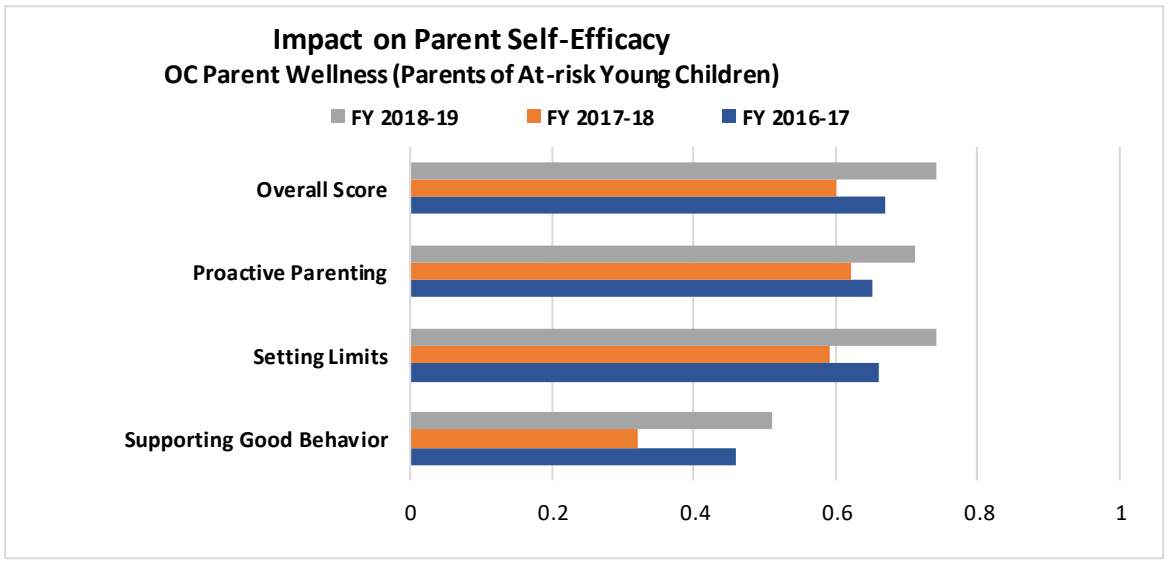


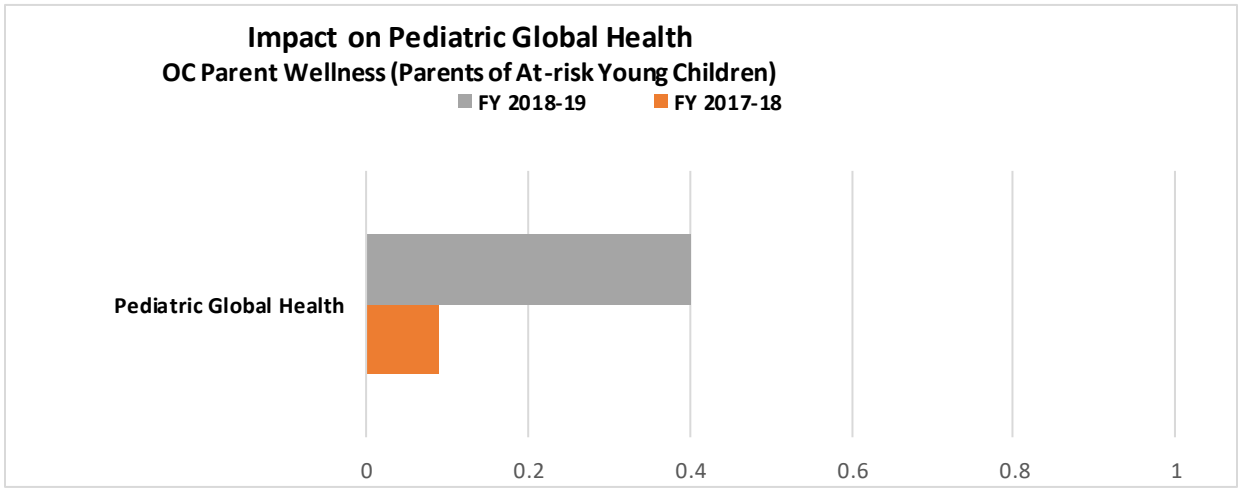
New/Expecting Parents: FY 2018-19



Referred by CPS/SSA: FY 2018-19

For families with young children exhibiting mild to moderate behavioral health symptoms that may impact their readiness for school, the program measures reductions in or prevention of prolonged suffering by having parents rate their children's global health, which was assessed via the PROMIS Pediatric Global Health-7 Proxy. It also aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed via the PARCA-SE. Ratings for both measures were provided at intake, every three months of program participation and program exit, and the change in scores between intake and follow-up is evaluated. Across the two years the PROMIS was completed, parents consistently reported high levels of global health in their children and high levels of parenting self-efficacy as they entered the program. Moreover, children were reported by their parents to have made additional, moderate gains in global health in FY 2018-19, and parents reported having made additional, moderate gains in different facets of parenting self-efficacy over all three years. Thus, services appeared to be effective in maintaining and/or enhancing the protective factor of global health among the young children, as well as parenting self-efficacy, in the at-risk families served in the program.





Challenges, Barriers and Solutions in Progress

Due to the challenges of serving all of Orange County from a centralized location, staff began to provide many services in the field. This resulted in additional challenges for clinicians who could not access real-time resource information while out in the field. Mobile phones were provided enabling clinicians to have immediate access to resources, work schedules, GPS/Maps and real-time consultation with the program Service Chief. For clinicians providing field-based services in South Orange County, which is particularly difficult to reach from the main clinic in the city of Orange, a satellite office and laptops were provided allowing clinicians to access the Electronic Health Record thereby assisting them in updating records in a more timely manner.

Community Impact

Since inception of its respective services, OC Parent Wellness has worked with more than 3,400 new and expecting parents, 900 families referred by Child Protective Services/SSA, and 1,900 families with young children at risk of not being ready for school. Clinicians work directly with parents and caregivers to address their mild to moderate behavioral health conditions (most commonly anxiety and depression), develop positive skills (i.e., communication, parenting), and improve family relationships and bonding, thus resulting in healthier, happier home lives for at-risk children. Program staff also provide consultation to various community partners and County agencies and educate them on the early signs of mental health symptoms and program eligibility requirements and referral processes, thus increasing families' access to timely and appropriate behavioral health services.

Veteran-Focused: Early Intervention Veteran Services (PEI)

Target Population and Program Characteristics

Early Intervention Veteran Services represents a merging of two similar veteran-focused early intervention programs that outreach to and enroll veterans from different sites: college campuses (the former College Veterans program) and veteran-focused community organizations such as the Veterans Resource Centers and the Veteran Service Organization (VSO; the former OC4Vets program). This combined program serves Orange County veterans and their families who currently or previously served in the United States Armed Forces, regardless of the branch, component, era, location(s) or characterization of discharge from their service. The original OC4Vets program began as an Innovation project and continued with PEI funding beginning February 2016. As part of the current Three-Year Plan consolidation, these programs were combined since they provide overlapping services for veterans and the primary difference was whether or not the veteran was referred for services on a college campus. 1 Veterans and their families are referred to the program by local veteran organizations such as the Veterans Service Office (VSO), Veterans Affairs Administration, Veterans Resource Centers at local community colleges, other campus staff or faculty, Orange County Superior Courts, Orange County Family Court, Peer Navigators, outreach workers and self-referral.

Services

The program is co-located at the Veterans Service Office (VSO) of OCCR and Veterans Resource Centers at seven local community colleges. Services include individualized behavioral health screening and assessment to determine whether further evaluation and/ or referrals to behavioral health services are needed, brief

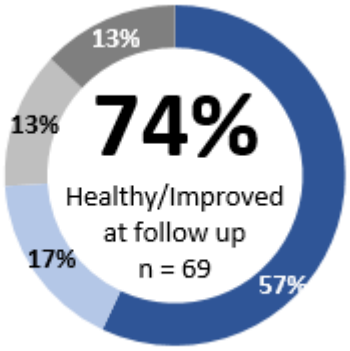
individual counseling, case management, employment and housing support services, referral and linkage to appropriate community resources, outreach and engagement activities, and community trainings. Culturally competent, skilled therapists utilize evidence-based practices such as cognitive behavioral therapy and motivational interviewing when providing brief counseling. Two clinicians are also trained in EMDR to serve veterans who are experiencing trauma, and all clinicians are trained in understanding the unique issues faced by veterans transitioning to civilian and student life. Peer Navigators who are veterans, provide support through their shared military experience and assist with navigating the health care system, employment assistance, and housing navigation. Participants involved in legal proceedings with Family Court, Military Diversion or Veterans Treatment Court are also provided clinical case management to support and advocate for them to seek behavioral health treatment in lieu of consequences such as jail or a restraining order.

Outcomes

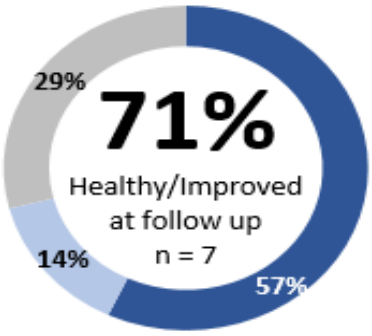
Veterans completed an OQ® measure at intake, every one to three months of program participation, and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. Because the OQ® is a measure of symptom distress and a tool to help inform care planning, beginning in FY 2018-19 the program began to administer the OQ® only to participants who were enrolled in individual counseling. In prior years all participants had been asked to complete the measure even if they were not receiving counseling.

The clear majority of those participating in therapy during FY 2018-19 reported healthy or reliably improved levels of distress at their most recent follow up. These findings are notably different from prior years when only approximately one- to two-thirds of all participants who completed the measure (even if not receiving counseling) reported healthy or reliably improved levels of distress.

		FY 2016-17	FY 2017-18	FY 2018-19
College Locations (original College Veterans)	Total Served	25	14	82
	Baseline + 1+ Follow-up OQ Completed	11	8	7
Community (original OC4Vets)	Total Served	139	104	118
	Baseline + 1+ Follow-up OQ Completed	13	39	69



Veteran Community Locations: FY 2018-19



College Locations: FY 2018-19

While the results, particularly recent ones, suggest that services help prevent symptoms from becoming severe and disabling, the HCA has taken steps to work with staff to improve its measure completion rate so that it can determine whether these results are unique to just participants who complete the forms, or whether this pattern is reflective of the overall veteran population receiving counseling services. Both providers engage with participants who are generally reluctant to ask for help and to discuss the personal traumas they have experienced and to counter this, staff worked closely with the veterans to build trust and establish rapport. In turn, this delayed the intake process and completion of measures. Steps have been taken to encourage more timely completion of forms, including providing training on administration timing and procedures, how to incorporate the results into care planning, and continuous support and follow-up. For veterans not receiving individual counseling but instead primarily receiving case management, information on referrals and linkage to needed county/community resources is provided in the "Summary of MHSA Strategies used by Early Intervention Programs" at the end of this section.

Challenges, Barriers and Solutions in Progress

As noted above, the program is working to improve its OQ® administration procedures and use as a clinical tool. It is also implementing changes with the hopes of expanding its reach and serving larger numbers of student veterans in Orange County. For example, in the first half of the FY, the County worked on streamlining intake procedures, engaging participants through phone check-ins, coordinating peer follow-ups, increasing community partnerships, coordinating with Veterans Affairs (VA) services, and increasing outreach efforts to engage those who are more difficult to reach. Starting January 1st, 2019 the provider switched to a County-contracted provider. In addition, some participants, particularly with their military-connected background, may hold cultural beliefs that deter them from asking for help. To address these barriers, the program is designed to support timely access to services by co-locating services in non-mental health settings already frequented by veterans (i.e., college campuses, VSO, Court).

Community Impact

The program has provided services to more than 720 veterans in the community since July 2012 and more than 250 Veterans in college since its inception in October 2011. Program staff has developed strong collaborations with a number of agencies that serve Orange County's veteran population, including the Veteran's Service Office with OCCR, Workforce Investment Office with OCCR, Office on Aging, Veterans Affairs Administration, Orange County Superior Courts, Orange County Family Court and Veterans Resource Centers at local community colleges in order to best meet the needs of Orange County's veterans.

Behavioral Health Services for Military Families (PEI)

Target Population and Program Characteristics

Behavioral Health Services for Military Families (BHSFMF) serves all members in the military family, including veterans, service members, spouses, partners and children. Eligible participants may self-refer or be referred by behavioral health providers throughout Orange County.

Services

BHSFSC utilizes trained clinicians and peer navigators with experience and knowledge of military culture to

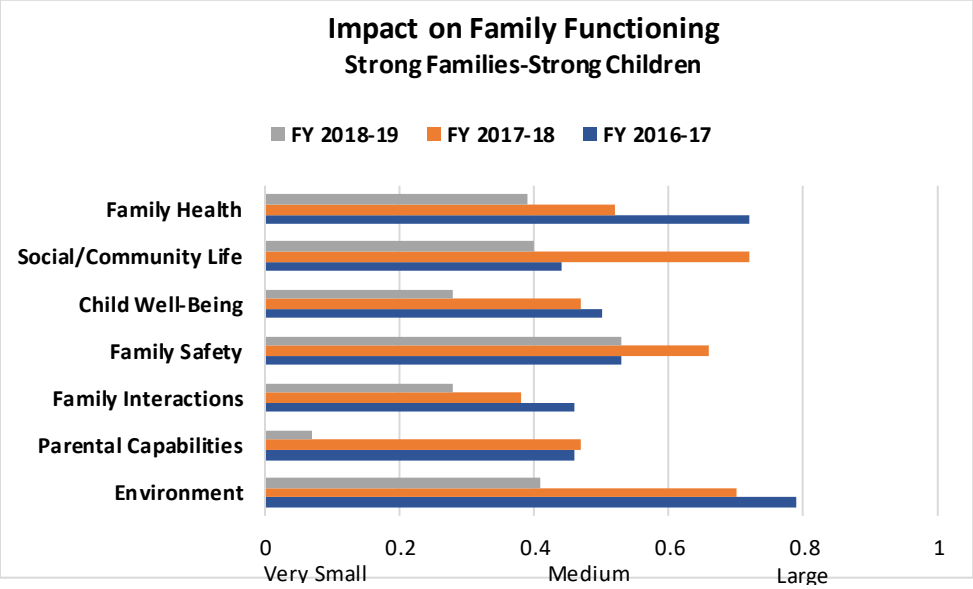
address mental health concerns encountered by veterans that may affect the whole family. Clinicians provide short-term individual and family therapy to address the impact of traumatic events and experiences on children and family members. Peer navigators provide one-on-one peer support, case management, and referrals and linkages to community resources. Additional services include outreach and engagement, 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. This program was approved as an Innovation project in 2014, launched services in July 2015 and transitioned to PEI funding in July 2020 after the Innovation project period ended.

Outcomes

To prevent the onset and/or worsening of mental health conditions, BHSFSC aims to increase the protective factors of 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.

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) across all three fiscal years, with greater effects observed in FY 2016-17 and FY 2017-18. Project services were also associated with small improvements in family interactions (e.g., relationship between caregivers), child wellbeing (e.g., school performance), and social/community life across all fiscal years. There were notably greater effects observed in social/community life in FY 2018-19 compared to FY 2017-18 and greater effects in child well-being and family interactions in FY 2016-17 and FY 2017-18 compared to FY 2018-19. The difference in effects observed in FY 2018-19 compared to previous fiscal years may be due to capacity issues, including understaffing within agencies and staff turnover, as well as reduced leverage funding from partners, resulting in increased referrals outside of the project to link families to needed support. However, 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.

		FY 2016-17	FY 2017-18	FY 2018-19
SFSC	Total Families Served	45	49	105
	Total Family Members Served	*288*	*323*	*413*
	Baseline + 1+ Follow-up NCFAS Completed	49	40	32



Challenges, Barriers and Solutions in Progress

BHSFSC has encountered several challenges throughout FY 2018- 19, including the complex referral system with the veteran and family courts, inconsistencies around assessing and linking participants to domestic violence services, unplanned staff turnover, participants' shifting needs, and a continuing need for participant legal assistance. To address court referrals, BHSFSC peer navigators refined their approach within each court to ensure that the referral process aligns with the participant's treatment progress. They established protocols to ensure that referrals into the BHSFSC program were given only after potential participants completed their court program. To ensure families with domestic violence concerns were adequately identified and served, BHSFSC implemented new strategies to engage veteran and military families during the initial phone screening, revised the language used with families about domestic violence to be more military competent, and provided additional training for staff. These efforts led to an increase in the identification of families needing support around domestic violence issues. In FY 2018-19, twenty-four families were identified compared to four families in FY 2017-18, six families in FY 2016-17 and three families in FY 2015-16. The project also experienced challenges related to staff turnover and participants' shifting needs. Due to the time it takes to train new staff, capacity issues were a concern and affected the speed at which new participants could enter the project. In order to address this, project staff was cross trained on multiple duties and were also utilized to train incoming staff in order to sustain the program's capabilities and address staffing shortages as they arose. More frequent staff trainings were conducted in order to keep new staff informed on project resources and processes. However, the challenge of clients' shifting needs remained and all staff were regularly updated on available services in the community. Finally, there was a continuing need for legal services for families, particularly around child custody issues. Most legal agencies have limited knowledge on how to help the non-veteran parent navigate potential benefits for their child. BHSFSC partner, Veterans Legal Institute, continues to work on finding viable solutions to support custodial non-veteran parents.

Community Impact

BHSFSC and its collaborative partners devoted considerable time to outreach and engagement activities throughout the community, as well as within County and community behavioral health programs. As a result

of these efforts, the project has provided services to 822 individual participants since its inception in July 2015. BHSFSC continues to strengthen its relationship with other veteran-serving agencies, including the Veterans Administration (VA), Long Beach, The Tierney Center at Goodwill, and the Los Alamitos Joint Forces Training Base. The relationship with the VA is especially significant in improving collaborative efforts, linking military-connected families to services and bridging the gap between agencies. They also continue to expand their reach into non-veteran serving institutions by building relationships within the Orange County School District. This collaboration at both the superintendent and individual school leadership level has not only increased their visibility within the community, it has given them the opportunity to provide on-site services within Orange County schools.

Children and Youth Expansion Services Transportation (CSS)

Target Population and Program Characteristics

The Children and Youth Expansion Services program is a major modification of the Youth Core Services program (Field-Based Track) from the FY 2017-18 Three-Year Plan. Based on recent community planning feedback and the needs/disparities assessment, Children and Youth Expansion services will broadly serve youth under age 21 who meet the following additional eligibility criteria and their families/caregivers:

- Living with serious emotional disturbance (SED) or serious mental illness (SMI) and
- Qualifies for Specialty Mental Health Services as part of the Pathways to Well-Being subclass (formerly known as "Katie A" and the original target population for the Youth Core Services program);
- Is in foster care, at risk of foster care involvement, and/or eligible for mental health services under the State-mandated program Therapeutic Foster Care (TFC) and referred by the Social Services Agency (SSA);
- Has Medi-Cal and qualifies for Specialty Mental Health Services;
- Has been screened for trauma in primary care settings through the ACES Aware Initiative and referred for mental health services; or
- Is struggling in school due to their SED/SMI and not already receiving or eligible for mental health services through the school or other provider.

Whenever possible, MHSA funds will act as a match to draw down Federal Financial Participation (FFP) funds and increase the number of children and youth who can be served through this program. Similarly, HCA will work with the Orange County Department of Education (OCDE) and local school districts to identify Local Control and Accountability Plan (LCAP) funds that can be used to leverage FFP and increase the number of students who can be served from school districts that are contributing dollars. Because this partnership with schools is new, planning for expansion of student-focused services will also include development of MOUs, data metrics and data-sharing agreements, referral procedures, etc., with the goal of launching services as soon as practicable in FY 2020-21. Children and youth can be referred to this program by community agencies, other behavioral health providers, pediatricians, SSA, school personnel, general community, families, etc.

Services

Outpatient services provided through this program are tailored to meet the needs of the youth and their family, and can include screening/ assessment, individual and family outpatient therapy, group therapy, crisis intervention and support, case management, referral and linkage to supportive services, and/or medication

management, if needed. Services are linguistically and culturally competent and provided in the clinic, out in the community or at a school (with permission) depending on what the youth/family prefers. For youth enrolled under Pathways to Well-Being, services will comply with program requirements, including those for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Child and Family Teams.

Outcomes

Although a performance outcomes measure has been implemented, outcomes are not available for reporting at this time due to data collection and reporting issues encountered by the provider. HCA will continue to work with the provider so that outcomes can be reported in future Plan updates.

Challenges, Barriers and Solutions in Progress

The provider for Pathways to Well-Being services (formerly Youth Core Services) continues to address issues related to confounding factors that may be influencing performance outcome data, such as low initial scores on the Outcome Questionnaire despite having significant behavioral health problems. Solutions to address these factors include having other parties related to the youth complete the questionnaire, assisting parents with literacy problems complete the questionnaire, and ensuring the questionnaire is completed at intake.

Community Impact

The program, while operating as the Youth Core Services Field-Based track, provided services to more than 1,700 youth since its inception in March 2016.

Services for the Short-Term Residential Therapeutic Program

Target Population and Program Characteristics

Starting in FY 2017-18, Services for the Short-Term Residential Therapeutic Program (S-STRTP; previously a track in the former Youth Core Services program called STRTP) was established to serve Wards and Dependents of the Court ages six to 17 and Non-Minor Dependents (NMD) ages 18 to 21 who need the highest level of behavioral health care in a trauma-informed residential setting. Residential costs are paid through the foster care system, and HCA contracts with the STRTP facilities to provide Medi-Cal Specialty Mental Health Services (SMHS) to eligible youth and NMDs placed under the Assembly Bill 403 mandate. All referrals to the program are made by Child Welfare or Probation with approval from the Interagency Placement Committee (IPC), which includes staff from Child Welfare, Probation and HCA.

HCA is currently in the process of contracting with up to eight facilities in which to provide services:

- Three providers are in varying stages of transitioning to Permanent STRTP Licensure.
- Three providers are provisionally licensed and in negotiations with HCA to contract for SMHS.
- Two providers are waiting for Provisional STRTP Licensure, and HCA anticipates entering into contract negotiations if they are approved.

Services

Per State legislation, youth who meet eligibility criteria can stay in an STRTP facility up to six months, with an option for a six-month extension, as needed, before transitioning to a less restrictive, more family-like setting. While in the placement, the STRTP will provide an integrated program of specialized and intensive behavioral health services that may include the following: individual, collateral, group, and family therapy; medication management; therapeutic behavioral services; intensive home-based services; intensive care coordination; and case management. Per the regulations, STRTP facilities are required to provide evidence-

based practices (EBP's) that meet the needs of its specific population. Thus, the specific treatment interventions may vary among the providers. In addition, the legislation requires that all providers must deliver trauma-informed and culturally relevant core services that include:

- Specialty Mental Health Services under the Medi-Cal Early and Periodic Screening, Diagnosis and Treatment program;
- Transition services to support children, youth and their families during changes in placement;
- Educational and physical, behavioral and mental health supports, including extra-curricular activities and social supports;
- Activities designed to support transitional-age youth and non-minor dependents in achieving a successful adulthood; and
- Services to achieve permanency, including supporting efforts for adoption, reunification, or guardianship and efforts to maintain or establish relationships with family members, tribes, or others important to the child or youth, as appropriate.

Outcomes

The STRTP facilities were ramping up in FY 2018-19 so there are no outcomes to report at this time.

Children and Youth Co-Occurring Medical and Mental Health Clinic

Target Population and Program Characteristics

The target population for the Children and Youth Co-Occurring Medical and Mental Health Clinic is youth through age 20 who are being seen primarily by Oncology, Endocrinology and Neurology services at a local hospital. Youth with severe eating disorders who are at risk of life-threatening physical deterioration are also served in this program. Parents and siblings play an integral part of the treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. Youth are referred to this program by physicians within the local children's hospital. Many of these children and youth are Medi-Cal beneficiaries with MHSA funds serving as a match to draw down federal funds.

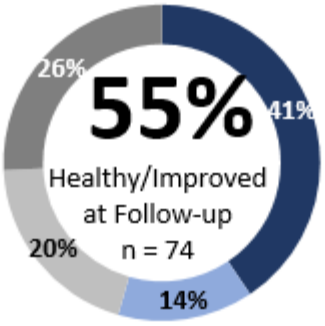
Services

This program provides individual and family outpatient therapy, case management, limited psychological testing and medication management, if needed. A variety of evidence-based and best practices are provided to meet the needs of the youth, with some of the more common clinical interventions including Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Trauma Focused CBT, and Exposure and Response Prevention (ERP). Program staff also have specialty training on the effects of medical and psychological co-existing diagnoses and employ evidence-supported treatments that promote healthy coping and self-management of their diagnoses. Clinicians regularly collaborate with other agencies and community groups to provide the support and services needed to treat a child's mental health condition and improve their psychosocial functioning. Some examples include collaboration with wraparound services for youth who have been removed from their family's care due to medical non-adherence (neglect); collaboration and communication with FSPs serving the program's children who are at risk of homelessness or are presenting with early signs of psychosis; and connecting children to additional services such as Therapeutic Behavioral Services (TBS) to provide intensive short term interventions (e.g., in home meal coaching for those with eating disorders). Program clinicians also have the unique opportunity to communicate directly and collaborate closely with the local children's hospital medical teams so that care can be coordinated and consistent across disciplines.

