Mental Health and Recovery Services

Cultural Competence Plan Update
Fiscal Year 2021/2022

Orange County Health Care Agency Mental Health and Recovery Services
Multicultural Development Program

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DIRECTOR'S MESSAGE

Dear Colleagues and Partners:

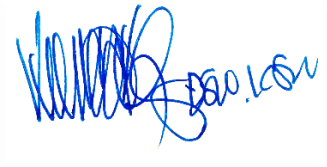
This past year has seen many opportunities and many challenges in the behavioral health space. The current nationwide focus on equity allows for significant avenues for operationalizing equity measures, such as we have here in Mental Health & Recovery Services (MHRS) in our service development and delivery.

As we continue to implement the goals created in last year's plan, we have tasked our Behavioral Health Equity Committee, made up of diverse staff and community members, to assist us in fully operationalizing the goals through a series of working groups that provide regular feedback, ideas and suggestions to the larger committee and HCA leadership.

As restated from last year, our goals remain as follows:

- Continue to develop diversity, equity, and inclusion as core components of the MHRS work in service to the community.
- Support the work of the Behavioral Health Equity Committee and its workgroups to enhance and deepen our relationship with the communities that we serve.
- Recruit and retain highly qualified, diverse bi-lingual and bi-cultural staff.
- Operationalize the Cultural Competence Plan Update by ensuring the state required Culturally and Linguistically Appropriate Services (CLAS) standards are met at every encounter with clients/participants/families.

As we strive to complete these goals and develop new ones, MHRS acknowledges that a reimagined, culturally inclusive behavioral health system, advances health equity, improves quality and helps eliminate health care disparities. That is our ultimate goal.



Dr. Veronica Kelley, LCSW
Chief of Mental Health and Recovery Services

INTRODUCTION

The Orange County Health Care Agency Mental and Recovery Services is responsible for delivering mental health and substance use services to Orange County residents who are experiencing major mental illness or substance use issues. Mental Health and Recovery Services provides the following services:

- Navigational Help
- Crisis Services
- Alcohol & Substance Use Services
- Children & Youth Services
- Adult (18+) Services
- Older Adult (60+) Services
- Wellness Promotion & Prevention

The vision, mission, and goals of the Orange County Health Care Agency are as follows:

VISION
Quality health for all.
MISSION
In partnership with the community, deliver sustainable and responsive services that promote population health and equity.
GOALS
Promote quality, equity, and value. Ensure the HCA's sustainability. Offer relevant services to the community.

According to SAMHSA's Office of Behavioral Health Equity, behavioral health equity is "the right to access high-quality and affordable health care services and supports for all populations, including Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islander and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality." The need to respond to changes in populations demographics prompted the Orange County Health Care Agency to establish the Office of Population and Health Equity 2021 and implement the Equity in OC initiative. This initiative brings together over 200 community-based organizations and stakeholders to address the social determinants of health and collaboratively work towards eliminating

health (including mental health and substance use) disparities across the populations of Orange County. Over the next decade, adolescents and older adults will become the fastest growing sub-group populations of Orange County.

Within Mental Health and Recovery Services, the proposed goals from last year's Cultural Competency Plan Update continue to be to:

1. Continue to ensure the CLAS Standards are implemented across programs and clinic levels.
2. Continue to support the Behavioral Health Equity Committee (BHEC) and its workgroups, which are formed in equitable and balanced partnership with members of the community, which includes leveraging the workgroups to promote community engagement meetings, especially in conjunction with the MHSA Office and the OPHE.
3. Continue to develop equity, diversity, and inclusion as core components of the County's work in service to the community through the following activities:
    a. Reviewing all County Policies, Procedures, and Operating Practices to ensure behavioral health equity is supported.
    b. Recruiting and retaining highly qualified bi-lingual and bi-cultural staff across all levels within MHRS.
4. Support the implementation of Anti-Racism Resolution (Resolution No. 21-028) of the Board of Supervisors, which reads:

    "NOW, THEREFORE, BE IT RESOLVED THAT THE ORANGE COUNTY BOARD OF SUPERVISORS declares out commitment to protect and improve the lives of Orange County residents in acknowledging the grave harms of racism, repudiate those who perpetrate acts of racism, and commit to work in our role as a county government to eradicate racism."

    On Tuesday, December 6, 2022, the Board of Supervisors declared racism "with its resultant social and health inequities" a public health crisis. The latest report on hate crimes indicated a 165% increase in 2021, with Asian Americans and Pacific Islanders as the populations most affected. In the resolution, the board vowed to "work to promote an inclusive, well-informed, and racial equity justice-oriented governmental organization that is conscious of injustice and unfairness through robust trainings and continuing education to expand the understanding of how racial discrimination affects individuals and communities most impacted by inequities." This declaration reinforces the work of MHRS in addressing equity in our services.

These goals are being implemented in collaboration with the Behavioral Health Equity Committee, and the progress to date has been:

- Promote community engagement meetings to provide information on mental health and recovery services available through the County and contracted agencies
- Distribute information in threshold languages
- Raise awareness around CLAS Standards and their implementation
- Continue to address implicit bias through self-paced and live trainings

Notes:

- The term Client and Consumer are used interchangeably throughout the plan. All terms are used to describe individuals receiving services from Mental Health and Recovery Services.
- In 2022, the agency implemented a title change from Behavioral Health Services to Mental Health and Recovery Services to better describe the scope of services. Both titles refer to mental health and substance use related services.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

National Standards for Culturally and Linguistically Appropriate Services (CLAS Standard) 2, 3, 4, 9 & 15.

1-I: County Mental Health System Commitment to Cultural Competence.

The County shall include the following in the Cultural Competence Plan Requirements (CCPR): Policies, procedures, or practices that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

The commitment to the principles of Cultural Competence is reflected 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 address each of these constructs in detail to provide guidance to Mental Health & Recovery Services (MHRS) in meeting the complex behavioral health needs of our communities in an equitable manner. Each section of this criterion will provide an overview of principles, practices, policies, documents, and official structures used throughout MHRS.

Policies, Procedures, or Practices

The focus on cultural competence is documented in several MHRS written policies and procedures. These include, but are not limited to:

*1.1 MHRS Policies and Procedures (Updated 2022)***

Policy Number	*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.

Policy Number	*Policy Details*
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 02.01.07	Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact. To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Behavioral Health Services (BHS) within the Mental Health Plan (hereby referred to as Orange MHF) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g. American Sign Language (ASL). This policy also applies to non-Medi-Cal clients receiving services within BHS.
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.

***Copies of all the Policies and Procedures listed above is in Appendix I.*

Program Oversight and Compliance

MHRS 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. MHRS 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/about-hca/behavioral-health-services/bh-services/policies-and-procedures
Addressing Opioid Crisis in Orange County	Relevant strategic plan for BHS	https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18
HCA Organizational Chart	Leadership within organization	https://sp.ochca.com/sites/HCAOrgCharts/Shared%20Documents/1)%20Health%20Care%20Agency/01.2022%20-%20OC%20HCA%20EXECUTIVE%20ORG%20CHART.pdf
Compliance Orientation, Education and Training	HCA Human Resources policies	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50206.docx
Informing Materials for Mental Health Plan Consumers	Accountability policies and procedures	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50869.pdf
Medi-Cal Consumer Rights Under the Orange County Mental Health Plan	Client care and rights	https://www.ochealthinfo.com/sites/hca/files/import/data/files/50870.pdf

Notes:

- Behavioral Health Services (BHS) is now Mental Health and Recovery Services (MHRS). The policies remain the same.
- The pending Office of Equity will continue to monitor and update the aforementioned policies and procedures to ensure they are current, up to date, and in compliance with current state and federal policies and procedures as needed in FY22/23.

1-II: The County shall show Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System.

The Cultural Competency Plan Requirements (CCPR) shall be completed by the county Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR. The county shall include the following in the CCPR:

1-II-A: A description of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local mental health planning processes and services development.

The MHSA office hosted seven Community Engagement Meetings (CEMS), two Provider Engagement Meetings (PEMS), and four focus groups, between February 15, 2022, and March 3, 2022.

In addition to emailing over 1,500 individuals, staff members reached out to the Older Adults community committee, the Equity Steering Committee, and the PEACE group to encourage community participation in meetings. HCA staff explained the County's desire to increase representation from members of the MHSA Priority Populations and hear directly from unserved and underserved individuals as part of the Community Program Planning Process (CPPP) for the FY 2022-23 Annual Plan Update. Meetings ranged from open to the public, to targeting specialty groups, and separate provider groups to create a safe and culturally competent setting to reach all target populations and stakeholders. Due to the COVID-19 pandemic, Community and Provider meetings were held virtually

over Zoom with participants joining via computer, tablet and/or phone. Meetings were conducted in English, Spanish, and Vietnamese. A total of 244 people registered for a CEM and approximately 135 attended.

2022 CEM OUTREACH TO PRIORITY POPULATIONS								
Community Engagement Meeting	**Date**	**Time**	**# Registered**	**Children**	**TAY**	**Adults**	**Older Adults**	**Additional Population Characteristics**
Community Stakeholders	2/15/2022	6-8 PM	17			X	X	Older Adults
Clinic Improvements Focus Group - Wellness Center West	2/15/2022	11 AM-12 PM	18		X	X	X	LGBTIQ+ Community, Older Adults
Clinic Improvements Focus Group - Wellness Center Central	2/16/2022	11 AM-12 PM	28		X	X	X	LGBTIQ+ Community, Older Adults
Older Adults Behavioral Health Council	2/16/2022	2-4 PM	11			X	X	Older Adults
Community Stakeholders - Vietnamese	2/16/2022	6-8 PM	8			X	X	Asian/Pacific Islander
Clinic Improvements Focus Group- Wellness Center South	2/17/2022	11 AM-12 PM	10		X	X	X	LGBTIQ+ Community, Older Adults
Community Stakeholders	2/22/2022	6-8 PM	24		X			Asian/Pacific Islander, Veterans
Community Stakeholders - Spanish	2/23/2022	6-8 PM	2			X	X	
PEACe & OC Peer Workforce	2/24/2022	10 AM-12 PM	46			X	X	Older adults, individuals living with a co-occurring substance use and mental health condition,
Clinic Improvements Focus Group - Virtual	2/24/2022	2-3 PM	3		X			Asian/Pacific Islander
Community Stakeholders	3/1/2022	6-8 PM	23			X	X	Older Adults
Providers	3/2/2022	10 AM-12 PM	41		X	X	X	Veterans
Providers	3/2/2022	6-8 PM	13			X		Asian/Pacific Islander

1-II-B: A narrative description addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

MHRS actively seeks opportunities to collaborate with communities and to increase its impact and reach with diverse communities. Prevention and Early Intervention Services contract with a variety of community-based organizations that provide services in various languages and address equity gaps in the system. These organizations provide an array of diverse culturally and linguistically appropriate services, and cater to specific needs of the community and populations they serve. Behavioral Health Equity Committee (BHEC) consists of several workgroups, including Deaf & Hard of Hearing, Spirituality, Outreach to Black/African-American Community, LGBTQ+, and Community Relations and Education. This list is in the process of expanding, to ensure we are able to identify and build relationships with additional population groups. The BHEC steering committee consists of both county and community members, with one of the seats designated for the liaison with the Behavioral Health Advisory Board (BHAB). Additionally, several seats on the BHEC steering committee are held by peers and family members.

The Behavioral Health Training Services (BHTS) oversees the contract for Crisis Intervention Trainings (CIT) for law enforcement and first responders to train them on how to effectively work with individuals and families who may be experiencing a mental health crisis, and how to provide them with resources for appropriate behavioral health services.

The acting ESM participates in the OC Sherriff's Interfaith Advisory Council and collaborates on ways to reduce stigma and address mental health challenges in various faith/spiritual communities.

The BHEC is expanding its efforts in meeting with community leaders, community-based organizations, clients and family members, and will be working more closely with the Behavioral Health Advisory Board to address concerns in the community and ensure that we are planning and implementing responsive services to our diverse communities. Additionally, BHEC is conducting outreach at various community events to raise awareness about the different workgroups and share opportunities to get involved.

1-II-C: A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

Currently, the county provides an annual cultural competence training that supports providers in delivery culturally appropriate services to our diverse communities. In addition to the annual training, the ESM reviews trainings provided to county staff and contracted providers to ensure cultural considerations are addressed. A list of cultural competence trainings are included in Criterion 5.

In addition to the aforementioned, BHTS, in collaboration with the contracted Behavioral Health Training Collaborative (BHTC), which is contracted to Western Youth Services, provides an array of community trainings related to:

- Suicide prevention
- Mental Health First Aid
- Trauma-Informed Care
- Self-Care for Professionals
- Recognizing and Responding to Client Needs
- LGBTQ+
- Improving Family Communications
- Multi-Cultural Mental Health Training
- Building Trauma-Informed School Communities
- Evidence-Based Clinical Trainings
- Multi-Part Trainings Supporting families and Individuals Living with Mental Illness.

BHTS and BHTC have formed an Orange County Cohort for Mental Health First Aid Trainers, and collectively provide MHFA trainings to community agencies, programs, and the public. Mental Health First Aid, offered through the National Council on Mental Wellbeing, is an 8-hour training course designed to provide community members key skills to help them identify signs and symptoms pertaining to substance use and mental health challenges, as well as equip them with skills to assist someone experiencing a mental health concern or crisis. MHFA was designed to reduce stigma around mental health, as well as raise awareness about resources available for support. Several populations find it difficult to openly discuss mental health or mental illness due to wide range of factors. Community members often find there to be stigma, barriers to service, lack of trust due to historical and communication issues, and spiritual beliefs. Offering MHFA to the community has served as an opportunity to openly discuss mental health (wellness

and illness), as well as provide tangible resources to access support, along with skills to have a conversation in a culturally attuned manner. The revised curriculum has placed greater emphasis on culture, with a focus on diversity and representation in their curriculum and scenarios. During FY21/22 there were a total of 53 MHFA trainings offered (Adult and Youth Curricula).

1-II-D: Share lessons learned on efforts made on the items A, B, and C above.

While we attempted to build up the Threshold Language Workgroup, there were challenges. We have identified various individuals who are interested in serving on this workgroup and will be expanding it to include both language and ethnic group. We are looking to have API, LatinX, and South Asian/Middle Eastern/North African (SAMENA) groups, to start with.

Additionally, we are looking to have a wider variety of populations represented in the BHEC subcommittees, to include individuals with disabilities, veterans, members of the Native/Indigenous groups, etc.. We are planning a BHEC Summit to being community members and organizations together to identify the needs and provide a platform for these subcommittees to be community-driven.

Finally, we will be expanding our cultural competency training offerings and work more closely with our providers to ensure they are ample opportunities for them to meet the cultural competency training requirements for continuing education.

1-II-E: Identify county technical assistance needs.

There are no areas requiring technical assistance at this time.

1-III: Each County has a Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competence.

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

1-III-A: Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural 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.

MHRS has a designated Ethnic Services Manager/Cultural Competency who is responsible for ensuring cultural competence tenets are embedded throughout the system of care and promotes the development of culturally-appropriate behavioral health services to meet the diverse needs of our racial, ethnic, cultural and linguistic populations in an equitable manner. The Ethnic Services Manager/Cultural Competency Officer retired in March 2022, and while the position is in recruitment (pending a reorganization), there is an Acting Ethnic Services Manager who is filling this position and reporting directly to the Chief of MHRS. (See Appendix VII – Mental Health and Recovery Services Re-organization Chart)

1-III-B: Written description of the cultural competence responsibilities of the designated CC/ESM.

The Ethnic Services Manager at OC HCA/MHRS is also in charge of the Multicultural Development Program. The ESM tasks and responsibilities are:

- Participate in the development and implementation of the Cultural Competence Plan, and coordination of the Cultural Competence Committee (CCC). In December of 2020 CCC members approved to change its name to Behavioral Health Equity Committee (BHEC).

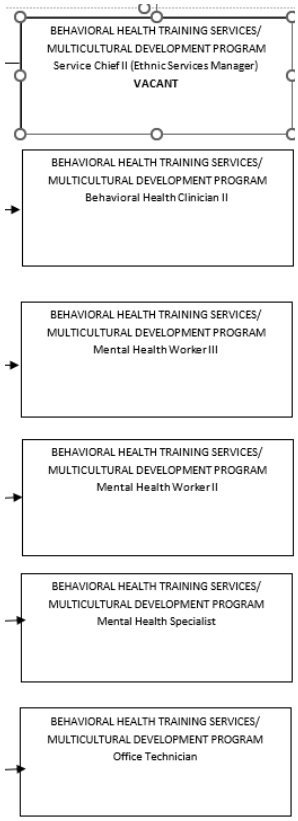
    - Develop, implement, and ensure accuracy of verbal interpretation and written translation (transliteration) services and materials into the threshold languages as well as American Sign Language (ASL).
    - Participate in all aspects of Mental Health Service Act (MHSA) program implementation strategies as well as performing required system evaluation and reports to the state Department of Health Care Services (DHCS).
    - Develop, coordinate, and facilitate the implementation of the state Department of Health Care Services 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 influence County systems of care; make recommendations to department management.

- Maintain an on-going relationship with community organizations, planning agencies, and the community at large.
- Review and approve all staff trainings for culturally competent content.
- Oversee the Multicultural Development Program (MDP), which aims to promote behavioral 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:

    - Developing, coordinating, and facilitating the implementation of a culturally responsive and inclusive plan for Orange County.
    - Developing, implementing, and ensuring the accuracy of verbal interpretation and written translation services and materials in all threshold languages.
    - Planning and organizing cultural diversity events at an organizational and community level, and;
    - Supporting strategies and efforts for reducing racial, ethnic, cultural, and linguistic disparities.

1-IV: Identify Budget Resources Targeted for Culturally Competent Activities.

1-IV-A: Evidence of a budget dedicated to cultural competence activities.



Within HCA MHRS, the Multicultural Development Program, highlighted above, is the unit dedicated to cultural competence activities. This unit coordinates requests for document translation, interpretation services, and leverages existing bilingual/bicultural staff across MHRS. There are more than 350 bilingual staff available to provide interpretation services as needed. The MDP program currently consists of 2 positions dedicated to interpretation and translation in Spanish and Vietnamese. Within the Behavioral Health Training Services (BHTS) team, MDP has access to additional staff who are able to assist with translation and interpretation services in Spanish, Arabic, Farsi, and Korean as part of their job responsibilities. The total budget for the MDP program for FY21/22 was set for $617,000. This budget is expected to change as we are currently undergoing a reorganization, and the new Office of Equity will be expanded and is in transition to the Director's Office.

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

As mentioned above, the current MDP budget allocated includes 3 Mental Health Professionals (1 coordinating the interpretation and translations services, 1 designated for Spanish interpretation and translations, 1 designated for Vietnamese interpretation and translation). Additionally, a part-time office support staff assists in the operations, a Deaf Services Coordinator, and an ESM oversees the department.

1. Interpreter and translation services;
   MDP utilizes both internal staff members for translation and interpretation services, along with external vendors: $300,00 (for ASL services) and $200,000 (for multiple languages).

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
   MDP staff are heavily involved in the Behavioral Health Equity Committee (BHEC) (by participating in various workgroups). The BHEC seeks to gain community participation and involvement in directly informing the Cultural Competence Plan (and update). The current workgroups are expanding to include additional groups that cater to various identified population groups, such as Native/Indigenous, Women, People with Disabilities, Veterans, to name a few.

   Additionally, the Prevention and Early Intervention (PEI) program funded the following programs:

   Mental Health Community Education Events for Reducing Stigma and Discrimination – these included mental health-related and artistic events that aim to reduce stigma and discrimination related to mental health. The events are open to individuals of all ages living in Orange County, with a specific events intended to reach identified unserved and underserved communities. The total budget was 1.2 million in FY 21/22, and reached 17,500 unduplicated participants. Events included:

   - La Vida A Todo Color and Celebrando Nuestra Cultura (Latino familes)
   - Casa De La Familia (Latino families w/ limited English proficiency)
   - LGBTQ Center of Orange County (LGBTQ youth & young adults)
   - Access California (Middle Eastern, South Asian and Muslim American Communities)
   - MECCA – "These Are Our Stories" (community at large, catering more specifically to threshold languages)
   - NAMI-OC - Loud and Proud Music and Art Festival (LGBTQ+/DHH)

   These programs will be discussed in further detail in Criterion 3.