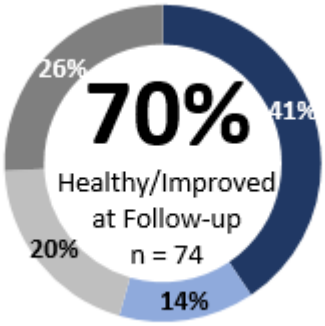
Outcomes

During the program's first year of implementation in FY 2016-17, it was determined that the outcome measure initially selected (PROMIS Pediatric) was not adequately detecting mental health symptoms in this population. As a result, the measure was discontinued and replaced with the YOQ 2.0. Individuals completed the measure at intake, every month of program participation and at discharge, and participants' scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms. The majority of youth (70%) served in FY 2018-19 reported healthy or reliably improved distress levels at follow-up, which was an increase over the 55% of youth in FY 2017-18. Importantly, there was a notable decrease in the proportion of youth reporting reliable worsening of their symptoms while receiving services. Longer lengths of stay may, in part, account for this jump in performance outcomes. As with the previous year, however, it should be noted that the baseline assessment may not reflect a true baseline for youth who had already been engaged in treatment prior to YOQ implementation. Nevertheless, results continue to suggest that the program's services are associated both with preventing symptoms of mental illness from becoming severe and disabling, as well as with meaningfully reducing suffering among those who report clinically elevated distress during program enrollment.

		FY 2016-17	FY 2017-18	FY 2018-19
Children & Youth Co-Occurring Medical & Mental Health Clinic	Total Served	348	445	376
	Baseline + 1 Follow-up YOQ Completed	-	74	74



CYBH Co-Occurring Medical/Mental Health: FY 2017-18



CYBH Co-Occurring Medical/Mental Health: FY 2018-19

Challenges, Barriers and Solutions in Progress

The CYBH Co-Occurring Clinic census has continued to increase since inception. Due to the unique nature of the population served, with co-occurring behavioral and physical health conditions, the program has provided on-going trainings for staff around documentation of services to ensure interventions are clearly tied to behavioral health impairments. The program utilizes primarily psychologists and psychologist fellows to provide direct treatment, but as the program has continued to grow, so have the needs of the population. The need for higher than expected case management support has necessitated the addition of clinical staff (i.e., (LCSW, LMFT, LPCC, ASW, AMFT, APCC) dedicated to support this role. During FY 2018-19, there was a significant increase in referrals to the program, which delayed access to the service. This led to an expansion of the program for FY 2019-20 to meet the projected needs of Orange County children and youth.

Community Impact

The program has already provided services to more than 785 youth and their families since its inception in July 2015, thus underscoring the need for these specialized services. Because the program is located on the medical campus, program staff has the opportunity to work directly with, and educate the medical team about, the effects of the child's mental health condition and how they can best support the child and their family in their overall recovery rather than focusing exclusively on medical outcomes.

Adult and Older Adult Programs

Outpatient Recovery (CSS)

Target Population and Program Characteristics

The Outpatient Recovery program is designed for adults ages 18 and older who are living with a serious mental illness and possible co-occurring substance use disorder. The program is operated at multiple locations throughout the county, with County-contracted locations referred to as Recovery Centers and County operated locations referred to as Recovery Clinics. Individuals are referred to the program by Plan Coordinators in the Adult and Older Adult Behavioral Health (AOABH) Outpatient Clinics after all emergent mental health issues have resolved. This typically occurs within the first 3 to 6 months of being opened in an AOABH clinic. Individuals are referred to the contracted Recovery Centers after they have been in the AOABH outpatient system of care for one year and have remained out of the hospital or jail, are stable on their medication regimen and have consistently attended their appointments.

Services

The Recovery Clinics/Centers provide case management, medication services and individual and group counseling, crisis intervention, educational and vocational services, and peer support activities. The primary objectives of the programs are to help adults improve engagement in the community, build a social support network, increase employment and/ or volunteer activity, and link to lower levels of care. As participants achieve their care plan goals and maintain psychiatric stability, they are transitioned to a lower level of care where they can continue their recovery journey.

Outcomes

The Outpatient Recovery program monitors performance by whether the program met or exceeded the following targets:

- Psychiatric hospitalization rate of less than 1% while participants are enrolled in Outpatient Recovery services
- Discharging at least 60% of those with known discharge dispositions (i.e., not discharged as missing in action, MIA) into a lower level of care

The program has met these goals across sites and fiscal years, with the exception of the number of discharges to lower level of care in FY 2016-17.

	FY 2016-17	FY 2017-18	FY 2018-19

Outpatient Recovery	People Served	Hospitalization Rate	Discharged to Lower Level of Care	People Served	Hospitalization Rate	Discharged to Lower Level of Care	People Served	Hospitalization Rate	Discharged to Lower Level of Care
Recovery Centers	1,937	0.7%	53%	1,933	0.5%	71%	1,732	0.4%	68%
Recovery Clinics	209 *	-	-	589	0.8%	62%	498	0.4%	65%

* *First year of operation (partial year)*

Challenges, Barriers and Solutions in Progress

After reviewing program data, the HCA modified how it calculated the rate of discharge to a lower level of care by removing from the calculation participants who dropped out of treatment for unidentified reasons (i.e., n=55 at Recovery Centers and 15 at Recovery Clinics in FY 2018- 19). Because these participants have left unexpectedly, a level of care determination cannot be made. In FY 2019-20, the HCA began tracking the progress a participant was making towards their goals (i.e., satisfactory, unsatisfactory), and goal progress at the time a participant leaves treatment for unknown reasons will be reported in future Plan Updates.

Nevertheless, the program recognizes that individuals can struggle with staying engaged in services when they experience changes in their treatment team or uncertainty over graduating from the program. Therefore, the program has taken steps to minimize premature discontinuation of services, such as providing peer support, planning social activities to help create a home-away-from-home environment for participants, offering to attend the first appointment with the new provider prior to discharge, and linking participants to community-based programs for continued social support prior to graduation. Programs have also identified graduates who are willing to return to speak with participants at the graduation ceremonies. This helps to encourage participants and allay concerns associated with obtaining treatment in the community and leaving the program where they have become comfortable.

Due to challenges with receiving appropriate referrals, the HCA has diligently worked on collaborating with referral sources and providing them with education on when in the individual's recovery journey it is most appropriate to refer clients to the program. In addition, the HCA has increased peer support provided in this program and hired 17 peers whose main focus is to assist individuals with transitions to different levels of care.

Community Impact

The needs of the individuals accessing the Recovery Centers and Clinics are uniquely met through services focused on reintegration into the community and overall independence. Individuals and their families are educated about the system of care, exposed to community resources and encouraged to set and meet new goals beyond those achieved at the program. Through obtaining employment, pursuing education and/ or participating in meaningful activities, individuals who graduate have a better understanding of the tools they can use to support and maintain their recovery after discharge.

Integrated Community Services (CSS)

Target Population and Program Characteristics

Integrated Community Services (ICS) serves individuals ages 18 and older who live with chronic primary medical care and mild to severe 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), Nurse Practitioners (NPs), registered nurses (RNs), and medical care coordinators are co-located in County 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

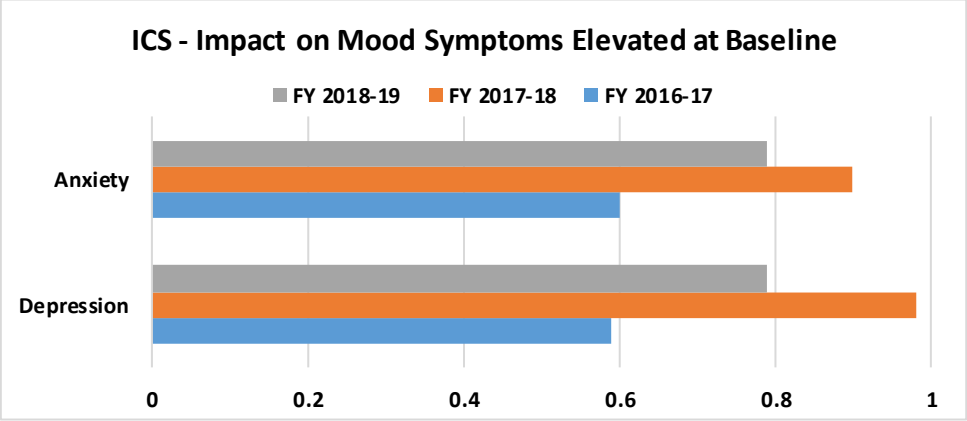
In addition to the medical care provided by the PCPs, NPs and RNs, ICS behavioral health staff conducts a number of psychoeducational support groups on topics such as nutrition, diet, chronic diseases, depression, anxiety, exercise and other physical and mental health care subjects. ICS clinicians also provide therapy, counseling, crisis assessment and intervention and utilize evidence-based and best practices such as Motivational Interviewing, Seeking Safety and Cognitive Behavioral Therapy. Peer Specialists also provide case management and help facilitate program participants' 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 healthcare and behavioral health needs. ICS community Home also participates in community outreach events to educate this hard to reach population about the services at ICS.

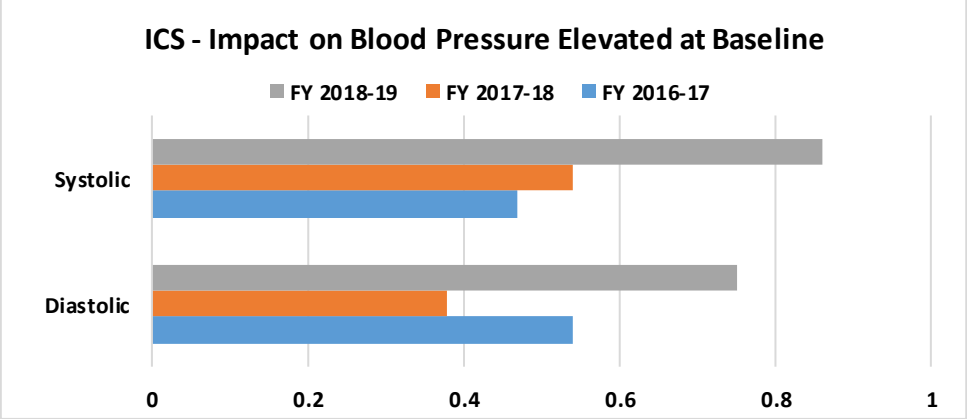
Outcomes

ICS monitored both mental health symptoms (i.e., depression as measured by the PHQ-9, anxiety as measured by the GAD7) and physical health markers (i.e., blood pressure) to assess program impact. Over the past two years, adults with elevated depression and/or anxiety at baseline (i.e., scores > 10), experienced large reductions in their symptoms at follow-up. In addition, adults who met criteria for hypertension at baseline (i.e., ≥ 140/90) demonstrated large decreases in their systolic and diastolic blood pressure during FY 2018-19, which is an improvement from the small to moderate decreases observed in previous years. ICS has diligently worked this past year to standardize procedures, processes and guidelines that resulted in increased staff retention and collaboration with the HCA, which may have contributed to these improved outcomes.

		FY 2016-17	FY 2017-18	FY 2018-19
Integrated Community Services	Total Served	467*	500	468
	Baseline + 1 Follow-up PHQ-9 Completed	140	66	94
	Baseline PHQ-9 Above Clinical Cutoff (>10)	105	45	63
	Baseline + 1 Follow-up GAD7 Completed	137	62	93
	Baseline GAD7 Above Clinical Cutoff (>10)	83	40	47
	Baseline Blood Pressure > 140/90	88	67	52

* *The time frame for FY 2016-17 was extended to capture all participants served in ICS when the program transitioned from INN to CSS in February 2016.*





Challenges, Barriers and Solutions in Progress

In the first quarter of FY 2019-20, the contracted provider serving the Korean community decided to terminate services. From December 2019, the HCA and program provider began working on a timeline that would allow a smooth transition for clients, and the contract will terminate on June 30, 2020. In March 2020, a new solicitation for ICS services was released and the HCA anticipates having a new provider of services in early in FY 2020-21.

Community Impact

The program has provided services to more than 2,100 adults since its inception as an Innovation project in

September 2011. ICS has helped improve participants' physical and mental well-being and fill an important gap in the BHS system of care. The program, through its partnership with a contracted provider that targets the Asian population, has also brought needed mental health services in a culturally accessible way to this underserved community.

Reference Notes

PHQ-9:
FY 2018-19: Prior M=17.5, SD=5.0; Since M=12.2, SD=7.2; t (62) = 6.08, p<.001, Cohen's d=.79
FY 2017-18: Prior M=19.6, SD=5.04; Since M=13.3, SD=7.67; t (44) = 6.22, p<.001, Cohen's d=.98
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 2018-19: Prior M=16.0, SD=3.5; Since M=11.7, SD=5.8; t (46) = 5.10, p<.001, Cohen's d=.79
FY 2017-18: Prior M=16.7, SD=3.6; Since M=12.1, SD=6.1; t (39) = 5.27, p<.001, Cohen's d=.90
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

Systolic Blood Pressure:
FY 2018-19: Prior M=151.3, SD=14.3; Since M=135.4, SD=17.2; t (51) = 6.11, p<.001, Cohen's d=.86
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 Blood Pressure:
FY 2018-19: Prior M=91.4, SD=9.3; Since M=83.5, SD=10.5; t (51) = 5.39, p=<.001, Cohen's d=.75
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

Older Adult Services (CSS)

Target Population and Program Characteristics

Older Adult Services (OAS) serves individuals ages 60 years and older who are living with serious and persistent mental illness (SPMI), experience 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 psychoeducation for participants, family members and caregivers. Evidence-based practices such as Cognitive Behavioral Therapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavioral Therapy (DBT), problem solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care.

Outcomes

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 recently served, 21%, had a nursing assessment completed in FY 2017-18 and 26% had an assessments completed in FY 2018-19. In contrast, approximately half (49%) had a nursing assessment completed in FY 2016-17. 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. As a result, staff had been spread out over multiple offices, which affected program operations and service delivery. The program moved to a new location in March 2019 and it is anticipated that an increase in nursing assessments will occur.

		FY 2016-17	FY 2017-18	FY 2018-19
Older Adult Services	Total Served	398	443	430

Challenges, Barriers and Solutions in Progress

OAS continues to encounter on-going issues collecting outcome measures that evaluate the program's performance (i.e., selection of an appropriate and feasible measure of symptom reduction, adequate completion rates of measures, etc.). Program staff has continued meeting to identify metrics appropriate for the target population being served. Future Plan Updates will report these outcomes once implemented. With the move to a new location, OAS staff can now offer EBP (Emergency Base Practice) groups and education for client and family members in a clubhouse atmosphere.

Community Impact

Older Adult Services collaborates with the Public Health Services Senior Health Outreach and Prevention Program (SHOPP), Council on Aging (Health Insurance Counseling and Advocacy Program, Friendly Visitor), Social Services Agency (Adult Protective Services), community senior centers, adult day health care, Alzheimer's Association, Ageless Alliance, local police departments, Orange County Probation Department, hospitals and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face. In particular, program staff works collaboratively with Adult Protective Services to help older adults who are abused by caretakers, are neglecting themselves, isolating or living in poor conditions. They reach out to homebound seniors who are in need of mental health services and are able to provide all mental health services in participants' homes when necessary. Staff also collaborates with the SHOPP program to conduct joint home visits with the HCA Public Health nurses to ensure that participants' mental and physical health needs are addressed. Finally, the OAS pharmacist conducts many educational events for both participants and professionals on issues relevant to older adults such as medication management, health- and mental health-related matters and community services.

Program of Assertive Community Treatment (CSS)

Target Population and Program Characteristics

The Program of Assertive Community Treatment (PACT) is the County operated version of a Full-Service Partnership program. Like the FSPs, it utilizes the evidence-based Assertive Community Treatment model to provide comprehensive, "whatever it takes", field-based outpatient services to persons ages 14 and older who are living with serious emotional disturbance or serious mental illness. Individuals enrolled in PACT may also have a co-occurring substance use disorder, experience social, cultural and/or linguistic isolation, and have had difficulty engaging with more traditional outpatient mental health services. The main difference

from an FSP is that the PACT specifically targets individuals who have had two or more hospitalizations and/or incarcerations due to their mental illness in the past year. The PACT accepts referrals from County-operated and, in the case of children, County-contracted outpatient clinics. The PACT staffing is separated into teams that provide age and developmentally targeted services (Children/youth ages 14-21, TAY ages 18-25, adults ages 26-59, older adults ages 60 and older). Youth ages 18-21 are served by the Child/Youth team or the TAY team based on their level of caregiver involvement and developmental age.

Services

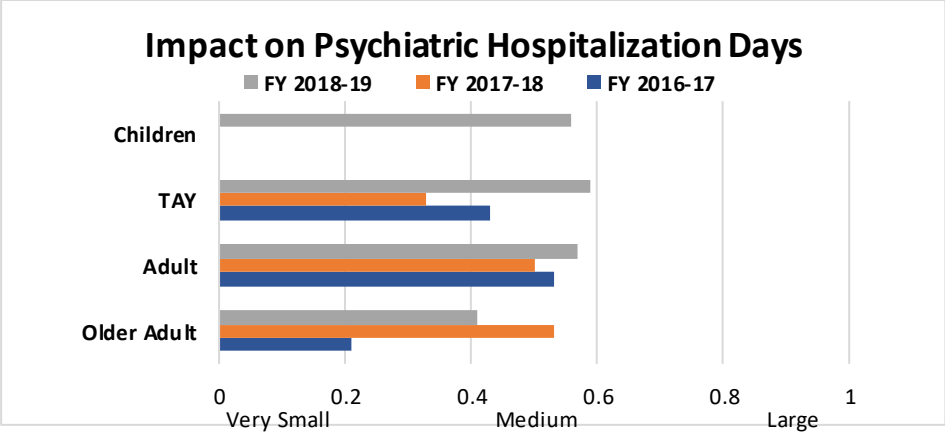
The PACT is staffed by multidisciplinary teams that provide an individualized treatment approach offering intensive, age-appropriate services out in the community. The teams include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and 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 Cognitive Behavioral Therapy. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family members, which can include family therapy, is provided. The PACT also provides intensive case management. Team members offer peer and/or caregiver 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. As needed, the PACT uses flexible funding to support the needs of participants and/or their families and is intended to cover the costs of services and supports not otherwise reimbursable, as well as items such as incentives, stipends, tickets/admission fees, food, refreshments, and ancillary supports such as child care or family involvement, etc. so that the participant may fully engage in the recovery-focused activity

Outcomes

Using the same approach as the FSPs, the PACT evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. For children/youth under age 18, PACT also evaluated grades and school attendance. 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. For all functional measures other than employment or education, only individuals who reported that they experienced the functional outcome (i.e., hospitalization, homelessness, incarceration) either before or after enrollment were included in the outcomes analysis. All TAY and adults were included in the employment analysis and all children/youth were included in the school attendance/grades evaluation.

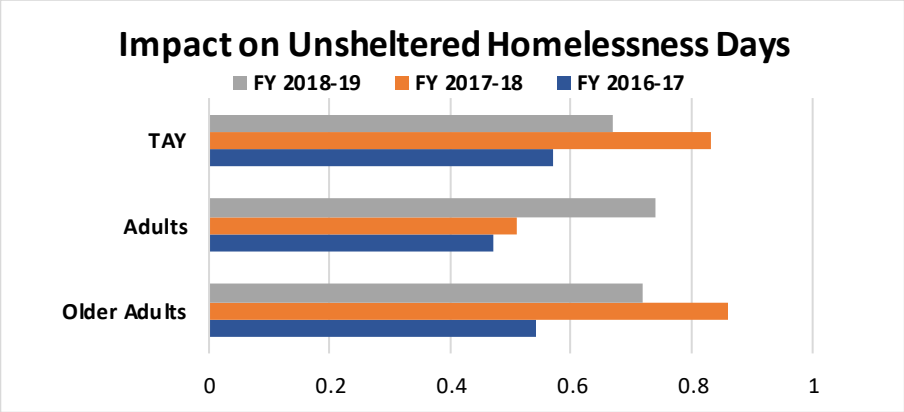
Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
Children/Youth	1	45	79
TAY	141	178	182
Adults	928	887	794
Older Adult	103	89	103

Psychiatric hospitalizations: Adults experienced a moderate reduction in psychiatric hospitalization days during each of the three fiscal years reported here, as did children/youth in FY 2018-19, the first full year in which the team serving this younger age group was fully operational. In contrast, TAY and older adults demonstrated some variability, ranging from small to moderate, in reduced days spent in the hospital while served in PACT. Older adults continue to face challenges with discharge placement options that can accommodate complex medical or physical needs of consumers, which has led to longer hospitalization stays during some years. TAY, on the other hand, experienced a moderate decrease in days hospitalized in FY 2018-19, an improvement from the two prior years. The HCA will continue to monitor the rates in future years to see if this improved reduction continues for TAY.

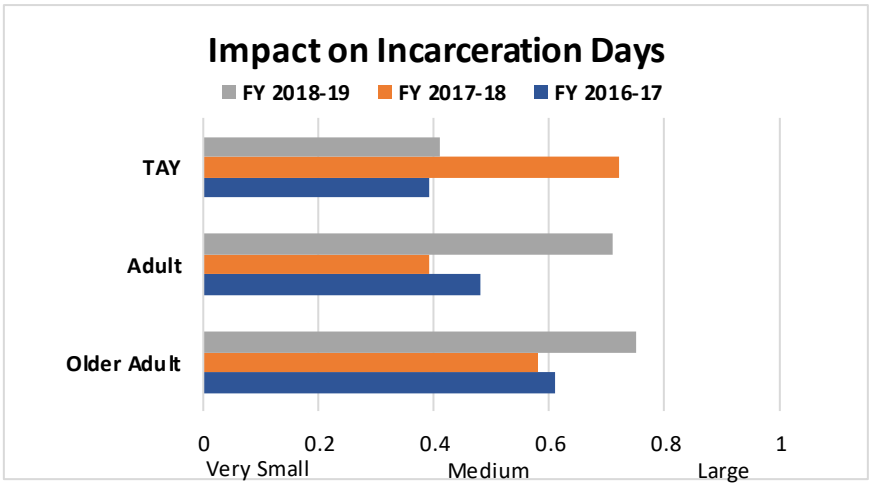


Homelessness: Because individuals who are homeless and living with SED/SMI are largely referred to FSP services, the number of individuals enrolled in PACT who experience unsheltered homelessness tends to be lower than those who are in an FSP. Consistent with this, no children/youth reported experiencing unsheltered homelessness in the year prior to enrollment in PACT and/or while receiving services in FY 2018-19.

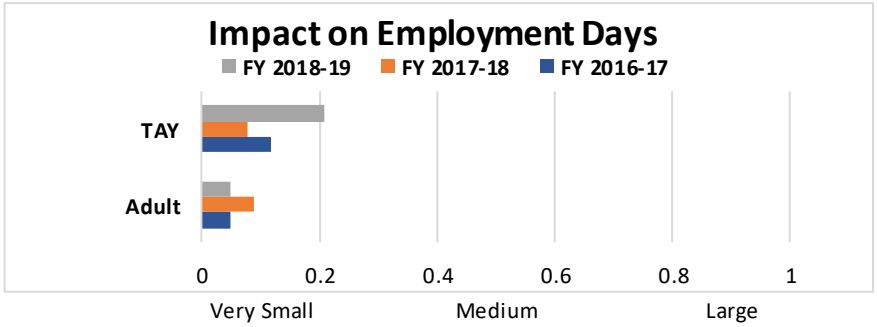
TAY, adults and older adults experienced moderate to large decreases in days spent homeless over each of the past three fiscal years (i.e., average days spent homeless while enrolled in PACT ranged from 1.5-2.5 weeks for TAY, 7-9 weeks for adults, 7-10 weeks for older adults). The number of TAY and older adults affected by homelessness tends to be much lower than the number of adults affected, thus the differences across the age groups may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in overall program efficacy. The HCA will continue to monitor trends in homelessness for PACT participants over time



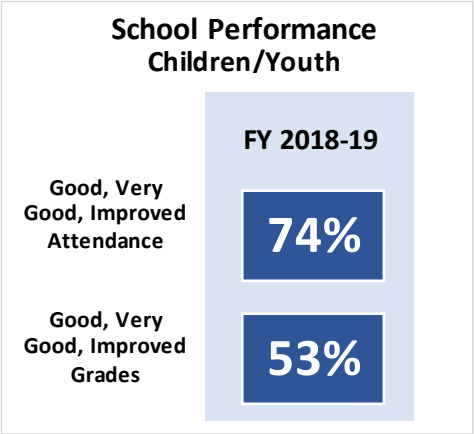
Incarcerations: TAY, adults and older adults enrolled in PACT also experienced moderate to large decreases in days spent incarcerated over each of the past three fiscal years (i.e., average days incarcerated while enrolled in PACT was typically 1-2.5 weeks across all three age groups). Similar to homelessness findings, the number of TAY and older adults who had been incarcerated tended to be much lower than the number of adults. Thus, the differences across age groups and fiscal years may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in program efficacy. The HCA will continue to monitor trends in incarceration for PACT participants over time.



In FY 2018-19, the first year in which the child/youth team was fully implemented, 2 of the 79 children/youth had experienced incarceration: one reported having been incarcerated 121 days prior to enrollment and no days in FY 2018-19, and the other reported having been incarcerated 30 days prior to enrollment and 19 days after.



Education: During FY 2018-19, for children/youth, 74% of youth showed good, very good or improved school attendance while enrolled in PACT, compared to the year prior to enrollment. In addition, 53% of youth showed good, very good or improved grades while enrolled in PACT. These findings are consistent with educational outcomes among FSP participants.