3. Outreach to racial and ethnic county-identified target populations;
   The various workgroups under the BHEC have reached out to their respective communities and populations to engage in discussions and collaborations. Additionally, Prevention and Early Intervention funds the Outreach for Increasing Recognition of Early Signs of Mental Illness. These programs are intended to reach "potential responders," i.e., community

members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At-risk individuals can include, but are not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

These programs will be discussed in further detail in Criterion 3.

4. Culturally appropriate mental health services;

   Bicultural and bilingual staff are hired to provide services and support in, at minimum, the six threshold languages. In addition to language proficiency and usage, MHRS also seeks to hire representatives of underserved cultural groups, such as veterans, LGBTQ+, Deaf and Hard of Hearing, to name a few.

   The Behavioral Health Referral Line (OC-LINKS) consists of staff who are bi-cultural and bi-lingual in the threshold languages, ensuring access to community members with someone who can help them navigate the system in their preferred language.

   An extensive list of community programs will be discussed in Criterion 3.

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

   A bilingual pay differential (up to $0.90/hour) is paid to certified (tested) bilingual employees. 362 employees were paid a bilingual pay differential (as of August, 2022).

Number of Bilingual Staff, by Position, August 2022

	Spanish	Vietnamese	Korean	Farsi	Arabic	Other	Grand Total
Behavioral Health Clinician I - II	127	17	11	4	6	1	166
Office Specialist	43	2	1	1	0	0	47
Mental Health Specialist	36	7	0	0	0	1	44
Mental Health Worker I - III	18	1	0	0	0	0	19
Service Chief I - II	13	4	0	0	0	0	17
Clinical Psychologist I - II	7	2	1	2	0	0	12
Office Technician	8	1	0	0	0	0	9
Health Program Specialist	3	0	2	0	0	1	6
Staff Assistant	4	2	0	0	0	0	6
Information Processing Technician	4	0	1	0	0	0	5
Psychiatrist	1	2	1	1	0	0	5
Office Assistant	3	1	0	0	0	0	4
Community Worker II	3	0	0	0	0	0	3
Comprehensive Care Nurse II	1	0	1	0	0	1	3
Program Supervisor I - II	1	0	0	2	0	0	3
Office Supervisor C - D	3	0	0	0	0	0	3
Staff Specialist	2	0	1	0	0	0	3
Community Health Assistant II	1	0	0	0	0	0	1
Contract Employee	1	0	0	0	0	0	1
Data Entry Technician	0	1	0	0	0	0	1
Information Processing Specialist	0	0	0	0	0	1	1
Nursing Assistant	0	0	0	0	0	1	1
Research Analyst IV	1	0	0	0	0	0	1
Supervising Comprehensive Care Nurse	0	1	0	0	0	0	1
Total	*280*	*41*	*19*	*10*	*6*	*6*	*362*

CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS

CLAS Standard: 2

2-I: General Population

2-1-A: Summarize the county's general population, race, ethnicity, age, and gender. The summary may be a narrative or a display of data.

Table 1: Orange County's General Population Summary 2021

Demographics Characteristics of Orange County		
	Population	*Percent of Total Population*
	Gender	
Male	1,598,436	49.8%
Female	1,610,836	50.2%
Other/Not Listed	---	0%
	Ethnicity	
White/Caucasian	1,328,850	41.4%
Hispanic/Latino	1,146,091	35.7%
Asian/Pacific Islander	592,162	18.5%
Black/African American	49,562	1.5%
Native American	6,907	0.2%
Multi Race/Other	85,700	2.7%
	Age	
0-5 years	217,476	6.8%
6-17 years	485,132	15.2%
18-59 years	1,770,945	55.5%
60+ years	735,719	23.1%
Total Population	*3,209,272*	

Source: Department of Finance Population Statistics (2021)

2-II: Medi-Cal Population Service Needs

2-II-A: Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender

In FY2021/2022, Orange County had 954,394 Medi-Cal eligible beneficiaries (See Table 2). An increase of 91,051 from the previous year.

Race/Ethnicity

Clients' race /ethnicity was as follows: 49.7%, Hispanic or Latino, 20.6% Asian and Pacific Islanders, 17.4% White/Caucasian, 1.8% Black/African American, 0.2% Native American, and 20.9% Multi-Race/Other.

Language

Clients' language preference was as follows: 57.0% English-speaking, 29.9% Spanish speaking, 11.3% Asian/Pacific Islander languages, 0.9% Other Indo-European languages, and 0.9% other languages.

Age

Clients by age group was as follows: 9.8% were between the ages of 0 to 5, 25.1% were between the ages of 6 to 17, 57.7% were between 18 to 59 years of age, and 17.9% were 60 years of age and older.

Gender

Clients by gender was as follows: 53.9% identified as female and 46.1% identified as male.

Medi-Cal Mental Health Clients

In FY2021/2022, Orange County had 23,310 Medi-Cal eligible beneficiaries (See Table 2). A decrease of 429 from the previous year.

Race/Ethnicity

Clients' race/ethnicity was as follows: 22.4% White/Caucasian, 45.6% Hispanic/Latino, 8.0% Asian/Pacific Islander, 3.5%, Black/African American, 0.3% Native Hawaiian, and 18.4% Multi-Race/Other.

Language

Clients' language preference was as follows: English 82.5%, Spanish 14.8%, and 6% other.

Age

Clients by age group was as follows: 2.3% were between the ages of 0 to 5, 40.6% were between the ages of 6 to 17, 49.4% were between 18 to 59 years of age, and 5.9% were 60 years of age and older.

Gender

Clients by gender was as follows: 50.6% identified as female and 49.4% identified as male.

Table 2A: Mental Health Program Medi-Cal Indicators for Calendar Year 2021

	Average Number of Medi-Cal Eligibles per Month		*Medi-Cal Clients*		*Penetration Rate*
	954,394		***23,310***		***2.4%***
Gender	*N*	*%*	*N*	*%*	*%*
Male	439,612	46.1%	11,818	49.4%	3.0%
Female	514,781	53.9%	12,129	50.6%	2.6%
Other/Not listed	0	0.0%	0	0.0%	0.0%
Race/Ethnicity	*N*	*%*	*N*	*%*	*%*
White/Caucasian	150,035	17.4%	5,313	22.4%	4.2%
Hispanic/Latino	429,250	49.7%	10,834	45.6%	2.7%
Asian/Pacific Islander	177,504	20.6%	1,891	8.0%	1.1%
Black/African American	15,436	1.8%	837	3.5%	6.1%
Native American	1,376	0.2%	72	0.3%	6.3%
Multi Race/Other	180,793	20.9%	4,363	18.4%	2.9%
Age	*N*	*%*	*N*	*%*	*%*
0-5 years	84,542	9.8%	543	2.3%	0.8%
6-17 years	216,756	25.1%	9,648	40.6%	4.7%
18-59 years	498,283	57.7%	11,730	49.4%	2.8%
60+ years	154,813	17.9%	1,389	5.9%	1.0%

Source: Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '21, CA EQRO report 2022

Table 2B: Mental Health Program Medi-Cal Indicators

	Number of Medi-Cal Eligibles[1]		*Medi-Cal Beneficiaries Served*[2]		*Penetration Rate*
	N	%	*N*	%	%
Primary Language					
English	523,357	57.0%	22,323	82.5%	4.3%
Spanish	274,495	29.9%	3,999	14.8%	1.5%
Asian/Pacific Islander Languages	103,663	11.3%	675	2.5%	0.7%
Other Indo-European Languages	8,071	0.9%	158	0.6%	2.0%
All Other Language	8,575	0.9%	774	2.9%	9.0%
Primary Language Total	*918,161*		*27,929*		*3.0%*

[1] *Source: CA Medi-Cal Eligibility Data System (MEDS) Extract, June 2021*

[2] *Source: Orange County Health Care Agency (FY 19/20), Electronic Health Record System (IRIS), BHS All DOS Report*

Medi-Cal Substance Use Disorder Clients

MHRS served 5,820 Medi-Cal Substance Use Disorder clients in Calendar Year 2021.

Race/Ethnicity

Clients' race/ethnicity was as follows: 34.0% White/Caucasian, 31.0% Hispanic/Latino, 2.8% Asian/Pacific Islander, 2.1%, Black/African American, 0.6% Native Hawaiian, and 27% Multi-Race/Other.

Age

Clients by age group was as follows: 3.8% were between the ages of 12 and 17, 87.9% were between 18 to 64 years of age, and 5.8% were 65 years of age and older.

Gender

Clients by gender was as follows: 35.1% identified as female and 62.4% identified as male.

Table 3: Substance Use Disorder Medi-Cal Indicators for Calendar Year 2021

	Average Number of DMC-ODS Eligibles per Month[1]		*DMC-ODS Beneficiaries who Received an Approved Service per Year*[1]		*Penetration Rate*[1]
	N	*%*	*N*	*%*	*%*
Gender					
Male	396,473	45.6%	3,725	62.4%	1.3%
Female	473,378	54.4%	2,095	35.1%	0.6%
Other/Not Listed	0	0%	0	0%	0%
Race/Ethnicity					
White/Caucasian	139,939	16.1%	2,031	34.0%	2.1%
Hispanic/Latino	382,711	44.0%	1,852	31.0%	0.7%
Asian/Pacific Islander	169,140	19.4%	165	2.8%	0.1%
Black/African American	14,180	1.6%	124	2.1%	1.4%
Native American	1,320	0.2%	36	0.6%	2.9%
Multi Race/Other	162,564	18.7%	1,612	27.0%	1.1%
Age[3]					
12-17 years	216,756	24.9%	224	3.8%	0.3%
18-64 years	498,283	57.3%	5,249	87.9%	1.2%
65+ years	154,813	17.8%	347	5.8%	0.4%
Total Population	*869,851*		*5,820*		*0.7%*

1 Behavioral Health Concepts, Inc., Drug Medi-Cal Approved Claims data for Orange County DMC-ODS Fiscal Year 2019-20, CA EQRO report 2021

2 Residents ages 0-11 were not included in the analysis of penetration rates.

2-II-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support analysis.

Medi-Cal Eligible to Medi-Cal Mental Health Beneficiaries Served

Race/Ethnicity

Based on the number of Medi-Cal eligible residents and the number of beneficiaries with an approved service, the following groups were underrepresented: Asian or Pacific Islander, Black or African Americans, Native American. On average, 20.6% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.0% received an approved service. The number of Native American residents who were Medi-Cal eligible and had an approved service was extremely low during 2019 (0.2% and 0.3%, respectively). Additionally,

similar trends were found for both White/Caucasian and Black/African American residents. A disparity can also be seen in White/Caucasian Medi-Cal beneficiaries at 22.4%, which was greater than their percentage of the Medi-Cal eligible population of 17.4%, while 3.5% Black/African received an approved service and only 1.8% were Medi-Cal eligible. Racial/Ethnic groups with the lowest penetration rates included Hispanic/Latino (2.7%), Asian Pacific Islander (1.1%), and Multi-Race/Other (2.9%).

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients, 29.9% of Medi-Cal eligible beneficiaries preferred Spanish, while only 14.8% of Medi-Cal clients served preferred Spanish. Most of the Medi-Cal clients preferred English (82.5%). In comparison, 57.0% of Medi-Cal eligible beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Spanish language group was 1.5%. The second lowest penetration rate was for the preferred Asian/Pacific Islander language group (0.7%).

Age

Youth between 0 to 5 years of age represented 2.3% of beneficiaries served, compared to 9.8% of Medi-Cal eligible. Youth ages 6-17 years represented 40.6% of beneficiaries served, compared to 25.1% of Medi-Cal eligible. Adults 18-59 years represented 49.4% of beneficiaries served, compared to 57.7% of Medi-Cal eligible. Older Adults 60+ years represented 5.9% of beneficiaries served compared to 17.9% of Medi-Cal eligible. By age group, the lowest penetration rate was for Older Adults (60+) at 1.0%, followed by Children at 0.8%. While the penetration rates for TAY and Adults were 4.7% and 2.8%, respectively.

Gender

Females represented 53.9% of the Medi-Cal eligible beneficiaries and only 50.6% received an approved service. A disparity can also be seen in male Medi-Cal beneficiaries at 49.4%, which was greater than their percentage of the Medi-Cal eligible population of 46.1%. By gender, the penetration rate was higher for males versus females (3.0% versus 2.6%). This data does not account for individuals who identify as other gender groups.

Medi-Cal Eligible to Medi-Cal Substance Use Disorder Beneficiaries Served

Race/Ethnicity

Although Latinos represented 44.0% of Medi-Cal eligible beneficiaries, they only represented 31.0% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander population. Although 19.4% of Medi-Cal eligible, they represented only 2.8% of the beneficiaries served. Further investigation is needed to identify why these two populations are using services less than other populations or are not in need of services. In contrast, the opposite trend was noted with the White/Caucasian and Native American populations. Caucasians represented 16.1% of Medi-Cal eligible beneficiaries and 34.0% of beneficiaries served. Native Americans represented 0.2% of Medi-Cal eligible and 27.0% of beneficiaries served. Native Americans have the highest penetration rate (2.9%) of all racial/ethnic groups, but this may be due to the fact that they are a very small percentage of the overall population.

Age

Adults (18 to 64 years) represented 87.9% beneficiaries served compared to 57.3% Medi-Cal eligible. This age group also had the highest penetration rate compared to the other groups (1.2% versus 0.3% and 0.4%). Youth (12-17 years) represented only 3.8% of beneficiaries served, compared to 24.9% of Medi-Cal eligible. Similarly, older adults (65+ years) represented 5.8% of Medi-Cal beneficiaries serviced, while 17.8% were approved for services.

Gender

Fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (35.1% versus 54.4%). In contrast, 62.4% of MediCal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 45.6%. By gender, the penetration rate was higher for males versus females (1.3% vs. 0.6%).

2-III: 200% of Poverty (minus Medi-Cal) Population and Service Needs.

2-III-A: Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender.

The tables below compare Orange County's total population with the total number of residents living at or below the 200% FPL. Results indicate that nearly one-

quarter of Orange County residents are living at or below the 200% FPL (692,000 compared to 3,209,272).

Table 4: Fiscal year 2021/2022 Population Under 200% FPL Minus Medi-Cal Eligible Beneficiaries

	Number
Gender	
Female	204,000
Male	114,000
Other/Not Listed	0
Race/Ethnicity	
White/Caucasian	95,000
Hispanic/Latino	163,000
Asian/Pacific Islander	54,000
Black/African American	2,000
Native American	*
Multi Race/Other	16,000
Age	
0-5 years	18,000
6-17 years	9,000
18-59 years	185,000
60+ years	106,000
Total	*318,000*

**Data unavailable for this population*

Source: California Health Interview Survey (2020)

Table 5: Orange County Population Under 200% of the Federal Poverty Line, Medi-Cal Beneficiaries 2021

	Average Number of Medi-Cal Eligibles per Month[1]		*Medi-Cal Beneficiaries who Received an Approved Service per Year*[1]		*County Wide Estimated Population Living at or Below 200% FPL (Medi-Cal Clients)*[2]		*County Wide Estimated Population Living at or Below 200% FPL (Non Medi-Cal Clients)*[2]	
	N	*%*	*N*	*%*	*N*	*%*	*N*	*%*
Gender								
Male	439,612	46.1%	11,818	49.4%	322,000	46.6%	114,000	35.8%
Female	514,781	53.9%	12,129	50.6%	369,000	53.4%	204,000	64.2%
Other/Not Listed	0	0%	0	0%	0	0%	0	0%

Race/Ethnicity								
White/Caucasian	150,035	17.4%	5,313	22.4%	171,000	24.9%	95,000	29.9%
Hispanic/Latino	429,250	49.7%	10,834	45.6%	360,000	52.3%	163,000	51.3%
Asian/Pacific Islander	177,504	20.6%	1,891	8.0%	147,000	21.4%	54,000	17.0%
Black/African American	15,436	1.8%	837	3.5%	10,000	1.5%	2,000	0.6%
Native American	1,376	0.2%	72	0.3%	*	*	*	*
Multi Race/Other	180,793	20.9%	4,363	18.4%	*	*	16,000	5.0%
Age								
0-5 years	84,542	9.8%	543	2.3%	51,000	7.4%	18,000	5.7%
6-17 years	216,756	25.1%	9,648	40.6%	83,000	12.0%	9,000	2.8%
18-59 years	498,283	57.7%	11,730	49.4%	379,000	54.8%	185,000	58.2%
60+ years	154,813	17.9%	1,389	5.9%	179,000	25.9%	106,000	33.3%
Total Population	*954,394*		*23,310*		*692,000*		*318,000*	

[1] Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '21, CA EQRO report 2022

[2]California Health Interview Survey (2020)

2-III-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Comparison of Medi-Cal Clients Served Fiscal Year 2021/2022 to County Population under 200% of FPL:

Race/Ethnicity

The percentages of African Americans/Black was higher in the Medi-Cal clients served group compared to the population under 200% of FPL. African Americans were 1.5% of the population in poverty, and 3.5% of the Medi-Cal clients served group. In contrast, the percentages of Asian/Pacific Islanders (API), Latino and Caucasian groups were lower in the Medi-Cal Clients served group compared to the population under 200% of FPL. The percentages of API Medi-Cal clients served was 8.0% compared to 21.4% of the population in poverty. The percentage of Latino Medi-Cal clients served was 45.6% compared to the 52.3% of the population in poverty. The percentage of Caucasian Medi-Cal clients served was 22.4% compared to the 24.9% of the population in poverty.

Age

The percentages of children (0-5 years) was lower in the Medi-Cal clients served group at 2.3% compared to the population in poverty at 7.4%. The percentage of youth between 6 and 17 years was higher in the Medi-Cal clients served group at 40.6% compared to the population in poverty at 12.0%. The percentage of Medi-Cal Adult clients served was lower at 49.4% compared to the population in poverty at 54.8%. The percentage of older adults (60+ years) served was lower in the Medi-Cal client group served compared to the population in poverty. Older adults were 25.9% of the population in poverty, but only 5.9% of Medi-Cal clients served.

Gender

The percentage of Medi-Cal male clients served was at 49.4% which was slightly higher compared to males under 200% of the federal poverty line (FPL) of 46.6%. The percentage of Medi-Cal female clients served was lower (50.6%) than females under 200% FLP at 53.4%.

Comparison of Non-Medi-Cal Clients Served in Fiscal Year 2021/2022 to County Population under 200% of FPL:

Federal Poverty Line (FLP) data was extracted from the California Health Interview Survey (CHIS, 2020). In total, 318,000 non-Medi-Cal beneficiaries who lived in Orange County were living at or below the 200% FPL in 2020 (see Table 2.8). The majority of these residents were either female, Hispanic/Latino, or between the ages of 18-59 years old.

Race/Ethnicity

The majority of Non Medi-Cal clients served was Latino at 51.3% but still slightly lower than the percentage of Latinos under 200% of FPL (52.3%). The data shows a similar trend for Asian/Pacific Islanders and Black/African Americans. White/Caucasian clients were served at a lower percentage 24.9% than White/Caucasian individuals under 200% of FPL (29.9%).

Age

Youth 17 years of age and under (7.4% and 12.0%, respectively) Non Medi-Cal clients served were higher than this age group under 200% of FPL (5.7% and 2.8%, respectively). Adults and Older Adults were served at lower percentages than Adults and Older Adults under 200% of FPL.

Gender

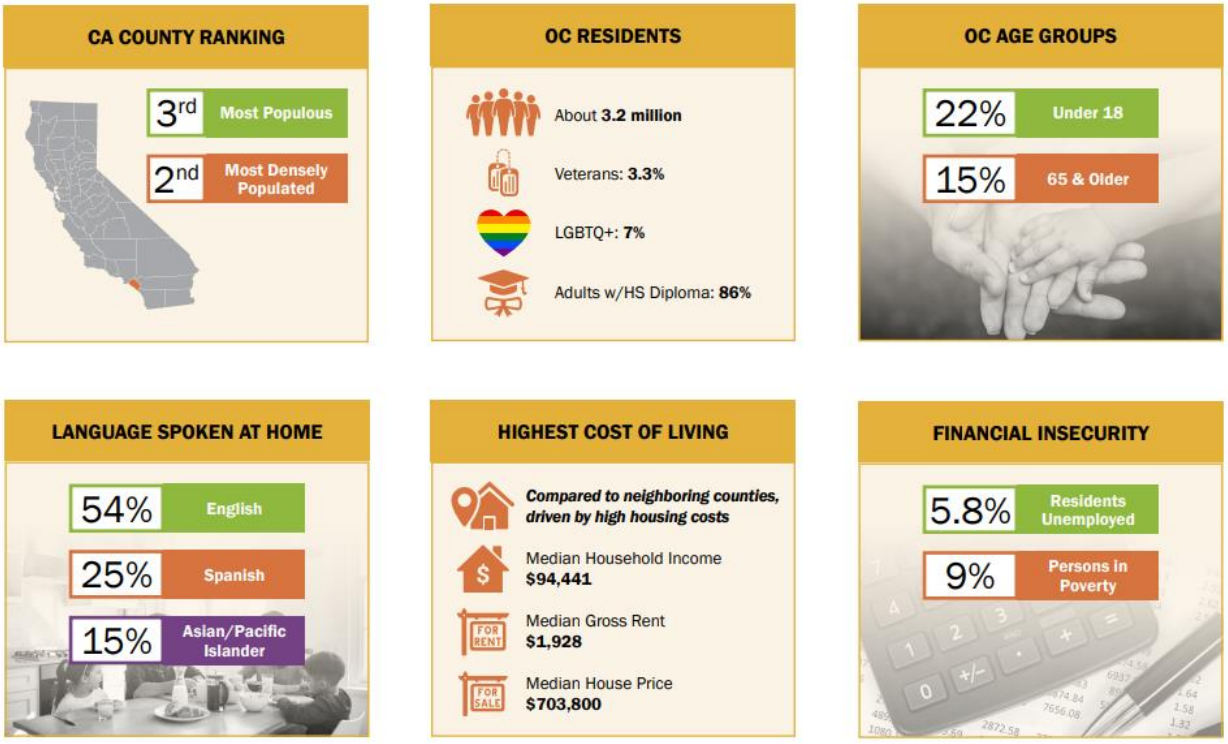
The percentage of Non Medi-Cal females 64.2% served was less than the females under 200% of FPL, 53.4%. The percentage of Non Medi-Cal males 35.8% was lower than males under 200% PPL (46.6%).

2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.

2-IV-A: From the CSS component of the county's approved Three-Year Program and Expenditure Plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age, and gender.

The tables below were pulled from the most recent Mental Health Services Act (MHSA) annual update (2022-23). 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.[1]

[1] Orange County Health Care Agency, Mental Health Services Act Three-Year Program Expenditure Plan, Fiscal Years 2022-23. Published Spring 2022. [https://ochealthinfo.com/sites/healthcare/files/2022-07/MHSA_2022-23_Plan_Public_Comment_v09.pdf]



Census, v2021
CA Health Interview Survey, 2021

Table 6: MHSA CSS Fiscal Year 2021/2022

OC CENSUS

ORANGE COUNTY RESIDENTS BY DEMOGRAPHIC CHARACTERISTIC

Age	2020 Census	Gender Identity	2020 Census	Race/EtŠicity	2020 Census
0-14 yrs	18%	Female	51%	African American/Black	2%
15-24 yrs	13%	Male	48%	American Indian/Alaskan Native	1%
26-59 yrs	48%	Transgender	1%	Asian/Pacific Islander	21%
60+ yrs	21%	Genderqueer	<1%	Caucasian/White	39%
		Questioning/Unsure	<1%	Latino/Hispanic	34%
2021 Population: 3,170,345		Another	<1%	Middle Eastern/North African	Not Collected
				Another	4%

CSS/MHSA

INDIVIDUALS SERVED IN CSS CLINICAL SERVICES DEMOGRAPHIC CHARACTERISTIC

Age	Estimated	Actual	Gender Identity	Estimated	Actual	Race/EtŠicity	Estimated	Actual
0-15 yrs	9%	13%	Female	42%	47%	African American/Black	7%	6%
16-25 yrs	16%	26%	Male	56%	52%	American Indian/Alaskan Native	1%	1%
26-59 yrs	48%	47%	Transgender	2%	0.1%	Asian/Pacific Islander	10%	10%
60+ yrs	12%	12%	Genderqueer	-	0.1%	Caucasian/White	42%	40%
			Questioning/Unsure	-	0.1%	Latino/Hispanic	34%	3%
Projected Duplicated: 62,389			Another	-	0.1%	Middle Eastern/North African	1%	1%
Actual Unduplicated: 11,646						Another	5%	10%

Demographic breakdown based on individuals entered into Electronic Health Record. Those served only in Supportive Services not included.

2-IV-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Age

The percentage of children (0-15 years old) in the CSS program at 13% is lower than what is reported in the Census, which is 18%. The percentage of Transitional Age Youth (16-25) in the CSS programs at 26% is higher than the 13% reported in the Census. Adults (26-59) served in the CSS were at 47%, which is comparable to the 38% listed in the Census. As for the Older Adults (60+ years), they are greatly underrepresented in the CSS programs at 12%, compared to the 21% listed in the Census.

Gender

The proportion of females and males in the MHSA-CSS Unduplicated Clients Served vary from the county population. The county female population is at 51%, yet only accounts for 47% of the actual, unduplicated clients served. The male population, at 48% is lower than actual, unduplicated clients served, which was 52%. The number of transgender, genderqueer, questioning/unsure, and other is similar between reported population in the Census and the clients served, which is <1% – however, this number is very low.

Race/Ethnicity

The percentage of Black/African Americans in the CSS programs is higher compared to their proportion of the county population (6.0% vs. 2.0%). The proportion of Asian/Pacific Islanders in CSS programs is lower compared to the Census (10% vs. 21%). The percentage of Latinos in CSS programs is also lower when compared to their proportion of the population 3.0% vs. 34.0%. The percentage of Caucasian is similar in CSS programs compared to their proportion of the county population (39% vs. 40.0%). Similarly, American Indian/Alaska Native is similar in CCS programs compared to the proportions reported in the Census (1% vs. 1%). CSS consumers who identified as Another ethnicity were overrepresented 10.0%, compared to their proportion of the county population (4.0%).

2-V: Prevention and early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations

2-V-A: Which PEI Priority Population(s) did the county identify in the PEI component of its Plan?

The County could choose from the following seven PEI Priority Populations:

1. Underserved cultural populations
2. Individuals experiencing onset of serious psychiatric illness
3. Children/youth in stressed families
4. Trauma-exposed
5. Children/youth at risk of school failure
6. Children/youth at risk of experiencing juvenile justice involvement
7. Individuals experiencing co-occurring substance use issues

Based on community feedback and data, the priority populations include the following: unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

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

CLAS Standards: 1, 10 &14

3-I: List the Target Populations with Disparities your County Identified in Medi-Cal and all MHSA Components (Medi-Cal, CSS, WET, and PEI Priority Populations)

The information and data provided throughout his Criterion comes from the MHSA 2022-2023 Play Update (https://www.ochealthinfo.com/sites/healthcare/files/2022-07/MHSA_2022-23_Plan_Public_Comment_v09.pdf)

Medi-Cal Target Population(s) with Disparities:

The Orange County Medi-Cal population for FY 2021/2022 includes 954,394 beneficiaries.

Disparities can be identified in all Racial/Ethnic Populations for Mental Health.

On average, 19.3% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.0% received an approved service. Caucasian (3.54%) and Native American (5.23%) populations were served at higher percentages when compared to the Asian Pacific Islanders (1.07%) Medi-Cal eligible populations.

In terms of age, residents over 60 years of age comprised 16.4% of the Medi-Cal eligible population, yet only 6.1% had an approved service. Older Adults (65+) had the lowest penetration rate of all age populations groups (0.46%). Children ages 0-5 had the second lowest penetration rate of all age populations groups (0.64%).

Spanish speakers comprised almost one-third of the Medi-Cal population (29.9%), but only 14.8% had an approved service. Similarly, those who spoke an Asian or Pacific Islander language made up 11.9% of the Medi-Cal population and only 3.0% had an approved service.

CSS Population with Disparities:

The number of actual unduplicated individuals served in CSS Clinical Services by demographic characteristics for FY 2020-2021 was 14,758. Of this population, disparities can be seen in the Older Adults 60+ (11% served compared to 20% of the population), and Asian Pacific Islander (10% served compared to 20% of the population). Both were served at lower percentages when compared to their percentage in the county overall population. The African American and the Young Adults (16-25 years old) populations,

were served at higher percentages when compared to their percentages in the county overall population.

WET Population with Disparities:

MHRS employed 974 employees as of August 2022 (noting there is currently a 27% vacancy rate). Disparities exist in the workforce with regards to gender and languages spoken. Of the 974 filled positions, 362 qualify for bilingual pay (37% of the current staff). The lowest penetration rates exist for the Spanish-Speaking and API communities.

When comparing the Medi-Cal eligible to Medi-Cal clients served, the penetration rate for the preferred Spanish language group was 1.5%. The second lowest penetration rate was for the preferred Asian/Pacific Islander language group (0.7%).

A workforce analysis and needs assessment will be completed in conjunction with the Southern California Regional Partnerships (SCRP) partners. The needs assessment will determine workforce patterns and trends to assist in informing the development of a new five-year plan which can be used to increase recruitment and retention strategies, ensure the hiring of a culturally responsive workforce, and build interest in the public mental health field. The new WET five-year plan will include data on the utilization rates of the five new WET focus areas. These areas include:

- Recruitment and Retention
- Pipeline Development
- Scholarships
- Stipends
- Loan Assumption Programs

PEI Population with Disparities:

PEI Priority Populations:

1. Unserved and underserved racial/ethnic communities
2. Immigrants and refugees
3. Children and youth who are at risk of school failure and/or juvenile justice involvement
4. Foster youth and non-minor dependents
5. Individuals who have been exposed to trauma or are experiencing the onset of serious mental illness
6. LGBTQ+ community
7. Those experiencing homelessness

SUD Medi-Cal Population with Disparities:

MHRS served 5,820 Medi-Cal Substance Use Disorder clients in Calendar Year 2021.

Of this population, disparities can be seen in the Youth and Older Adults. These populations were served at lower percentages when compared to their percentages as Medi-Cal beneficiaries. In contrast, the Caucasians and Adult (18+) populations were served at significantly higher percentages than their percentage of Medi-Cal beneficiaries. Fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (35.1% versus 54.4%). In contrast, 62.4% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 45.6%.

3-I-A: From the above identified PEI Priority Population(s) with disparities, describe the process and rationale the county used to identify the target population(s) (with disparities).

As noted in Criterion 2, the County of Orange, Orange County Health Care Agency (OCHCA), Mental Health and Recovery Services (MHRS) and community stakeholders embarked on an extensive community planning process to identify priority populations, strategic priorities and to develop concepts to be included in the PEI Strategic Plan for approval by the State.

In preparation for the community planning process for the FY 2021-22 Annual Plan Update, the HCA reviewed the current status of each of OC's MHSA priorities. Based on this review, as well as HCA's commitment to ongoing discussions with community stakeholders from unserved and underserved populations, this year's community planning focused on engaging with community members to pinpoint potential approaches that would be responsive and tailored to two identified PEI priority populations: Mental Health Awareness & Stigma Reduction and creation of the Office of Suicide Prevention.

The newly formed Office will be responsible for identifying and implementing promising pilot programs utilizing the above-referenced systems-approach for each of the initial populations of focus: youth and young adults, men in their middle years and older adults. The Office will also be responsible for integrating new and existing services and supports across the suicide prevention continuum and throughout the entire County to ensure all suicide prevention activities are linked to other behavioral health activities/services and directly targeted populations in need. The Office will create a systems approach to suicide

prevention that leverages existing community and agency resources to build hope, purpose and connection for individuals in need.

The approach with the Mental Health Awareness & Stigma Reduction focused on expanding mental health awareness and stigma reduction campaigns, trainings and community education focused on increasing awareness of mental health signs and available resources, as well as reducing stigma associated to mental illness.

3-II: Identified Disparities (Within the Target Populations)

3-II-A: List disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Medi-Cal:

As previously described above, disparities exist in Orange County for specific populations. For the Medi-Cal population, disparities can be seen in access to services for all racial/ethnic groups.

Asian/Pacific Islanders (API) represent 20.6% of the Medi-Cal Eligible population yet the API Medi-Cal population served is 8%, therefore the API penetration rate is 1.1%.

For Latinos, there is a lack of access and service utilization in general, having a penetration rate at 2.7% and being the largest Medi-Cal beneficiary population at 45%.

Caucasians represented 17.4% of Medi-Cal beneficiaries and 22.4% of beneficiaries served by MHRS. Caucasians have a penetration rate of 4.2%.

African Americans represented 1.8% of Medi-Cal beneficiaries and 3.5% of beneficiaries served by MHRS. African Americans have a penetration rate of 6.5%.

Native Americans represented 0.2% of Medi-Cal beneficiaries and 0.3% of beneficiaries served by MHRS. African Americans have a penetration rate of 6.3%.

When examining the Medi-Cal population by age, Children 0-5 have the lowest penetration rate at 0.8%. Followed by Older Adults (60+ Years old) at 1.0% and Adults (26-59) at 2.8%. Children (6-17) have the highest penetration rate at 4.7%.

When examining the Medi-Cal population by preferred language, the penetration rate for the preferred Spanish language group was 1.5% and for API 0.7%.

CSS Population:

For the Community Services and Support (CSS) Population, disparities in access to services can be seen among older adults (60+ years old). While older adults constitute 21% of the county population, they are only 12% of CSS clients.

Disparities in access to services can be seen with Asian and Pacific Islanders and Latinos, pointing to racial/ethnic disparities in access to services. Asian and Pacific Islanders constitute 21% of the county population they were only 10% of CSS clients. Latinos are the most underrepresented. Latinos constitute 34% of the county population they were only 3% of CSS clients. In contrast, Black/African Americans constitute 2% of the county population and represented 6% of CSS clients served. White/Caucasian represent 40% of the CSS clients served.

WET Population:

As of June 2022, MHRS had 362 staff who were paid bi-lingual pay differential. This represents about 37% of the MHRS active workforce. Spanish speakers comprised almost one-third of the Medi-Cal population (29.9%) yet represent 77% of the workforce who receive bi-lingual pay. MHRS is working with HR to actively recruit bilingual staff in more threshold languages to better meet the needs of our beneficiaries.

PEI Population:

For the Prevention and Early Intervention (PEI) Population, disparities in access to services can be seen among older adults (60+ years old) and TAY (16-25 years old). While older adults constitute 21% of the county population, they are only 17% of PEI clients. While TAY constitute 13% of the county population, they are only 8% of PEI clients.

Disparities in access to services can be seen with Latinos, pointing to racial/ethnic disparities in access to services. Latinos are the most underrepresented. Latinos constitute 34% of the county population they were only 29% of CSS clients (MHSA Plan, 2020-21). In contrast, Black/African Americans constitute 2% of the county population and represented 13% of PEI clients served.

3-III: Identified Strategies/Objectives/Actions/Timelines

3-III-A: List the strategies identified for the Medi-Cal population as well as those strategies identified in the MHSA plan for CSS, WET, and PEI components for reducing the disparities identified.

Medi-Cal:

Providers are contractually required to participate in cultural competency trainings and provide culturally and linguistically appropriate services. Programs are subject to test calls to assess the effectiveness of information delivery, customer services, and language access services.

The programs listed below in the MHSA components also cater to Medi-Cal beneficiaries and aim to reduce disparities and increase access to services.

CSS Plan:

Community Services and Supports (CSS) is the largest of all five MHSA components and receives 76% of the Mental Health Services Funds. It supports comprehensive mental health treatment for people of all ages who are living with a serious mental health condition that is significantly impacting their daily activities and functioning. CSS develops and implements promising or proven practices designed to increase underserved groups' access to services, enhance quality of services, improve outcomes and promote interagency collaboration.

- **The Children and Youth Clinic Services** program serves youth under age 21. 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 available in Spanish and Vietnamese, and provided in a culturally competent manner in the clinic, in the community or at a school (with permission) depending on what the youth/family prefers or is clinically appropriate.

- 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 role in the

treatment process, given the disruption to the family structure when the survival of one family member becomes the family's main focus. This program specializes in foster youth, homeless/at-risk of homelessness, and LGBTQ+.

- 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 up to 21 who need the highest level of behavioral health care in a trauma-informed residential setting. The program specializes in working with foster youth, criminal-justice involved, and trauma-exposed individuals. 50% of the youth served through this program identify as Latino/Hispanic, and 15% identify at African American/Black. The language capacity of the direct service providers includes Farsi, Korean, Mandarin, and Spanish.

- 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. The language capacities of the direct service providers includes Arabic, Farsi, Korean, Mandarin, Spanish, and Vietnamese. The program specializes in serving ethnic communities, especially those recovering from SUD and trauma-exposed individuals.

- **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. Clients served in these programs are diverse and come from Black/African American, Latino, Vietnamese, Korean and Iranian communities.

- A **Full-Service Partnership** (FSP) is designed to provide intensive, community-based outpatient services to a county's most vulnerable individuals, and the OC Health Care Agency has established eligibility criteria to ensure that the FSPs reach Orange County residents who are experiencing disparities in access to behavioral health care. The target population includes individuals of all ages who are living with a SED or SMI; unserved or underserved; and are homeless, at risk of homelessness, involved in the criminal justice system, frequent users of inpatient psychiatric treatment, culturally or linguistically isolated, and/or have complex medical needs. Orange County has four distinct FSP programs organized by the MHSA-defined age groups (i.e., Children, TAY, Adult, Older Adult, Veterans, Vietnamese). In addition to tailoring services and supports to the members' age and developmental stage, three (i.e., Children, TAY, Adult) offer additional tracks for individuals with more specialized needs and providers within these specialized tracks often serve individuals across multiple age groups. FSPs specialize in serving various ethnic communities in the following languages: Arabic, Farsi, Khmer, Korean, Mandarin, Spanish, and Vietnamese.
- 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 (SED) or serious mental illness (SMI). Individuals enrolled in the 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. Language capacities of the direct service providers include Korean, Spanish, and Vietnamese. White/Caucasians represented about 46% of clients served.

- The **Peer Mentor and Parent Partner Support** program serves individuals who are living with a serious emotional disturbance (SED) or serious mental illness (SMI), may also have a co-occurring substance use disorder, and would benefit from the supportive services of a Peer Specialist. Peer Specialists may include peer or youth mentors and/or parent partners who work with participant's family members who would benefit from the supportive services of a parent mentor. Program specializations include foster youth, parents, criminal-justice involved, ethnic communities, LGBTQ+, and Veterans/Military-Connected. Farsi, Mandarin, Spanish, and Vietnamese languages are available.

- Orange County funds three **Wellness Center** locations that serve adults 18 and older who are living with a serious mental illness and may have a co-occurring disorder. Members are relatively stable in, and actively working on their recovery, which allows them to maximize the benefits of participating in Wellness Center groups, classes and activities. The Centers serve a diverse member base and Wellness Center West, in particular, has a unique dual track program that provides groups, classes and activities in English and monolingual threshold languages that meet the cultural and language needs of the population located in the city of Garden Grove. The predominant threshold language in the monolingual track is Vietnamese.

- The **Multi-Service Center for Homeless Mentally Ill Adults** (MSC) program, formerly call Courtyard Outreach, serves residents ages 18 years or older who are experiencing homelessness and living with a serious mental illness and/or co-occurring substance use disorder. The outreach team links individuals receiving supportive services at the Multi-Service Center to mental health and/or substance use services. 52% of clients served are White/Caucasian, while 32% are Latino/Hispanic, 14% are Black/African American, 5% are API, and 1% American Indian/Alaskan Native.

- **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 MHRS 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 are available in Spanish, Vietnamese, and Laotian.

- The **WarmLine** provides emotional peer support to unserved and underserved Orange County residents who are experiencing mild to moderate symptoms of a mental health disorder or who are at risk of developing a mental health disorder, challenges at school and/or trauma exposure. The program also serves family members.

- 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. The CAT also includes the Psychiatric Emergency Response Teams (PERTs), which consist of CAT clinicians who are stationed at police departments or ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned cities or regionally.

- **Crisis Stabilization Units** (CSUs) provide the community with 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 units serves 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). The CSUs can be accessed directly by individuals experiencing a crisis, as well as by family members, law enforcement and others in the community who believe an individual has an emergent behavioral health need. Of the clients served, 8% identify as API, 46% as White/Caucasian, and 8% as Black/African American.