Challenges, Barriers and Solutions in Progress

The Child/Youth team launched in June 2017. The first year involved extensive outreach to bring awareness about this program as a possible referral source. Now that the team is fully operational, one challenge has been the reluctance of the children/youth to use existing work/ vocational programs. Instead, they prefer to seek employment on their own with coaching from program staff. The program supports participants by providing guidance on obtaining employment and offers the assistance of Peer Specialists and Mental Health Workers. In addition, the HCA would like to offer services to children/youth and their families in additional threshold languages but will need additional staff to meet this need. The TAY, Adult and Older Adult teams have all recently been expanded due to increasing demand for PACT services. There are currently 5 vacancies due to staffing turnover, and the HCA hopes to begin hiring for these positions in the coming fiscal year. Like the FSPs, PACT struggles with supporting its participants in engaging in and/or sustaining employment. The program and its participants face many of the same challenges as the FSPs, such as difficulty identifying flexible employers and lack of participant work experience and/or confidence. Thus, staff is working to increase individuals' participation in volunteer work and/or educational/training courses as a way to enhance skills that will help them succeed and feel comfortable in the workforce. While finding safe and affordable housing is a challenge faced by all PACT teams, the difficulty identifying housing options for older adults on Social Security and Supplemental Security Income who need assisted living and/or ADL-compliant housing is especially problematic. The Older Adult team continually works to expand a list of available resources, however limited options continue to make it very difficult to provide safe and timely placement of older adults. The Older Adult team is also encountering increasing challenges in serving those who are experiencing age-related cognitive decline. Such decline can have a negative impact on medication compliance and follow-through with medical and other appointments. The program addresses this challenge by utilizing the Peer Mentoring program and Older Adult Life Coaches. Peers and coaches assist older adults with making and/or attending appointments and by working closely with IHSS and SHOPP nurses and medical providers.

Community Impact

The PACT teams in Orange County target high-risk underserved populations, which include monolingual Asian/Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with serious mental illness. The program has shown a modest reduction in psychiatric hospitalization and incarceration

days, thereby reducing the need for high-cost crisis services for these individuals.

Reference Notes

Psychiatric Hospitalization Days

Children/Youth:
- FY 2018-19: Prior M=29, SD=27.4; Since M=16.5, SD=10.8; t(7)=1.4, p<0.21; Cohen's d=0.56, -44%
- FY 2017-18: -
- FY 2016-17: -

TAY:
- FY 2018-19: Prior M=42.2, SD=68.2; Since M=7.6, SD=30.6; t(113)=5.6, p<0.001; Cohen's d=0.59, -84%
- 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, -64%
- 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, -73%

Adults:
- FY 2018-19: Prior M=47.4, SD=78.3; Since M=7.4, SD=24.7; t(590) = 12.12, p<0.001; Cohen's d=0.57, -84%
- 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, -79%
- 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, -81%

Older Adults:
- FY 2018-19: Prior M=40.7, SD=75.5; Since M=8.6, SD=32.9; t(63) = 3.07, p=0.003; Cohen's d=0.41, -79%
- 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, -89%
- 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, -44%

Homeless Days

Children/Youth:
- FY 2018-19: None reported

TAY:
- FY 2018-19: Prior M=71.8, SD=89.8; Since M=11.2, SD=29.8; t(16) = 2.53, p=0.022; Cohen's d=0.67, -84%
- 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, -73%
- 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, -74%

Adults:
- FY 2018-19: Prior M=165.4, SD=131.0; Since M=52.4, SD=93.1; t(207)=10.47, p<0.001; Cohen's d=0.74, -68%
- 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, -57%
- 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, -54%

Older Adults:
- FY 2018-19: Prior M=174.6, SD=152.5; Since M=69.0, SD=115.1; t(30)=3.50, p<=0.002; Cohen's d=0.72, -60%
- 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, -74%
- 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, -57%

Incarceration Days

Children/Youth:
- FY 2018-19: See narrative for number of days for two youth who reported having been incarcerated

TAY:
- FY 2018-19: Prior M=50.9, SD=94.6; Since M=14.1, SD=32.6; t(13)=1.38, p=0.19; Cohen's d=.41, -72%
- 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, -79%
- 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, -58%

Adults:
FY 2018-19: Prior M=61.7, SD=83.4; Since M=7.1, SD=21.9; t(176)=8.29, p<0.001; Cohen's d=.71, -89%
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, -67%
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, -70%
Older Adults:
FY 2018-19: Prior M=78.3, SD=99.3; Since M=12.6, SD=25.5; t(13)- =2.40, p=0.032; Cohen's d=.75, -84%
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, -84%
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, -69%

Employment Days
Children:
Not assessed for children
TAY:
FY 2018-19: Prior M=26.8, SD=69.3; Since M=46.8, SD=98.4; t(96)=-2.04, p=0.044; Cohen's d=-.21, 75%
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, 29%
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, 22%
Adults:
FY 2018-19: Prior M=29.7, SD=77.9; Since M=34.33, SD=83.1; t(640)=-1.20, p=0.231; Cohen's d=-.05, 15%
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, 33%
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, 21%

Continuum of Care for Veterans and Military Families (INN)

Target Population and Program Characteristics

The Continuum of Care for Veteran & Military Children and Families Innovation project integrates military culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. 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. The target population served includes active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

Services

Peer Navigators with lived military experience 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. Additional services include referral and linkage to County and community programs. Drug Medi-Cal of Care for Veteran & Military Children and Families was implemented July 1, 2018. 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. Innovation funds for this project will end June 30, 2021.

Outcomes

During FY 2018-19, program staff collaborated with 10 FaCT FRC sites to integrate services throughout Orange County and to increase their visibility within the community. Staff conducted 37 community outreach

events and will continue to expand services into the remaining five FRC sites in coming fiscal years. Peer Navigators, clinicians and the Veterans Legal Institute conducted 151 staff trainings for FRC staff, which included 38 specialty trainings on military legal issues, domestic violence and housing. During the program's initial year, staff refined the FRC intake procedures to better screen for both military affiliation and domestic violence, created a comprehensive training on working with military-connected families, and began developing an online, military-specific training platform for all FRC staff. In FY 2018-19, 37 military-connected families (n=140 individual family members) were served. A total of 475 case management and 83 clinical sessions were provided to families, which included 281 specialty sessions focused on housing and domestic violence. Due to their lived experience and extensive training, the Peer Navigators were able to identify needs and appropriately refer the families to resources, thereby increasing the likelihood that families would receive needed services in a timely manner.

Challenges, Barriers and Solutions in Progress

The largest challenge within the first year of services was the immense collaboration involved to move the project into existing Family Resource Centers throughout Orange County. Each FRC has its own culture and process tailored to meet the needs of its unique community. Learning how to best serve within each FRC included embedding the project staff fully into the FRC. This included attending FRC-related events and meetings and working closely with the staff to learn their specific system and design. Project leadership staff also invested time to meet with key stakeholders within the FRC network's FACT Leadership Council as well as the FRC's Coordinators Council. Due to all of the partner agencies involved, implementing new processes takes time. Project staff continues to work on refining processes in order to reduce this barrier. Another challenge was the trend towards families indicating a present or past experience with domestic violence. The collaborative partner agency Human Options was able to provide specialty clinical and case management to these families and to also meet and train FRC Coordinators on how to screen, assess and respond to these families.

Community Impact

The lead agency for this project, Child Guidance Center, and their collaborative partners, is committed to informing nonmilitary community organizations about the importance of identifying, engaging and serving military families to best meet their needs. These partners presented at the FaCT Annual Conference on "The Sacrifices of Service: The Unique Experiences of Military Members, Veterans, and Their Families" and facilitated two breakout sessions that focused on the current systems in place for military families, its gaps, and solutions to address those gaps. This was the first time in the history of the FaCT conference that a breakout session was conducted regarding military-connected families. To further train community agencies on the topic, the collaborative partners also provided an in-service training available to all FRC staff and community providers throughout Orange County titled, "Building Military Cultural Competency in the FRCs to Collaboratively Serve Military Families." These trainings were well received by both the FRC staff, the FaCT Program Administrators, and has increased interest on being trained in this area amongst community providers.

Supportive Services

Transportation (CSS, PEI)

Target Population and Program Characteristics

The Transportation program currently serves adults ages 18 and older, who have a serious mental illness or substance use disorder, and 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. Based on results of the community planning process, this program is being expanded to provide transportation assistance to participants enrolled in PEI programs. In addition, HCA will explore: 1) options for expanding services to youth and to families with children, including those who must be transported in child safety seats; 2) the feasibility of expanding the program to include transportation assistance to support services that help address social determinants of health; and 3) how to leverage transportation assistance provided by other partners and agencies (i.e., Cal Optima, etc.) so that efforts are not being duplicated unnecessarily.

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 ability to stop and get their prescriptions filled as necessary.

Outcomes

The contract began 7/1/2018, with the first ride on 7/12/2018. The total number of rides provided in its first year of operations was 22,202.

Challenges, Barriers and Solutions in Progress

One of the biggest challenges for this program is for clients to remember to schedule their transportation service 24-hours in advance of their appointment times. The purpose of this is to allow the Transportation provider to schedule its fleet of drivers the night before for their appointments the next day. With the high demand for transportation services on a daily basis (Monday-Friday), in all regions of the county, it has been very challenging for drivers to get to their scheduled pick-up/drop-off locations on time without the 24-hour notice. In an effort to ensure drivers can be at the right place at the right time, the Transportation provider has identified the highest utilized areas, and increased its driver fleet in those areas during known times when there is a high need, which has resulted in minimizing any delays for pick-ups/drop-offs. Additional contingency plans are under development that will enable the Transportation provider to meet the high demands despite not always getting a 24-hour notice for service.

Supported Employment

Target Population and Program Characteristics

The Supported Employment (SE) program serves Orange County residents 18 and older who are living with serious 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.

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 to develop 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.

Outcomes

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 68% met this benchmark during FY 2018-19, continuing the trend of an increasing graduation rate since FY 2016-17. This is notable as improving employment outcomes for adults in the BHS system of care continues to be challenging for many other programs.

Numbers Served	FY 2016-17	FY 2017-18	FY 2018-19
TOTAL	405	474	432
New Enrollments	*291*	*334*	*311*
% Served Who Graduated	58%	49%	68%

Challenges, Barriers and Solutions in Progress

During FY 2017-18, SE experienced changes in staffing by only having one program manager managing the two regions instead of two managers. There was also rapid staffing turnover at both North and South. In addition, referrals to the program in South County have been low, and the provider has increased its outreach efforts to programs in that region to improve referrals

Community Impact

The Supported Employment program has provided services to more than 3,000 adults since its inception August 2006. The program has established a strong presence within Orange County through its collaboration with County and County-contracted clinics and other behavioral health programs, as well as its numerous presentations at job fairs, the Wellness Centers and local MHSA steering committee meetings

MHSA/CSS Housing Program

Target Population and Program Characteristics

In contrast to the programs described above that provide time-limited shelter in combination with behavioral health services and supports, the MHSA/CSS Housing Program facilitates the creation of long-term, independent supportive housing for transitional aged youth, adults and older adults with serious mental illness who may have a co-occurring substance use disorder and are experiencing homelessness or risk of homelessness. Additional eligibility requirements can vary at each location due to requirements of other funding partners.

The program funds development costs and Capitalized Operating Subsidy Reserves (COSR). Development costs are used for the acquisition, construction and/or rehabilitation of permanent supportive housing. COSR primarily helps cover the difference between what a resident is able to pay and the cost of operating the unit during the time the resident is working on obtaining entitlement and/or employment income. Behavioral health and other supportive services are located on- and off-site to ensure access to a continuum of services that help residents adjust to and maintain their independent housing.

Original funding allocations for this program included:

- A one-time State allocation of $8 million in FY 2006-07 to develop permanent supportive housing for individuals with serious mental illness who were receiving services in the Full Service Partnership programs. Funds were used to develop 34 housing units in two developments
- A one-time State allocation of $33 million in FY 2007-08 carved out of the CSS allocation (i.e., MHSA Housing Program) and used for 10 housing developments that created an additional 194 new units of PSH in Orange County

The table below provides details about these projects which resulted in the development of 194 new PSH MHSA units for eligible tenants and their families.

Housing Projects Funded by One-Time Allocations							
Project	Year	1-Bedroom Units	2-Bedroom Units	Manager's Unit	Total MHSA Units	Total Units Including MHSA	TOTAL
Alegre Apartments	2015	11	0	1	11	104	$2,912,200
Avenida Villas	2014	24	4	1	28	29	$6,519,200
Capestone Apartments	2014	19	0	1	19	60	$4,445,468
Cotton's Point Seniors	2014	15	0	1	15	76	$2,022,400
Depot at Santiago	2018	10	0	1	10	70	$1,615,320
Diamond Apartments	2009	15	9	1	24	25	$1,583,222
Doria Apartments , Phase I	2011	10	0	1	10	60	$1,500,000
Doria Apartments, Phase II	2013	8	2	1	10	74	$2,019,850
Fullerton Heights	2018	18	6	1	24	36	$6,300,000
Henderson House	2016	14	0	0	14	14	$3,542,884
Oakcrest Heights	2018	7	7	1	14	54	$2,550,798
Rockwood Apartments	2016	14	1	1	15	70	$3,222,974
TOTAL					194	672	$37,895,786

MHSA Special Needs Housing Program (SNHP)

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an on-going and persistent need for housing for individuals living with serious mental illness and who are homeless or at risk of homelessness. As such, multiple CSS transfers to the SNHP operated by the California Housing Finance Agency's (CalHFA) occurred over several years:

- $5 million in FY 2016-17 following local community planning input
- $20 million total in FY 2017-18 upon directive by the Board of Supervisors
- $70.5 million total in FY 2018-19 was approved upon directive by the Board of Supervisors
    - To date, $40 million was transferred to the SNHP to fund the development of new MHSA-eligible housing units throughout Orange County, leaving a balance of $30,500,000 available for future projects
    - On December 12, 2019, the Board approved allocating $10 million to the 2020 Supportive Housing Notice of Funding Availability and the remaining $20.5 million to the Orange County Housing Finance Trust (Trust)

NO PLACE LIKE HOME

Authorized by Governor Brown in 2016 and approved by California voters in November 2018, No Place Like Home (NPLH) dedicates $2 billion in bond proceeds for the development of permanent supportive housing for individuals who are living with serious mental illness or serious emotional disturbance and who are experiencing homelessness, chronic homelessness, or risk of chronic homelessness. NPLH offers competitive and non-competitive funding streams for housing development, and the County must provide a 20 year service commitment to residents in NPLH-funded units. Orange County has several applications currently under review.

Challenges, Barriers and Solutions in Progress

The HCA recognizes that the demand for safe housing for individuals living with mental illness and their families is far outpacing current availability. Thus, staff continually look to identify new opportunities for developing housing for this vulnerable population, which includes staying apprised of other funding opportunities and leveraging resources with other community and County partners.

In September 2018, CalHFA issued an initial notice to jurisdictions that they would discontinue the Program considering the passage of Proposition 2 and the creation of the No Place Like Home (NPLH) program. On November 29, 2018, CalHFA provided a final notice to counties that the SNHP would be discontinued and no longer accept additional applications for eligible projects after January 3, 2020, which is why remaining funds were not transferred to the SNHP.

Community Impact

Increasing access to permanent supportive housing helps to break the cycle of homelessness for many individuals with serious mental illness by improving housing stability, employment and mental and physical well-being. In addition, these MHSA units are integrated in larger housing developments that provide non-MHSA units of critically needed affordable housing in Orange County.

Workforce Education and Training

The mission of the MHSA Workforce Education and Training (WET) component is to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and is capable of providing consumer and family-driven services. Thus, WET offers education and trainings to county staff and contracting community partners that promote well-being, recovery and resilience. The WET Coordinator also serves as a liaison to the Southern California Regional Partnership (SCRP) of WET Coordinators. WET Coordinators from neighboring counties collaborate on and coordinate mutual projects such as trainings, core competencies and conferences to increase workforce diversity and opportunities in the public mental health system.

Following the passage of Proposition 63, the state provided each county with a one-time funding allocation to develop its WET infrastructure. Orange County's allocation of $8,948,100 was exhausted in FY 2013-14. Since then, available dollars from Community Services and Supports (CSS) have been used to fund WET. Counties are allowed to transfer CSS funds to WET, as well as Capital Facilities and Technological Needs (CFTN) and the Prudent Reserve, so long as the total amount of the transfers within a fiscal year do not exceed 20% of the county's most recent five-year average of its total MHSA allocation. Orange County continues to fund WET programs, described in greater detail below, to serve the Orange County behavioral health workforce, mental health consumers and their family members.

Collectively, WET programs continue to reach a large audience, with FY 2018-19 demonstrating a 21% increase in attendance from FY 2016-17. In FY 2018-19, roughly 10,831 individuals and/or community members attended WET trainings and activities. Attendance in previous fiscal years found that 6,258 and 8,949 individuals attended WET trainings and activities in FYs 2017-18 and 2016-17, respectively.[7]

Workforce Staffing Support

Program Description/Impact

The Workforce Staffing Support (WSS) program performs three functions: (1) Workforce Education and Training Coordination, (2) Consumer Employment Specialist Trainings and One-on-One Consultations, and (3) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the Orange County behavioral health workforce, consumers, family members, and the wider Orange County community. In FY 2018-19, WSS programs provided trainings to a total of 3,927 individuals including County staff, County-contracted staff and general community members. This is an increase from FY 2017-18, where a total of 3,108 individuals attended WSS trainings. In FY 2016-17, WSS programs provided trainings for 4,689 individuals.

- **Workforce Education and Training Coordination:** Orange County regards coordination of workforce education and training as a key strategy to promoting recovery, resilience and culturally competent services. Multidisciplinary staff members design and monitor WET programs, research pertinent training topics and contents, and provide and coordinate trainings. As noted in the table, WET provided a large number of in-person professional development trainings between FYs 2016-17 and 2018-19. Training topics included Law and Ethics, 5150/5585 Involuntary Hospitalization and Designation, Patients' Rights Respect and Dignity, Rights for Individuals in Inpatient and Outpatient Mental Health Facilities, Developing and Enhancing Competence in Clinical Supervision, Group and Individual Crisis Response, Housing Placement, Raising Awareness About First Episode of Psychosis, Response to Active Shooters, Meeting of the Minds, Continuum of Care, and Understanding ASAM Criteria in the Context of the California Treatment System.
  In FY 2018-19 only one online training was offered as the HCA transitioned to a new Learning Management System (LMS) where employees now have access to over 70 online trainings annually.

- **Consumer Employment Specialist Trainings/One-on-One Consultations:** As part of WSS, a Consumer Employment Support Specialist works with Behavioral Health Services, contract providers and community partners to educate consumers on disability benefits. The specialist provided training on topics such as Ticket to Work, Reporting Overpayment, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to consumers who requested more in-depth guidance.

[7] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

WSS Trainings and Consultations	FY 2016-17		FY 2017-18		FY 2018-19	
	Trainings	Attendees	Trainings	Attendees	Trainings	Attendees
Professional Development	136[2]	3,997[2]	102[8]	2,556[2]	82	3,351
Consumer Employment Support	67	691	65	551	63	575

- **Multicultural Development Program:** The Multicultural Development Program (MDP) consists of staff with language proficiency and culturally-responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also provides translation/interpretation services utilizing in-house staff and a contracted provider. During FY 2018-19, there was a dramatic increase in the number of interpretation services provided in Spanish, Vietnamese, Arabic, Farsi and ASL,[9] which was attributable to the fact that HCA programs are more aware of and, thus, utilizing the different interpretation resources now available. This includes interpretation services provided on-site and over the phone.

  MDP staff and Language Line services also translated, reviewed and field-tested a total of 223 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2018-19, which was level from the previous fiscal year.[10] In addition, a Licensed Marriage Family Therapist (LMFT) serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language (ASL) interpretation support is provided at trainings, MHSA Steering Committee and community meetings.

  In FY 2017-18, the Ethnic Services Manager and staff continued organizing the Cultural Competence Committee meetings. The Committee consists of multi-ethnic partners and multi-cultural experts in Orange County who meet and provide input on how to incorporate cultural sensitivity and awareness into the BHS system of care. Although the overall count of unduplicated participants declined in FY 2018-19 compared to the previous two fiscal years, this was likely due to meeting cancelations. The goal of these meetings was to provide linguistically and culturally-appropriate behavioral health information, resources and trainings to underserved consumers and family members.

Multicultural Development Activities	FY 2016-17	FY 2017-18	FY 2018-19
Interpretations	95 on-site	241 on-site	2,392 on-site & telephone
Translated Documents	442	216	223
Cultural Competence Committee Meeting Attendance	223	219	188

- **Liaison to Regional Workforce Education and Training Partnership:** The Liaison represents Orange County in the following activities: coordinating regional educational programs; disseminating information and strategies regarding consumer and family member employment throughout the region; sharing strategies that increase diversity in the public mental health system workforce; disseminating Orange County program information to other counties in the region; and coordinating regional actions that can take place in Orange County such as Trauma-Informed trainings, the annual conference focused on hard-to-reach clients, and cultural humility trainings.

Mental Health Career Pathways

Program Description/Impact

Mental Health Career Pathways offers courses 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 to solidify the personal and academic skills necessary to work in behavioral health. Most REI staff have personal lived experience.

Similar to previous fiscal years, in FY 2018-19, REI provided a total of 161 trainings to 567 active students. Of the 274 newly enrolled students, 72% identified themselves as living with a behavioral health condition, 10% identified themselves as family members of those living with a behavioral health condition and 18% identified as both. In FY 2017-18, REI provided 156 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. In FY 2016-17, REI provided 187 trainings to 750 active students. In FY 2016-17, REI provided 187 total trainings to 750 active students. Of the 223 newly enrolled students, 54% identified themselves as living with a behavioral health condition, 30% identified themselves as family members of those living with a behavioral health condition and 16% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. REI enrolled 274 new students in FY 2018-19, 292 new students in FY 2017-18, and 223 in FY 2016-17. During FY 2018-19, fewer students engaged in Academic Advisement and Success Coaching sessions. This was due to staff turnover during the fiscal year, but since then, REI has made efforts to recruit and fill vacant positions.

REI Student Mentoring	FY 2016-17	FY 2017-18	FY 2018-19
Academic Advisement (duplicated)	**2,130**	**2,525**	**2,096**
Success Coach Contacts (duplicated)	**1,119**	**1,999**	**1,264**
Total	**3,249**[11] Duplicated	**4,524** Duplicated	**3,360** Duplicated
	1,384[12] Unduplicated	**1,627** Unduplicated	**1,567** Unduplicated

[11] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.
[12] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

In addition, REI offers a wide variety of trainings, including Introduction to Microsoft Excel Spreadsheets, Elementary Spanish for Public Speaking, Introduction to Psychology, Case Management, Vocational Skills Building, and Self-Esteem and Confidence (see "Workshops & Classes" in table below). REI collaborates with adult education programs, links students to local community colleges for prerequisite classes, and provides accredited college classes and certificate courses on-site.

REI also offers a series of pre-vocational workshops to prepare students to enter the workforce. These workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers ESL and GED classes for students to benefit employment opportunities. A high percentage of students completed the REI workshops and classes in FY 2018-19 and FY 2017-18 (see "Pre-Vocational Courses" below). This increase in completion rates from FY 2016-17 is due to an administrative efficiency created when WET consolidated classes and workshops and staff were better able to track course completion rates. However, there was a decrease in the number of students who completed Extended Education courses in FY 2018-19 due to several reasons (see "Extended Education" below), including:

- Extended Education courses meet more frequently, compared to other workshops and college courses in the REI curriculum.
- The Extended Education course model is an open entry and exit format. This creates a revolving door for students who may need courses on a short-term basis.
- The REI College Courses have a strict dropout policy due to popularity of the courses being offered. This creates a higher level of commitment for those students to complete their courses, compared to Extended Education courses.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program 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 certification, students must complete nine 3-unit courses and a 2-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies (see "College Credit Course" below).

REI Workshops and Courses	FY 2016-17	FY 2017-18[13]	FY 2018-19
Workshops & Classes	**95 offered 66% completion rate**	**76 offered 95% completion rate**	**79 offered 83% completion rate**
Pre-Vocational Courses	**65 offered 94% completion rate**	**51 offered 91% completion rate**	**52 offered 93% completion rates**
Extended Education	**10 offered 71% completion rate**	**12 offered 71% completion rate**	**14 offered 54% completion rate**
College Credit Course	**17 offered 93% completion rate**	**16 offered 85% completion rate**	**16 offered 86% completion rate**

[13] Data was reported incorrectly in the FY 19-20 MHSA Plan Update.

Summary

This section provided a detailed review of BHS programs, highlighting their status for the reporting period. Each program presented its outcomes, and areas of cultural intersections were noted where possible. Material was highlighted to provide a greater focus on gender, culture, ethnicity, and outcomes in those programs. Changes to Criterion 3 for 2020 include the addition of program data and summary information from our Substance Use Disorders Division. This addition of this program further clarifies the work of BHS in reaching marginalized communities, such as the homeless, for whom substance use disorders are endemic.

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

Cultural Competence Committee

Recognizing the need for a dedicated and distinct Cultural Competence Committee, HCA BHS formed the Cultural Competence Committee (CCC) in 2016. The Committee includes members from the community and the Health Care Agency who also represent or serve persons from the diverse ethnic and cultural groups in Orange County. The Cultural Competence Committee's overarching goal was initially defined to "increase cultural awareness, sensitivity, and responsiveness to the needs of diverse cultural populations in order to foster hope, wellness, resilience and recovery in our communities."

The CCC began meeting monthly 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.

Following the events of 2020 a new sub-committee was formed to address the fast changing landscape of the county concerning the devastating effects of the Coronavirus pandemic on the unserved and underserved communities as well as the local and national outcry following the killing of George Floyd. In May 2020 the formation of a new sub-committee named the Community Relations and Education (CORE) Sub-Committee was discussed and the subcommittee's regular meetings started in July 2020. The CORE Sub-Committee met several times in the summer and Fall of 2020 and developed a document to define the governing structure of CCC. The name of the Cultural Competence Committee (CCC) was changed to Behavioral Health Equity Committee (BHEC) and the Governing Structure document was finalized in December 2020.

BHEC's vision as defined by the Governing Structure states that: *Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups.* In accordance with the Governing Structure a Steering Committee and several Work Groups are to be formed. The BHS will appoint a Co-Chair on its behalf and the Steering Committee will elect the community Co-Chair.

A copy of the Governing Structure as approved by BHS is included in Appendix II.

Cultural Competence Committee Summary of Accomplishments -FY 2018-19:

- From its inception in May 2016, through December of 2020, BHEC (CCC) held 46 meetings (10 meetings in 2018-2019). The meetings were held virtually since May 2020.
- More than 30 organizations/contract providers/county departments and programs were represented at BHEC meetings. Average number of attendees per meeting was 20 during FY 2018-2019. The average number of attendees at BHEC meetings held virtually since May 2020 increased to more than 30 per meeting. 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. Martin Luther King Day
    10. Black History Month
    11. Asian American and Pacific Islander Heritage Month
    12. Mental Health Matters Month
    13. Memorial Day
    14. 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, 2018 and 2019. The multicultural Potluck held virtually in December 2020 attracted more than 20 attendees. Three members made virtual presentations about a meal from a culture they identified with.
- Increased awareness of cultural practices/traditions among CCC members/organizations through the 14 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 about Jewish Holidays was launched in September 2018. A second Culture Corner video about celebration of Kwanzaa in Black/African American communities was produced and launched

in December 2020.

- Cultural Competence Communication Partnership (CCCP) idea was developed at CCC, presented to the agency management and taken on the road to several programs. The objective of CCCP was to decentralize and standardize access to language services throughout the agency. Presentations were made at BHS programs' monthly meetings attended by over 80 managers, service chiefs and program supervisors.
- Multilingual Afterhours Greeting project was developed at CCC and was presented to the BHS top management.

Cultural Competence Committee Members

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Summary

During the year 2020, The Behavioral Health Equity Committee's (BHEC) [formerly Cultural Competence Committee (CCC)] activities were thoroughly reviewed. Although the work of BHEC is an ongoing effort, it was determined that the activities of the BHEC had been successful during the year covered by this report. The Committee's impact and contributions to BHS were in the following key areas:

1- BHEC created a forum for bringing the County and community-based organizations and contract providers and members of the community at large together to learn best practices in order to have services that are culturally and linguistically appropriate to the needs of the populations that we serve. Several of the above referenced programs, informed and influenced by the public private partnership, have succeeded in raising awareness among members.
2- The committee assisted the BHS programs to decentralize and standardize the language services.
3- BHEC expanded its membership to include several peer support specialists and individuals with lived experience. The committee has also started partnership with other government entities starting with the OC Department of Education.
4- Developed BHEC's Governing Structure document.
5- Deepened our relationship with the communities we serve especially the unserved and underserved communities. In this respect we have reached out to the Black/African American community and have started dialogue with one organization that focuses its services on the Back/African American population in OC.

CRITERION 5: TRAINING ACTIVITES

Developing a culturally and linguistically aware workforce is essential to providing effective services. Cultural Competence requires that direct service providers learn a set of values, understand varied cultural experiences, and establish skills to utilize when providing specialty mental health services to clients. Training curriculum should be targeted toward providing direct service providers with skills focused on cultural sensitivity and an understanding of how the participant, their mental illness and/or substance use, their experience with the behavioral health system, and the stigma of mental illness and/or substance use, has impacted their access to services. In this section the Orange County Multicultural Development Program will describe the cultural awareness trainings that were provided during FY 2018-19.

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.

Additionally, it is required that cultural considerations are embedded into all trainings providing Continuing Education (CE/CME) units, as described in the training 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. Trainings focused in skill building and education are conducted to address cultural sensitivity and humiliation, as well as reduce stigma and discrimination within the behavioral health system. This is done in order 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 Trainings

Cultural Competence trainings are comprised of several topics, including those related to behavioral health best practices (certification and re-certification), as well as development of clinical skills related to common evidence-based practices and trauma-informed care. These trainings were developed for clinicians, service providers and community members. Trainings were also provided to medical community members, such as doctors and registered nurses, to improve their daily practices. Additional trainings were targeted toward support for staff who 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 hard of hearing and have limited English or other written language reading skills.

Cultural competence trainings were provided for staff and stakeholders on a variety of topics. Data for the following tables was pulled from the Department's raw evaluation form data. Table 5.1 below is a chart that provides information on the cultural development trainings provided during FY 2018-19. Training curricula described the ethnic disparities among Latino, Vietnamese, Korean, Iranian, and Arabic cultures. Specifically, these topics helped to address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County.

In response to DMC-ODS requirements for specific training topics, the Behavioral Health training Services department developed a partnership with UCLA-ATTC to bring high quality SUD-focused trainings to BHS staff and contract providers, including Case Management, Effectively Using Motivational Interviewing with SUD populations, Relapse Prevention, etc. The list of trainings will be highlighted in yellow. To respond to ongoing trends and requests from providers, other trainings related to Medication Assisted Treatment (MAT) and Opioid Use were offered as well throughout the year. Utilizing an e-learning platform, ASAM training is provided upon request at no charge to fulfill ASAM A and B requirements.

5.1 Name of the Trainings Qualified as Cultural Trainings, FY 2018-19[1]

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
5150 LPS Initial Certification[2]	4	113	27	20
5585 Initial Certification Training	3	91	18.45	13.5
Bio-Spiritual Focusing Training: Accompanying Self and Others on the Journey Part I	1	24	6	6
Bio-Spiritual Focusing Training: Accompanying Self and Others on the Journey Part II	1	18	6	6
Child Adolescent Needs & Strengths (CANS)[3]	1	69	19.5	22
CBT and Relapse Prevention Strategies*	1	123	6	6
Clinical Supervision Addressing Vulnerable Populations: Helping Supervisees Adopt a "Multicultural Relational Perspective"	1	65	6	6
Elements of Effective and Ineffective Supervision	1	111	6	6
Communicating Effectively with the Deaf / Hard of Hearing People	2	20	2	0
Community First Conference	1	453	5.6	0
Crisis in Faith	1	*	2	2
Crisis Intervention Training (CIT) Dispatcher	5	122	0	0
Crisis Intervention Training (CIT) I	12	333	0	0
Crisis Intervention Training (CIT) II	7	79	0	0
Crisis Intervention Training (CIT) III	3	32	0	0
Cultural Competency Training (Online)	1	2623	1	1
Dialectical Behavioral Therapy - Consultation	1	21	1.5	0
EMDR Basic Training Part 1	1	33	20.45	20

EMDR Basic Training Part 2	1	32	20.45	20
EMDR Monthly Consultation	11	76	16.5	4
Housing and Placement Training	4	76	22	0
Law & Ethics: Client Welfare, Therapist Responsibility	1	138	6.5	6
Confidentiality and Ethical Issues Facing Substance Abuse and Mental Health Providers*	1	153	6.5	6
Liberating Latina/o	1	81	3.15	3
Marijuana and Psychopharmacology*	1	98	3	3
Mental Health First Aid (Adult)	16	310	0	0
Mental Health First Aid (Public Safety)	4	122	0	0
Mental Health First Aid (Spanish)	1	35	0	0
Mental Health First Aid (Youth)	2	37	0	0
Mental Health First Aid (Private)	1	27	0	0
Motivational Interviewing*	1	46	6	6
Moving Forward: A Strategic Approach to Tobacco Recovery in Behavioral Health Programs	1	43	6.15	6
Non-Violent Crisis Intervention Training (NVCI)[4]	17	253	120	102
NVCI Half-Day (Re-certification)	3	40	9	9
Peer - Resilience	1	17	80	0
Project Kinship (Medication & Spirituality, Substance use & Spirituality)	1	60	3	0
Recovery - Promise of Hope	3	139	9	9
Recovery Based Treatment Planning	1	120	3.5	3.5
Seeking Safety*	1	82	6	6
Spirituality Conference	1	153	6.5	5.5
Spirituality Training (Moral/Spiritual Injury)	1	44	3	3
Trauma Informed Care Part 1	1	119	6	6
Trauma Informed Care Part 2	1	197	6	6
Trauma Informed Care Part 3	1	207	6	6
Trauma Informed Care Part 4	1	126	6	6
Veteran's Conference	1	207	6.5	6
Vicarious Trauma and It's Spiritual Implications	1	87	3	3
Working Effectively in Behavioral Health Setting with Sign Language Interpreters	2	0	2	0
Working with Sign Language Interpreters	2	1	2	0
Workplace Violence - Active Shooter Response[5]	4	161	8	0
Grand Total	**146**	**7,762**	**527.25**	**358.5**

[1] No CEUs were given for CIT or MHFA

**DMC-specific Trainings*

[2] 5150 - 4 trainings conducted, but only 3 reported in our database

[3] CANS - Two-day training (Day 2 - option of two dates offered)
[4] NVCI inclusive of Adults and Children
[5] Workplace Violence - 4 trainings conducted, but only 3 reported in our database
* Attendance could not be determined because no sign-in-sheets or evaluation forms were collected for this training

Table 5.2 and 5.3 below describes staff and stakeholders professional and personal role identification. In some cases, one person may identify as multiple roles. The majority of participants identified as County (34.8%) or Community-Based (19.2%) Direct Service Providers. Most participants identified as Community Members (25.7%), Family Members (15.7%), and/or Parents (13.8%). Roughly 17% of participants also identified as something other than what was listed in Table 5.3.

5.2 Cultural Development Training Attendance by Participants' Professional Role, FY 2018-19

*Attendance by function**	*Total Number*	*Percentage*
County Administrator/Manager	640	10.1%
County Direct Service Provider	2,205	34.8%
County Support Staff	903	14.2%
Community-Based Administrator/Manager	609	9.6%
Community-Based Direct Service Provider	1,218	19.2%
Community-Based Support Staff	768	12.1%
Total	***6,343***	***100.0%***

*Some attendees reported multiple professional roles

5.3 Cultural Development Training Attendance by Participants' Personal Role, FY 2018-19

*Attendance by function**	*Total Number*	*Percentage*
Consumers	747	11.6%
Parents	891	13.8%
Family Members	1,009	15.7%
Community Member	1,654	25.7%
Caregiver	501	7.8%
Teacher	128	2.0%
Student	373	5.8%
Youth	34	0.5%
Other	1,100	17.1%
Total	***6,435***	***100.0%***

*Some attendees reported multiple personal roles

Relevance and Effectiveness of All Cultural Competence Trainings

The HCA Cultural Competence training for health care professionals focuses on skills and knowledge that value diversity, understand and respond to cultural differences, and increase awareness of providers' and care organizations' cultural norms. Trainings can provide facts about patient cultures or include more

complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds (Govere 2016*, Cochrane-Horvat 2014*).

A key component of the HCA Cultural Competence trainings is to increase attendees' cultural understanding and skills related to increase client satisfaction and improved behavioral health outcomes. These concepts are likely to help decrease disparities among underserved or underrepresented groups.

There is strong evidence that cultural competence training for health care professionals improves providers' knowledge, understanding, and skills for treating patients from culturally, linguistically, and socio-economically diverse backgrounds (Govere 2016*, Gallagher 2015*, Truong 2014, Renzaho 2013, Like 2011, Patel 2019*, Horky 2017*, Cruz-Oliver 2017*, Fox 2016*). Cultural competence trainings can also improve patient satisfaction (Govere 2016*, Truong 2014, Renzaho 2013, Like 2011, Clifford 2015*). In some circumstances, patients whose providers completed training report better opinions of their clinicians or participate longer in mental health counseling than patients whose providers did not (Cochrane-Horvat 2014*). These trainings help clinicians and staff to communicate with clients in a culturally sensitive way and to better understand the presenting problem. It is also possible that by improving clients' satisfaction with the services this would increase service utilization and hence help reduce disparities.

Data Collection and Methodology

To collect data on trainings effectiveness, the HCA MDP implements a post-test only design for collecting participant responses. This evaluation design is also implemented across all trainings provided by Behavioral Health Training Services (BHTS), regardless if cultural considerations are built into the curriculum.

Over the last three years, steps have been taken to improve data quality and tracking. In FY 2018-19, evaluation form data was collected after each BHTS/MDP training and entered using an online data collection system (e.g., SurveyMonkey). Training information was also tracked in an independent Excel Workbook so as to monitor the number of trainings facilitated each year. At this time, the Orange County Health Care Agency was also in the midst of revising the demographic questions and categories that should be included on data collection forms throughout the Behavioral Health Department.

At the start of July 2019, a new evaluation form and data tracking system were developed in order to consolidate data tracking and collection. Questions on the revised BHTS/MDP evaluation forms focus on knowledge gained as a result of the training, usefulness of course materials, effectiveness of training presenter and curriculum, as well as overall satisfaction with the training. Updated information regarding participant demographics are also collected in order to satisfy both local and state data collection requirements (Samples of the Evaluation forms can be found in Appendix III).

In addition to the evaluation form revisions, BHTS/MDP developed a new Microsoft Access database to routinely track data throughout the department. This was developed for two reasons:

1. To replace the existing Excel Workbook that was used to track information regarding BHTS/MDP trainings, and
2. To serve as the main database where all training and evaluation form data are entered.

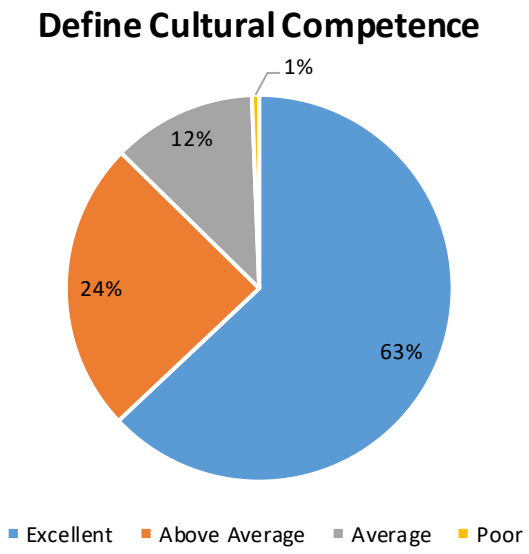
This database helps to track information regarding all trainings provided by BHTS/MDP, including:

- Training Title, Date, Time, Location
- Board Accreditation Information
- Number of CE/CME Credits Provided
- Culturally Competent Trainings
- Trauma-Informed Care Trainings
- Drug Medi-Cal Trainings
- Mental Health Service Act (MHSA) Categories
- Training Sponsor
- Registration and Attendance Counts
- Evaluation Forms Received

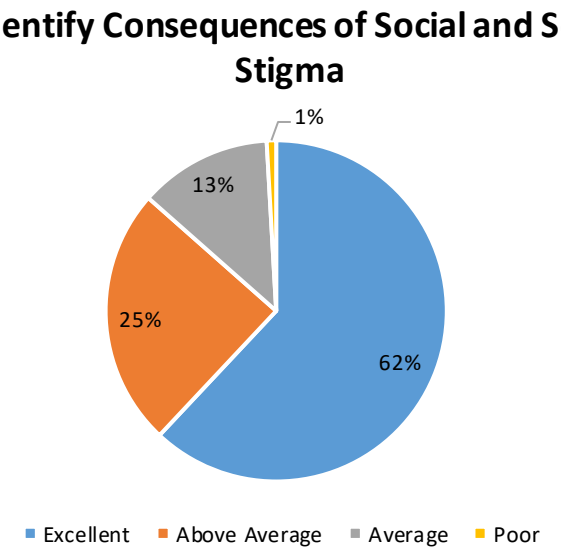
With the development of this new data tracking system, BHTS/MDP can now routinely review data to determine what trainings have been offered and areas where more trainings are needed.

Analysis of Annual Cultural Competence Training

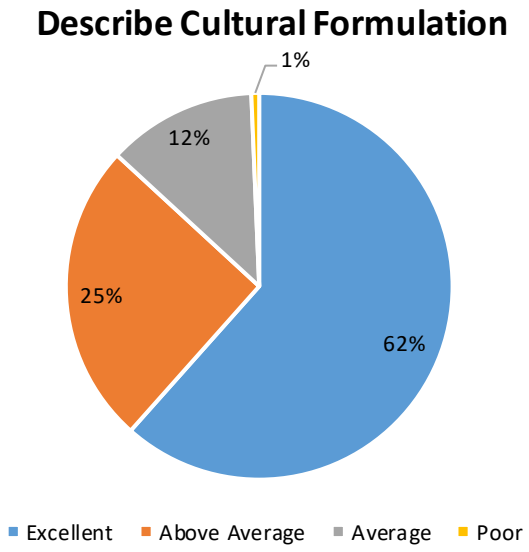
The annual online Cultural Competence training is provided to both County- and Contract-operated staff (Appendix III). In November 2018, a new Cultural Competence training was launched and while providing demographics and other population information on the diverse communities in OC the training focused on culture, cultural humility, stigma and self-stigma, unconscious bias, micro aggression, racism and cultural formulation. To enhance the quality of the training several images and video clips were included. At the end of the training, participants were provided an online evaluation regarding their experience. Overall, participants felt the educational objectives discussed during the training were useful. As a result of the training, the majority of participants who engaged in the FY 2018-19 training felt they could clearly define cultural competence as it relates to culture, competence, race, and ethnicity in order to identify strategies for recognizing diversity and embracing uniqueness (24% above average and 63% excellent).



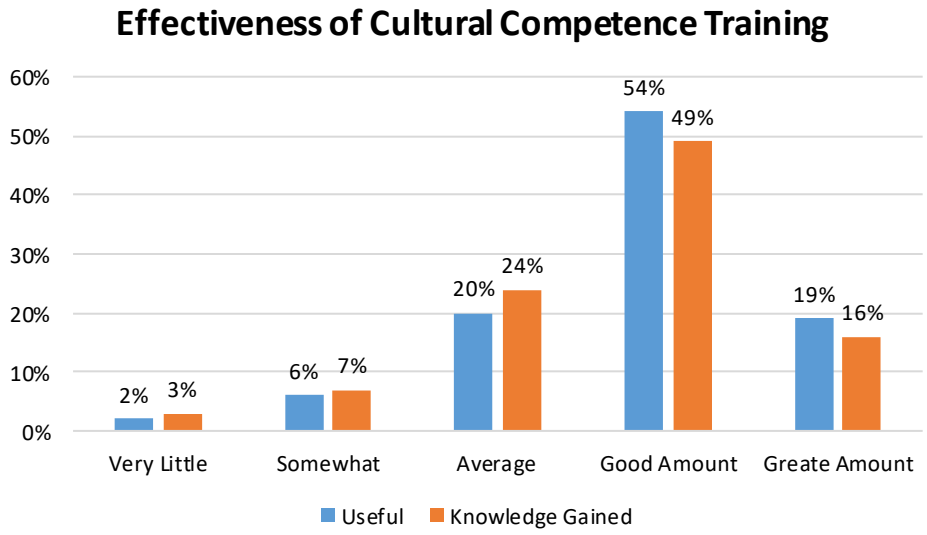
Similarly, roughly 87% of participants felt the training provided an above average (25%) or excellent (62%) description of how to identify the consequences of social and self-stigma. The focus of this objective was to understand how these concepts related to public health and its influence of the unconscious thoughts on judgement, stereotyping, and racism in our community.



Finally, eight out of every ten participants felt they could describe cultural formulation as a result of the training (25% above average and 62% excellent). The purpose of this objective was to assess how cultural formulation approaches, which integrate a culturally response approach, are incorporated in to service attitudes and interactions with clients to reduce the effects of stereotyping.



Questions were also constructed to determine the overall effectiveness of the Cultural Competence training. In general, the majority of participants found the training to be useful for their clinical work (54% and 19%, respectively) and learned new information (49% and 16%, respectively).



In terms of overall program quality and satisfaction, the majority of participants felt the quality of the training was excellent (58%) or above average (27%). Similarly, the presenter was perceived as able to effectively communicate knowledge of the subject matter (59% excellent and 26% above average). While 87% of participants indicated they were satisfied with the training, roughly nine out of every ten participants would recommend this training to someone they know (90%) or found this training to be user friendly (97%).

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

Descriptions of some cultural development trainings offered during FY 2018-19 are included in the table listed in **Appendix IV**. These trainings were developed to provide County, Contract, and Community members with the skills necessary to interact with varied client experiences (e.g., racial, ethnic, cultural, and linguistic experiences).

Summary

Behavioral Health Services engaged in an active year of training, with cultural competence being a significant focus of work. The subject matter experts who provided the trainings for BHS staff and contract providers were strongly encouraged to include material in the training that explored the cultural considerations related to the subject of their trainings and to include this as one of the learning objectives of their training. BHS requires that all trainings be vetted by its Ethnic Services Manager who reviews the training for cultural sensitivity, principles of cultural competence, and to ensure that the training provided an inclusive, multi-cultural focus.

Once vetted for content, the training flyer carries the language, "This training qualifies as a cultural development training." Therefore, all trainings managed through Behavioral Health Training Services are screened to ascertain they qualified as cultural development trainings. Further, the annual, mandatory, Cultural Competence training is highly regarded and has very high levels of participation. BHS continues to work toward ensuring that all trainings meet the criteria for cultural competence and sensitivity. However, BHS continues to explore ways to bring higher levels of cultural awareness to our staff through high quality, evidence-based trainings. Overall, the commitment to provide trainings that qualify as cultural development trainings remains one of the most significant strengths of BHS.

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

Introduction

BHS remains strongly committed to recruiting, retaining, and promoting a multi-cultural, highly skilled workforce. The following section provides information about recruitment and retention efforts of our behavioral health professionals that are in line with the Recovery-focused philosophy. This section documents the assessment, needs, specific competencies, and current strategies used by BHS to engage and strengthen our workforce.

Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experience with, the Identified Unserved and Underserved Populations

Recruitment

The purpose of the booklet is to introduce high school students, college students, and those interested in pursuing all of the exciting career opportunities that exist in the mental health and substance abuse field in the counties of California's public service departments.

Use of social media to advertise new positions and recruitments such as the sample below.

Assessment of County Workforce

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 August 2020, was a collaborative effort between the County's Behavioral Health Training Services (BHTS) department and its Human Resources Division. 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, Mandarin/Chinese, 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. Comparing the number of filled to vacant positions, the greatest need was among Psychiatrists (General, Child and Adolescents, Geriatric), Psychiatric Mental Health Nurse Practitioners and Mental Health Workers.

6.1 Number of PMHS Employees and Vacancies, August 2020[1]

	N
Total Number of Current PMHS Employees	1245
Total Number of PMHS Vacancies	198
Total Number of Current PMHS Direct Service Filled Positions	796.5
Total Number of Current PMHS Direct Service Vacancies	126

[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.

6.2 Currently Filled and Vacant BHS Positions, August 2020[1]

	Number of Positions Filled	*Number of Vacancies*	*Total Number of Positions*
Mental Health Worker	5	1	6
Psychiatrist - General	0.5	1	1.5
Psychiatric Mental Health Nurse Practitioner	14	4	18
Executive and Management Staff	35	6	41
Psychiatric Mental Health Clinical Nurse Specialist	17	1.5	18.5
Mental Health Specialist	29	3	32
Licensed Clinical Social Worker	379.5	72.5	452
Licensed Clinical Psychologist	51	9	60
Psychiatrist - Geriatric	10	2	12
Psychiatrist - Child and Adolescent	11.5	5	16.5
Total	***552.5***	***105***	***657.5***

[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. 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 into 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, August 2020

	Total Number
Number Employed	5
Number of Vacancies	1
Total Peer Positions Available	6

Language Proficiency

There are six threshold languages in Orange County. They include Spanish, Vietnamese, Farsi, Korean, Mandarin/Chinese, and Arabic. As of August 2020, all employees in Orange County's BHS system spoke English. Of the 474 BHS staff who spoke a language other than English, 61.8% of the workforce were able to provide services in Spanish, 10.1% in Vietnamese, 2.5% in Korean, 1.7% in Farsi, and 0.6% in Arabic. (Table 6.4 on the following page) However, there is a need for more staff who speak Mandarin/Chinese, which is another threshold language in Orange County. 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 (Table 6.5 on the following page). Staff mostly likely to indicate they could provide bilingual services included Behavioral Health Clinicians, Mental Health Specialists, Office Specialists, Mental Health Workers, and Service Chiefs.

6.4 Languages Spoken by BHS Staff, August 2020

	Frequency	*Percent*
Spanish	293	61.8%
Vietnamese	48	10.1%
Korean	12	2.5%
Farsi	8	1.7%
Arabic	3	0.6%
Other Languages	7	1.5%
Missing Language Identification	103	21.7%
Total	***474***	100.0%

*Other included Cambodian, Cantonese, Mandarin, Tagalog, and Tongan

6.5 Number of Bilingual Staff, by Position, August 2020

	Spanish	Vietnamese	Korean	Farsi	Arabic	Other Languages	Missing Information	Total
Behavioral Health Clinician I-II	138	21	9	4	3	0	21	196
Mental Health Specialist	42	8	1	0	0	0	15	66
Office Specialist	40	4	0	1	0	0	20	65
Mental Health Worker I-III	23	1	0	0	0	0	2	26
HCA Service Chief I-II	10	5	0	1	0	1	6	23
Office Technician	8	1	0	0	0	0	9	18
Office Assistant	4	1	0	0	0	0	4	9
Information Processing Technician	5	0	0	0	0	0	3	8
Deputy Public Guardian II	3	1	0	0	0	0	2	6
Office Supervisor C-D	3	0	0	0	0	0	3	6
Staff Specialist	3	0	0	0	0	0	3	6
Contract Employee	1	0	0	0	0	0	2	3
Community Worker II	4	0	0	0	0	1	0	5
Sr. Deputy Public Guardian	2	0	0	0	0	0	1	3
Comprehensive Care Nurse II	1	0	1	0	0	3	1	6
HCA Program Supervisor I-II	1	0	0	2	0	0	0	3
Staff Assistant	1	1	0	0	0	1	1	4
Behavioral Health Nurse	0	2	0	0	0	0	1	3
Psychiatrist	0	1	0	0	0	0	2	3
Health Education Associate	1	0	0	0	0	0	0	1
Research Analyst III-IV	1	0	0	0	0	0	1	2
Data Entry Technician	0	1	0	0	0	0	1	2
Estate Administration Specialist II	0	0	0	0	0	0	2	2
Secretary III	1	0	0	0	0	0	0	1

Supervising Deputy Public Guardian	1	0	0	0	0	0	0	1
Health Program Specialist	0	0	1	0	0	0	0	1

6.5 (Continued) Number of Bilingual Staff, by Position, August 2020

	Spanish	*Vietnamese*	*Korean*	*Farsi*	*Arabic*	*Other Languages*	*Missing Information*	*Total*
Sr. Comprehensive Care Nurse	0	0	0	0	0	0	1	1
Information Processing Specialist	0	0	0	0	0	0	1	1
Sr. Office Supervisor C-D	0	0	0	0	0	0	1	1
Supervising Comprehensive Care Nurse	0	1	0	0	0	0	0	1
Nursing Assistance	0	0	0	0	0	0	0	0
Total	***293***	***48***	***12***	***8***	***3***	***7***	***103***	***474***

*Other included Cambodian, Cantonese, Mandarin, Tagalog, and Tongan

Summary

The recruitment of highly skilled staff remains somewhat of a challenge for BHS, most especially in recruiting psychiatrists, and psychiatric nurse practitioners. These medical specialists are in short supply nation-wide, and BHS continues to seek qualified applicants regularly. New strategies to increase recruitment are regularly considered.