- 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, case managers 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, County and County-contracted CSUs, our CAT teams and emergency department

personnel. Of the clients served by IHCS, 47% identify as Latino/Hispanic, 32% as White/Caucasian, 11% as API, and 5 % as Black/African American.

- The **Crisis Residential Services** (CRS) program provides highly structured, voluntary services in a residential setting for individuals who are experiencing a behavioral health crisis and meet eligibility requirements. Individuals ages 12 and older can be referred if they have been evaluated for psychiatric hospitalization, can be safely referred to a less restrictive, lower level of care and they and/or their family are experiencing considerable distress. Individuals must be referred by hospitals (for the Children's and TAY sites), County CAT/PERTs or Adult and Older Adult County or County-contracted Specialty Mental Health Plan programs (i.e., the program does not accept walk-ins, self-referrals). The Adult CRS program currently has 42 beds available at four sites operated by three contractors located throughout Orange County. The language capacity of the direct service providers includes Arabic, Farsi, Khmer, Korean, Mandarin, Spanish, and Vietnamese. 45% of the clients served identify as White/Caucasian, 33% as Latino/Hispanic, 7% as Black/African American, and 6% as API.

WET Plan:

Workforce Education and Training (WET) component is intended to increase the mental health services workforce and to improve staff cultural and language competency. The Covid-19 pandemic significantly impacted the Behavioral Health workforce. The need for mental health and recovery services has become increasingly evident as individuals and families have experienced loss of loved ones, physical health, scarcity of food and other resources, isolation, and loss of employment. Many opportunities have become available to health care professionals in the private sector to address the growing need for services. During the community engagement process, stakeholders reported the impact of these changes on service delivery including increased wait times, less provider availability, turnover in staff, and new inexperienced staff. Expanding Workforce Education and Training programs will support hiring, training, and retaining high quality staff members.

- 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 OC behavioral health workforce, consumers, family members and the wider OC community. During FY 2020-21, WSS provided trainings to a total of 1,698 individuals including County staff, County-contracted staff, and general community members. This was a decrease from previous fiscal years where between 2,000 to 3,000 individuals were provided trainings. This is mostly attributed to the impact of the COVID-19 global pandemic. Additionally, during the beginning of the fiscal year, WET was still developing best practices to help with facilitating trainings using virtual platforms.

- 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 coordinates requests and provides translation/interpretation services through in-house staff and a contracted provider. During FY 2020-21, there was a continued increase in the number of interpretation services provided in Spanish, Vietnamese, Arabic, Farsi and ASL both onsite and over the phone. This increase appeared, in part, to be related to an increase in COVID-19-related document translation requests.

  Program staff translated, reviewed and field-tested a total of 379 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2020-21, which was more than the previous fiscal years.1 In addition, a Licensed Marriage Family Therapist serves in the MDP as a Deaf and Hard-of-Hearing Coordinator to ensure that American Sign Language interpretation support is provided at trainings and community meetings. In FY 2020-21, the Ethnic Services Manager facilitated the Cultural Competence Committee (CCC) meetings. The CCC consists of multi-ethnic partners and multi-cultural experts in OC who meet to provide input on how to incorporate cultural sensitivity and awareness into the Behavioral Health Services (BHS) system of care and how to provide linguistically and culturally appropriate behavioral health information, resources, and trainings to underserved consumers and family members.

  In FY 20-21, the name of the committee changed to the Behavioral Health Equity Committee (BHEC) to provide a more comprehensive description of the work being done in the committee. Furthermore, a governing structure was developed and steering committee membership was formed. Attendance and interest in CCC (now called the BHEC) increased, especially after social injustice events occurred in our nation.

- The **Training and Technical Assistance** (TTA) program offers trainings on evidence-based practices, consumer and family member perspective, multicultural competency for mental health providers, and mental health training for law enforcement. The number of trainings offered in this area fluctuates from year to year depending on the number of professional development requests from HCA staff and community members. Additionally, the TTA program not only hosts several behavioral health trainings each year, but also provides CE units to other departments in the HCA requesting trainings for their clinical or medical staff. Examples of requested trainings include The Pandemic: What is Reveals About Inequities in Medicine, Expanding Treatment Options for the Growing Mental Health Pandemic, PCIT without ISMs, and Translating Culturally Responsive Leadership Into Action. In FY 2020-21, TTA provided 42 trainings for 6,699 attendees. The increase in the number of individuals and/or community members who engaged in TTA trainings is largely due to the launch of the new Cultural Competency training in September 2020. It was required that all HCA staff and contract providers completed the training during Fall 2020. In FY 2019-20, TTA provided 78 trainings for 3,642 attendees, 89 trainings for 5,711 attendees were provided in FY 2018-19, and in FY 2017-18, 88 trainings were facilitated to 2,573 attendees.
- **Mental Health Career Pathways** offers courses through the Recovery Education Institute (REI), which prepares individuals living with mental health conditions 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.
- The **Residencies and Internships** program trains and supports individuals who aspire to work in the public mental health system. The California Psychology Internship Council (CAPIC) matches pre-doctoral candidates with a placement site based on a set of criteria. WET requests the same number of interns each year. However, CAPIC will match based on the number of students who have enrolled and site availability. All CAPIC students were placed in a Children Youth Behavioral Health (CYBH) site during FY 2020-21., WET's Neurobehavioral Testing Unit (NBTU) closed in August 2020 due to lack of qualified and willing CAPIC students seeking placement in a neurobehavioral testing unit. In FY 2018-19, two student interns were placed at WET's NBTU and four were placed

at CYBH sites. Additionally, in FY 2017-18, four student interns were placed at WET's NBTU and two were placed at CYBH sites. All interns were supervised by a licensed psychologist.

- The **Financial Incentives Program** (FIP) is an internal program that seeks to expand a diverse bilingual and bicultural workforce by providing financial incentive stipends to BHS County employees seeking bachelor's (BA/BS) and master's (MA/MS) degrees, and to address the community psychiatrist shortage by offering loan repayment for psychiatrists working in the OC public mental health system. In FY 21/22, the WET office continued to support existing FIP contracts but did not open up the new application cycle. This program is scheduled to resume in FY 22/23 as part of the Workforce Retention strategies in addition to the loan repayment program offered through the OSHPD WET grant. The pre-approved budget and number of eligible applicants determine the exact number of students/psychiatrists who are enrolled in FIP each year. FY 2018-19 showed a decline in the number of graduate student stipends awarded. Although the county still faces a shortage of community psychiatrists, the number participating in FY 2018-19 was nearly double that of FY 2017-18.

PEI Plan:

MHSA dedicates 19% of its allocation to Prevention and Early Intervention (PEI), which is intended to prevent mental health conditions from becoming severe and disabling and to improve timely access for people who are underserved by the mental health system. Compared to the 2020 OC Census, Black/African American are served at 9% (compared to 2% in population); Asian/Pacific Islander are served at 16% (compared to 21% of population). Most notably, 24% of those served by PEI identify as "Another," while that number is 4% in the OC Census.

- The **Mental Health Community Education Events for Reducing Stigma and Discrimination** program hosts mental health-related educational and artistic events that aim to reduce stigma and discrimination related to mental health. Collectively, the events are open to individuals of all ages living in Orange County, with specific events intended to reach identified unserved and underserved communities. A time-limited Request for Application (RFA) is periodically released inviting individuals and organizations to submit proposals for events. Examples of events that have received funding include art workshops and exhibits, plays, conferences, multi-cultural musical and dance performances, and other related activities. Events cater to various ethnic

communities, including those who speak Arabic, Farsi, Khmer, Korean, Spanish, and Vietnamese. Future plans include Mandarin. Additionally, programs cater to LGBTQ+, as well as Older Adults.

- The **Outreach for Increasing Recognition of Early Signs of Mental Illness** program is intended to reach "potential responders," i.e., community members who are working with or likely to encounter individuals who are experiencing, or at elevated risk of experiencing, a mental health challenge. At-risk individuals can include, but are not limited to, PEI Priority Populations such as unserved and underserved racial/ethnic communities; immigrants and refugees; children and youth who are at risk of school failure and/or juvenile justice involvement; foster youth and non-minor dependents; individuals who have been exposed to trauma or are experiencing the onset of serious mental illness; the LGBTQ community; and those experiencing homelessness.

- **School Readiness** serves families with children from birth to age eight who are exhibiting behavioral problems and emotional distress which places them at increased risk of developing a mental health condition and failing in school. These families often face issues related to crowded living conditions, neighborhoods affected by gangs and drugs, a history of violence in the family, and history of separation from loved ones. Many of the families served are also monolingual (i.e., Spanish, Vietnamese).

- **Parent Education Services** (PES) serves at-risk children birth-18 years of age and family members, including parents, partners, grandparents, single parents, teenaged parents, guardians and other caregivers in need. Participating families may experience behavioral health or mental health issues, substance use or co-occurring disorders, or child welfare or juvenile justice system involvement. They may also be homeless, single-parent households, exposed to domestic violence or other trauma, recent immigrants or refugees, or have a child with disabilities (cognitive, emotional, and/or physical). Parents or caregivers are referred to PES from community agencies, schools or other PEI programs that have assessed participants and identified the need for parent education. Languages of the direct service providers include Arabic, Farsi, Korean, Spanish, and Vietnamese.

- The **School-Based Behavioral Health Interventions and Support** (SBBHIS) program provides a combination of prevention and early intervention services designed to empower families, reduce risk factors, build resilience and

strengthen culturally appropriate coping skills in at-risk students and families. Services are provided in elementary, middle and high school classrooms and/or group settings in school districts identified as having the highest rates of behavioral issues based on the California Healthy Kids Survey (CHKS), Academic Performance Index (API) scores and/or suspension and expulsion data as reported by school districts. A majority of those served through this program identify as Latino/Hispanic (53%).

- **Family Support Services** (FSS) serves families in which children, youth or adults are experiencing behavioral health conditions or other stressful circumstances that may place the family at-risk. FSS collaborates with community and mental health service providers, especially those that serve ethnically diverse and monolingual communities, to help assess the needs of its community members. By working closely with individuals who know the community, the program is better able to identify those who could benefit from this prevention program. Language capacities of the direct service providers include Farsi, Korean, Spanish, and Vietnamese.

- **OC Links** is the Mental Health & Recovery Services (MHRS) line that provides information and linkage to any of the OC Health Care Agency's MHRS, including crisis services, via telephone and online chat. Because the navigators who staff the line are clinicians, they can work with callers and chatters experiencing any level of behavioral health issue, ranging from prevention through crisis identification and response. Beginning January 2021, OC Links began operating 24 hours a day, 7 days a week, and cater to all of Orange County's threshold languages.

- **MHRS 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. White/Caucasian are overserved (47% compared to the OC Census at 39%) as well as Black/African American (6% compared to the OC Census at 2%), while Asian/Pacific Islander population is underserved (17% compared to the OC Census at 21%).

- **Integrated Justice Involved Services** is a collaboration between MHRS and Correctional Health Services (CHS) (including Project Kinship) that serves adults ages 18 and older who are living with mental illness and detained in an Orange County Jail. 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 people returning to jail by providing access and linkage to needed behavioral health and supportive services.

- The **Suicide Prevention Services** program services are available to individuals of all ages who 1) are experiencing a behavioral health crisis and/or suicidal thoughts, 2) have attempted suicide and may be living with depression, 3) are concerned about a loved one possibly attempting suicide, and/or 4) are coping with the loss of a loved one who died by suicide. The program serves a broad range of people of all ages, and individuals can be self-referred or referred by family members, providers or other partner agencies. The toll-free, accredited hotline operates 24 hours a day, 7 days a week. This program is now supported by a new Office of Suicide Prevention, which was established in the HCA's Mental Health and Recovery Services area upon the direction of the Orange County Board of Supervisors in 2021.
- 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 a PEI mental health specialist to determine early onset of a mental health condition and program eligibility. This program's language capacity for direct service providers was limited to Spanish, with 53% of the clients served identifying as Latino/Hispanic.
- 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.
- The **Orange County Parent Wellness Program** (OCPWP) provide services to at-risk and stressed families with children under age 18, including 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.

- **Community Counseling and Supportive Services** (CCSS) serves residents of all ages 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 are uninsured or underinsured, monolingual Spanish speaking, and have a history of family or domestic violence and/or early childhood trauma. Beginning FY 2020-21, OC ACCEPT merged with CCSS and expanded its capacity to provide specialized expertise working with individuals identifying as Lesbian, Gay, Bisexual, Transgender, Intersex or Questioning (LGBTIQ), and the important people in their lives. CCSS is designed to help participants address the early symptoms of depression, anxiety, alcohol and/or drug use, suicidal thoughts, violence and Post Traumatic Stress Disorder (PTSD), 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 identifying as LGBTIQ. This program also has an American Sign Language (ASL) language capacity, in addition to Spanish and Vietnamese.
- The **Early Intervention Services for Older Adults** (EISOA) program provides behavioral health early intervention services to older adults ages 50 years and older who are experiencing the early onset of a mental health condition and/or who are at greatest risk of developing behavioral health conditions due to isolation or other risk factors, such as substance use disorders, physical health decline, cognitive decline, elder abuse or neglect, loss of independence, premature institutionalization and suicide attempts. Participants are referred from senior centers, Family Resource Centers, community centers, faith-based organizations and the PEI Outreach to Increase Recognition of Early Signs of Mental Illness program. Languages utilized include Arabic, Farsi, Khmer, Korean, Mandarin, Spanish, and Vietnamese. 40% of the clients served are from the API community.
- **OC4Vets** are veteran-focused early intervention programs that support targeted subpopulations within the Orange County veteran community: adult veterans and military connected individuals, veterans engaged with County Courts, veteran college students, and military connected families with children under the age of 18 (the latter of which used to be the standalone Innovation project, Behavioral Health Services for Military Families). The OC4Vets, County- and contract-operated programs serve Orange County veterans and 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.

3-IV: Additional Strategies/Objectives/Actions/Timelines and Lessons Learned.

3-IV-A: List any new strategies not included in Medi-Cal, CSS, WET, and PEI. Note: New strategies must be related to the analysis completed in Criterion 2.

Several Innovation projects address the current disparities across Orange County:

- The **Behavioral Health System Transformation** (BHST) project is an innovation project designed to create a system that can serve all Orange County residents, regardless of insurance status, type, or level of clinical need. Its primary purpose is to promote interagency and community collaboration related to mental health services, supports or outcomes, with the goal of introducing a new practice or approach to the overall mental health system, including, but not limited to, prevention and early intervention.

- The **Psychiatric Advance Directives** (PADs) project is an INN project designed to help counties improve a consumer's access to appropriate services and quality of care while preserving the individual's life goals and mental health preferences. PADs are a means for increasing self-determination and autonomy by empowering individuals to make decisions about their own lives. PADs serve to improve positive outcomes for consumers at risk of involuntary care, homelessness, unnecessary hospitalizations, and involvement with the criminal justice systems through all stages of life.

3-IV-A-I: Share what has been working well and lessons learned through the process of the county's development of strategies, objectives, actions, and timelines that work to reduce disparities in the county's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

<u>CSS: What is working well, and lessons learned include:</u>

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

employment goals, and giving back to the community via volunteer opportunities. Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. Services are provided by individuals with lived experience and are based upon a model of peer-to-peer support in a non-judgmental environment. A wide variety of weekend, evening and holiday social activities are provided for members to increase socialization and encourage (re)integration into the community. The ultimate goal is to reduce reliance on the mental health system and to increase self-reliance by building a healthy network of support which may involve the members' family, friends or significant others. The Wellness Centers utilize Member Advisory Boards (MABs) composed of members who develop or modify programming and evaluate the successes or failures of groups, activities and classes. They also use a community town hall model and member Satisfaction and Quality of Life surveys to make decisions about programming and activities.

A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to 2 hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the need for extensive travel. With the centers operating in the west, central and south regions of the county, access has improved. The south county center is particularly challenging when it comes to public transportation, as the majority of bus routes are no longer in operation in that region. To assist individuals with accessing and utilizing the south center, the HCA has authorized the utilization of its Transportation program to assist those individuals with the most challenging transportation needs to get to the south center. An additional challenge that surfaced for each of the Wellness Centers during FY 2020-21 was the onset of the Covid-19 pandemic, which resulted in program closures for in-person services and a transition to remote group operations via Zoom, Webex and other platforms. All three Centers were impacted in daily attendance, as many members do not have the ability to participate in remote groups. However, daily participation did increase over time, and in late FY 2020-21 all the programs transitioned to hybrid programming, which offers both in-person services at reduced capacities to comply with state and local guidelines, as well as continued remote services. This had a significant impact on participation in the programs, and daily attendance continues to increase. Many members are still hesitant to participate in in-person services due to the pandemic, especially among older adults, however, members who have chosen to participate in in-

person services have expressed gratitude to be able to attend the programs and join in face-to-face groups and activities, as well as reconnect with members that they had lost touch with during program closures and the need to limit interactions in the community. The hybrid programming supported with increasing participation in the events and groups, which have programs tailored to Farsi, Korean, Spanish, and Vietnamese speakers.

Another lesson learned from the Full Service Partnership (FSP) programs is the need for culturally-specific FSP's. As such, three new FSP's are being developed to cater to the following populations: Spanish-speaking, Vietnamese-speaking, and Veterans communities.

PEI: What is working well, and lessons learned include:

The former **Outreach and Engagement Collaborative** was intended to conduct outreach to hard-to-reach communities, including LGBTQ+, communities of color, monolingual populations. This program used to be broken into regional programs. There was success in raising awareness, however the regional approach posed some challenges because certain target populations outside the region had a hard time to access the services. One of the limitations was the inability of the provider to reach a target population across the county due to geographic restrictions. While collaborations formed, there were gaps in coordination. As a result, an RFP was formed based on lessons learned from partners in community titled **Mental Health and Well-Being Promotion for Diverse Communities**. When PEI looked at the data, communities of color and priority populations (such as Veterans and LGBTQ+) continued to be underserved. Consequently, An RFP went out from the Office of Suicide Prevention that focused specifically on the priority target populations while incorporating a peer-based component in each program. One of the main goals of this program is to break cultural barriers and normalize conversations around mental health and wellness in communities of color and in historically underserved priority populations.

Services focus on individuals who are especially isolated and at risk of developing a behavioral health condition or who are displaying early signs of emotional or behavioral health concerns and continue to be unserved or underserved especially individuals from diverse communities that include communities of color, veterans and individuals who identify as Lesbian Gay, Bisexual, Transgender, Queer (LGBTQ).

Orange County data indicates that individuals from diverse communities continue to demonstrate poor mental health outcomes and continue to be underserved in

Orange County. These communities have been identified as being at a disproportionately higher risk of developing a behavioral health condition when compared to the general population and if left unaddressed or untreated, it will be at greater risk of worsening. The COVID-19 pandemic has exacerbated these risks and has had a negative impact on the mental health and well-being of these groups. (2021-2022 Orange County Mental Health Services Act (MHSA) Prevention and Early Intervention Annual Plan Update).

The higher mental health disparity in these diverse communities is not unique to Orange County. These mental health disparities are linked to a variety of risk factors including stigma, stress due to economic hardships, lack of access to health care, isolation, trauma, lack of culturally appropriate care among other factors and may cause delays in help-seeking, ultimately leading to poorer health outcomes including a higher risk of suicide. Mental Health and Well-Being Promotion for Diverse Communities Services were put in place to promote access to mental health and wellness programs to better address mental health needs of individuals from these diverse communities. Services focus on promoting mental health wellness and preventing mental illness and or substance use disorders with a goal to increase connectedness, reduce prevailing stigma, and improve help-seeking behaviors. The services are designed to support individuals' wellbeing by increasing their awareness and knowledge of behavioral health issues including the associated risk and protective factors, and available community resources in the County. All services are designed to be peer driven, and accomplished_through outreach, information dissemination, community education and events, skills building, socialization group activities, and one-one interactions and relationships with families and individuals representing the target population. Appropriate referrals and linkages to resources and support is provided as needed.