The addition of Peer Support Specialists has greatly increased BHS' ability to meet the needs of our participants by creating a well-trained, multi-disciplinary workforce. These employees, who all have "lived experience" of behavioral health issues, assist the participant in normalizing their experience, provide hope for recovery, model appropriate behavior, reduce stigma, and assist in service participation. Peer Support Specialists are regular County employees and a separate work classification is being developed for them. Though the integration of Peer Support Specialists is showing promise, issues of peer integration with clinical staff remain and are being addressed. Current clinicians sometimes remain confused as to the role of these specialists and are not sure how to best utilize their services. Trainings such "Peer Supervision" and "Recovery: Promise of Hope" continue to educate BHS professionals on the importance of the peer support specialist role as well clarify their roles. These issues are currently being addressed and the Peer Support Specialists are slowly being integrated into the mainstream of service provision.

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

Language assistance is offered to Orange County beneficiaries of Health Care Agency Services using a myriad of resources, both County- and Contract-operated. The Tables 7.1 through 7.5 examine the interpretation and translation services utilized during FY 2018-19. During this fiscal year, the Multi-Cultural Development Program provided interpretation and translation services in-house. Language Line also provided interpretation services, which contract with HCA to provide additional services. Additionally, American Sign Language (ASL) services were contracted through an external program called Western Interpreting Network (WIN).

Starting in November of 2017, Language Line began providing over the phone interpretation services to several behavioral health programs across Orange County. In FY 2018-19, this program facilitated 2,014 calls, which accumulated to roughly 586 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 Chinese, Korean and Arabic (see Table 7.2). In FY 2018-19, out of the 2,014 total calls, roughly 93% were made in one of those languages.

7.1 Total Number of Telephone Interpretation Services Provided by Month, FY 2018-19

Month	Number of Calls	Minutes on Call	Facilitated Hours
July-18	153	2,693	44.9
August-18	177	2,812	46.9
September-18	154	2,782	46.4
October-18	185	2,952	49.2
November-18	140	2,178	36.3
December-18	150	2,493	41.6
January-19	193	3,534	58.9
February-19	176	2,919	48.7
March-19	167	3,069	51.2
April-19	177	3,118	52.0
May-19	221	4,379	73.0
June-19	121	2,214	36.9
Total	***2,014***	***35,143***	***585.7***

Source: Language Line Telephone Interpretation Report, FY 18-19

7.2 Top Five Over the Phone Translation Requests, FY 2018-19

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	1,296	21,678	361.3
Vietnamese	330	5,584	93.1
Mandarin Chinese	100	1,671	27.9
Korean	85	1,775	29.6
Arabic	56	1293	21.6
Total	***1,867***	***32,001***	***533.4***

Source: Language Line Telephone Interpretation Report, FY 18-19

The HCA departments that most often requested language translation services included, MHSA Community Supportive Services (Adults), Children and Youth Services, Correctional Mental and Medical Health, and Adult Mental Health Services (Outpatient Crisis; see Table 7.3).

7.3 Behavioral Health Programs to Request Interpretation Services, FY 2018-19

Program Name	Number of Calls	Minutes on Call	Facilitated Hours
MHSA - Community Supportive Services (Adults)	1,193	20,935	348.9
Children and Youth Services	242	4,152	69.2
Correctional Mental Health	165	2,456	40.9
Correctional Medical Services	131	1,587	26.5
Adult Mental Health Services (Outpatient/Crisis)	115	2,960	49.3
MHSA - Community Supportive Services - Children	57	1,278	21.3
MHSA - Prevention and Early Intervention	78	1,254	20.9
Alcohol and Drug Use Services	22	411	6.9
Public Guardian	5	69	1.2
Behavioral Health Services Administration	2	22	0.4
Adult Mental Health Services (Inpatient/Housing)	2	11	0.2
Juvenile Health Services	2	8	0.1
Total	***2,014***	***35,143***	***585.6***

Source: Language Line Telephone Interpretation Report, FY 18-19

Staff from the Multi-Cultural Development Program also provide in-person interpretation services (see Table 7.4). In-person translation services were also provided primarily in Spanish, Portuguese, and Vietnamese. In FY 2018-19, there were 59 requests for in-house ASL interpretation services, which totaled to 316.5 hours.

7.4 Hours Billed for In-Person Interpretation by Threshold Language, FY 2018-19

	Number of Interpretations	Facilitated Hours
American Sign Language*	59	316.5
Spanish	46	140.5
Portuguese	25	34.0
Vietnamese	20	60.0
Khmer	2	5.3
Korean	3	6.0
Mandarin Chinese	8	14.0
Total	***163***	***576.3***

Source: WET Interpretations Log Database, FY 18-19

In 2018-19, several ASL services were also provided by WIN. A total of 272 ASL services were conducted at various departments and programs throughout Orange County, which totaled to over 550 hours of service (see Table 7.5). In some cases, two interpreters were requested by a program to provide services. In this case, the total number of interpreter hours facilitated was significantly higher at 811 hours.

7.5 Contracted ASL Services through WIN: Total Number of Hours by Program, FY 2018-19

	Total Number of Services	Hours	Interpreter Hours**
Child and Youth Services	69	88.8	96.8
Community Counseling & Support Services	40	68.8	85.3
Cultural Competency Committee	30	58.25	76.5
School Ten Inc. Anaheim	29	57	101
CONREP	26	49	49
Anaheim Alcohol/Drug Abuse Services	22	56.5	98
MHSA Training Program	19	100.75	198
KC Services	14	35.65	67.8
Westminster Dual Diagnosis Program	9	17	17
Open Access	5	8	8
Other*	9	14.5	14.5
Grand Total	***272***	***554.25***	***811.9***

*Other includes 17th Street TesMng Trmnt & Care, Adult Mental Health Services (Anaheim), BHS/PrevenMon & IntervenMon, CorrecMonal Health Services, Outreach and Engagement Team, Public Guardian

**Interpreter hours is higher than the total number of hours because in some cases two interpreters attended one event.

Source: WIN Annual Report (BHS Only), FY 18-19

The Multi-Cultural Development Program also helps with creation and review of document translations (see Table 7.6). This could include PowerPoint presentations, brochures, and surveys that are used across BHS. During FY 2018-19, document translation requests were primarily made for Vietnamese, Arabic, Korean, and Spanish. This accounted for 80% of the total number of document translation requests.

7.6 Document Translation Request by Threshold Language, FY 2018-19

	Total Number	Percent
Vietnamese	36	24%
Arabic	29	20%
Korean	27	18%
Spanish	27	18%
Farsi	20	14%
Chinese	7	5%
Khmer	2	1%
Grand Total	***148***	100%

Source: WET Interpretations Log Database, FY 18-19

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 appropriate 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, Arabic and Simplified Chinese 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.

Summary

BHS meets the requirements to provide multi-lingual services using a variety of different methods. BHS employs staff who provide interpretation to those with limited English proficiency, and translation of all documents into the six threshold languages. Through full-time staff and a contracted vendor, BHS engages with those who speak American Sign Language (ASL). All County staff who provide direct care are trained in the use of Language Line and utilize this service when necessary to assist in providing linguistically appropriate services. Overall, it has been a successful year for our Multi-Cultural Development Program with several staff being hired to fill vacancies. The program is fully staffed and is actively providing services daily.

CRITERION 8: ADAPTATION OF SERVICES

Client driven/operated recovery and wellness programs

Peer Mentor programs and use of Peer Specialists throughout system

There is growing attention and respect in the behavioral health field for the unique and valuable skills of people with lived experience (i.e., peers) in the workplace. Peer support services have been shown to improve social functioning, quality of life, engagement, and retention in treatment, as well as to reduce health care costs, psychiatric hospitalizations, and incarcerations in the people they serve. Peer specialists/Parent Partners/Youth Partners utilize skills they have acquired through lived experience and training to support individuals in their recovery, with the goal of instilling a sense of hope and empowerment. Peers serve as role models, mentors, and advocates of recovery and well-being for the people they serve. They are strategically placed in service areas throughout our BHS system of care including PACT programs, Recovery Outpatient, Crisis Services Unit, Veterans programs, Supported Employment programs, Re-Entry programs, Older Adult services, and Children's Services.

The "The Wellness Center" is a peer run center that provide 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. 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 who have 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.

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).

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.

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.

Responsiveness of mental health services

Peer / Consumer Testimonial
"I was fortunate to have been a Spiritual Peer Lead at the very first day of the Wellness Center when it was on Bush Street in Santa Ana. Eventually I was Team Lead... Members trickled into our doors not knowing what to expect. Being a Peer and working with other Peers was a great experience. Better yet, we as a team were very effective in helping the members wherever they were in their recovery. We taught classes and had social hour for the members from week one. Many members came back because they were appreciated and respected. The Center is thriving, and it is because it is run by Peer Mentors with different levels of recovery, who can see eye to eye with its members." JR

Peer Workforce Development Initiative

The Peer Workforce Development Initiative for Behavioral Health Services kicked off with a summit in July 2018 where we brought peer specialists, supervisors, and management together to discuss key focus areas around peer workforce challenges and successes. From this summit, we identified 3 priority focus areas: (1) To develop an Organizational Understanding of the Peer Role (2) Strengthen the Peer Workforce through Retention, Supervision, and Career Ladder (3) Create a Wellness Culture and Reduce Stigma.

As a result of the strategic planning sessions held in October 2018, 3 Action Resilience Teams (ART) were formed to focus on the priority areas. Each group of 8 members representing peers, supervisors/managers, and direct line staff will be meeting about once a month to discuss action steps and progress towards achieving the identified goal.

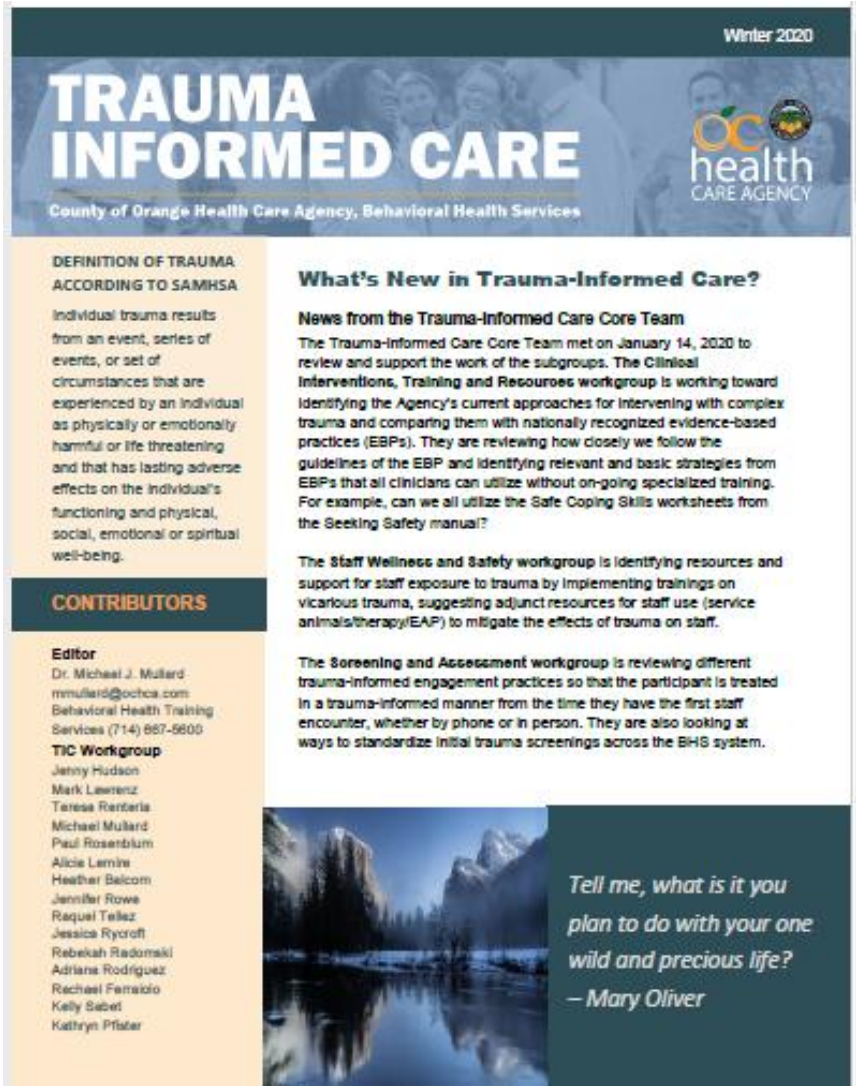
In late 2019, we re-organized the ART groups to more efficient workgroups with focused attention on specific goals and tasks. These workgroups are: the Workplace Wellness Advocate (WWA) program; New Hire Peer Orientation workgroup; Tools and Resources for Supervisors of Peers; Peer Supervision Practice Guideline; Peer Support Practice guideline; Policies for Standardized Peer Support Services Documentation and Billing.

Trauma-Informed Care Initiative

In May of 2018, the first members of the Trauma-Informed Learning Collaborative for BHS met to discuss the goals and priorities for the initiative. This formed the Trauma-Informed Care Core Implementation Team (TIC-CIT) consisting of representatives from each BHS service area. Based on the results of the first Wellness-Oriented Trauma-Informed Care Organizational Self-Assessment (WOTIC OSA) completed by over 400 BHS staff in June 2018, the team decided to focus on *Domain 3: Wellness and Trauma, Educated and Responsive Workforce*. The team collaborated with the existing Peer Workforce Development Initiative in developing a

Workplace Wellness Advocate (WWA) program and supported several trauma-focused training hosted by the Behavioral Health Training Services department throughout the year. The team also prioritized the need to develop current practice guidelines for all BHS staff based on SAMHSA's standardized definition from Tip 57.

With support from management, the Core Implementation Team has identified 3 focus areas for continuing the work towards being a trauma-informed system. Working groups have been established with CIT staff as the leads to continue the work and system change. In response to improving communication about our transformation to a more Trauma-Informed care system, we created a Trauma-Informed Newsletter (see below for a sample and in Appendix). The newsletter seeks to provide updated information about the TIC Workgroup activities, the implementation progress, and successes. It is hoped that the newsletter will be a fun and informative way to highlight the importance of trauma-informed services as well as provide a better understanding of the benefits for further integration of this model into all programs.



Winter 2020

TRAUMA INFORMED CARE

County of Orange Health Care Agency, Behavioral Health Services

DEFINITION OF TRAUMA ACCORDING TO SAMHSA

Individual trauma results from an event, series of events, or set of circumstances that are experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional or spiritual well-being.

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What's New in Trauma-Informed Care?

News from the Trauma-Informed Care Core Team

The Trauma-Informed Care Core Team met on January 14, 2020 to review and support the work of the subgroups. **The Clinical Interventions, Training and Resources workgroup** is working toward identifying the Agency's current approaches for intervening with complex trauma and comparing them with nationally recognized evidence-based practices (EBPs). They are reviewing how closely we follow the guidelines of the EBP and identifying relevant and basic strategies from EBPs that all clinicians can utilize without on-going specialized training. For example, can we all utilize the Safe Coping Skills worksheets from the Seeking Safety manual?

The **Staff Wellness and Safety workgroup** is identifying resources and support for staff exposure to trauma by implementing trainings on vicarious trauma, suggesting adjunct resources for staff use (service animals/therapy/EAP) to mitigate the effects of trauma on staff.

The **Screening and Assessment workgroup** is reviewing different trauma-informed engagement practices so that the participant is treated in a trauma-informed manner from the time they have the first staff encounter, whether by phone or in person. They are also looking at ways to standardize initial trauma screenings across the BHS system.

Cultural/Linguistic Options Available to Clients

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.

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

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

BHS Medi-Cal Provider Information

Medi-Cal Mental Health Plan - Provider Directory

Medi-Cal Mental Health Plan - Provider Directory - PDF Version

MC MHP Handbook and Provider Directory Lobby Notice

Consumer Handbook - Guide to Medi-Cal Mental Health Services

This guide will help you know what specialty mental health services are, if you may get them, and how you can get help from the Orange County MHP.

For general information and accessibility issues please call:

Orange County Mental Health Plan
Phone: 800-723-8641
For TTY/TDD users, call 711

- Medi-Cal Handbook (English) also in large print version
- Medi-Cal Handbook (Arabic) also in large print version
- Medi-Cal Handbook (Farsi) also in large print version
- Medi-Cal Handbook (Korean) also in large print version
- Medi-Cal Handbook (Spanish) also in large print version
- Medi-Cal Handbook (Vietnamese) also in large print version

Form Name https://intranet.ochca.com/forms/#bhs	Form Number	Click Icon to View Form
1) Contact Information - Language Services @ MDP	Information Sheet	
2) Telephonic Interpretation - Request Service	Information Sheet	
3) Onsite Interpretation - Instructions	Information Sheet	
4) Onsite Interpretation - Request Service - Blank Form	Information Sheet	
5) Onsite Interpretation - Request Service - Sample Completed Form	Information Sheet	
6) ASL Interpretation - Instructions	Information Sheet	
7) ASL Interpretation - Request Service	Information Sheet	
8) Document Translation - Instructions	Information Sheet	
9) Document Translation - Request Service Form	Information Sheet	

Quality of Care: Contract Providers

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. Below is standard language in all BHS contracts under Compliance Sections:

CONTRACTOR shall comply with the provisions of the ADMINISTRATOR's Cultural Competency Plan submitted and approved by the state. ADMINISTRATOR shall update the Cultural Competency Plan and submit the updates to the State for review and approve annually. (CCR, Title 9, §1810.410.subds.(c)-(d).

Failure to comply with the obligations stated in this Compliance Paragraph shall constitute a breach of the Agreement on the part of CONTRACTOR and grounds for COUNTY to terminate the Agreement. Unless the circumstances require a sooner period of cure, CONTRACTOR shall have thirty (30) calendar days from the date of the written notice of default to cure any defaults grounded on this Compliance Paragraph prior to ADMINISTRATOR's right to terminate this Agreement on the basis of such default.

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."

Below are some samples of contracts from BHS service areas:

- 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 develop0/28ment 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."

- 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 e v e r y reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e. the unserved and underserved. In the staffing section of 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."

Quality Assurance

In this section, we will describe the current or planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services.

Authority & Quality Improvement Services (AQIS) is a Behavioral Health Services (BHS) function area that supports programming in the other two BHS function areas: Adult and Older Adult Behavioral Health (AOABH) and Children, Youth and Prevention Behavioral Health (CYPBH) Services. It supports BHS' two managed care programs, the Mental Health Plan (MHP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS) as well as their other mental health and Substance Use Disorder (SUD) programming.

Outcome measures vary by the type of program and their specific goals. Clients are assessed on a variety of domains (e.g., recovery, social support, life functioning) depending on the type of services received (*see POW Cross-Cutting Indicators on next page*). When selecting outcome measures, we aim for measures that are psychometrically sound and validated with diverse populations. Outcome measures are translated in all threshold languages and information on race/ethnicity, age, gender, language spoken, and other detailed demographics are collected. This allows for outcome measures to be broken out for diverse groups, when needed to assess for differences.

POW Cross-Cutting Indicators

<table>
<tr><th></th><th colspan="2">Primary Point of Entry into BHS System</th><th colspan="4">Spectrum of Treatment and Services Provided</th></tr>
<tr><th>Cross-Cutting Indicators</th><th>Crisis Assessment</th><th>Assessment, Referral, and Linkage</th><th colspan="2">Prevention</th><th>Early Intervention</th><th>Treatment & Recovery</th><th>Treatment - Acute Stabilization</th></tr>
<tr><td>Global Health</td><td></td><td></td><td colspan="2">PROMIS Global Health</td><td></td><td></td><td></td></tr>
<tr><td>Recovery</td><td></td><td></td><td colspan="3"></td><td>MORS</td><td></td></tr>
<tr><td>Self-Sufficiency/ Resilience</td><td></td><td></td><td colspan="3"></td><td>OC Self-Sufficiency/ Resilience Matrix</td><td></td></tr>
<tr><td>Mood/Affect - General</td><td rowspan="3">EHR Hospital Assessment</td><td>Modified SBIRT/ SAMHST</td><td colspan="5" rowspan="3">YOQ/OQ/SOQ
AUDIT-C/DAST/Assist CRAFFT/SACS</td></tr>
<tr><td>Substance Abuse</td><td rowspan="3">Risk/Needs Screen</td></tr>
<tr><td>Social Support/ Functioning</td></tr>
<tr><td>Suicidal Ideation</td><td rowspan="2">Risk/Needs Screen</td><td colspan="3"></td><td>Risk/Needs Screen</td><td></td></tr>
<tr><td>Trauma Exposure*</td><td colspan="3"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Hospitalizations</td><td rowspan="3">Risk/Needs Screen</td><td rowspan="3">Risk/Needs Screen</td><td colspan="3"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Incarcerations</td><td colspan="3"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Homelessness</td><td colspan="3"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Employment /Education</td><td></td><td></td><td colspan="3"></td><td>Employment/Education</td><td></td></tr>
<tr><td>Violence/ Aggression</td><td rowspan="3">EHR Hospital Assessment</td><td rowspan="2">Risk/Needs Screen</td><td colspan="3"></td><td></td><td></td></tr>
<tr><td>Psychosis</td><td colspan="3"></td><td></td><td></td></tr>
<tr><td>Medical Illness/ Conditions</td><td></td><td colspan="3"></td><td></td><td></td></tr>
<tr><td>Referrals</td><td colspan="4">Referrals</td><td>Referrals</td><td>Referrals</td></tr>
<tr><td>Linkages</td><td colspan="4">Linkages</td><td>Linkages</td><td>Linkages</td></tr>
</table>

- Some indicators assessed across the entire system (Mood/affect, Substance abuse, Social support/functioning, Suicidal ideation, Referrals and Linkages)

- Light gray areas: here are no cross-cutting recommended for these areas: however, some programs may still need to assess some of these indicators. (In those cases, we will recommend those programs adopt the standard measures that have been recommended for those parts of the system.)

The Consumer Perception Surveys are offered to all mental health plan clients who obtain services during one-week periods in November and in May. Clients in Adult Services receive the Mental Health Statistics Improvement Program (MHSIP). Clients in Children and Youth Services who are age 12 or older receive the Youth Services Survey (YSS). Parents and guardians of clients in Children and Youth Services receive the Youth Services Survey for Families (YSS-F). These instruments include validated scales that measure the following:

- Service Satisfaction
- Accessibility of services
- Service quality/cultural appropriateness
- Participation in treatment planning
- General satisfaction
- Service Outcomes
- Perception of outcomes
- Functioning
- Social connectedness

Grievance and Appeals Resolution Processes

In this section we describe our beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve Grievance and Appeals.[14]

The beneficiary has several ways to file a grievance:

- Use a Grievance/Appeal Form and self-addressed envelope available to the beneficiary at the various County and County-Contracted outpatient behavioral health programs.
- Call (866) 308-3074 or TDD (866) 308-3073 and speak with a person who will accept and submit your grievance.
- Tell the treatment provider (either the staff or the facility's representative) that you would like to submit a grievance, and they will complete a Grievance/Appeal form with the beneficiary and submitted for them.

An appeal is available only to a Medi-Cal beneficiary, some services need to be pre-authorized by the health plan before the beneficiary can receive them. When the behavioral health provider thinks the beneficiary will need ongoing services, but the health plan denies, reduces, delays or terminates any of your pre-authorized services, the beneficiary may request a review of this action. This process is called an appeal. If the beneficiary is denied services because the health plan determines the services are not medically necessary, the beneficiary may request a review of this action. This process is also called an appeal. There are three ways to file an appeal, as mentioned above. The beneficiary may request an expedited appeal, which must be decided within 72 hours, if the beneficiary believe that a delay would cause serious problems with their behavioral health including problems with the ability to gain, maintain or regain important life functions.

The grievance/appeal forms are in the County's threshold languages - Chinese, Korean, Vietnamese, English, Spanish, Farsi, Arabic and can be readily accessible at the county/county-contracted outpatient behavioral health program lobby and via County website - https://www.ochealthinfo.com/bhs/about/aqis/aoabh/downloads.

AQIS has a team of competent clinical staff under the Managed Care Support Team (MCST) who have the cultural and linguistic capability of investigating grievance via English and Spanish. Within AQIS, MCST is able to utilize staff to provide translation and interpreter services in Chinese, Korean, Vietnamese and Farsi. Arabic, American Sign Language and other language services are available and assistance can be found using the County Employee Directory to locate an available interpreter and/or translations services. The County also has the Language-Access Phone Line for interpreter services that is available at any time. In addition, the County also utilizes contracted entities to provide translation services for the publication of materials (i.e. brochures, posters, etc.) when in-house resources are not readily available as well.

The County recently contracted services to Mental Health Systems, Inc. to provide Patients' Rights Advocacy

[14] This regulation refers to the Beneficiary Problem Resolution Process defined in Title 9, Sections 1850.206, 1850.207, 1850.208, 1850.209

Services (PRAS) as of July 2020. The MCST has oversight of the advocates who conduct investigations for grievances/appeals using the County grievance/appeal forms. This program has patients' rights postings, grievance/appeals form and other materials in the threshold languages and are made available to the beneficiaries at the various locations listed below:

- County and County-Contracted Outpatient Behavioral Health Clinics
- County and County-Contracted Behavioral Health Residential Facilities
- County Correctional Behavioral Health Services
- Inpatient Behavioral Health Facilities

Their materials are also online and available at https://www.mhsinc.org/patients-rights-advocacy-services-downloads/.
Once the investigator/advocate is assign to the grievance/appeal, they have 90 days to investigate and come up with a resolution letter. The investigation entails:

- Interviewing the beneficiary to collect information about their dissatisfaction
- Reviewing the beneficiary chart records
- Interviewing the providers (i.e. clinician, Service Chief, Program Director) for detailed information related to the beneficiary's dissatisfaction
- An objective analysis to mediate and determine a resolution

Any grievance/appeal received in a written language (other than English) will be translated into the language that the beneficiary wrote in.

Grievance Process and CLAS

The AQIS investigators is made up of culturally diverse and qualified clinicians that are educated and trained in cultural competency via their graduate education and requirements from their board certified organization (i.e. Board of Behavioral Sciences). The County requires all employees to complete an annual Cultural Competency training offered by the Behavioral Health Training Services (BHTS). In addition, the BHTS offers a wide variety of optional cultural competency trainings throughout the year that are specific to racial, ethnic and cultural backgrounds. Including trainings on how to work with an interpreter and conflict resolution. The staff may also seek these types of trainings outside of BHTS for enrichment and continued education.

The PRAS advocates attend an annual statewide patients' rights 3-day conference hosted by the California Office of Patients' Rights. The conference entails a wide variety of workshops that train advocates on the distinct components of patients' rights, conflict resolution and how to conduct proper and detailed investigations including the various types of patients' rights trainings that can be offered to providers and patients. As part of their County-contractual requirement, PRAS is required to provide annual trainings to all providers and patients at the various programs/facilities that serve the behavioral health population about their rights. BHTS also offers cultural competency trainings and interpreter trainings that are made available to the advocates as well.

Provide notice in signage, translated materials, and other media about the right of each individual to provide feedback, including the right to file a complaint or grievance.

AQIS and PRAS have ensured that all notice in signage, contact numbers, translated materials and other media mediums are available for individuals to provide feedback about the rights and the right to file a grievance/appeal is made available county-wide. The materials are accessible via the County and PRAS website. Paper grievance/appeal forms, brochures and posters are accessible and available at the County and County-Contracted Outpatient Behavioral Health clinics, inpatient, correctional and residential behavioral health facilities.

The MCST and PRAS are in frequent contact with the beneficiaries throughout the investigation process and provides new updates to the beneficiary during the grievance/appeals process. Also a final resolution letter is given to the beneficiaries generally describing the steps taken to finalize the conclusion of the grievance/appeal. If conflict arises when attempting to resolve a grievance/appeal at the lowest level then it can be escalated to the County program managers for further assistance to ensure the grievance/appeal is resolved to the beneficiary's satisfaction. The cultural and linguistic appropriateness is maintained throughout the grievance/appeal process.

The MCST program provides consultation and education to the programs daily and trains on a regular basis about the grievance requirement and process. The MCST also educates the individual beneficiaries who filed a grievance/appeal about their rights and the grievance requirements and process. MCST also obtains feedback, suggestions and comments from California Department of Health Care Services (CDHCS) and other auditing entities. MCST is also receptive with obtaining feedback, suggestions and comments from behavioral health programs/facilities and beneficiaries to help improve the grievance/appeal system.

PRAS also provides education, consultation, trainings, system advocacy and community outreach that includes obtaining feedback, suggestions and comments. Their services entails:

- **Provide Trainings:** Patients' Rights Advocates provide trainings and in-services on patient/resident rights to patients in inpatient psychiatric units; outpatient mental health services, residents in Board and Care facilities, correctional facilities and the mental health community. Advocates are also certified to provide CEUs for mental health professionals and Board and Care Administrators.
- **System Advocacy:** Patients' Rights Advocates monitor mental health facilities for compliance with patients' rights laws. The advocates review and comment on policies and practices that impact recipients of mental health services. They coordinate with other advocates for system reform and analyze state and federal legislation, along with regulatory developments.
- **Community Outreach:** Patients' Rights Advocates provide education and reach out to mental health patients to improve their ability to advocate for themselves and represent patients' interest in public forums (e.g. town-hall meetings, Mental Health Board, Residential Community Meetings, etc.).
- Hire patient advocates or ombudspersons (QSource, 2005).

The County contracted services to Mental Health Systems, Inc. to provide Patients' Rights Advocacy Services as of July 2020. It was created in response to California legislation requiring each county mental health director to appoint patient rights advocates to protect and further the Constitutional and statutory rights of people receiving mental health services. The MCST has oversight of the advocates who conduct investigations on grievances/appeals specific to the inpatient behavioral health setting. PRAS has a contractual agreement to educate, train, investigate and advocate for patients in the locations listed above. The materials they provide are readily available in the various setting mentioned above and are available online at https://www.mhsinc.org/patients-rights-advocacy-services-downloads/.

AQIS has a team of competent clinical staff under the Managed Care Support Team (MCST) who have the cultural and linguistic capability of investigating grievance via English and Spanish. Within AQIS, MCST is able to utilize staff to provide translation and interpreter services in Chinese, Korean, Vietnamese and Farsi. Arabic, American Sign Language and other language services are available and assistance can be found using the County Employee Directory to locate an available interpreter and/or translations services. The County also has the Language-Access Phone Line for interpreter services that is available at any time. In addition, the County also utilizes contracted entities to provide translation services for the publication of materials (i.e. brochures, posters, etc.) when in-house resources are not readily available as well.

If conflict arises when attempting to resolve a grievance/appeal at the lowest level then it can be escalated to the County program managers for further assistance to ensure the grievance/appeal is resolved to the beneficiary's satisfaction. The cultural and linguistic appropriateness is maintained throughout the grievance/appeal process.

The MCST also conducts a quarterly review to identify specific and multiple complaints about a provider to initiate a Corrective Action Plan (CAP). The purpose of the CAP is to address the specific and multiple concerns brought up by the beneficiaries during this process, including ensuring improvement in the ability to provide quality of care and services. In the event a particular provider continues to receive grievances related to the services and interactions with the beneficiaries, a formal corrective action is implemented to escalate the concerns. This has resulted in some providers being terminated or reported to Human Resources for further disciplinary actions. This process helps maintain the overall quality assurance for the programs that the County oversees.

Summary

The adaptation of services for clients with specific needs has been a significant focus of our activities this year. The integration of Peer Support Specialists has strengthened our BHS system. These staff provide specific skills and value to our behavioral health consumers. The Peer Support Specialists (also known as Peer Mentors or Peer Navigators) assist those who receive behavioral health services to more actively participate, as well as improve recovery outcomes by helping participants improve their daily quality of life.

In 2018, BHS decided to move towards a more trauma-informed approach to care; thus, the Trauma-Informed Care Initiative was created with representation across our BHS system. The initiative is designed to train all BHS staff in principles of trauma and its amelioration through trauma-sensitive services. This will have a positive effect for both staff and participants as BHS seeks to implement trainings, groups, procedures, and practices that support staff in managing the secondary traumatic stress that often occurs when working with traumatized populations. The overall goal is to improve care outcomes for participants, reduce staff turnover and to provide a better environment where both staff and participants are treated with greater dignity and respect. BHS is committed to an annual performance assessment to track progress toward this goal.

Finally, BHS continues to utilize a robust grievance processes to manage and resolve conflicts surrounding cultural and linguistic appropriateness as well as behavioral health care. The Authority and Quality Improvement Services (AQIS) Division is comprised of a diverse workforce who investigate potential conflicts and seek a just resolution. Investigations are facilitated in the participant's language, with several of the AQIS investigators being bi-lingual. Patient ombudsmen are utilized to assist patients in advocating for their needs within the plan.

The adaptation of services is designed to ensure that BHS is responsive not only to its participants but also to its workforce in order to provide a synergy that will not only improve behavioral health outcomes but also provide stability to all of the divisions of BHS. BHS is currently considering how best to collect outcome data to best demonstrate progress made in these areas, especially in Trauma-Informed Care.

CONCLUSION

BHS hopes that this Cultural Competence Update for 2020 has assisted the State of California in reviewing our current philosophies, principles, and practices. Solidly rooted in SAMHSA's Recovery Model, and drawing from a wide-range of multi-cultural thought, BHS continues to actively work toward improving our training in multi-cultural practices including cultural humility, in order to better meet the needs of a diverse community and a diverse workforce.

Probably the most significant update to this year's Plan is the creation of the Office of Population Health and Equity. After the senseless killing of George Floyd, BHS understood that significant action was required in order to further operationalize our commitment to behavioral health equity, and create closer links to the community, especially for marginalized and under-represented populations. We are hopeful that this office will be successful in its scope and outreach.

The Cultural Competence Committee has been reorganized into the Behavioral Health Equity Committee (BHEC) with the intention of bringing greater community participation to this group. The BHEC, with its workgroups will hopefully assist in suggesting or implementing strategies that are identified in the Cultural Competence Plan. The Steering Committee is recommending that the initial workgroups focus on the following topics: Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of the threshold languages or have Limited English Proficiency (LEP) and or other communication needs; Veterans and Military; and LGBTIQ issues.

Given the current high level of civil unrest in the U.S. due to perceived inequities, cultural competence will continue to remain a crucial focus for public agencies across the country. The coming years will present an opportunity to BHS to reach out to our communities and build greater links. BHS will continue to report on successes and challenges encountered in the coming years.

APPENDIX I: POLICIES AND PROCEDURES GOVERNING CULTURAL COMPETENCE

Informing Materials for Mental Health Plan Consumers and Intake/Advisement Checklist

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Informing Materials 02.06.02 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	8/9/16

SUBJECT: Informing Materials for Mental Health Plan Consumers and Intake/Advisement Checklist

PURPOSE:

To provide County of Orange consumers with appropriate informing materials and accurately document the provision of these materials as well as Advance Directives.

POLICY:

Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.

SCOPE:

This policy applies to all consumers of the Orange County Mental Health Plan (MHP) and will be followed by all Behavioral Health Services (BHS) County and County Contracted staff providing Specialty Mental Health Services (SMHS).

REFERENCES:

BHS P&P 02.06.01 Advance Directives

BHS P&P 02.05.01 Notice of Privacy Practices

FORM:

Health Care Agency Mental Health Plan (MHP) Intake/Advisement Checklist, F346-753

PROCEDURE:

I. All newly admitted consumers in the Mental Health Plan shall be given, at a minimum, the following materials:

   A. Notice of Privacy Practices (NPP)

   B. The Advance Directives Information Sheet (For adults only)

SUBJECT: Informing Materials for Mental Health Plan Consumers and Intake/Advisement Checklist

C. The MHP Guide to Medi-Cal Mental Health Services

D. MHP Provider List

II. If, at the time of admission, the consumer is unable to accept and utilize these materials due to the consumer's emotional condition, then the information shall be given as soon as the consumer is able to accept and utilize it.

III. These materials shall be available in the threshold languages in hard copy and in audio version.

IV. BHS Staff shall provide the materials in the appropriate language and/or format to meet the consumer's needs.

V. BHS Staff shall actively inquire of each newly admitted consumer whether the consumer wishes to have the informing materials in audio version. The response shall be documented on the MHP Intake/Advisement Checklist.

VI. Completion of the Mental Health Plan (MHP) Intake/Advisement Checklist:

A. The provision of the above materials shall be documented using the Mental Health Plan Intake/Advisement Checklist (Advisement Checklist).

B. The Intake/Advisement Checklist shall be completed each time a consumer is admitted for mental health services. BHS Staff shall:

1. Inquire and document the language in which the consumer would like to receive the informing materials.

2. Offer or ask if the consumer would like to receive the informing materials in audio version and in their preferred language.

a) Have the consumer document by checking "yes" or "no" to this question.

3. For all MHP consumers, have the consumer/legal guardian check "yes" or "no" to the question to document receipt of each of the following informing materials:

a) The MHP Guide to Medi-Cal Mental Health Services

b) MHP Provider List

c) Notice of Privacy Practices (NPP)

d) Completed Receipt of the Notice of Privacy Practices

e) Car Seat Regulation

SUBJECT: Informing Materials for Mental Health Plan Consumers and Intake/Advisement Checklist

f) Offered Voter Registration (over 18 consumers or guardian)

VII. Advance Directive:

A. All consumers 18 years and older shall be provided with, and note the receipt of, the Advance Health Care Directive Information Sheet on the Intake/Advisement Checklist.

B. All consumers shall be informed that at any time they develop an Advance Directive or want to update the one on file, they can provide the revision and the BHS staff shall place the update in the consumer record (reference BHS P&P 02.06.01 Advance Directives).

VIII. Signatures:

A. Once the Intake/Advisement Checklist has been completed both the consumer/legal guardian and BHS staff are to sign and date the Intake/Advisement Checklist and file in the consumer record.

Cultural Competence Committee

Health Care Agency Behavioral Health Services Policies and Procedures	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	10/12/16

SUBJECT: Cultural Competence Committee

PURPOSE:

To provide policy direction and procedural guidelines for the Cultural Competence Committee (CCC) of the Orange County Health Care Agency (HCA) Behavioral Health Services (BHS).

POLICY:

It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.

SCOPE:

The CCC will be reflective of the community, including county management level and line staff, consumers and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The BHS CCC will function as a local forum for service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County.

The CCC will provide BHS with cultural competence related information, community feedback and recommendations regarding:

1. The functioning of local behavioral health service systems.
2. The mental health service needs of ethnic and cultural groups.
3. The provision by BHS of a collaborative process that is informed and influenced by community interests, expertise, resources and needs.
4. The establishment and maintenance of a meaningful dialogue with HCA BHS that addresses cultural and linguistic issues referenced from the active participation of cultural groups that are reflective of the community.

The CCC will be integrated within the Behavioral Health system, and:

1. Address cultural and linguistic competence; review the cultural competence plans of all BHS services and programs; and address the cultural competence issues at the county.

2. Provide reports to the BHS Quality Assurance/Quality Improvement Program, and an annual Report of CCC activities.

3. Provide input into the planning and implementation of services at the county.

4. Directly transmit recommendations to HCA executive level, and transmit concerns to the Behavioral Health Director.

5. Participate in and review county Mental Health Services Act (MHSA) planning and stakeholder process, and review county MHSA plans for all MHSA components.

6. Participate in and review client developed programs (wellness, recovery, and peer support programs).

7. Participate in revised Cultural Competence Plan Requirements (CCPR) (2014) development.

REFERENCES:

CCPR: http://www.dhcs.ca.gov/services/MH/Documents/CCPR10-02Enclosure1.pdf

National CLAS Standards: http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, 2010.

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competence Plan, Updated 2015.

Cross, T.L., Bazron, B.J., Dennis, K.W. & Isaacs, M.R. (1989), Towards *a* culturally competent system of care. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care: A Blueprint for Advancing and Sustaining CLAS Policy and Practice. (April, 2013).

DEFINITIONS:

Definitions of terms which operationalize the aim and scope of the BHS Cultural Competence Committee:

Culture - The integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.

Culture defines the preferred ways for meeting needs. Culture may include parameters such as age, county of origin, degree of acculturation, generation, educational level, family and household composition, gender identity and sexual orientation, health practices including the use of traditional healer techniques, linguistic characteristics—including language(s) spoken, written, or signed, perceptions of health and well-being and related practices, physical ability or limitations and cognitive ability or limitations, political beliefs, racial and ethnic groups, religious and spiritual characteristics, socioeconomic status, etc. (CLAS Standards, April 2013).

Cultural Competence - Cultural competence refers to the ability of organizations and individuals to work effectively in cross-cultural or multicultural situations. The emphasis is on the interaction/communication with diverse communities and among ethnic groups to assess their needs and effectively engage with them. Cultural competence is an evolving process, which at its core is "quality of care".

Organizational Cultural Competence - The existence of policies, procedures, practices, and organizational infrastructure to support the delivery of culturally and linguistically sensitive and appropriate health care services where “culture” is broadly defined.

Individual Cultural Competence - Set of congruent attitudes, knowledge, and skills that enable the person or individual to interact effectively in cross-sectional situations.

PROCEDURES:

I. The CCC will be represented by five categories of members to ensure that the various ethnic and cultural groups, and persons and providers with knowledge and experience can articulate their perspectives and concerns:

   A. Consumers;

   B. Family members;

   C. Community service providers;

   D. Local management staff of HCA BHS; and

   E. Community representatives.

II. The CCC will have a minimum of two members from each category that reflects the county’s demographics of ethnic and cultural diversity.

III. The CCC and the Ethnic Services Manager (ESM) will assess CCC membership annually to ensure that all five categories are represented, and will actively work to suggest persons who can be of benefit to the ethnic and cultural community, and consumers of HCA BHS programs and services.

IV. The CCC members should live and/or work in the Orange County area.

V. The ESM will submit an annual report to the HCA BHS Director, indicating pertinent population trends and developments that should be represented in the CCC membership.

VI. At least annually, the Multicultural Development Program should offer new CCC members appropriate orientation and training regarding the objectives, policies and programs of HCA BHS.

VII. CCC membership will be inclusive to community members interested in participating. CCC members who have not attended for several meetings will be asked if they wish to continue their CCC membership.

VIII. The CCC Co-Chairs (ESM and appointed Co-Chair) report to the HCA BHS Director.

IX. CCC Goals:

A. To provide BHS with community perspectives in culturally competent program functioning and new and/or changed programs needed for county residents to assure optimal performance outcomes.

B. To review the cultural competence effectiveness of new BHS programs and services and proposed changes that impact the access to services for both county operated and county contracted programs.

X. Principles of CCC Formation and Cooperation:

A. The CCC shall consist of not less than 10 members, with at least two members representing each of the five categories of membership. New members should be recruited to ensure that each category is fully represented. While there is no fixed size limit on the number of members for the CCC, the CCC Co-Chairs can set limits for the size of each group to assure that each can function at optimal levels.

B. The CCC annual report to the BHS Director should include particular attention to the Committee's activities, projects, and accomplishments. In addition, problems, obstacles, needs, new issues, and changing priorities should be addressed that pertain to Cultural Competence.

C. The CCC is Co-Chaired by the ESM and a member of the committee. The Co-Chair will be nominated by the CCC and appointed by the ESM.

D. The ESM and CCC Co-Chair will function as a team, dividing responsibilities and activities in a complementary manner in order to promote full and complete discussion and deliberation by members and to increase CCC productivity and effectiveness.

E. The CCC will form sub-committees and task forces as appropriate and necessary each year for conducting cultural competency requirements and activities.

F. The CCC may adopt its own bylaws and procedures to facilitate its work, as long as there is no conflict with Departmental policy, County/State statutes, regulations and policies.

G. The CCC should participate in the Countywide MHSA Planning Committee to foster consensus on the planning strategies and directions to be taken by HCA BHS.

XI. CCC Meetings:

A. Meetings may occur as needed during the year, at places and times to be determined by the CCC, based on objectives, issues to be addressed and tasks to be accomplished.

B. All of the CCC general meetings are to be open to the public.

C. Brief minutes (including records of attendance, proposals, recommendations, etc.) shall be taken at every general and special meeting of the CCC. Each matter reported should reflect the consensus of the Committee as well as alternative perspectives. Copies of the minutes should be forwarded to the BHS Director and other BHS management staff, Co-Chairpersons of the CCC, the Mental Health Board, the Alcohol Drug Advisory Board and other staff as appropriate.

D. The ESM will encourage full and appropriate participation and involvement of all CCC members. Clerical support and services shall be made available as appropriate and needed to further the work of the CCC and its sub-committees.

E. The ESM, will take responsibility for providing the CCC with a range of appropriate, informational materials concerning HCA BHS, County and State guidelines, policies, procedures, evaluations and programs. The ESM will endeavor to assure that these and other materials are received by CCC's and distributed to members in a timely manner.

Field Testing of Written Materials

Health Care Agency Behavioral Health Services Policies and Procedures	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.05 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Field Testing of Written Materials

PURPOSE:

To ensure written materials for Behavioral Health Services (BHS) Mental Health Plan (MHP) have been field tested by consumers, family members or significant others to ensure comprehension.

POLICY:

Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension.

Written materials include, but are not limited to:

- MHP Consumer Handbook
- MHP Provider List
- General Correspondence
- Beneficiary grievance and fair hearing materials
- Confidentiality and release of private health information
- MHP orientation materials
- SMHS education materials

SCOPE:

All County and County Contracted clinics providing Specialty Mental Health Services (SMHS) through BHS MHP.

REFERENCES:

State Department of Mental Health - Approved Cultural Competency Plan, 2010

MHP and DMC-ODS Provider Directory

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.04 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	11/6/19

SUBJECT: MHP and DMC-ODS Provider Directory

PURPOSE:

To ensure that Medi-Cal Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) beneficiaries receive and or have access to a Provider Directory that includes alternatives and options for cultural / linguistic services.

POLICY:

All beneficiaries receiving behavioral health services from the County of Orange Health Care Agency (HCA) Behavioral Health Services (BHS) will receive and/or have access to a copy of the appropriate Provider Directory.

SCOPE:

This policy pertains to all Orange MHP and DMC-ODS County and County contracted clinicians, Plan Coordinators, student interns and volunteers providing services within the Orange MHP and DMC-ODS programs.

REFERENCES:

MHSUDS Information Notice: 18-020 Federal Provider Directory Requirements for Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties

Department of Mental Health Information Notice No: 02-03 - Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services Cultural Competency Plan Requirements

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Update 2018

Mental Health Plan Intake/Advisement Checklist (F346-753)

Drug Medi-Cal Organized Delivery System (DMC-ODS) Intake/Advisement Checklist (F346-791)

SUBJECT: MHP and DMC-ODS Provider Directory

PROCEDURES:

I. Provider Directory Requirements

A. The Orange MHP and DMC-ODS Provider Directory shall be made available in electronic form and paper form upon request.

B. Both the Orange MHP and DMC-ODS Provider Directories are available in the threshold languages and comply with the language and format requirements outlined in 42 CFR §438.10(d).

1. Information is presented in a manner and format that is easily understood and readily accessible;

2. Include taglines in the prevalent non-English languages in the State explaining the availability of free written translation or oral interpretation services to understand the information provided;

3. Use 12 point or larger font size for all text;

4. Include a large print tagline (18 point font or larger) and information on how to request auxiliary aids and services, including the provision of materials in alternative formats, at no cost to the beneficiary; and,

5. Include the toll-free and TTY / TDY or California Relay Service telephone number for the Orange MHP and DMC-ODS customer service unit (i.e., 24 hours, 7 days per week toll-free telephone number).

C. The Orange MHP and DMC-ODS Provider Directory is monitored monthly for accuracy and includes the following information for licensed, waivered, or registered mental health providers and licensed substance use disorder services providers employed by the Orange MHP and DMC-ODS or County Contracted providers who provide Medi-Cal services.

D. Orange MHP and DMC-ODS Provider Directories includes:

1. The provider's name and group affiliation, if any;

2. Provider's business address (e.g., physical location of the clinic or office);

3. Telephone number(s);

4. Email address, as appropriate;

5. Website URL, as appropriate;

6. Specialty, in terms of training, experience and specialization, including board certification (if any);

SUBJECT: MHP and DMC-ODS Provider Directory

7. Services / modalities provided, including information about populations served (i.e., perinatal, children/youth, adults);

8. Tagline statement regarding needing to contact the provider to verify if they are accepting new beneficiaries.

9. The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);

10. The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,

11. Whether the provider's office / facility is Americans with Disabilities Act (ADA) compliant.

E. In addition to the information listed above, the Provider Directory also includes the following information for each rendering provider:

1. Type of practitioner, as appropriate;

2. National Provider Identifier number;

3. California license number and type of license; and,

4. An indication of whether the provider has completed cultural competence training.

F. The following notation is included in both the Orange MHP and DMC-ODS Provider Directory:

> "Services may be delivered by an individual provider, or a team of providers, who is working under the direction of a licensed practitioner operating within their scope of practice. Only licensed, waivered, or registered mental health providers and licensed substance use disorder services providers are listed on the Plan's provider directory."

II. The staff shall give the appropriate version of the Provider Directory to all beneficiaries at the time of admission and shall be made available upon request to any beneficiary or their active representative. The Provider Directory shall be available in all threshold languages as well as in paper form and electronically via the Orange County internet webpage.

III. The person to whom the request for a Provider Directory is made shall be responsible to ensure the beneficiary, family member or significant others receives the appropriate Provider Directory.

IV. For every newly admitted beneficiary, the admitting staff shall document the provision or offer of the appropriate Provider Directory on the appropriate Intake/Advisement Checklist.

Distribution of Translated Materials

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.03 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	8/3/16

SUBJECT: Distribution of Translated Materials

PURPOSE:

To ensure availability of culturally and linguistically appropriate written information in the identified threshold languages to assist consumers in accessing Specialty Mental Health Services (SMHS) in the Mental Health Plan (MHP).

POLICY:

Behavioral Health Services (BHS) is committed to providing consumers with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.

SCOPE:

These procedures apply to all County operated and County Contracted programs within the Mental Health Plan (MHP) involved in the linkage and direct provision of SMHS to consumers.

REFERENCES:

California Code of Regulations, Title IX, Chapter 11, Section 1810.410 (a)

Department of Mental Health Information Notice No. 97-14, Page 14

County of Orange, Health Care Agency, BHS, Cultural Competency Plan, Update, 2010.