The Mental Health and Well-Being Promotion for Diverse Communities consists of over 24 organizations and provides the following services to the target populations listed below:

Mental Health and Wellbeing Promotion Services

Provider Site Location	Target Population	Services
OCAPICA **Garden Grove, CA**	▪ Communities of color Asian & Pacific Islander (API) ▪ South Asian Arab American, Middle Eastern, North African (SAMENA) ▪ Black	▪ Outreach events (through Subcontractors) ▪ Peer support ▪ Workshops/educational groups ▪ Community education events / activities ▪ Referrals ▪ Linkages
LHA **Santa Ana, CA**	▪ All Orange County's Latinx multi-generational communities	▪ Community Outreach (Telephone and Text Banks; Door-to-door; Creative Outreach; Mini Street Campaigns) ▪ Large-scale and small-scale community educational events ▪ Social Media & Digital Marketing Campaigns ▪ Community-based workshops ▪ Peer Support Services
SSG **Garden Grove, CA**	▪ LGBTQ+	▪ Community Events (large and small scale) ▪ Community Outreach Activities ▪ Workshops/Educational Groups ▪ Peer Support ▪ Social Media/Digital Marketing Campaigns
US Vets **Tustin, CA**	▪ Veterans and military connected individuals, and their families	▪ Peer Support ▪ Community Events ▪ Community Outreach Activities ▪ Workshops/Educational Groups ▪ Social Media/Digital Marketing Campaigns

3-V: Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities

(Criterion 3, Section I through IV requires counties to identify strategies, objectives, actions, and timelines to reduce disparities. This section asks counties to report processes, or plan to put in place, for monitoring progress.)

3-V-A: List the strategies/objectives/actions/timelines provided in Section III and IV above and provide the status of the county's implementation efforts (i.e. timelines, milestones, etc.).

Through the MHSA community planning process, the three strategic priorities identified were: (1) Mental Health Awareness and Stigma Reduction, (2) Suicide Prevention, and (3) Access to Services.

The following charts will highlight each of the strategic priorities along with the priority populations identified, the strategies, and the progress updates.

STRATEGIC PRIORITY: Mental Health Awareness & Stigma Reduction

Expand campaigns, trainings & community education focused on increasing awareness of mental health signs & available resources, as well as reducing stigma

Priority Populations	Strategies	Progress Update
▪ LGBTIQ individuals ▪ Boys ages 4-11 ▪ Transitional Age Youth (TAY) ages 18-25 ▪ Adults ages 25-34 and 45-54 ▪ Unemployed adults ▪ Homeless individuals ▪ Individuals living with co-occurring mental health and substance use conditions ▪ Older Adults ages 60+	▪ Engage through Social Media, Internet, Events/Fairs, TV, radio, newspapers, senior centers for older adults ▪ Focus on positive messages, simple language, good visuals & color, slogans & phrases, not jargon ▪ Cultural representation (authentically) ▪ Use trusted sources, celebrities, influencers ▪ Increase inter-agency collaboration and group activities	Continue outreach and awareness initiatives targeting TAY populations ▪ In 2021 HCA hosted a Virtual Veteran's Conference which was attend by 114 people. ▪ The StigmaFreeOC Website continues to outreach to the community, with 398 Organizations taking the pledge to be Stigma Free. ▪ The HCA website (www.ochealthinfo.com) was updated through work with a web designer to improve the organization and navigation for public usage. ▪ OC Directing Change videos were shown prior to Angels Baseball games on Ballys Sports West as well as shared during Mental Health Awareness Month. ▪ Due to the COVID-19 pandemic, an in-person Directing Change Award Ceremony has been postponed.

STRATEGIC PRIORITY: Access to Behavioral Health Services

Improve access to behavioral health services and address transportation challenges

Priority Populations	Strategies	Progress Update
▪ Youth ▪ Families with children living with a mental health condition ▪ Asian/Pacific Islander ▪ Latino/Hispanic ▪ Black/African American	▪ Train staff on mobile technology, telehealth, other remote service options ▪ Avoid merely providing devices (ex. Headsets and phones) due to issues with privacy and Wi-fi access ▪ Avoid using a one-size fits all approach with both the language of content and the content itself, all material should be population specific ▪ Use culturally appropriate and representative images, materials in preferred language(s) ▪ Collaborative, group, community activities ▪ Identify clinic lobby and common areas in MHRS outpatient clinics eligible and in need of upgrades. Conduct needs assessment. Encumber funds: up to $80k/clinic (Max/NTE $400k) to improve clinic lobby and common areas ▪ Focus on the positive, use encouraging phrases ▪ Avoid depicting sadness, despair or vulnerability through colors, imagery, stigmatizing and/or illness-focused language	▪ Developed digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices. ▪ 55% of respondents from the community survey in FY 2021-22 reported they have adequate and reliable internet access via mobile devices, unlimited Wi-Fi and/or a data plan. ▪ Partnered with First 5 OC and Be Well OC in creating additional promotional and educational materials for families with young children. ▪ The MHSA office has developed a workgroup and identified 7 potential lobby and common areas in MHRS outpatient clinics in need of upgrades. The workgroup meets regularly and is working with a vendor to develop designs. ▪ Conducted focus groups to gather needs assessment (including focus on the positive, encouraging phrases, and vibrant colors) and direct input from consumers. ▪ Continue to coordinate through peer project manager (e.g., PEACe, the MHRS peer workgroup and Workplace Wellness Advocates) on clinic improvements. ▪ Developed an art strategy to enhance the art programs through the use of an art committee with consumers to create artwork that will be used in clinics. ▪ Transportation contract expanded to support more priority populations.

STRATEGIC PRIORITY: Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations	Strategies	Progress Update
▪ People from all MHSA age groups ▪ Homeless individuals ▪ Individuals living with co-occurring mental health and substance use conditions ▪ LGBTIQ individuals ▪ Veterans	▪ On October 6, 2020, the Board of Supervisors directed the County to establish the Office of Suicide Prevention (OSP) to reach out to high-risk populations to find and engage those in need, maintain contact with those in need and support continuity of care, improve the lives of those in need through comprehensive services and supports, and build community awareness, reduce stigma and promote help-seeking ▪ Create a systems approach to suicide prevention ▪ Build hope, purpose, and connection for individuals in need. ▪ Promising pilot programs ▪ Integrate new and existing services and support throughout suicide prevention	▪ OSP Office and OSP Division Manager was announced on 8/2/2021. The Office of Suicide Prevention will coordinate suicide prevention efforts at the Agency level and interface with local and statewide initiatives to identify and facilitate the implementation of evidence based and promising suicide prevention activities in Orange County. ▪ Continue expanded reach of activities/campaigns (also leverage Cal MHSA's Know the Signs information: • Suicide Prevention campaign for Adult/Older Adult Men • Adult "Help is Here" website • Youth "Be a Friend for Life" website ▪ The OSP has established a Community Suicide Prevention Initiative (CSPI) Coalition for implementation of a variety of suicide prevention initiatives through public and private partnerships. ▪ All prevention services and activities are designed to promote wellness and improve connectedness and build resiliency and protective factors and reduce risk factors. ▪ A countywide Connect OC Coalition for TAY populations was launched to provide a platform for youth from colleges, universities, and the community at large to connect with each other, promote mental wellness activities, educate the community on a wide array of mental wellness, stigma reduction and suicide prevention topics and increase help-seeking behavior in the community. ▪ Outreach and awareness targeting TAY was conducted through innovative approaches such as theater and plays, forums such as Honest Hour, podcasts and Instagram and Facebook live events focusing on mental health themes followed by discussions with the audience.

Additionally, the Behavioral Health Equity Committee (BHEC) is collaborating with the Office of Population Health and Equity to increase community involvement in the community planning process as well identifying ways to reduce disparities, especially as they pertain to various cultural and linguistic populations.

3-V-B: Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

There are several mechanisms that are used to monitor the reduction and elimination of disparities. These include, but are not limited to:

- Monitor penetration rates for target and priority populations.
- Identify and support population-specific programs and curriculum.
- Continue to expand cultural competence and cultural humility trainings for county and contracted staff.
- Expand the bi-lingual and bi-cultural workforce to better serve the population.
- Monitor population demographics across PEI and CSS components of the MHSA Plan

3-V-C: Identify County technical assistance needs.

No technical assistance required at this time.

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

CLAS Standard: 13

4-I: The County has a Cultural Competence Committee, or other Group that Addresses Cultural Issues and has Participation from Cultural Groups, that is reflective of the Community.

4-1-A: Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).

The Cultural Competence Committee (formed in 2016) consists of members from the community and the Health Care Agency who also represent or serve persons from the diverse racial, ethnic, and cultural groups in Orange County. The overarching goal was "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."

In 2020, following the devastating inequities highlighted by the Coronavirus pandemic, as well as the murder of George Floyd, a Community Relations and Education (CoRE) sub-committee was formed to develop a governing structure for the CCC that puts equity at the forefront. The result was a change in the name from CCC 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 were formed in the first quarter of 2021. At that time, the Director of Behavioral Health Services appointed Bijan Amirshahi, the ESM at the time, as the Co-Chair on its behalf and the community members of the Steering Committee elected Iliana Soto Welty as the community Co-Chair. In September 2021, Bijan Amirshahi stepped down from his position as Co-Chair (while still serving as the ESM), and Deana Helmy was appointed as his replacement.

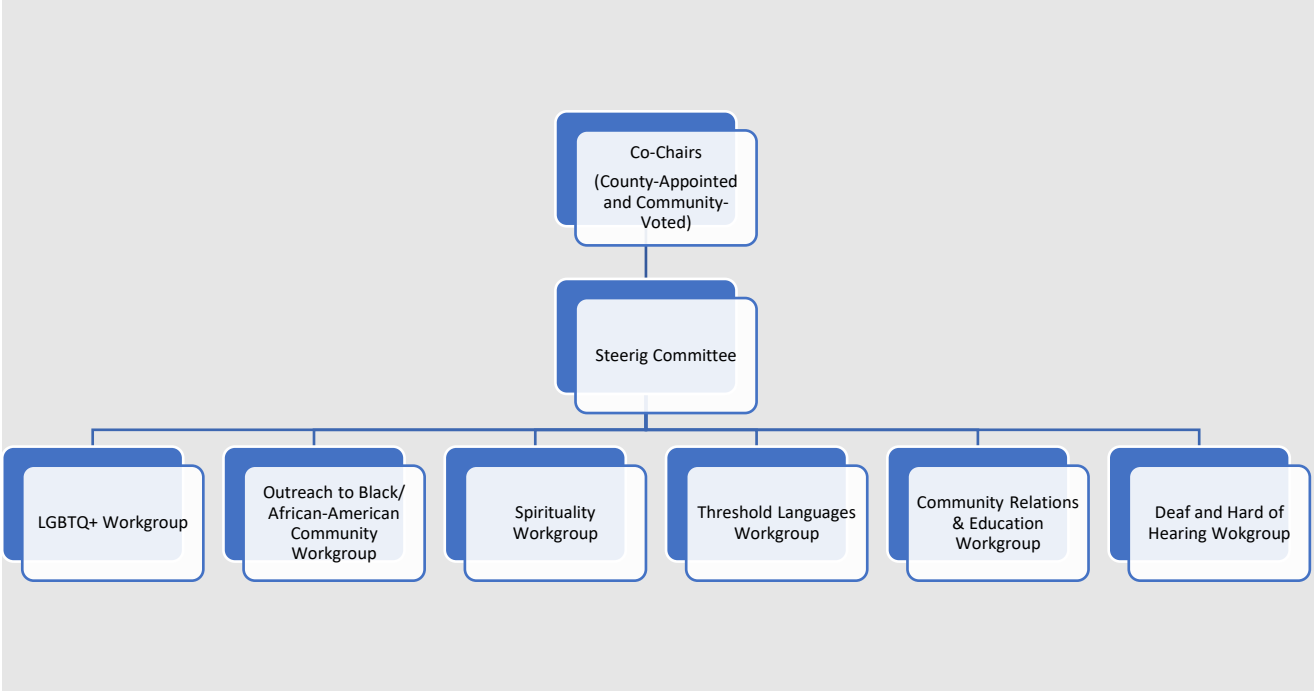
A copy of the Governing Structure as approved by MHRS is included in .

4-1-B: The County shall include the following in the CCPR: Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

The BHEC has a governing structure and by-laws that address the values, objectives

4-I-C: Organizational Chart

Current Organizational Chart of the Behavioral Health Equity Committee:



4-I-D: Committee membership roster listing member affiliation, if any.

Name	Organization
Abdeh, Iman	MECCA
Adelekan, Patricia	Community
Anguiano, Lloraley	Orange County Health Care Agency
Anh, Ellen	Korean Community Services
Arnold, Margery	RCBO

Arnot, Michael	Children's Cause OC
Aziz, Samar	Sabil USA
Banicki, Wendy	Orange County Health Care Agency
Brack, Yvonne	Orange County Health Care Agency
Burney, Lenora	Orange County Health Care Agency
Choe, Susan	Orange County Health Care Agency
Chiu, Irene	OCAPICA
Davis, Mark	Orange County Health Care Agency
Deeble-Reynolds, Stacy	Orange County Department of Education
Doroudian, Negar	Orange County Health Care Agency
Eftekharzadeh, Sohail	Wellness Center - Central
Englund-Giri; Bergit	Orange County Health Care Agency
Flores, Kim	Community
Gibbs Danny	Orange County Health Care Agency
Grande, Andre	ICNA Relief
Graziano, Elizabeth	Orange County Health Care Agency
Hanifzai, Wali	Qazizada Foundation
Helmy, Deana	Orange County Health Care Agency
Hernandez, Elizabeth	Orange County Health Care Agency
Hill, Dave	RDF Church
Kalk, Karin	Orange County Health Care Agency
Kellman, Allison	Orange County Health Care Agency
Kim, Yuri	Orange County Social Services
Lu, Paul	NAMI
Lu, Pham	Orange County Health Care Agency
McCleese Belinda	Orange County Health Care Agency
McNally, Steve	Community
Merritt, Alex	Orange County Health Care Agency
Mugrditchian, Annette	Orange County Health Care Agency
Mullard, Michael	Orange County Health Care Agency
Ngo, Hannah	Orange County Health Care Agency
Nguyen, Hieu	Orange County Health Care Agency
Nguyen, Kelvin	Viet-care
Nguyen, Nicki	Orange County Health Care Agency
Nguyen, Tricia	Southland
Ortega, Christy	Orange County Health Care Agency
Ortizo, Johann	APAIT
Paddison David	Partners 4 Wellness
Peong, Vattana	Cambodian Family
Perez, Victor	Re Imagine OC
Portillo, Edward	NAMI

Pham, Lu	Orange County Health Care Agency
Pickering, Kenneth	Orange County Health Care Agency
Ramirez, Jessica	Orange County Health Care Agency
Rao, Bhuvana	Orange County Health Care Agency
Renteria, Teresa	Orange County Health Care Agency
Reynolds, John	Orange County Health Care Agency
Roberts, Dwayne	Community
Rowe, Cheryl	Orange County Health Care Agency
Salamati, Armin	Orange County Health Care Agency
Sayyedi, Maryam	OMID
Sharifaei, Joya	Community Member
Smith, Courtney	GREEN Foundation
Tabesh, Nikoo	Orange County Health Care Agency
Taylor, Gary	Community
Thornton, April	Orange County Health Care Agency
Tran, Duan	Cal State Fullerton and member of BHAB
Tran, Thuy	St. Joes
Wang, Jon	unknown
Soto Welty, Iliana	Mind-OC
Whetsell, Brittany	Orange County Health Care Agency
Williams, Cyntralia	Orange County Health Care Agency
Williams, Johniece	Be Well
Williams, Kel	LGBTQ Center OC
Wright, Ernesta	GREEN Foundation
Yang, Emily	OCAPICA

4-II: The Cultural Competence Committee, or Other Group with Responsibility for Cultural Competence, is Integrated within the County Mental Health System.

4-II-A: Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:

The BHEC bylaws and governing structure, attached, highlight the role of BHEC as it pertains to the MHSA planning and stakeholder process, CCPR development, and communicating to the Chief of Mental Health and Recovery Services. Currently, the Office of Equity is being formed and will continue to collaborate and integrate with the MHSA community planning process, as well as working closely with the client developed programs (wellness, recovery, and peer support programs).

4-II-B: Provide evidence that the Cultural Competence Committee participates in the above review process

The MHSA Coordinator and the BHEC Chair work together to ensure that the BHEC is involved in the community planning process, provides feedback to the MHSA Coordinator, and reviews the MHSA Plan. Moving forward, the MHSA Coordinator and the BHEC Chair will ensure community involvement and participation in the development of client-centered programs. Additionally, the CCPR incorporates feedback provided from the BHEC steering committee and workgroup members.

4-II-C: Annual Report of the Cultural Competence Committee's Activities including:

- **Detailed discussion of the goals and objectives of the committee;**
  - Were the goals and objectives met?
  - If yes, explain why the county considers them successful.
  - If no, what are the next steps?
- **Reviews and recommendations to county programs and services;**
  The BHEC and subcommittees review and make recommendations to departments' programs and services annually through the MHSA annual update (at various community planning process meetings) and as requested by MHRS and its partners.
- **Goals of cultural competence plans;**
  The required goals of the CCP are:
  - Commitment to Cultural Competence
  - Updated assessment of service needs
  - Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
  - Client/Family/Family member/Community Committee: Integration of the Committee within the county mental health system
  - Culturally competent training activities
  - County's commitment to growing a multicultural workforce: Hiring and retaining culturally and linguistically competent staff
  - Language Capacity
  - Adaptation of Services

  No updates or changes to the cultural competency plan goals have been made.

- Human resources report;
  Not applicable – there was no report requested by BHEC Committee
- County organizational assessment;
  In FY 2021/2022, the BHEC did not conduct a county organizational assessment. In 2023, BHEC will be reviewing the MHSA Summit results, as well as organize a BHEC Summit to guide their work.
- Training plans
  Training plans were developed in collaboration with the department's Workforce Education and Training (WET) program, also referred to as Behavioral Health Training Services (BHTS).

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

CLAS Standard: 4

5-I: The County System shall require all Staff and Stakeholders to receive Annual Cultural Competence Training.

5-I-A: The County shall develop a three-year training plan for required cultural competence training that includes the following:

• The projected number of staff who needs the required cultural competence training. This number should be unduplicated;
• Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period 3.
• How cultural competence has been embedded into all trainings

In 2021, 4,021 staff and contracted providers completed the annual cultural competence training. We anticipate the number for 2022 to exceed 4,021, based on the expansion of programs and services and the filling of vacant positions.

MHRS (Policy 2.01.01 requires all MHRS County and County Contracted staff to complete an annual cultural competency training. Per the policy:

- 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.
- The Service Chief/Supervisor of each MHRS 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.
- 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.

MHRS county and contracted staff are expected to take Cultural Competence trainings. It is the goal of the ESM, with the support of the Chief of MHRS, to develop new material specifically related to cultural

competency and how staff incorporate culturally and linguistically appropriate services into their work with clients, consumers, co-workers, and the public alike. All staff are required to complete at least one hour of cultural competency training annually. Contracted providers are required to take this training as well, and is highlighted as a requirement in all contracts.

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 on skill building and education are conducted to address cultural sensitivity and humility, as well as reduce stigma and discrimination within the behavioral health system. This is done to prepare, develop, and maintain a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members with valuable, lived experience.

5-II: Annual Cultural Competence Trainings

5-II-A: Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function:

Cultural competence trainings are comprised of several categories: those related to behavioral health best practices; those requiring on-going recertification; clinical skills development 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, in order 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, stakeholders, and community members on a variety of topics. Table 5.1 below is a chart that provides information on the cultural development trainings provided during FY

2020-21 (See Appendix IV for training descriptions and details). These topics helped to address the unique strengths and needs of clients from the diverse ethnic and cultural communities in Orange County.

5.1 Name of Cultural Development Trainings, FY 2020-21[1]

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
2021 Virtual Meeting of the Minds Mental Health Conference	1	102	6.0	6
Adult Mental Health First Aid	4	54	30.0	0
Building the Beloved Community Through Cultural Humility (CIBHS)	1	33	2.0	2
Clinical Supervision: A Lens on Multicultural Competency	1	135	6.0	6
Cognitive Behavioral Therapy and Relapse Prevention Strategies	1	61	3.0	3
Cognitive-Behavioral Therapy (CBT) and Relapse Prevention (RP) Strategies	1	40	3.0	3
Confidentiality Issues Facing Substance Use Disorder and Mental Health Providers	1	50	2.0	3
Coping with the Journey of Grief and Mourning	1	123	3.0	3
Crisis Intervention Training (CIT)	28	321	152.0	0
Cultural Competency 2.0 Training	1	579	1.0	1
Cultural Competency 3.0 Training	1	4,021	1.0	0
Early Childhood Mental Health: Foundational Principles and Practices	2	112	15.0	24
Eye Movement Desensitization & Reprocessing Basic Training Part 2	1	35	20.0	20
Eye Movement Desensitization & Reprocessing Therapy with Children and Adolescents	1	18	3.0	3
Getting the Best From Yourself and Others: Using MBTI Type to Optimize Leadership Effectiveness (CIBHS)	1	33	2.0	2
Leading and Developing Teams Through a DEI Lens (CIBHS)	1	38	2.0	2
Moral Reconation Therapy	1	14	26.0	26
Recovery Based Clinical Practice	1	36	2.0	2
Recovery: The Promise of Hope	1	30	3.0	3
Self-Care for Holiday Blues and COVID Stress & Anxiety	1	61	2.0	0
Suicide Awareness Training	2	398	12.0	12

The Pandemic: What it Reveals About Inequities in Medicine - What if Offers in Systemic Solutions	1	33	2.0	2
Translating Culturally Responsive Leadership Into Action	1	30	2.0	2
Trauma and Parenting During a Pandemic	1	78	3.0	3
Trauma-Informed Care Approaches for Working with Individuals with Substance Use Disorders	1	48	3.0	3

5.1 (Continued) Name of Cultural Development Trainings, FY 2020-21

	Total Trainings	*Number of Attendees*	*Combined Hours*	*Combined CEs Given*
Veteran's Conference - 2020 Annual OC Community Behavioral Health Summit	1	135	7.0	5
Youth Mental Health First Aid	3	52	18.5	0
Total	***61***	***6670***	***331.5***	***136***

Note: No CEUs were given for CIT or MHFA
Source: Behavioral Health Training Services, Internal Data Tracking System (FY 20-21)

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. Most participants identified as County (31%) or Community-Based (20%) Direct Service Providers. Personally speaking, the majority of participants identified as Community Members (27%), Family Members (17%), and/or Parents (16%). Roughly 8% 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 2020-21

*Attendance by function**	*Total Number*	*Percentage*
County Administrator/Manager	576	11%
County Direct Service Provider	1557	31%
County Support Staff	688	14%
Community-Based Administrator/Manager	516	10%
Community-Based Direct Service Provider	1007	20%
Community-Based Support Staff	710	14%
Total	***5,054***	***100%***

**Some attendees reported multiple professional roles*
Source: Behavioral Health Training Services, Evaluation Form Data (FY 20-21)

5.3 Cultural Development Training Attendance by Participants' Personal Role, FY 2020-21

*Attendance by function**	*Total Number*	*Percentage*
Consumers	1065	10%
Parents	1644	16%
Family Members	1695	17%
Community Member	2751	27%
Caregiver	763	7%
Teacher	551	5%
Student	772	8%
Youth	135	1%
Other	844	8%
Total	*10,220*	*100%*

**Some attendees reported multiple personal roles*
Source: Behavioral Health Training Services, Evaluation Form Data (FY 20-21)

5-II-B: The County shall include the following in the CCPR: Annual cultural competence trainings topics shall include, but not be limited to the following:

- Cultural Formulation
- Multicultural Knowledge
- Cultural Sensitivity
- Cultural Awareness
- Social/Cultural Diversity (Diverse groups, LGBTQ, SES Elderly, Disabilities, etc.)
- Mental Health Interpreter Training
- Training staff in the use of mental health interpreters
- Training in the use of Interpreters in the mental health setting

The annual Cultural Competence training is provided to both County- and Contract-operated staff. In November 2018, a revised Cultural Competence training was launched and focused on culture, cultural humility, stigma and self-stigma, unconscious bias, micro-aggression, racism, and cultural formulation.

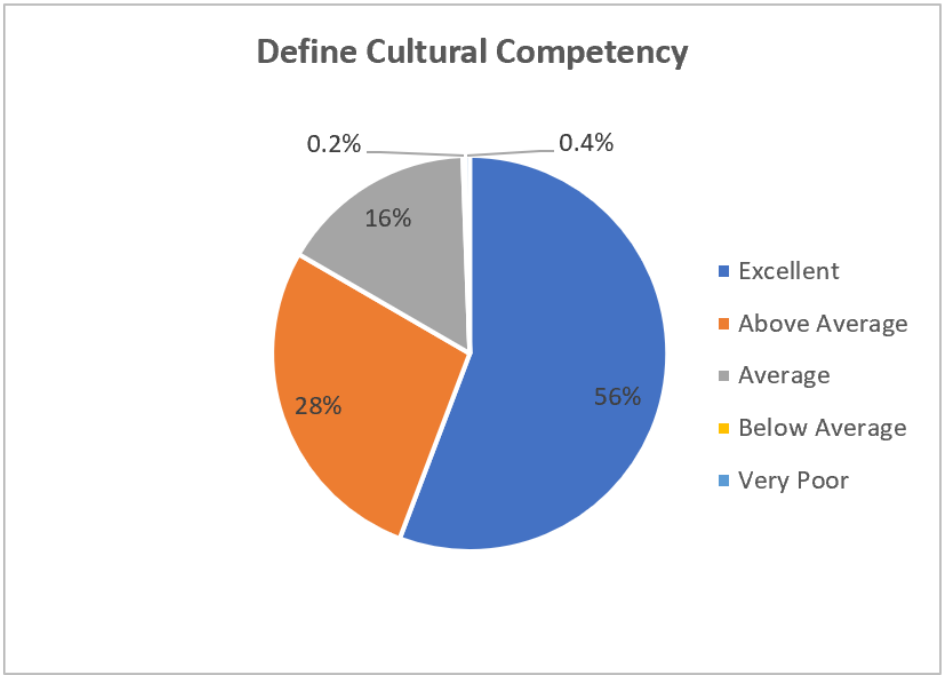
5-III: Relevance and Effectiveness of all Cultural Competence Trainings.

5-III-A: Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:

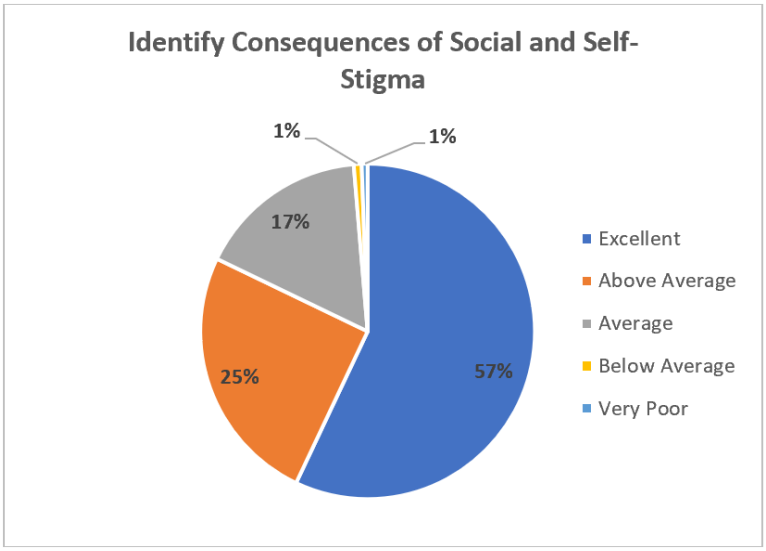
- Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;

- Results of pre/post-tests (Counties are encouraged to have a pre/posttest for all trainings);
- Summary report of evaluations; and
- Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
- County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

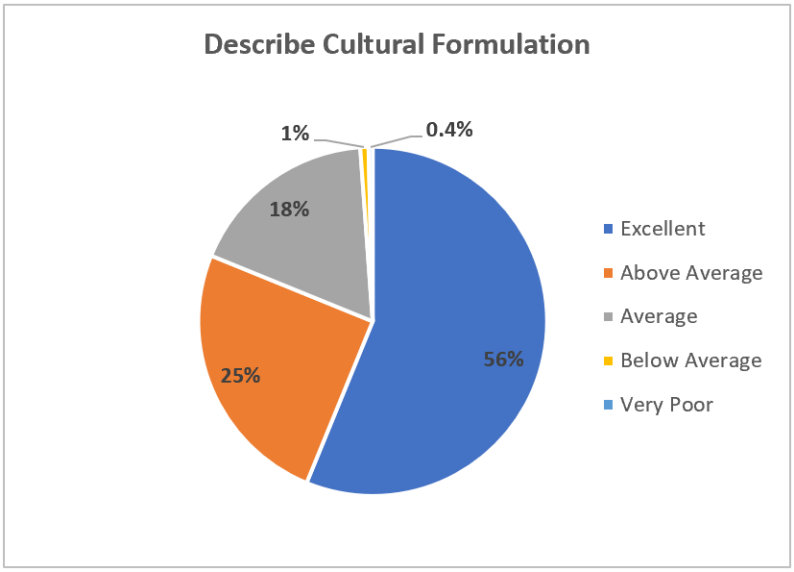
The annual Cultural Competence training is provided to both County- and Contract-operated staff. In November 2018, a revised Cultural Competence training was launched and focused on culture, cultural humility, stigma and self-stigma, unconscious bias, micro-aggression, racism, and cultural formulation. To enhance the quality of the training several images and video clips were included. At the end of the training, participants were encouraged to take an online evaluation regarding their experiences. 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 2020-21 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 (28% above average and 56% excellent).



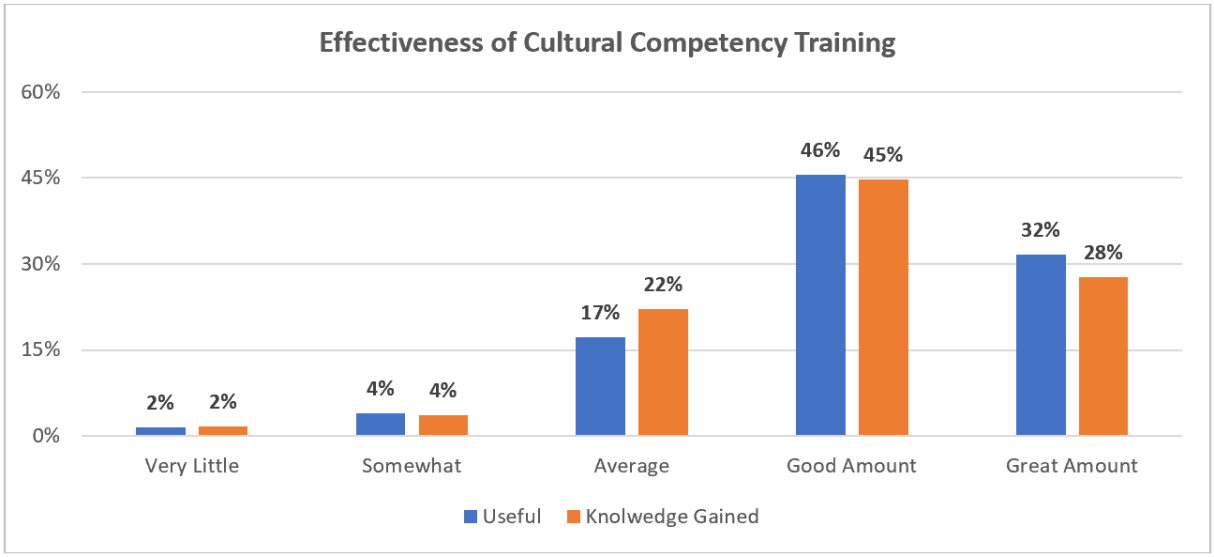
Similarly, roughly 80% of participants felt the training provided an above average (25%) or excellent (57%) description of how to identify the consequences of social and self-stigma. The focus of this objective was to understand how these concepts related to public health and its influence of the unconscious thoughts on judgement, stereotyping, and racism in our community.



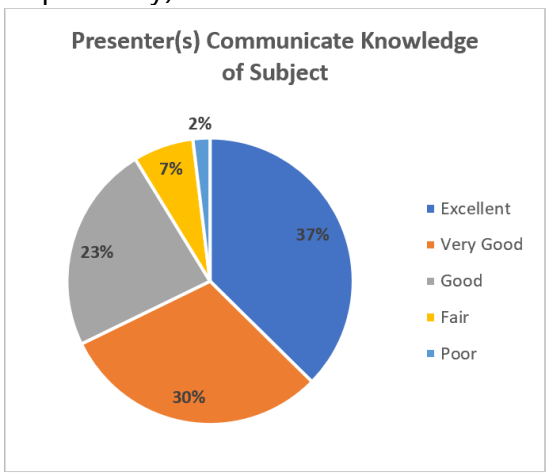
Finally, eight out of every ten participants felt they could describe cultural formulation as a result of the training (25% above average and 56% excellent). The purpose of this objective was to assess how cultural formulation approaches, which integrate a culturally response approach, are incorporated into service attitudes and interactions with clients to reduce the effects of stereotyping.

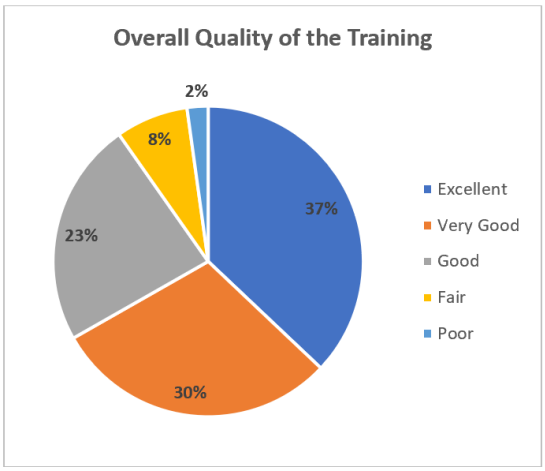


Questions also determined the overall effectiveness of the Cultural Competence training. In general, the majority of participants found the training to be useful for their clinical work (46% and 32%, respectively) and learned new information (45% and 28%, respectively).



This Cultural Competency training was closed in December 2020 to make way for a new Cultural Competency training that focused on unconscious bias in the workplace. In September 2020, an updated Cultural Competency training was launched for all County- and Contract-operated programs. While no Continuing Education (CE) units were provided, this training focused on understanding and identifying unconscious/implicit bias in the workplace. Of those who provided feedback for this training, 67% of participants felt the training quality was very good (30%) or excellent (37%). Additionally, the presenter was perceived as knowledgeable by 67% of respondents (30% very good and 37% excellent; respectively).





The HCA Cultural Competence training 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.

A key component of the HCA Cultural Development/Competence trainings are to increase attendees' cultural understanding and skills related to increased client satisfaction and improved behavioral health outcomes. These concepts also reduce disparities among underserved or underrepresented groups.

5-IV: Counties must have Process for the Incorporation of Client Culture Training throughout the Mental Health System.

5-IV-A: Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities.

- Recovery: The Promise of Hope

5-IV-B: The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretakers', personal experiences with the following:

- Family focused treatment;
- Navigating multiple agency services; and
- Resiliency.

Family Focused Treatment:

- Trauma and Parenting During a Pandemic

Resiliency:

- Building the Beloved Community Through Cultural Humility
- Coping with the Journey of Grief and Mourning
- Self-Care for Holiday Blues and COVID Stress & Anxiety

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

CLAS Standard: 3 & 7

6-I: Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experienced with, the Identified Unserved and Underserved Populations.

MHRS 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. At present, MHRS is coping with a vacancy rate of approximately 27%. This means that approximately one third of our positions are waiting to be filled or are recently vacated. There are many reasons contributing to this vacancy rate such as the impact of COVID on staff resilience, current hiring and retention practices, and competitive pay.

One of the main agency goals for this year's Cultural Competence Plan Update is the hiring and retention of a bi-lingual and bi-cultural workforce. This has become a priority for management to increase penetration rates and further create linkages to the community to increase trust and build confidence in our services.

6-I-A: Extract and attach a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component. Rationale: Will ensure continuity across the County Mental Health System.

Workforce Education and Training (WET) Component from the Mental Health Services Act Three Year Integrated Plan for Fiscal Years 2020/2023.

The passage of the Mental Health Services Act (MHSA) in November 2004, provided a unique opportunity to increase staffing and other resources to support public behavioral health programs.

MHSA funds increased access to much needed services, and progress toward statewide goals for serving children, Transitional Age Youth (TAY), adults, older adults, and their families.

California's public behavioral health system has suffered from a shortage of behavioral health workers, changes in mental health occupational classifications, and underrepresentation of diversity of professionals with consumer and family member experience. To address challenges faced by the public behavioral health workforce, the MHSA included a component for Mental Health Workforce Education and Training (WET) programs.

WET is a program that provides various training opportunities to MHRS staff and contract agency staff, promotes the hiring of a culturally diverse workforce, offers financial incentives to recruit and retain staff, recruits volunteers for the department, facilitates clinical intern programs, supports the inclusion and incorporation of consumers and their family members into the behavioral health workforce, and is committed to addressing workforce shortage within Orange County through utilization of various strategies to recruit and retain qualified behavioral health employees.

WET carries forth the vision of the MHSA to create a transformed, culturally competent system that promotes wellness, recovery, and resilience across the lifespan of all age groups and all cultural backgrounds.

WET MHSA Legislative Goals

Address workforce shortages and deficits identified in the workforce needs assessment:

- Increase in the number of employees hired in identified needs assessment areas
- Increase in pre-licensed to licensed baseline statistics
- Increase in the number of qualified applications received for clinical positions
- Increase in MHRS pre-licensed clinicians hired (interns vs. non-interns)

Designate a WET Coordinator:

- WET Coordinator designated

Educate the workforce on incorporating the general standards:

- Training documented addressing these standards
- Training evaluations

Increase the number of clients and family members of clients employed in the public mental health system:

- Increased number of peer support specialists and parent/youth partners hired

Conduct focused outreach and recruitment to provide equal employment opportunities in the public mental health system for individuals who share the racial/ethnic, cultural, and/or linguistic characteristics of clients, family members of clients, and others in the community who have serious mental illness and/or serious emotional disturbance:

- Documented efforts that target the identified population
- Documented career fairs including locations

Recruit, employ, and support the employment of individuals in the public mental health system who are culturally and linguistically competent, or at a minimum, are educated and trained in cultural competence:

- Documented efforts that target the identified populations
- Adherence to cultural competency training requirement
- Increase in hiring of culturally competent staff
- Increase in the number of bilingual staff, bilingual applicants, and bilingual interns

Provide financial incentives to recruit or retain employees within the public mental health system:

- Financial incentives implemented
- Tracking for employee scholarship applicants

Incorporate the input of clients and family members of clients, and when possible, utilize them as trainers and consultants in public mental health WET programs and/or activities:

- Documented meetings with clients and family members
- Documented trainings facilitated by clients and family members

Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities:

- Documented meetings with diverse racial/ethnic populations

Establish regional partnerships:

- Participate in meetings

In FY 2021/2022, MHRS conducted a workforce analysis and needs assessment in conjunction with our Southern California Regional Partnership (SCRP) partners. The needs assessment determines workforce patterns and trends to assist in informing

the development on a new five-year plan, which can be used to increase recruitment and retention strategies, ensure the hiring of a culturally responsive workforce, and build interest in the public mental health field. The new WET five-year plan is programmed to be completed in 2022 and will include data on the utilization rates of the five new WET focus areas. The five new focus areas include recruitment and retention, pipeline development, scholarships, stipends and loan assumption programs. These five new focus areas were determined as a result of our Southern California Regional Partnerships (SCRP).

6-I-B: Compare the Workforce Needs Assessment data for the WET component of the Plan with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

MHRS is working on collecting information on the ethnic make-up of its workforce. The information provided below lists the clinicians in our workforce (County clinicians and combined County and Contracted Clinicians). The greatest disparity indicates the female workforce at 72.6% (County clinicians) and 75.8% (combined County and contracted clinicians). This is an overrepresentation of the 50.2% in the general population, and 50.6% of beneficiaries who received an approved service. Male clinicians represent 27.4 % of County clinicians and 24.1% (combined county and contracted clinicians), which is an underrepresentation of the 49.8% of males in the general Orange County population and the 49.4% of Medi-Cal beneficiaries who received an approved service.