FORMS:

Mental Health Plan Consumer Handbooks http://ochealthinfo.com/bhs/about/medi cal

Grievance and Appeal Process Pamphlets, F346-656 (06/16) DTP58

Grievance and Appeal Process Posters, F346-675 (06/16) DTP64

Mental Health Plan Provider List http://ochealthinfo.com/bhs/about/medi_cal

SUBJECT: Distribution of Translated Materials

PROCEDURES:

I. The Service Chief/Program Director of each County operated or County Contracted program providing SMHS for the MHP is responsible for maintaining adequate numbers of these materials at their programs and for ensuring that the materials are posted and made readily available to consumers.

II. Grievance and Appeal posters in each threshold language shall be prominently displayed in an area accessible to all consumers at each location.

III. Mental Health Plan Consumer Handbooks in the appropriate threshold languages shall be offered to consumers during the initial intake to each clinic, or upon request. These Consumer Handbooks shall be available in an area accessible to all consumers at each location.

IV. Mental Health Plan Provider lists in the appropriate threshold language shall be offered to consumers during the initial intake to each clinic or upon request.

Meeting Consumer Language Needs

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.02 ☐ New ☒ Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral health Services	Signature on File	9/21/16

SUBJECT: Meeting Consumer Language Needs

PURPOSE:

To ensure that consumers have access to linguistically appropriate services through staff or interpreters proficient in the consumer's primary language.

POLICY:

All Behavioral Health Service (BHS) consumers shall have access to linguistically appropriate services.

SCOPE:

These procedures apply to all BHS County and County contracted programs involved in the linkage and treatment of consumers receiving services.

REFERENCES:

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410

Department of Mental Health Information Notice No. 02-03

County of Orange, Health Care Agency, BHS, Cultural Competency Plan, Criterion 7 - Language Capacity (Update 12/30/10)

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURES:

I. Signage shall be posted at each BHS County and County Contracted clinic notifying Limited English Proficient (LEP) consumers that they have the right to receive free language assistance services.

II. Each BHS clinic will have available a BHS Staff Bilingual Directory of linguistically proficient staff/interpreters throughout BHS. This BHS Staff Bilingual Directory shall be updated at least every two years. The Multicultural Development Program may be contacted for the updated BHS Staff Bilingual Directory.

SUBJECT: Meeting Consumer Language Needs

III. Each BHS County and County Contracted clinic shall have access to a Language Line or other identified interpretative service.

IV. Access logs shall indicate whether an interpreter was needed and the response by the consumer to offers of interpretive services.

V. When consumers' language needs fall outside the identified threshold languages, the following steps shall be taken to link the consumer to appropriate services:

A. Staff shall refer to the BHS Staff Bilingual Directory of linguistically proficient staff interpreters to attempt to link the consumer with services in their primary language

B. When a staff interpreter is identified, the immediate supervisor shall make every attempt to ensure staff availability to provide the requested interpreting service.

C. If there is no staff person available to act as an interpreter, staff may access a language line to determine what services the consumer needs and/or to provide services using the language line until other appropriate interpretive services are located.

D. Staff shall attempt to locate and link consumers with services that are linguistically and culturally appropriate. Linkage may be made with a community service organization providing interpretive services.

E. Staff shall not expect that family members will provide interpreter services.

1. A consumer may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services.

2. Minor children should not be used as an interpreter.

VI. In order to facilitate Cultural/Linguistic Proficiency and access, BHS will:

A. At least every other year, all BHS County and County Contracted clinicians, student interns, and volunteers shall be surveyed to determine proficiency in a variety of cultural/linguistic skills that they are able to make available at each clinic. Cultural proficiencies will be self-declared.

B. Program Managers shall be informed in advance of the survey distribution. The Service Chiefs/Program Directors for each clinic site shall be responsible for ensuring the survey of all clinicians under their supervision.

C. The Service Chiefs/Program Directors shall ensure all completed surveys are forwarded to the Multicultural Development Program within the established timeframe.

D. The Multicultural Development Program shall approve the BHS Staff Bilingual Directory using only those staff with cultural/linguistic proficiencies that are supported by current survey documentation.

Cultural Competency

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.01 ☐New ☒Revised

	SIGNATURE	**DATE APPROVED**
Director of Operations Behavioral Health Services	Signature on File	8/29/19

SUBJECT:	Cultural Competency

PURPOSE:

The purpose of this policy is to set standards and expectations for the provision of culturally competent service delivery.

POLICY:

All of Behavior Health Services (BHS) County and County Contracted providers shall be culturally competent.

SCOPE:

This policy applies to all functions of Behavioral Health Services (BHS) providing Mental Health Services and/or Substance Use Services.

REFERENCES:

Department of Mental Health Information Notice 02-03: Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services - Cultural Competence Plan Requirements

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Updated, 2018

California Code of Regulations, Title IX, Chapter 11

Code of Federal Regulations (CFR), Title 42, Section 438.206 (c) 2

National Culturally and Linguistically Appropriate Services (CLAS) Standards (2013)

PROCEDURES:

I. Each program will follow the guidelines for cultural competency as agreed in the State's approved Cultural Competency Plan.

SUBJECT: Cultural Competency

II. Consultation regarding said guidelines shall be obtained as needed from the Multicultural Development Program.

III. All BHS County and County Contracted staff shall complete an annual cultural competence training. This training will include gender identity as a component of culturally appropriate care.

IV. The Behavioral Health Training Services (BHTS) unit shall indicate on all training announcements and certificates if the particular training qualifies to meet the requirement for cultural competence training.

V. The Service Chief/Supervisor of each BHS staff person shall be responsible to ensure that the mandatory annual cultural competence training occurs and shall keep evidence of the training for each staff person.

VI. Contract organizations are expected to ensure that all staff have, at a minimum, one hour of training in and related to cultural competence annually. Contract organizations shall keep documentation of this training and report completion of such training by all direct service providers, administration, and support staff to the Contract Monitor/Consultant.

VII. The BHTS unit shall report annually to the Community Quality Improvement Committee on the attendance at cultural competence trainings. The reporting shall include the reporting requirements of DHCS Information Notice 10-17, or any subsequent DHCS requirements that may supersede Information Notice 10-17.

Training Specifically Pertaining to Cultural Competency

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Human Resources Staff Development 03.01.03 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File	9/21/16

SUBJECT: Trainings Specifically Pertaining to Cultural Competency

PURPOSE:

The purpose of this policy is to establish a uniform method of reviewing the nature and adequacy of Behavioral Health Services (BHS) trainings that address cultural issues and to define class attendance requirements for all County and County Contracted BHS staff providing clinical care.

POLICY:

BHS trainings that address cultural issues shall be of the highest possible quality. Toward this end, the Multicultural Development Program shall provide review, feedback and consultation on all trainings that address cultural issues prior to the training date.

SCOPE:

This applies to all BHS County and County Contracted programs.

REFERENCES:

County of Orange Health Care Agency, Behavioral Health Services, Cultural Competency Plan Updated, 2010

Department of Mental Health: DMH Information Notice 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services- Cultural Competency Plan Requirements

California Welfare & Institutions Code Section 5600.2 (g)

California Welfare & Institutions Code Section 5600.9 (a)

National CLAS Standards, 2013

SUBJECT: Trainings Specifically Pertaining to Cultural Competency

PROCEDURES:

I. Proposed trainings that meet the criteria of addressing cultural issues shall be forwarded to the Multicultural Development Program for review and comment at least two months prior to the training event.

II. An outline and instructor vitae for the proposed course shall be submitted to the Multicultural Development Program for review.

III. The Multicultural Development Program shall review the materials and provide feedback to the training coordinator within three working days.

   A. Feedback shall include at a minimum suggestions, if any, regarding cultural content.

IV. The Multicultural Development Program shall provide consultation as needed to improve the quality of trainings that address cultural issues.

V. It is required that all BHS County and County Contracted staff will complete a mandatory annual cultural competence training.

APPENDIX II: BEHAVIORAL HEALTH EQUITY COMMITTEE (BHEC) – GOVERNING STRUCTURE

Behavioral Health Services (BHS)

Behavioral Health Equity Committee Governing Structure

2020

Approval by BHS Director *Print Name*	Signature	Date
Jeffrey Nagel, Ph.D.		12/7/20

Behavioral Health Equity Committee (formerly known as Cultural Competence Committee)
Governing Structure

BEHAVIORAL HEALTH SERVICES

Behavioral Health Equity Committee (BHEC)

GOVERNING STRUCTURE

I. Vision

Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups. Based on SAMHSA's Behavioral Health Equity[1] tips, key strategies will be focused on data, policy, quality, and communication:

a) The *data strategy* utilizes available federal, state, county and community data to identify, monitor, and respond to behavioral health disparities.

b) The *policy strategy* promotes policy initiatives that strengthen the impact of BHS programs in advancing behavioral health equity.

c) The *quality practice and workforce development strategy* helps BHS to expand the behavioral health workforce capacity to improve outreach, engagement, and quality of care for unserved and underserved populations.

d) The *communication strategy* increases awareness and access to information about behavioral health disparities and strategies to promote behavioral health equity.

The BHEC will further develop and make recommendations around these key strategies to be included in the Cultural Competency Plan annual update.

II. Role and Purpose

The BHEC seeks to impact and advise BHS policies and initiatives by:

a) Strategically focusing on racial, ethnic, LGBTQI and other cultural groups in BHS programs

b) Using a data-informed quality improvement approach to address racial and ethnic disparities in BHS programs

c) Recommending that BHS policies, initiatives, and collaborations include emphasis on decreasing disparities

d) Proposing innovative, cost-effective training strategies to a diverse workforce

The BHEC will satisfy the above role by conducting the following activities to promote increased cultural awareness, sensitivity and responsiveness in OC's behavioral health services:

a) Culturally and linguistically appropriate services: The BHEC will advise Orange County Behavioral Health Services on ways to improve access and engagement with individuals who have Limited English Proficiency (LEP) and/or other communication needs.

[1] https://www.samhsa.gov/behavioral-health-equity

b) Trainings: The BHEC, through the Multicultural Development Program (MDP), works with Behavioral Health Training Services to create and coordinate trainings focused on cultural sensitivity, awareness and humility; and to ensure that other trainings include cultural considerations related to the subject of the training and that such considerations are included as one of the training objectives.

c) Leadership: The BHEC will work closely with the BHS leadership in promoting elimination of community health disparities and inequity in Behavioral Health Services.

III. Operationalized Values

The BHEC will strive to work in a manner that is consistent with its values:

a. Equity – *Attaining the highest level of behavioral health for all by addressing root causes of inequities.* The BHEC's membership, activities, and planning processes will be inclusive of the diverse communities in Orange County, especially those where data indicate to have disparities in health.

b. Inclusive – *Health includes physical, mental, spiritual, economic, environmental, and educational factors that contribute to it.* The BHEC's membership and planning processes will be inclusive of a broad range of perspectives representing the various factors that contribute to health.

c. Collaborative –*requires a partnership between many entities including residents, health care providers, community-based organizations, faith-based organizations, schools, businesses, and government.* The BHEC will conduct its activities in a collaborative manner and actively engage community partners in working towards its shared vision and goals.

d. Multi-dimensional – *Culture must be understood at the individual, family, and system levels.* The BHEC will ensure that planning processes consider the various dimensions of culture.

IV. Membership

a. Representation: The BHEC is composed of individuals who are dedicated to cultural diversity and equity and come from a variety of backgrounds. The BHEC shall be a body representing a broad cross-section of interests and experiences. The BHEC does not limit membership from for-profit entities. Joining the BHEC as a means for solicitation or using meetings as a forum for solicitation is prohibited and may be cause for removal. The BHEC shall strive to include at minimum:

i. Representation from the following suggested organizations:
- Orange County Health Care Agency, Public Health Services
- Orange County Health Care Agency, Behavioral Health Services
- Orange County Social Services Agency
- Orange County Department of Education
- Cal Optima
- Children and Families Commission of Orange County
- Orange County 211

ii. Representatives with the following expertise or perspectives:
- Community based organizations
- Outreach and engagement programs
- Bilingual/bi-cultural
- Black/African Americans
- LGBTQI

Veterans
Faith-based organizations
Community health center
Healthcare provider or other affiliation
Local government
Public safety
Transportation
Universities, colleges, and other research institutions
Advocacy organizations

iii. Individuals, including community members, who can represent perspectives of populations identified as having lived experience with the Behavioral Health system. Examples include, but are not limited to, persons with behavioral health conditions or family members of a person with a behavioral health condition.

iv. Other at-large members involved in assessing and/or promoting cultural diversity and equity

b. Term: There is no limit to the number of years a member may serve. Membership will be renewed based on members' interest and ability to serve every two years.

c. Selection: Individuals or representatives of organizations wishing to participate on the BHEC may request to join the BHEC as a voting member by submitting a written application. The application will be reviewed and voted upon by the BHEC Steering Committee. Applications approved by the BHEC Steering Committee will be forwarded via email to BHEC members for review prior to the next BHEC meeting. The BHEC will strive to come to consensus about approval of applications. When consensus cannot be reasonably reached, a vote of BHEC members will be conducted via email. Approved applicants will join the BHEC as a voting member at the first BHEC meeting after their application is approved.

d. Member Responsibilities: In order to complete these tasks, BHEC members have the following responsibilities:

i. Participate in scheduled meetings. Meetings will occur at least three times a year. Attendance to meetings will be monitored. The BHEC Steering Committee may contact members with excessive absences to discuss their interest and ability to serve on the BHEC.
ii. Commit to serving on at least one BHEC work group.
iii. Communicate information about the activities of the BHEC to the community and partners.
iv. Assist the BHEC in identifying resources to support the work of the BHEC.
v. Support BHEC activities, such as data collection, town halls, etc.

V. Officers

a. Co-Chairs: There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by Ethnic Services Manager or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC from among the members unaffiliated with the County of Orange and its agencies.

b. Community Co-Chair Term: The term for the Community Co-Chairs shall run for two years from January to December.

c. Community Co-Chair Selection: The Community Co-Chair shall be selected by the BHEC by majority vote at the last scheduled BHEC meeting before the start of a new term, usually in December.

d. Officer Responsibilities:

i. **Behavioral Health Services Co-Chair:** The Ethnic Services manager or a representative of Orange County Health Care Agency, Behavioral Health Services shall serve as a permanent Co-Chair of the BHEC. In collaboration with the Community Co- Chair, the BHS Co-Chair will set meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. The BHS Co-Chair shall rotate the responsibilities of chairing individual meetings with the other BHEC Co-Chair.

ii. **Community Co-Chair:** The BHEC shall select a Co-Chair from members unaffiliated with the County of Orange agencies participating on the BHEC. The Community Co-Chair, in collaboration with the Behavioral Health Services Co-Chair, will set the meeting agenda; facilitate BHEC meetings; establish committees and ad-hoc work groups as needed. Each Community Co-Chair shall rotate the responsibilities of chairing individual meetings with the BHS Co-Chair.

VI. Voting

The BHEC will strive to govern by consensus. When consensus cannot be reasonably reached, official actions taken by the BHEC shall be adopted by a majority vote. Each individual member present, not by proxy, will have one vote.

VII. Meetings

The BHEC shall schedule meetings at least three times per year at the discretion of the BHEC Steering Committee. Meetings will be open to the public, but only members may vote.

VIII. Committees and Work Groups

a) **Steering Committee:** The BHEC Steering Committee will be charged with the general oversight of affairs of the BHEC including review and setting of the BHEC agenda and review and recommendation of BHEC member applications. Seats on the BHEC Steering Committee will be determined by the BHEC and may include Co-Chairs, representatives from each committee, and other individuals such as representation from the school districts, hospital, city government, and academic institutions and representation of specific populations.

b) **Work Groups:** The BHEC shall establish or identify work groups, or task forces as it deems necessary to accomplish its purpose and role. This may include establishing or designating work groups to implement strategies related to priorities identified in the Cultural Competence Plan.

c) **Suggested work groups:** Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of the threshold languages or have Limited English Proficiency (LEP) and or other communication needs; Veterans and Military; LGBTIQ

IX. Additional rules and procedures

The BHEC may establish any rules or procedures it so deems appropriate by consensus or majority action of the BHEC.

APPENDIX III: SAMPLES OF TRAINING EVALUATION FORMS

Cultural Competence 2.0 Online CE Training Survey

Orange County Health Care Agency
Navigation and Training Division
Behavioral Health Training Services

Training: Cultural Competency Online Training (CE)

Instructions: To receive Continuing Education (CE) credits for this online training, complete your information and the mandatory evaluation in order to receive your certificate of completion. Your input will help us maintain proper CE credit documentation, determine the effectiveness of this training, and improve training program quality. Thank you.

1. **Please enter your name (precisely with Last, First) as it will appear on the Certificate of Completion (example: Luna, Bella) [TEXT ENTRY]**

2. **Please enter your Supervisor's information:**
   Supervisor Name (Last, First): _____
   Supervisor's email address: _____

3. **Do you work for the County or a Community-Based Organization/Contractor (Please select ONE)?**
   ☐ County ☐ Community-Based Organization/Contractor

4. **IF COUNTY IS SELECTED: What is the name of your division and program?**
   Name of your Division (e.g., CYPBH, P&I) _____
   Name of your Program (e.g., CAT, CCSS) _____

5. **IF COMMUNITY-BASED ORGANIZATION/CONTRACTOR IS SELECTED: What is the name of your agency/program? [TEXT ENTRY]**

6. **Please select your work location from the drop-down menu. [PULL FROM SURVEYMONKEY]**

7. **If you wish to receive a CE certificate, please enter your license number here (Example: PSY1234, LMFT1234).**

8. **What is your age?**
   ☐ 16-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

RACE / ETHNICITY *(Please select ALL of the race and ethnicity categories you identify with.)*

9. **What is your race/ethnicity?**

- ☐ **American Indian / Alaska Native**
  - ☐ Alaska Native
  - ☐ Aleut
  - ☐ American Indian
  - ☐ Inuit
  - ☐ Other American Indian / Alaskan Native
- ☐ **African / African American / Black**
  - ☐ African
  - ☐ African-American / Black
  - ☐ Afro-Caribbean
  - ☐ Algerian
  - ☐ Other African Descent
- ☐ **Asian**
  - ☐ Asian Indian / South Asian
  - ☐ Bangladeshi
  - ☐ Cambodian
- ☐ **Pacific Islander**
  - ☐ Guamanian
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ **Latino / Hispanic**
  - ☐ Caribbean
  - ☐ Central American
  - ☐ Cuban
  - ☐ Mexican / Mexican American / Chicano
  - ☐ Puerto Rican
  - ☐ South American
  - ☐ Spanish
  - ☐ Other Latino / Hispanic
- ☐ **White / Caucasian**
  - ☐ Arab / Arab-American

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- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mien
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Thai
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Eastern European
- ☐ European
- ☐ Iranian / Persian
- ☐ Iraqi
- ☐ Lebanese
- ☐ Palestinian
- ☐ Middle Eastern - Other
- ☐ Other White / Caucasian
- ☐ **Decline to State**
- ☐ **Other (please specify)** _____

LANGUAGE – PRIMARY / PREFERRED

10. **What is your English ability?**
☐ Fluent ☐ Limited ☐ None ☐ Decline to State

11. **What is your primary language?**
☐ Arabic ☐ Armenian ☐ ASL ☐ Cambodian
☐ Cantonese ☐ English ☐ Farsi ☐ Khmer
☐ Korean ☐ Mandarin ☐ Russian ☐ Spanish
☐ Tagalog ☐ Vietnamese ☐ Other _____ ☐ Decline to State

GENDER INFORMATION *(Please select ONE that best describes you.)*

12. **What is your sex assigned at birth?**
☐ Male ☐ Female ☐ Intersex ☐ Decline to State

13. **What is your current gender identity?**
☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State
☐ Questioning or unsure of gender identity ☐ Another gender identity _____

14. **What is your sexual orientation?**
☐ Gay ☐ Lesbian ☐ Heterosexual or Straight ☐ Bisexual ☐ Queer
☐ Questioning or unsure of sexual orientation ☐ Another sexual orientation ☐ Decline to State

DISABILITY *(Please select ALL that apply.)*

15. **Do you have any disabilities?** A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.
- ☐ No, I don't have any of these disabilities
- ☐ Difficulty seeing
- ☐ Difficulty hearing or having speech understood
- ☐ Other communication disability
- ☐ Physical / mobility disability
- ☐ Chronic health condition
- ☐ Learning disability
- ☐ Dementia
- ☐ Developmental Disability
- ☐ Other mental / cognitive (e.g., traumatic brain injury) _____
- ☐ Other disability _____
- ☐ Decline to state
- ☐ Participant unable to answer

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MILITARY STATUS

16. **What is your military status?**

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

17. **Has one of your family members served in the military? If yes, what is their military status?**

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

18. **What is your organizational role? (Please select only one box)**

	Admin/Manager	Direct Service Provider	Support Staff
County	☐	☐	☐
Community-based Organization/Contractor	☐	☐	☐

19. **Of the roles listed below, which ones do you best identify with? (Please check all that apply)**

☐ Consumer ☐ Parent ☐ Family Member ☐ Community Member / General Public ☐ Caregiver
☐ Teacher ☐ Student ☐ Youth ☐ Other (please specify) _____

20. **What is your current professional status? (Please select only one box)**

☐ MD ☐ RN ☐ Psychologist ☐ LCSW ☐ LMFT ☐ LPCC ☐ CADC/CATC/RAS
☐ Unlicensed Staff ☐ Intern ☐ Peer Support Worker ☐ Faith-based Partner ☐ Not a service provider

21. **Based on your experience(s) today, how useful were each of the training components in meeting the following educational objectives listed on the training announcement?**

	Very Poor	Below Average	Average	Above Average	Excellent	N/A
Define cultural competency as it relates to culture, competence, race and ethnicity.	☐	☐	☐	☐	☐	☐
Identify how the consequences of social and self-stigma influences one's unconscious thoughts, judgements, and stereotypes.	☐	☐	☐	☐	☐	☐
Describe cultural formulation interviewing practices that integrate culturally responsive approaches into service attitudes and interactions with clients to reduce the effects of stereotyping.	☐	☐	☐	☐	☐	☐

22. **Please select your rating for:**

	Poor	Fair	Good	Very Good	Excellent
The presenter(s) ability to communicate knowledge of the subject.	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐

23. **How much did you learn as a result of this CE program?**

☐ Very Little ☐ Little ☐ Some ☐ A Good Bit ☐ A Great Deal

24. **How useful was the content of this CE program for your practice or other professional development?**

☐ Not useful ☐ A Little Useful ☐ Somewhat Useful ☐ A Good Deal Useful ☐ Extremely Useful

25. **What is most useful and/or helpful to you with this training?**

☐ Contents are useful for my work ☐ Online option was more convenient ☐ CE credit offer

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☐ Other (please specify) _____

26. **Was this online training user friendly?**

☐ Yes ☐ No

27. **Based on my experience(s) with this program:**

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
I would recommend this program to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during my most recent activity with this program.	☐	☐	☐	☐	☐
Overall, I am satisfied with this program and the services I received here.	☐	☐	☐	☐	☐

28. **Please provide any comment(s) about your experience and/or suggestions for future trainings.**

_____

_____

_____

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Cultural Competence 2.0 Online CME Training Survey

Orange County Health Care Agency
Navigation and Training Division
Behavioral Health Training Services

Training: Cultural Competency Online Training (CME)

Instructions: To receive Continuing Medical Education (CME) credits for this online training, complete your information and the mandatory evaluation in order to receive your certificate of completion. Your input will help us maintain proper CME credit documentation, determine the effectiveness of this training, and improve training program quality. Thank you.