Table 6.1 Current Workforce by Gender Fiscal Year 2021/2022

	Total Population[1]	*County Wide Estimated Population Living at or Below 200% FPL (Medi-Cal Clients)*[2]	*Average Number of Medi-Cal Eligibles per Month*[3]	*Medi-Cal Beneficiaries who Received an Approved Service per Year*[3]	*MHRS Workforce* (County Clinicians)	*MHRS Workforce (County & Contracted Clinicians)*
Total	3,209,272	692,000	954,394	23,310	759	3,229
Female	1,610,836	369,000	514,781	12,129	551	2,449
Percentage of Female	50.2%	53.4%	53.9%	50.6%	72.6%	75.8%
Male	1,598,436	322,000	439,612	11,818	208	780

Percentage of Male	49.8%		46.6%		46.1%		49.4%		27.4%	24.1%	
Other/Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0%

[1]*Department of Finance Population Statistics (2021)*

[2]*California Health Interview Survey (2020)*

[3] *Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '21, CA EQRO report 2022*

6-I-C: If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the Department's review of the WET component of its plan.

Not applicable

6-I-D: Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.

<u>Recruitment</u>

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

Additionally, through the Southern Counties Regional Partnership (SCRP) efforts to develop workforce pipelines and reach students in high schools and local colleges, career development handouts and brochures have been developed in partnership with Health Workforce Initiative (HWI) and will be distributed to all of the SCRP 10 Counties, including Orange County.

In an effort to attract candidates to Orange County Mental Health and Recovery Services positions, the Workforce and Education Training (WET) office developed a pamphlet called Workforce Education and Reimbursement Programs. This pamphlet has been distributed at hiring fairs and is available on our website as well as on the Human Resources recruiting website. This tool has also assisted current staff in locating scholarships and loan repayment programs which has become a retention tool as well.

Needs by Occupational Category

Across County-operated MHRS programs, there is a need to fill vacant positions among Public Mental Health Services (PMHS) 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 79% of the needed positions are currently filled. Comparing the number of filled to vacant positions, the greatest need was among Psychiatrists (Child and Adolescents, General), Psychiatric Mental Health Clinical Nurse Specialists, Mental Health Workers, and Behavioral Health Clinicians. MHRS plans to add Alcohol and Other Drug (AOD) certified counselors to the list of staff positions along with the creation of a Peer Support Specialist classification.

6.1 Number of PMHS Employees and Vacancies, August 2022[1]

	Total Number
Total Number of Current PMHS Employees	1,340
Total Number of PMHS Vacancies	366
Total Number of Current PMHS Direct Service Filled Positions	834
Total Number of Current PMHS Direct Service Vacancies	255

[1] *The total number of current PMHS direct service filled positions does not include Executive and Management staff (see table 6.2). The numbers presented in this table are reflective of only staff who provide direct services to the community.*

6.2 Currently Filled and Vacant MHRS Clinical Positions, August 2022[1]

	Number of Positions Filled	*Number of Vacancies*	*Total Number of Positions*
Behavioral Health Clinician	481	142	623
Mental Health Specialist	158	34	192
Licensed Clinical Psychologist	55	7	62
Mental Health Worker	53	16	69
Executive and Management Staff	52	5	57
Psychiatrist - Geriatric	28	5	33
Psychiatric Mental Health Nurse Practitioner	18	2	20
Psychiatric Mental Health Clinical Nurse Specialist	17	8	25
Psychiatrist - Child and Adolescent	17	6	23
Psychiatrist - General	0	3	3
Total	*879*	*228*	*1107*

[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.*

MHRS has a Peer Workforce Development Initiative (PWDI) that consults with the Director's Office to support and promote peer positions throughout MHRS. Currently, there are 53 employed peer specialists, and the PWDI is exploring ways to recruit and retain qualified peer workers.

6.3 Number of Peer Specialists Providing Services, August 2022

	Total Number
Number Employed	53
Number of Vacancies	16
Total Peer Positions Available	69

6-I-E: Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

The WET program experienced the following challenges for FY2021/2022:

- Competitive salary
- Lengthy process from application to onboarding
- Lack of availability of flexible schedules (including telecommuting)
- Burnout
- Competition for qualified staff with other systems
- Breakdown in behavioral health pipeline and career pathways
- Shortages in specific classifications (licensed therapists, psychiatrists, mental health specialists, and an absence of Certified Alcohol and Drug Counselor as a classification)
- Decentralized MHRS internship program

The WET program has taken the following actions to address the challenges:

- Developing behavior health expertise in primary care by using paraprofessional staff to develop the capacity of the system (including behavior health coaching)
- Develop core competencies and training plans (based on staff roles and responsibilities)
- Establish a behavior health career pipeline in collaboration with the K-12 system
- Partner with local higher education institutes to provide education that will enable workers to advance professionally
- Implement a leadership development program for staff working in MHRS
- Continue to provide relevant trainings offering free continuing education units (CE's)
- Centralize the coordination of supervision and internships

6-I-F: Identify County technical assistance needs.

There are no identified technical assistance needs at this time.

CRITERION 7: LANGUAGE CAPACITY

CLAS Standard: 5, 6 & 8

7-I: Increase Bilingual Workforce Capacity

7-1-A: Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

7-1-A-1: Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs:

MHRS is committed to providing culturally and linguistically appropriate services to our clients, and as such, aims to recruit bilingual and bicultural applicants, and retain bilingual and bicultural staff. The language skills needed are listed on job announcements in an effort to appeal to candidates with various backgrounds and language capacities.

In FY 2021/2022, MHRS employed 362 bilingual employees, accounting for 37% of the workforce.

The majority of bilingual staff speak Spanish (77.3%), but other languages spoken by staff include:

- Vietnamese
- Korean
- Farsi
- Arabic
- Cantonese
- Mandarin
- Tagalog
- ASL

7-I-A-2: Updates from the CSS or WET component of the county's Plan on bilingual staff members who speak the languages of the target populations.

Table: MHRS Bilingual Staff by Language and Skill Level for FY 2021/2022

Number of Bilingual Staff, by Position, August 2022

	Spanish	Vietnamese	Korean	Farsi	Arabic	Other	Grand Total
Behavioral Health Clinician I - II	127	17	11	4	6	1	166
Office Specialist	43	2	1	1	0	0	47
Mental Health Specialist	36	7	0	0	0	1	44
Mental Health Worker I - III	18	1	0	0	0	0	19
Service Chief I - II	13	4	0	0	0	0	17
Clinical Psychologist I - II	7	2	1	2	0	0	12
Office Technician	8	1	0	0	0	0	9
Health Program Specialist	3	0	2	0	0	1	6
Staff Assistant	4	2	0	0	0	0	6
Information Processing Technician	4	0	1	0	0	0	5
Psychiatrist	1	2	1	1	0	0	5
Office Assistant	3	1	0	0	0	0	4
Community Worker II	3	0	0	0	0	0	3
Comprehensive Care Nurse II	1	0	1	0	0	1	3
Program Supervisor I - II	1	0	0	2	0	0	3
Office Supervisor C - D	3	0	0	0	0	0	3
Staff Specialist	2	0	1	0	0	0	3
Community Health Assistant II	1	0	0	0	0	0	1
Contract Employee	1	0	0	0	0	0	1
Data Entry Technician	0	1	0	0	0	0	1
Information Processing Specialist	0	0	0	0	0	1	1
Nursing Assistant	0	0	0	0	0	1	1
Research Analyst IV	1	0	0	0	0	0	1
Supervising Comprehensive Care Nurse	0	1	0	0	0	0	1
Total	*280*	*41*	*19*	*10*	*6*	*6*	*362*

7-I-A-3: Total annual dedicated resources for interpreter services in addition to bilingual staff.

As mentioned in Criterion 1, MHRS utilizes Language Line for interpretation (telephonic and onsite) and translation services, and Accurate Communications for American Sign Language (ASL) services. These services

are budgeted based on utilization rates and estimates for each year. A contract for the agency-wide vendor, Language Line, is budgeted for up to $200,000 annually. For American Sign Language services, the budget is up to $300,000 agency-wide.

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 7.6 examine the interpretation and translation services utilized during FY 2020-21. During this fiscal year, the Multi-Cultural Development Program provided interpretation and translation services in-house. Language Line, the contracted vendor, also provided document translation and interpretation services. Additionally, American Sign Language (ASL) services were contracted through a vendor called Accurate Communications, Inc.

Starting in November of 2017, Language Line began providing telephonic interpretation services to several behavioral health programs across Orange County. In FY 2020-21, this program facilitated 4,317 calls, which accumulated to roughly 1,293.4 hours of telephonic interpretations (see Table 7.1). Additionally, most telephonic interpretation services provided during FY 2020-21 were in Spanish, followed by Vietnamese, Korean, Mandarin Chinese, and Farsi (see Table 7.2). In FY 2020-21, out of the 4,317 total calls, roughly 93% were made in one of those languages.

7.1 Total Number of Telephonic Interpretation Services Provided by Month, FY 2020-21

Month	Number of Calls	Minutes on Call	Facilitated Hours
July-20	318	5,830	97.2
August-20	323	5,735	95.6
September-20	324	5,738	95.6
October-20	344	6,311	105.2
November-20	302	5,392	89.9
December-20	321	5,995	99.9
January-21	304	5,301	88.4
February-21	361	7,054	117.6
March-21	439	8,198	136.6
April-21	496	8,888	148.1
May-21	424	6,803	113.4
June-21	361	6,359	106.0
Total	*4,317*	*77,604*	*1,293.4*

Source: Language Line Telephone Interpretation Report, FY 2020-21

7.2 Top Five Telephonic Interpretation Requests, FY 2020-21

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	2,823	47,270	787.8
Vietnamese	643	11,483	191.4
Korean	250	4,904	81.7
Mandarin	174	4,266	71.1
Farsi	106	2,597	43.3
Total	*3,996*	*70,520*	*1,175.3*

Source: Language Line Telephone Interpretation Report, FY 2020-21

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

7.3 Health Care Agency Programs to Request Telephonic Interpretation Services, FY 2020-21

	Number of Calls	Minutes on Call	Facilitated Hours
Mental Health & Recovery Services - Admin.	6	61	1.0
MHSA - Community Supportive Services - Adults	1036	16,023	267.1
MHSA - Community Supportive Services - Children	1306	26,006	433.4
MHSA - Prevention and Early Intervention	197	3,124	52.1
Adult Mental Heath Services - Outpatient/Crisis	318	5,901	98.4
Public Guardian	28	448	7.5
Children and Youth Services	1038	19,671	327.9
Alcohol and Drug Use Services	80	1,331	22.2
Correctional Mental Health	308	5,039	84.0
Total	*4,317*	*77,604*	*1,293.4*

Source: Language Line Telephone Interpretation Report, FY 20-21

Staff from the Multi-Cultural Development Program also helped to coordinate across HCA, as well as provided in-person interpretation services (see Table 7.4). In-person interpretation services were provided primarily in American Sign Language.

7.4 Hours for In-Person Interpretation Services, FY 20-21

	Number of Interpretations	Facilitated Minutes	Facilitated Hours
Requested by the Multi-Cultural Development Program			
American Sign Language	75	6,275.0	104.6
Requested by Health Care Agency Program(s)			
American Sign Language	199	26,190.0	436.5
American Sign Language & Spanish	10	1,200.0	20.0
Total	*284*	*33,665.0*	*561.1*

**Data was pulled from the two sources in the WET Interpretation Log and Accurate Communications Inc.*

Source: WET Interpretations Database, FY 20-21 and Accurate Communications Inc. Invoices FY 20-21

In 2020-21, several ASL interpretation services were provided by Accurate Communications, Inc. A total of 284 ASL interpretation services were conducted for various departments and programs throughout Orange County, which totaled to 561.1 hours of service (see Table 7.5).

7.5 Contracted American Sign Language Services Total Number of Hours by Type of Event, FY 2020-21

	Total Number of Services	Facilitated Minutes	Facilitated Hours
Services Facilitated for the Multi-Cultural Development Program			
Meeting	55	3,725.0	62.1
Training	18	2,400.0	40.0
Other	2	150.0	2.5
Services Facilitated for Health Care Agency Program(s)			
Clinical Sessions	99	11,910	198.5
Doctor Appointment	34	4,080	68.0
Evaluation / Assessment	25	3,000	50.0
Home Visit	3	360	6.0
Meeting	39	4,680	78.0
Training	8	3,240	54.0
Unknown Event Name	1	120	2.0
Total	*284*	*33,665.0*	*561.1*

Source: WET Interpretations Database, FY 20-21 and Accurate Communications Inc. Invoices FY 20-21

The Multi-Cultural Development Program also helped with the creation and review of document translations (see Table 7.6). This included PowerPoint presentations, brochures, and surveys that were used across MHRS. During FY 2020-21, document translation requests were primarily made for Vietnamese, Arabic, Korean, Farsi, and Chinese.

7.6 Document Translation Request by Threshold Language, FY 2020-21[1]

	Total Number	Percent
Vietnamese	82	22%
Arabic	75	20%
Korean	73	19%
Farsi	66	17%
Chinese[2]	49	13%
Spanish	32	8%
Other[3]	2	1%
Total	*379*	100%

[1] *All Canceled or No Reply Requests were removed from this analysis*
[2] *Includes Simplified Chinese/Mandarin or Traditional Chinese*
[3] *Other includes Khmer and Tagalog*
Source: WET Interpretations Log Database, FY 19-20

7-II: Provide Services to Persons who have Limited English Proficiency (LEP) by using Interpreter Services.

7-II-A: Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:

- **A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals.**

  MHRS provides and maintains 24-hour Access & Referral Lines for all clients. The line links callers to behavioral health services, responds to urgent conditions, and provides beneficiary problem resolution through grievances and appeals.

  - Medi-Cal clients seeking specialty mental health (SMH) services are directed to call the 24/7 Access Line at (800) 723-8641. Clients who speak a language other than English can call (866) 308-3074; TTY services are available at 866-308-3073.

- Drug Medi-Cal clients seeking Substance Use Disorder (SUD) services are directed to call the SUD Beneficiary Access Line at (800) 723-8641. Clients who speak a language other than English can call (855) 625-4657; TTY services are available at 714-834-2332.

Access & Referral Lines are equipped, and required to, provide language services and interpretation for all individuals through bilingual staff or through one of the six (6) contracted language services providers. It is the department's policy to ensure beneficiaries have access to appropriate linguistic services and ensure beneficiaries are made aware of these services offered for both mental health and substance use disorder services. This information is located in the Beneficiary Handbooks all members receive, and information is posted at all department locations. The Mental Health Plan Beneficiary Handbook and the Drug Medi-Cal Organized Delivery System Member Handbooks are posted on the MHRS Website https://www.ochealthinfo.com/providers-partners/county-partnerships/medical/mental-health-plan-and-provider-information in English, Spanish, Arabic, Farsi, Korean, Vietnamese, and large print. Additionally, these handbooks are available in an audio format as listening files in the aforementioned languages. Hard printed copies are available at all department locations. Below is a data sample of the MHP and SUD Utilization for the 24/7 Access Line from September through November 2021.

- **Consider use of new technologies such as video language conferencing. Use new technology capacity.**

The Multicultural Development Program, in conjunction with Behavioral Health Training Services, have utilized video interpretation for ASL interpreters. Additionally, interpretation rooms area available via Zoom during virtual meetings and trainings.

- **Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.**

MHRS has a phone line that individuals may call to access support and services. **OC LINKS Information and Referral Hotline** (1-855-OC-LINKS/625-4657) is a 24-hour hotline for individuals to call or chat online with a clinical navigator at www.ochealthinfo.com/oclinks. This is the behavioral health line for information, referral, crisis, and assessment. OC Links navigators serve at the Crisis Assessment Team dispatch as well.

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

- For **telephonic interpretation services** the service requester 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) interpretation services**, the service requester completes the *Onsite Interpreter Request Form* and emails it to: onsiterequests@fluentLS.com.
- For **documents translation services**, an email request can be sent to Language Line services at translation@languageline.com. A request can also be submitted through the website at: https://www.languageline.com/translation-localization-request.

- **Training for staff that may need to access the 24-hour phone line with statewide tollfree access so as to meet the client's linguistic capability.**

All MHRS staff receive training on how to access the 24-hour language phone line in order to meet the client's linguistic capability and are required to learn how to use this language line provided by the County's contracted provider. All instructions and service request forms are available on HCA's intranet page.

7-II-B: Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

Language posters are in each of the MHRS clinic waiting rooms to assist consumers and family members in asking for an interpreter in their preferred language. Clients are informed in writing, in their primary language, of their rights to language at no cost.

Outlined in 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." This means that all non-English or limited English-speaking persons have the right to receive services in their preferred language and can request an interpreter. If an interpreter is requested, one must be provided at no cost and people seeking services do not have to bring their own interpreters. Verbal interpretation of a client's rights, benefits and treatments is also available in one's preferred language. Information is provided in alternative formats if someone cannot read or has "visual challenges." The written

materials are available in Orange County's six threshold languages including Spanish, Vietnamese, Farsi, Korean, Arabic and Simplified Chinese as well as English.

7-II-C: Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

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.
Also, each client receives a client handbook which outlines the rights of clients to be provided an accommodation, such as an interpreter. MHRS has developed policies requiring that such assistance be provided. (Meeting Beneficiary/Client Language needs Policy 02.01.02).

7-II-C-1: Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.

Currently, there is no infrastructure in place for providing standardized feedback to the contract vendor. This is something we hope to look forward to exploring in order to improve services.

7-II-D: Share historical challenges on efforts made on the items A, B, and C above. Share lessons learned.

The need to have multi-lingual and multi-cultural staff available at each of the clinic sites, along with proper training for each staff member on the availability of language services and how to utilize these services.

7-II-E: Identify County technical assistance needs.

- Guidance on written/printed materials
- Shortage of in-person ASL interpreters
- Guidance on alternative formats for written information for individuals who are visually impaired

7-III: Provide Bilingual Staff and/or Interpreters for the Threshold Languages at all Points of Contact.

Note: The use of language line is viewed as acceptable provision of services only when other options are unavailable.

7-III-A: Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for the languages spoken by community.

Bilingual staff and interpreter vendors are available in languages spoken by the community. Front office staff greet the client and if they notice the client does not speak English, they point to the language poster that is available and visible to the client to identify the language needed. If there is a bilingual staff who speaks the client's language, they are called upon to provide interpretation. If not, staff use the Language Line for interpretation, and this is documented in the client's file.

7-III-B: Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.

Language posters are available and posted in a visible manner for clients to reference. Staff are trained to assist clients who speak a language.

7-III-C: Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

MHRS bilingual and contracted language services vendors are available during business hours in the county's threshold languages. MHRS bilingual staff proficiency is tested by the county Human Resources Department. Contract language vendors provide evidence of their staff's proficiency in threshold languages in their proposals to provide services and as requested by the county.

7-III-D: Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

To ensure MHRS bilingual staff are linguistically proficient, they must pass a verbal and written exam. This is done through the Human Resources Department. The testing

7-IV: Provide Services to all LEP Clients not Meeting the Threshold Language Criteria who Encounter the Mental Health System at all Points of Contact.

7-IV-A: Policies, procedures, and practices the county uses that include the capability to refer, and otherwise link, clients who do not meet the threshold language criteria (e.g., LEP clients) who encounter the mental health system at all key points of contact, to culturally and linguistically appropriate services.

The following is provided as part of Policy 02.01.02: Meeting Beneficiary/Client Language Needs:

When beneficiary/client's language needs fall outside the identified threshold languages, the following steps shall be taken to link the beneficiary/client to appropriate services:

A. Staff shall refer to the MHRS 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 beneficiary/client 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.

7-IV-B: Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Clients who do not met the threshold language criteria are appropriately linked to bilingual certified staff. If there is no staff available, MHRS staff will utilize the Language Line to provide appropriate language services. Table 7.1 above shows evidence of telephonic interpretation services.

7-IV-C: Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:

- **Prohibiting the expectation that family members provide interpreter services;**
- **A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and**
- **Minor children should not be used as interpreters.**

  The aforementioned criteria are addressed in multiple MHRS Policies, including, but not limited to: Policy 02.01.02: Meeting Beneficiary/Client Language Needs and Policy 02.01.07: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact.

CRITERION 8: ADAPTATION OF SERVICES

CLAS Standard: 12

8-I: Client-Driven/Operated Recovery and Wellness Programs.

8-I-A: List client-driven/operated recovery and wellness programs.

MHRS has three client driven/operated recovery and wellness centers:

1. Wellness Center South – located in Lake Forest
2. Wellness Center Central – located in Orange
3. Wellness Center West – located in Garden Grove

8-I-A-1: Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.