1. **Please enter your name (precisely with Last, First) as it will appear on the Certificate of Completion (example: Luna, Bella) [TEXT ENTRY]**

2. **Please enter your Supervisor's information:**
   Supervisor Name (Last, First): _____
   Supervisor's email address: _____

3. **Do you work for the County or a Community-Based Organization/Contractor (Please select ONE)?**
   ☐ County ☐ Community-Based Organization/Contractor

4. **IF COUNTY IS SELECTED: What is the name of your division and program?**
   Name of your Division (e.g., CYPBH, P&I) _____
   Name of your Program (e.g., CAT, CCSS) _____

5. **IF COMMUNITY-BASED ORGANIZATION/CONTRACTOR IS SELECTED: What is the name of your agency/program? [TEXT ENTRY]**

6. **Please select your work location from the drop-down menu. [PULL FROM SURVEYMONKEY]**

7. **If you wish to receive a CME certificate, please enter your license number here (Example: PSY1234, LMFT1234).**

8. **What is your age?**
   ☐ 16-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

RACE / ETHNICITY *(Please select ALL of the race and ethnicity categories you identify with.)*

9. **What is your race/ethnicity?**

- ☐ **American Indian / Alaska Native**
  - ☐ Alaska Native
  - ☐ Aleut
  - ☐ American Indian
  - ☐ Inuit
  - ☐ Other American Indian / Alaskan Native
- ☐ **African / African American / Black**
  - ☐ African
  - ☐ African-American / Black
  - ☐ Afro-Caribbean
  - ☐ Algerian
  - ☐ Other African Descent
- ☐ **Asian**
  - ☐ Asian Indian / South Asian
  - ☐ Bangladeshi
  - ☐ Cambodian
- ☐ **Pacific Islander**
  - ☐ Guamanian
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ **Latino / Hispanic**
  - ☐ Caribbean
  - ☐ Central American
  - ☐ Cuban
  - ☐ Mexican / Mexican American / Chicano
  - ☐ Puerto Rican
  - ☐ South American
  - ☐ Spanish
  - ☐ Other Latino / Hispanic
- ☐ **White / Caucasian**
  - ☐ Arab / Arab-American

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- ☐ Chinese
- ☐ Filipino
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mien
- ☐ Pakistani
- ☐ Sri Lankan
- ☐ Thai
- ☐ Vietnamese
- ☐ Other Asian
- ☐ Eastern European
- ☐ European
- ☐ Iranian / Persian
- ☐ Iraqi
- ☐ Lebanese
- ☐ Palestinian
- ☐ Middle Eastern - Other
- ☐ Other White / Caucasian
- ☐ **Decline to State**
- ☐ **Other (please specify)** _____

LANGUAGE – PRIMARY / PREFERRED

10. What is your English ability?

☐ Fluent ☐ Limited ☐ None ☐ Decline to State

11. What is your primary language?

☐ Arabic	☐ Armenian	☐ ASL	☐ Cambodian
☐ Cantonese	☐ English	☐ Farsi	☐ Khmer
☐ Korean	☐ Mandarin	☐ Russian	☐ Spanish
☐ Tagalog	☐ Vietnamese	☐ Other _____	☐ Decline to State

GENDER INFORMATION *(Please select ONE that best describes you.)*

12. What is your sex assigned at birth?

☐ Male ☐ Female ☐ Intersex ☐ Decline to State

13. What is your current gender identity?

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State

☐ Questioning or unsure of gender identity ☐ Another gender identity _____

14. What is your sexual orientation?

☐ Gay ☐ Lesbian ☐ Heterosexual or Straight ☐ Bisexual ☐ Queer

☐ Questioning or unsure of sexual orientation ☐ Another sexual orientation ☐ Decline to State

DISABILITY *(Please select ALL that apply.)*

15. Do you have any disabilities? A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

- ☐ No, I don't have any of these disabilities
- ☐ Difficulty seeing
- ☐ Difficulty hearing or having speech understood
- ☐ Other communication disability
- ☐ Physical / mobility disability
- ☐ Chronic health condition
- ☐ Learning disability
- ☐ Dementia
- ☐ Developmental Disability
- ☐ Other mental / cognitive (e.g., traumatic brain injury) _____
- ☐ Other disability _____
- ☐ Decline to state
- ☐ Participant unable to answer

MILITARY STATUS

16. What is your military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired

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☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

17. Has one of your family members served in the military? If yes, what is their military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

18. What is your organizational role? (Please select only one box)

	Admin/Manager	Direct Service Provider	Support Staff
County	☐	☐	☐
Community-based Organization/Contractor	☐	☐	☐

19. Of the roles listed below, which ones do you best identify with? (Please check all that apply)

☐ Consumer ☐ Parent ☐ Family Member ☐ Community Member / General Public ☐ Caregiver
☐ Teacher ☐ Student ☐ Youth ☐ Other (please specify) _____

20. What is your current professional status? (Please select only one box)

☐ MD ☐ RN ☐ Psychologist ☐ LCSW ☐ LMFT ☐ LPCC ☐ CADC/CATC/RAS
☐ Unlicensed Staff ☐ Intern ☐ Peer Support Worker ☐ Faith-based Partner ☐ Not a service provider

21. Based on your experience(s) today, how useful were each of the training components in meeting the following educational objectives listed on the training announcement?

	Very Poor	Below Average	Average	Above Average	Excellent	N/A
Define cultural competency as it relates to culture, competence, race and ethnicity.	☐	☐	☐	☐	☐	☐
Identify how the consequences of social and self-stigma influences one's unconscious thoughts, judgements, and stereotypes.	☐	☐	☐	☐	☐	☐
Describe cultural formulation interviewing practices that integrate culturally responsive approaches into service attitudes and interactions with clients to reduce the effects of stereotyping.	☐	☐	☐	☐	☐	☐

22. Please select your rating for:

	Poor	Fair	Good	Very Good	Excellent
The presenter(s) ability to communicate knowledge of the subject.	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐

23. How much did you learn as a result of this CME program?

☐ Very Little ☐ Little ☐ Some ☐ A Good Bit ☐ A Great Deal

24. How useful was the content of this CME program for your practice or other professional development?

☐ Not useful ☐ A Little Useful ☐ Somewhat Useful ☐ A Good Deal Useful ☐ Extremely Useful

25. What is most useful and/or helpful to you with this training?

☐ Contents are useful for my work ☐ Online option was more convenient ☐ CE credit offer
☐ Other (please specify) _____

26. Do you intend to make changes or apply what you have learned from this training?

☐ Yes ☐ Change already in place ☐ Not relevant to my work

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27. What changes do you intend to make, if any?

_____

_____

28. What barrier(s) do you expect to encounter in your attempts at change?

☐ No barriers ☐ No self-discipline to change ☐ No time to apply/practice new changes

☐ Change is not possible in current condition/system

29. How much commercial bias was presented by the speaker(s) or the training?

☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very high

30. Was this online training user friendly?

☐ Yes ☐ No

31. Based on my experience(s) with this program:

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
I would recommend this program to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during my most recent activity with this program.	☐	☐	☐	☐	☐
Overall, I am satisfied with this program and the services I received here.	☐	☐	☐	☐	☐

32. Please provide any comment(s) about your experience and/or suggestions for future trainings.

_____

_____

_____

_____

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APPENDIX IV: TABLE OF CULTURALLY COMPETENT TRAININGS

Training Title	*Training Description*	*Presenter(s) Name*
5150 LPS Initial Certification	This training is intended to educate the county and contracted adult and older adult mental health service providers about the 5150 process and impart the skills necessary to conducting assessments for and initiating involuntary detention for a 72-hour psychiatric hold. The 5150 training will cover relevant laws, historical information, criteria to initiate a hold, timeline and patient rights. The clinicians' role in the 5150 process, risk assessment techniques, as well as the steps to initiate a hold will be discussed. In addition, an overview of 5585 designation will be included in the event that there is a minor involved. This training is also designed to provide the clinician with the knowledge to test and pass certification.	Nicole Garcia, LMFT Lance Lindgren Annette Tran, LCSW
5585 Initial Certification Training	The target population for this training is County and County-Contracted Children and Youth Behavioral Health Service providers requiring 5585 certification to perform their job duties, which includes conducting risk assessments of minors and initiating involuntary detention for a 72-hour psychiatric hold. An overview of the history, explanation of 5585 and associated LPS legislature will be discussed. This training is intended to educate the practitioner about the 5585 process and provide the skills necessary to initiate a 5585 hold and paper work completion. Additionally, an overview of 5150 designation will be included in the event that there is an adult involved. This training is also designed to provide the clinician with the knowledge to test and pass certification for designation.	Various
Bio-Spiritual Focusing Training: Accompanying Self and Others on the Journey Part I	This twelve-hour presentation, taught over two sessions, will introduce clinical staff to the use of Bio-Spiritual Focusing as a tool in both self-care and in psychotherapy. The training will teach participants the necessary skills to facilitate a Focusing session for themselves and their patients. These two workshops will introduce participants to the use of Bio-Spiritual Focusing and lead them through a series of experiences for their own self-growth, and so that they can facilitate the process in others. This series of workshops is especially designed to help clinicians and patients increase their spiritual and psychological resilience as well as provide a gentle means to heal past traumatic memories.	Michael Mullard, Ph.D., LMFT Sr. Jeanne Fallon, C.S.J.

Bio-Spiritual Focusing Training: Accompanying Self and Others on the Journey Part II	This twelve-hour presentation, taught over two sessions, will introduce clinical staff to the use of Bio-Spiritual Focusing as a tool in both self-care and in psychotherapy. The training will teach participants the necessary skills to facilitate a Focusing session for themselves and their patients. These two workshops will introduce participants to the use of Bio-Spiritual Focusing and lead them through a series of experiences for their own self-growth, and so that they can facilitate the process in others. This series of workshops is especially designed to help clinicians and patients increase their spiritual and psychological resilience as well as provide a gentle means to heal past traumatic memories.	Michael Mullard, Ph.D., LMFT Sr. Jeanne Fallon, C.S.J.
Child Adolescent Needs & Strengths (CANS)	This presentation provides an overview of the CANS version and Transformational Collaborative Outcomes Management (TCOM). TCOM's overall framework, key concepts and how its multilevel approach directly benefits children and families will be discussed. The principles and best practices in using the CANS as TCOM's assessment strategy, a communication framework, and tools to monitor outcomes and inform care plans will also be addressed. Using mock vignettes and small group activities, this interactive session will prepare users for certification and use of the CANS.	April D. Fernando, Ph.D.
CBT and Relapse Prevention Strategies	The purpose of this skill-building review training is to provide participants with an overview of Cognitive-Behavioral Therapy (CBT) and Relapse Prevention (RP) strategies and resources to encourage the use of these interventions in daily clinical practice. Topics include key principles of classical and operant conditioning and modeling; functional analysis and the five "W's" of a client's drug use; triggers and craving; drug-refusing skills; the clinician's role in CBT; and strategies to schedule and construct a 24-hour behavioral plan.	James Peck, Psy.D.
Clinical Supervision Addressing Vulnerable Populations: Helping Supervisees Adopt a 'New Multicultural Relational Perspective'	In this six-hour course, participants will receive core knowledge of current clinical supervisory practices and learn how to incorporate a multicultural relational perspective (Hardy, 2016) in supervision, with an emphasis on serving vulnerable populations (e.g., homeless persons, justice-involved adults, LGBTQ individuals). Information and practice dealing with legal/ethical issues in supervision from a multicultural relational perspective is included. In addition, supervision issues including boundaries and workplace professionalism will be discussed from a standpoint honoring diversity with cultural humility.	Mary M. Read, Ph.D., LMFT

Communicating Effectively with the Deaf / Hard of Hearing People	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
Community First Conference	The annual Community First Conference is an educational forum designed to assist law enforcement personnel, mental health professionals, judicial officers, and other social service provider with current research, social protocols, and practical information about services provided to persons with a mental illness.	Heather Williams, Psy.D. Sergeant Jerry MacDonald
Crisis in Faith	This two-hour training for County clinicians, supervisors, and community partners will include a discussion around the importance of assessing and incorporating spirituality into the therapeutic alliance. This training will cover the differences between religion and spirituality, assessing spirituality at intake and recent research on ethical integration strategies. Ways for the clinician to consult, gather data and support the client in spiritual areas will be explored. Clinicians will be exposed to the realities and challenges in the integration of religion and spirituality so that treatment can move forward in a way that is useful for clients and authentic for clinicians.	Chaplain Paul Cobb, M.A.
*Crisis Intervention Training (CIT) Dispatcher	This course will provide public-safety dispatchers with an overview of mental illness, tools to assess suicidal callers and crisis intervention techniques.	Debbie Konstantakos, GWC Instructional Team
*Crisis Intervention Training (CIT) I	The Basic course introduces law enforcement officers to types of mental illnesses and provides them a better understanding of crisis and how to give basic intervention and assistance.	Various instructors
*Crisis Intervention Training (CIT) II	The Intermediate course provides updates from Level 1 and teaches law enforcement officers techniques to de-escalate mental health crisis in a controlled learning environment with the aid of an Interactive Video Training Simulator	Various instructors

*Crisis Intervention Training (CIT) III	The Advanced course is a comprehensive overview of CIT that implements all skills learned in Levels 1-2 in a controlled learning environment with the aid of Live Roleplaying Scenarios.	Various instructors
Cultural Competency Training (Online)	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity and diversity as well as stigma and self-stigma are discussed. The training also demonstrates the influence of unconscious thought on our judgement as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace uniqueness of other cultures beyond the mainstream American culture.	Bijan Amirshahi, LMFT, LPCC
*Dialectical Behavioral Therapy Evidence Based Training	In-person Consult 90 minutes for clinicians who attended the training in January 2018 and are actively implementing DBT at work.	Julie Orris, PsyD
EMDR Basic Training Part 1	The EMDR Basic Training (weekend 1 and 2) is designed for licensed mental health practitioners who treat adults and children in a clinical setting. EMDR is a comprehensive psychotherapy that accelerates the treatment of a wide range of pathologies and self-esteem issues related to disturbing events and, approach that requires supervised training for full therapeutic effectiveness and client safety. The training will consist of lecture, live and videotaped demonstrations and supervised practice.	Deborah Silveria, Ph.D.
EMDR Basic Training Part 2	The EMDR Basic Training (weekend 1 and 2) is designed for licensed mental health practitioners who treat adults and children in a clinical setting. EMDR is a comprehensive psychotherapy that accelerates the treatment of a wide range of pathologies and self-esteem issues related to disturbing events and present life conditions. EMDR is guided by the Adaptive Information Processing model which addresses the unprocessed memories that appear to set the basis for a wide range of dysfunction. EMDR is a specialized approach that requires supervised training for full therapeutic effectiveness and client safety. The training will consist of lecture, live and videotaped demonstrations and supervised practice.	Deborah Silveria, Ph.D.

EMDR Monthly Consultation	EMDR monthly consultation group is designed to enhance clinicians' understanding and skills in using EMDR therapy and to address any issues in utilizing EMDR therapy with their current clients. The consultation will consist of lecture, case presentations, and interactive discussions. Clinicians must have completed at least the EMDR Basic Training Part 1 to be able to participate in the consultation group. EMDR is a comprehensive psychotherapy. It is guided by the Adaptive Information Processing model which addresses the unprocessed memories that appear to set the basis for a wide range of dysfunction.	Keunho Keefe, Ph.D.
Housing and Placement Training	This training is for any Behavioral Health Services County or non-county contracted staff. Participants will learn/refresh themselves on the Health Care Agency's Adult and Older Adult Behavioral Health (AOABH) substance use treatment and mental health housing services. Staff will learn what services are available, identify appropriate level of care, who is eligible and how to access these services.	Various Instructors
Law & Ethics	This training will address multicultural child rearing practices in a framework that includes poverty and immigration. A culturally sensitive approach to assessment and intervention will be emphasized, including guidelines for working with families from diverse populations. In addition, this training will focus on the basic legal and ethical issues related to suicide, social media, and substance use. Participants will review current expert opinion, legal updates and standard of care related to (1) proper use of DSM-5 when diagnosing substance related disorders; (2) updates on relationship between social media and suicide; (3) American Academy of Pediatrics suicide assessment; (4) substance use disorders and the risk of suicide; (5) legal and ethical issues with informed consent and "safety agreements;" and (6) Non-suicidal self-injury (NSSI). Literature updates, along with relevant Codes of Ethics will be included in all areas of discussion.	Pamela Harmell, Ph.D.

Liberating Latina/o	This three-hour presentation for county clinicians, supervisors and community partners will address factors identified as barriers for Latinas/os in the utilization of mental health services, the role of culture in service delivery, and how providers of services can implement culturally relevant interventions that are consistent with underserved Latina/o communities. Specific topics that will be discussed include expanding our notion of culture, implicit bias, the role of religion and spirituality in the delivery of therapeutic services, and trauma informed care. The training will cover recent literature on psychotherapy with Latina/o communities and provide conceptual and theoretical frameworks for addressing the specific needs of Latina/o communities from multiple perspectives.	Miguel Gallardo, PsyD
Marijuana and Psychopharmacology	This training will provide information on the pharmacology and effective intervention and treatment of marijuana abuse. Participants will learn about how Marijuana including who tends to use it, and its acute and chronic effects. Information on how marijuana is used as a medicine and the legal questions surrounding medical marijuana will also be discussed. Specific strategies that clinicians can utilize to communicate effectively with clients who are either using marijuana for medical or recreational purposes or considering its use will also be discussed.	Grant Hovik, MA
Mental Health First Aid (MHFA; Adult)	Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. This training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a person in crises and connect them with help.	Various instructors

Mental Health First Aid (MHFA; PUBLIC SAFETY)	Mental Health First Aid for Public Safety teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. It focuses on the unique experiences and needs of public safety personnel and is a valuable resource that can make a difference in their lives, their coworkers' and families' lives, and the communities they serve. This training covers defusing crises, promoting mental health literacy, combatting stigma of mental illness, enabling early intervention through recognition of signs and symptoms and connecting people to care.	Various instructors
Mental Health First Aid (MHFA; Spanish)	Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. This training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a person in crises and connect them with help.	Various instructors
Mental Health First Aid (MHFA; Youth)	Youth Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders in youth. This 6-hour training gives adults who work with youth the skills they need to reach out and provide initial support to children and adolescents (ages 6-18) who may be developing a mental health or substance use problem and help connect them to the appropriate care. The training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a child or adolescent in crisis and connect them with help.	Various instructors
Mental Health First Aid (MHFA; Private)	Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. This training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a person in crises and connect them with help.	Various instructors

Motivational Interviewing	Motivational interviewing (MI), a treatment approach developed by William Miller, has been well-established as an effective way to promote behavioral changes in individuals. Following a brief review of the fundamental MI principles and micro-skills, this experiential MI Skill Development training will focus on helping clients to engage in change-talk, and then make commitments to make behavioral changes based on goals that they have identified. Ample time will be devoted to role-play-practice to enable participants to gain skills necessary to elicit change-talk from clients with low levels of readiness for change, thereby increasing levels of motivation and moving them toward action to address their substance use issues	Andrew S. Kurtz, MA, MFT
A Strategic Approach to Tobacco Recovery in Behavioral Health Programs	Tobacco cessation is critical to the recovery of persons with mental illnesses and addictions. These individuals are at multiplicative risk for tobacco use, have greater difficulty quitting smoking, and consequently, have a higher risk for tobacco-related death and disability. The majority of smokers with behavioral health conditions want to quit smoking and can quit smoking when they have access to proven psychosocial and medication treatments. At the same time, these individuals are likely to need tailored supports and services. In this training we will outline low burden, evidence-based practices, as well as agency guidance regarding staff training, workflows, treatment planning, self-care and sustainability.	Chad D. Morris, Ph.D. Cindy Wang Morris, PsyD
Non-Violence Crisis Intervention (NVCI)	This six-hour training is designed for the staff who work directly with behavioral health consumers in an outpatient/recovery center setting. Early intervention and non-physical methods for preventing or managing disruptive behavior will be emphasized for the best possible "care, welfare, safety and security" of all those who are involved in a crisis situation.	Various instructors
Non-Violence Crisis Intervention (NVCI; Adult)	This six-hour training is designed for the staff who work directly with behavioral health consumers in an outpatient/recovery center setting. Early intervention and non-physical methods for preventing or managing disruptive behavior will be emphasized for the best possible "care, welfare, safety and security" of all those who are involved in a crisis situation.	Various instructors

Non-Violence Crisis Intervention (NVCI; Youth)	This six-hour training is designed for the staff who work directly with behavioral health consumers in an outpatient/recovery center setting. Early intervention and non-physical methods for preventing or managing disruptive behavior will be emphasized for the best possible "care, welfare, safety and security" of all those who are involved in a crisis situation.	Various instructors
Non-Violence Crisis Intervention (NVCI; Re-Certification)	This three-hour training is a recertification/refresher course for all county staff who works directly with behavioral health consumers in an outpatient/recovery center setting. Clerical, medical, clinical staff and supervisors will be trained on crisis prevention that emphasizes early intervention and nonphysical methods for preventing or managing disruptive behavior. The goal is to provide for the best possible "Care, Welfare, Safety, and Security" of all those who are involved in a crisis situation.	Various instructors
Peer – Resilience	This 80-hour course is mandatory for all new BHS Peer Personnel. This is a foundational training that will provide peer personnel the knowledge and skills to be successful in their role as a Peer or Parent and Youth Partner in BHS.	Chris Martin
Project Kinship (Medication & Spirituality, Substance use & Spirituality)	Project Kinship, founded in 2014, is an organization dedicated to providing support and training to lives impacted by incarceration, gangs, and violence through hope, healing, and transformation. The goal of this training is to enhance participant's awareness of working with the "system impacted" populations and their families and "how to" work and address issues with this population.	Steven Kim, MSW Mary Vu Iammarino, LCSW
Recovery: The Promise of Hope	This training will address issues related to the process of recovery from persistent and severe mental illnesses and/or substance use. The training will consist of two parts: In the first half, recovery and guiding principles of recovery will be defined, and the factors promoting and hindering recovery will be discussed in depth including video clip interviews with individuals in the process of recovery. In the second half, four of these same individuals will share their stories of recovery with the audience, followed by a question and answer session.	Keunho Keefe, Ph.D.

Recovery Based Treatment Planning	This training will consist of two parts: The first part will be a guided large group discussion of three vignettes of the same person. It will illustrate how using recovery-based principles-person-centered instead of illness-centered, strengths-based instead of deficits-based, and client-driven instead of professional-driven, can alter how we relate to the client and what services we recommend. The second part will be a lecture focused on specific skills involved in recovery-based treatment planning: Growth-oriented goal setting, building hope, shared decision making and collaboration, supporting learning-by-doing, and building self-sustainability.	Mark Ragins, M.D.
Seeking Safety	Seeking Safety is an evidence-based treatment for trauma and substance use which teaches present-focused coping skills to help clients attain safety in their lives. Basic information on trauma, posttraumatic stress disorder (PTSD) and co-occurring disorders will be provided. Key themes relevant for this population will be discussed, including dissociation, self-injury, reenactments, and stage-based models of treatment, emotional responses by staff, staff self-care, and diversity issues. Trauma-informed versus trauma-specific treatment will also be highlighted. This training is highly clinically-oriented and will offer the opportunity to role-play client scenarios. Real-world challenges will be emphasized, including power struggles, threatened harm to self and/or others, and reenactment of classic trauma roles. Assessment tools and resources will also be provided.	Summer Krause, LPC, CADCIII
Spirituality Conference	This year's spirituality conference will focus on the developmental/lifespan perspective when integrating spirituality with behavioral health care. Topics will include the relevance of a lifespan perspective for behavioral health and developing a working definition of spirituality. The importance of spirituality-driven language as it pertains to the Recovery Model will be introduced as well as integrating a developmental awareness of childhood spiritual experiences. Breakout sessions will address various developmental stages and highlight the role of spirituality across the lifespan.	Various instructors

Spirituality Training (Moral/Spiritual Injury)	This three-hour workshop is designed for counselors and therapists who work with trauma. Participants will review symptoms of Post-Traumatic Stress Disorder (PTSD) and identify and define moral and spiritual injury in the life of a Combat Veteran. Additionally, therapists and counselors will explore the relation between a Veteran's moral/spiritual injury and events occurring at home and in combat. Participants will understand the value of Veterans' and First Responders' trainings for their recovery. Participants will then consider the phases of Post Traumatic Growth (PTG) and its role in healing of spiritual and moral injury in the life of the Combat Veteran and First Responder. Application of the PTG Model to physical and mental injuries will also be explored.	Chaplain (Colonel) Robert Blessing
Trauma Informed Care: Trauma Informed Foundations (Part 1)	This workshop, the first in a 4-Part series will teach core trauma-informed competencies, concepts and definitions. Training objectives will include the development of a foundational county-wide understanding of trauma and trauma-informed transformation; will present key resources from SAMHSA and the National Child Traumatic Stress Network (NCTSN); will build staff skills related to identifying, building, and measuring safety; will distinguish between physical and emotional safety issues; will seek to improve service delivery to populations that continue to struggle with safety; and will address the inevitable impact of trauma work on the workforce.	Gabriella Grant
Trauma Informed Care: Trauma and Substance Treatment (Part 2)	This training focuses on improving the treatment of trauma when it co-occurs with substance abuse, as well as their integration when only one condition is under treatment. Using standards from SAMHSA's TIP 57 and the Concept of Trauma and Guidance for a Trauma-Informed Approach, attendees will develop a strong skill set to treat clients who struggle with these common conditions. Evidenced-based practices will be identified and foundational skills will be practiced during the training. This training is part of a series, however those who did not attend the prior topic (Foundations) will be able to fully participate.	Gabriella Grant

Trauma Informed Care: Neurobiology of Trauma: An Update on the Science of Trauma (Part 3)	This training is designed to demonstrate how trauma affects the brain, the decision-making processes and coping, through an evidence-based and easy-to-learn method. It will give staff a deeper understanding of why clients behave in ways that may appear illogical or self-destructive and to promote direct skills-building practice related to safety. This training will help staff and consumers understand the lasting effect of trauma on physical and behavioral health as well as how service and healthcare delivery systems can use direct skills-building to promote safety.	Gabriella Grant
Trauma Informed Care: PTSD/Complex PTSD and Dissociation (Part 4)	This training focuses on the definitions and distinctions between trauma, PTSD, complex PTSD, dissociation and related terms. Attendees will review resources related to the SAMHSA definition of trauma, the PTSD diagnosis as well as a related construct called Developmental Trauma Disorder, developed by van der Kolk as a separate diagnosis from PTSD. While some clients may exhibit PTSD symptoms, many, if not most clients in a publicly funded program will have exposure to trauma, trauma-related symptoms like substance use or similar unsafe behaviors and a strong dissociative defense to protect themselves within relationships of unequal power dynamics. No prior education or background is required except for the informational prerequisites mentioned above. Prerequisite materials will be provided shortly before the training.	Gabriella Grant
Veteran's Conference	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.	Various instructors

Second Hand Shock - Vicarious Trauma and Its Spiritual Implications	This three-hour workshop is designed for counselors and therapists who work with trauma. Participants will be able to define and recognize the symptoms of PTSD, vicarious trauma, and burnout. Participants will be able to define moral injury and its relationship to vicarious trauma, and identify ways that seeking spiritual renewal can prevent vicarious trauma. Participants will also learn other resilience building strategies to prevent vicarious trauma, and how moral injury reconciliation can be beneficial in treating the moral injury associated with trauma.	Deborah Silveria, Ph.D.
Working Effectively in Behavioral Health Setting with Sign Language Interpreters	In this course participants will have an opportunity to learn the primary role of interpreter, gain understanding the possible negative impact of the use of family member 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	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 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
Workplace Violence (Active Shooter Response)	This training serves as a partnership between law enforcement and the community to save lives and mitigate the trauma that can result from workplace violence, and will provide participants with an overview of the impact of active shooter/mass casualty incidents. Participants will learn about the law enforcement response to these incidents, as well as understand the psychological, physical and financial impacts of an active shooter incident. Participants will also develop protocols in order to increase survivability and decrease the number of victims, as well as become aware of the resources available that could mitigate the lasting effects of trauma.	Investigator Shane Millhollon Heather Williams, PsyD