All of the Wellness Centers listed above accommodate for various ethnic and linguistic differences. Wellness Center West has a Vietnamese track that offers groups for that specific population. Additionally, bilingual staff offer Spanish groups s well. Wellness Centers Central offers programming in Spanish, Vietnamese, Korean, Japanese and Farsi, while Wellness Center South offers programming in both Farsi and Spanish.

In addition to language, each of the Wellness Centers listed above also has programming catered to Older Adults, TAY population, and LGBTQ+ community.

8-I-A-2: Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

Each of the Wellness Centers provides a wide range of groups and classes, several of which are racially, ethnically, culturally, and linguistically specific. Some examples of these groups are:

LGBTQ+ Share & Care Support Group – provides an open-minded, helpful, safe, and kind environment and atmosphere for LGBTQ+ community to discuss their successes and concerns exclusive of outside influence.

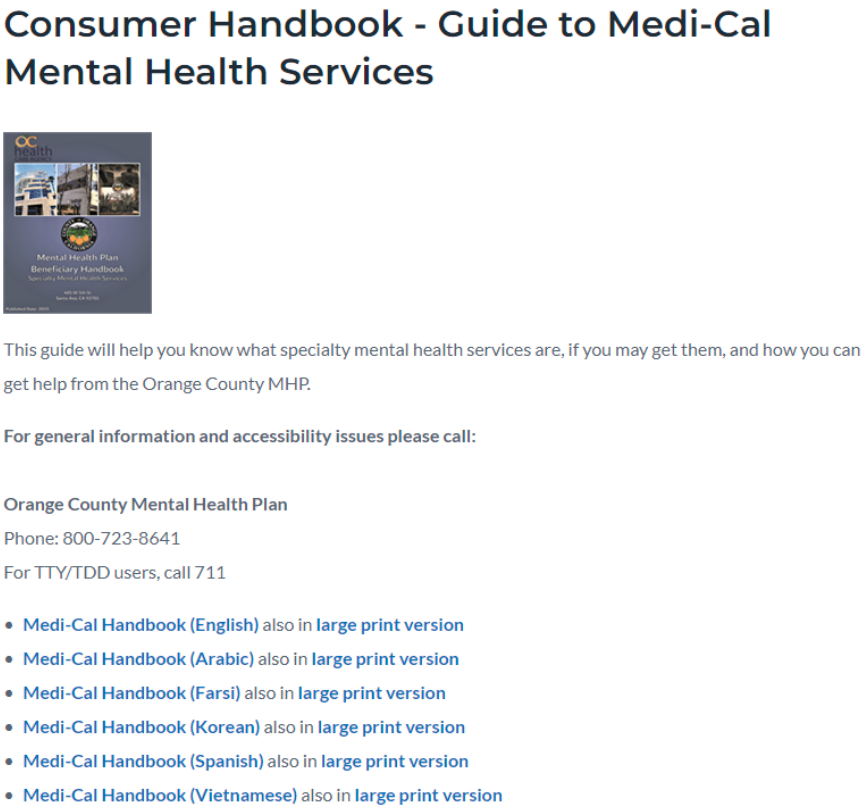
Other specific, client-driven groups include:

- Our Stories-TAY Art Workshop
- Men's Group
- Women's Group
- Tai Chi
- West African Drumming

8-II: Responsiveness of Mental Health Services

8-II-A: Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, nontraditional mental health provider.

The MHRS website includes a link to the Online Provider Directory for both MHP and DMC-ODS. The Medi-Cal Provider Directory is listed on the website and is available electronically as well as in hard copy to beneficiaries. This is available in all threshold languages, in both regular and large print.



Consumer Handbook - Guide to Medi-Cal Mental Health Services

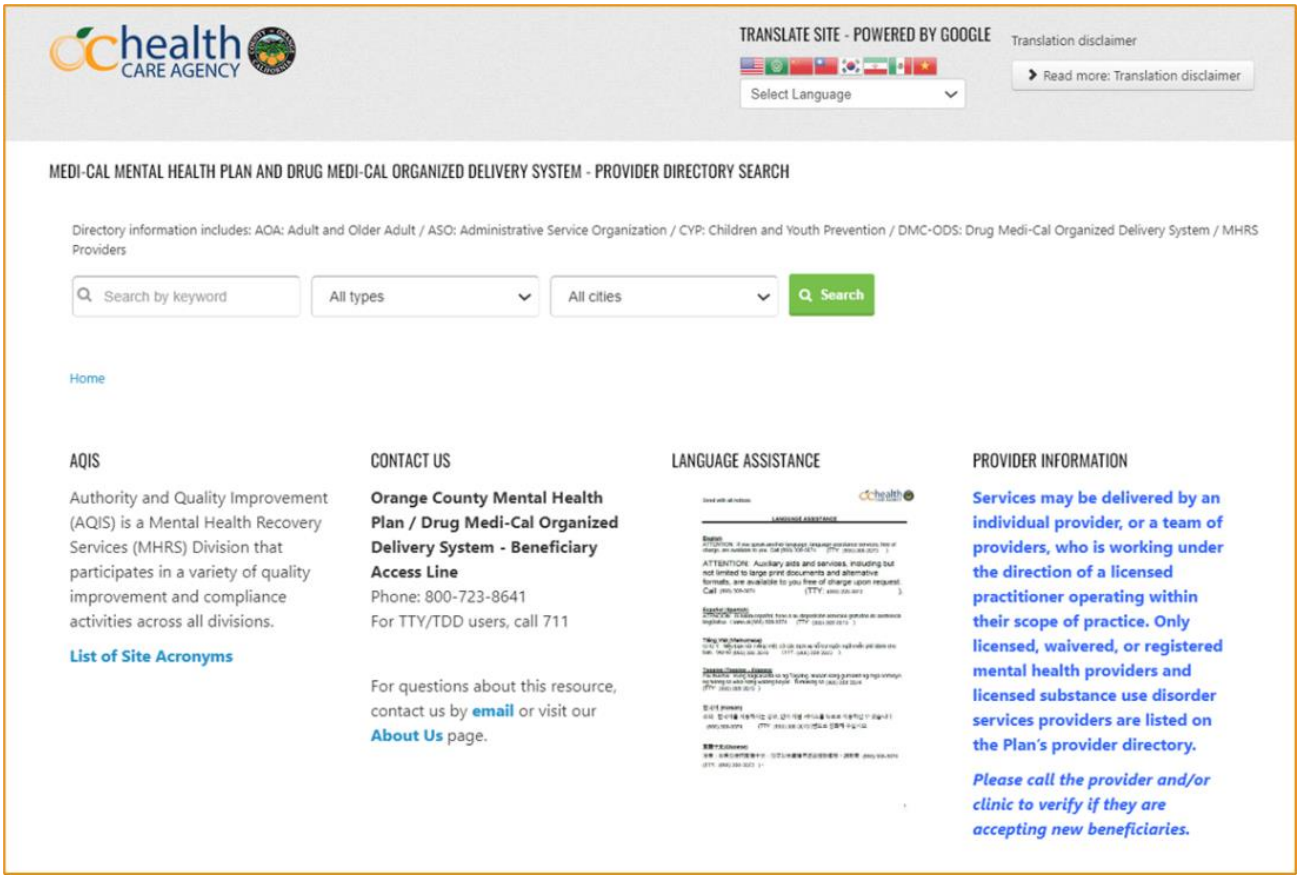
This guide will help you know what specialty mental health services are, if you may get them, and how you can get help from the Orange County MHP.

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**

Hyperlink to the Online Provider Directory: www.ochealthcareagency.com/mhp-dmcods



Provider Directory Booklet:

MHP: https://www.ochealthcareagency.com/mhp/

DMC-ODS: https://www.ochealthinfo.com/providers-partners/authority-quality-improvement-services-division-aqis/quality-assurance-18

8-II-B: Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.

The Member Services Brochure and Provider Directories contain information on the availability and location of all providers. A link to these materials is available on the website, which is posted in each of the lobbies in all threshold languages.

8-II-C: Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. (Outreach requirements as per Section 1810.310, 1A and 2B, Title 9):

MHRS publishes and maintains the Medi-Cal Beneficiary Handbook for both specialty mental health services as well as services under the Drug Medi-Cal Organized Delivery System (DMC-ODS). These handbooks include information on the scope and nature of services provided, as well as information on how to access these services.

- Policy 01.03.06 (Access Criteria for Specialty Mental Health Services)
- Policy 01.03.07 (Access Criteria for Drug-Medi-Cal Organized Delivery System)

8-II-D: Evidence that the county has assessed factors and developed plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services. Such factors should include:

- Location, transportation, hours of operation, or other relevant areas; Cultural Competency Plan Update Fiscal Year 2020-2021 101.

- Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and

- Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

Transportation:

- The Transportation program 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 or primary care appointments or select supportive services (particularly housing-related). Individuals are referred by their MHRS treatment provider, following an assessment of their transportation needs and history of scheduled appointments missed due to transportation issues.

- Transportation services are offered Monday through Friday for most behavioral health programs, and seven days per week for the County's CSU's and Royale Therapeutic Residential Center. 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 a 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 can also stop and get their prescriptions filled as necessary. Transportation services have also been authorized for use by both CSS and PEI field outreach teams for a one-time use to link participants served in the field to their initial behavioral health appointments. In addition, Transportation services are also used to link participants being discharged from the County and County-contracted Crisis Stabilization Units or Royale Therapeutic Residential Center to their follow-up appointments at either of the County's Open Access clinics. CSU's and RTRC, staff make the transportation arrangements on behalf of clients, and those clients will be assessed at their permanent clinical homes for future authorization for the use of Transportation Services and the ability to make their own arrangements.

Test Calls:

- Policy 06.02.01 (Test Call Procedure for Monitoring Administrative Service Organization (ASO) Access Quality and Compliance. MHRS monitors the Beneficiary Access Line (BAL) and their compliance with their regulations and quality of the services they provide. Test calls are conducted quarterly and assess the following areas:

- Responsiveness of the Access Line 24-hours a day, seven days a week;
- Access to afterhours care;
- Knowledge and helpfulness of the access line staff; and
- Recording of the call on the Telephone Access Log. Calls made in threshold languages are to test response capability to non-English languages.

Family Resource Centers

Orange County has 16 Family Resource Centers (FRCs) located throughout the county. These FRC's are an example of non-threatening settings that reduce stigma and offer a variety of prevention and early intervention services supporting the health and wellness of individuals and families. FRC locations within local communities allows services to be tailored to the specific needs and cultural requirements of individualized communities. Every FRC provides six core services: (1) parenting classes, (2) counseling, (3) information and referral, (4) family support services, (5) case management, and (6) domestic violence personal empowerment program.

8-III: Quality of Care: Contract Providers

8-III-A: Evidence of how a contractor's ability to provide culturally competent mental health services is taken into account in the selection of contract providers, including the identification of any cultural language competence conditions in contracts with mental health providers.

Orange County's commitment to ensure that services are culturally competent is also documented in provisions that have been incorporated into MHRS provider contracts. Below is standard language in all MHRS 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 MHRS 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 every reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e., the unserved and underserved. In the staffing section of P&I contracts, additional language is used, such as, "Contractor shall make its best effort to include bilingual/bicultural services to meet the diverse needs of the community threshold languages as determined by County. Whenever possible, bilingual/bicultural staff should be retained. Any staffing vacancies occurring at a time when bilingual and bicultural composition of the staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless Administrator consents."

8-IV: Quality Assurance Requirement

A description of current or planned processes to assess the quality of care provided for all consumers under the consolidation of specialty mental health services. The focus is on the added or unique measures that shall be used or planned in order to accurately determine the outcome of services to consumers from diverse cultures including, but not limited to, the following:

8-IV-A: List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.

Authority & Quality Improvement Services (AQIS) is a MHRS function area that supports programming in the other two MHRS function areas: Adult and Older Adult Behavioral Health (AOABH) and Children, Youth and Prevention Behavioral Health (CYPBH) Services. It supports MHRS' 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. 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.

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:

1. Service Satisfaction
2. Accessibility of services
3. Service quality/cultural appropriateness
4. Participation in treatment planning
5. General satisfaction
6. Service Outcomes
7. Perception of outcomes
8. Functioning
9. Social connectedness

8-IV-B: Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and its culturally and linguistically competent services.

While the Workplace Wellness Advocacy Program sends out a survey measuring recovery orientation in various worksites – this survey is completed by the identified Workplace Wellness Advocate(s) after speaking to staff and supervisors/managers. In the upcoming year, the Office of Equity will collaborate with WWA to include cultural diversity in its workforce and measure the perception of staff towards culturally and linguistically competent services at their specified sites.

Additionally, monthly townhall meetings are held with the Chief of MHRS and serves as an opportunity to provide feedback to leadership.

8-IV-C: Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

The beneficiary problem resolution process for grievance and complaint/issues are as follows: In this section we describe our beneficiary problem resolution processes

that are culturally and linguistically appropriate to identify, prevent, and resolve Grievance and Appeals.

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 on your behalf, 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 - BHS Medi-Cal Provider Information | Orange County, California - Health Care Agency (ochealthinfo.com)

The Authority and Quality Improvement Services (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 can 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, TURN Behavioral Health Services to provide Patients' Rights Advocacy 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 Orange County Patients' Rights Advocacy Services - MHS/TURN (turnbhs.org)

Once the investigator/advocate is assigned 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 and counselors 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 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.

The PRAS provides notice in signage, translated materials, and other media about their mental health rights, 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.

The 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 with Mental Health Systems TURN Behavioral Health Services 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 Orange County Patients' Rights Advocacy Services - MHS/TURN (turnbhs.org).

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 can 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.

APPENDIX I: POLICIES AND PROCEDURES GOVERNING CULTURAL COMPETENCE

Policy 02.01.01 - Cultural Competency

Health Care Agency **Mental Health and** **Recovery 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 Mental Health and Recovery Services	_Signature on File_	__2/14/2023___

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 Mental Health and Recovery Services (MHRS) County and County Contracted providers shall be culturally competent.

SCOPE:

This policy applies to all functions of MHRS 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, Mental Health and Recovery Services, Cultural Competency Plan Updated, 2022

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)

SUBJECT: Cultural Competency

PROCEDURES:

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

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

III. All MHRS 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 MHRS 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.

Policy 02.01.02 - Meeting Beneficiary/Client Language Needs

Health Care Agency **Mental Health and** **Recovery 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 Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Meeting Beneficiary/Client Language Needs

PURPOSE:

To ensure that beneficiaries/clients have access to linguistically appropriate services through staff or interpreters proficient in the beneficiary/client's primary language.

POLICY:

All Mental Health and Recovery Services (MHRS) beneficiary/clients shall have access to linguistically appropriate services.

SCOPE:

These procedures apply to all MHRS 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

PROCEDURE:

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

II. Each MHRS clinic will have available a MHRS Staff Bilingual Directory of Linguistically proficient staff/interpreters throughout MHRS. This MHRS Staff Bilingual

Directory shall be updated at least every two years. The Multicultural Development Program may be contacted for the updated MHRS Staff Bilingual Directory.

III. Each MHRS 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 beneficiary/client's language needs fall outside the identified threshold languages, the following steps shall be taken to link the beneficiary/client to appropriate services:

A. Staff shall refer to the MHRS 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 beneficiary/client 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, MHRS will:

A. At least every other year, all MHRS 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 MHRS Staff Bilingual Directory using only those staff with cultural/linguistic proficiencies that are supported by current survey documentation.

Policy 02.01.03 - Distribution of Translated Materials

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

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

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:

Mental Health and Recovery Services (MHRS) is committed to providing beneficiaries/clients with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.

SCOPE:

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

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, 2022.

FORMS:

Mental Health Plan Consumer Handbooks

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

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 beneficiaries/clients.

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 beneficiaries/clients at each location.

IV. Mental Health Plan Provider Directory in the appropriate threshold language shall be offered to beneficiaries/clients during the initial intake to each clinic or upon request.

Policy 02.01.04 - MHP and DMD-ODS Provider Directory

Health Care Agency **Mental Health and** **Recovery 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 Mental Health and Recovery Services	_Signature on File__	_2/14/2023___

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) Mental Health and Recovery Services (MHRS) will receive and/or have access to a copy of the appropriate Provider Directory.

SCOPE:

This policy pertains to all MHRS 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 2022

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

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

Page 1 of 4

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);

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.

Policy 02.01.05 - 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

SUBJECT: Field Testing of Written Materials

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, BHS Cultural Competency Plan, Update, 2010

California Welfare and Institutions Code, Division 9, Part 3, Chapter 8.8, Article 5, 14684

FORMS:

Publication Field Test Feedback Sheet

PROCEDURE:

I. Each BHS Program is responsible for notifying the Multicultural Development Program (MDP) when new or altered forms and/or documents need translation.

II. MDP translates the forms or send to a contractor for translation into threshold languages.

III. Upon translation of forms, the MDP will, when available, have the document reviewed for accuracy of translation.

IV. Upon completion of translation, the MDP shall field test the document.

V. MDP staff shall coordinate obtaining assistance from consumers, family members, or significant others. Each shall participate in field testing the written material and compete a brief questionnaire documenting their ability to understand the written material.

VI. After feedback has been received, the MDP and Authority and Quality Improvement Services (AQIS) shall analyze the results of the submitted questionnaires and make appropriate changes if needed.

VII. Feedback regarding any recommended changes shall be given to the respective programs. Once changes have been implemented, the document shall be stamped "Field Tested and Approved by the Multicultural Development Program."

Policy 02.01.06 - 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.

Policy 02.01.07 - Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.07 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Meeting Deaf and Hard of Hearing Language Needs at Key Points of Contact

PURPOSE:

To ensure that all Deaf and Hard of Hearing Medi-Cal beneficiaries receiving services in Orange County Mental Health and Recovery Services (MHRS) within the Mental Health Plan (hereby referred to as Orange MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) have access to linguistically appropriate services through staff or interpreters proficient in beneficiary's primary language, e.g., American Sign Language (ASL). This policy also applies to non-Medi-Cal clients receiving services within MHRS.

POLICY:

All MHRS beneficiaries/clients shall have access to linguistically appropriate services.

SCOPE:

This policy apply to all functions of MHRS County and County contracted programs involved in the linkage and treatment of beneficiaries/clients receiving services.

REFERENCES:

Code of Federal Regulations (CFR), Title 28, Part 35, ADA of 1990

California Code of Regulations (CCR), Title 9, Chapter 11, Section 1810.410 (a) (2) (b) (e) (3)

DMH Information Notice No. 02-03 Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services-Cultural Competence Plan Requirements

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURE:

I. As defined in the Orange MHP and in the DMC-ODS, each service site is considered a key point of contact for Orange County.

II. Auxiliary aides must be made available to Deaf and Hard of Hearing beneficiaries/clients. Aides to be used will be determined in consultation with the beneficiary/client to determine what aide(s) is (are) the best fit. These aides may include but are not limited to the following:

A. Qualified sign language interpreter

B. Note takers

C. Screen readers

D. Written materials

E. Telephone handset amplifiers

F. Assistive listening systems or devices

G. Hearing aid-compatible telephones

H. Communication boards

I. Open or closed captioning, including real-time captioning

J. Video remote interpreting services (VRI)

K. voice, text and video-based telecommunication products and systems

L. Videotext displays

M. Description of visually presented materials

N. Exchange of written notes

O. Video relay services

P. Other effective methods of making orally delivered materials available to the Deaf and people who are hard of hearing.

III. For Non-Emergency Sign Language Interpreting Service, the MHRS County staff shall contact the MHRS contracted interpreting agency (current agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation - Instructions) with requests for ASL interpreters during routine clinic hours. The Deaf Services Coordinator may be contacted for assistance with the request procedure if needed. A short notice fee will be applied by the contracting agency, if a request is made in less than 72 hours for non-emergency counseling services. County Contracted providers will need to contract with an interpreting agency to arrange for Non-Emergency Sign Language Interpreting Services.

IV. For Emergency Sign Language Interpreting Service when the primary MHRS contracted agency is unable to provide services or is unavailable, if the immediate need arises during the day, on a weekend, or after hours, the staff shall contact a secondary interpreting agency. (Secondary interpreting agency information available at HCA Forms under MHRS Forms-Language Service ASL Interpretation-Instructions). The Deaf Services Coordinator may be contacted for assistance with the request procedure during business hours, if needed. The higher fees are applied to all emergency cases. County Contracted providers will need to contract with an interpreting agency to arrange for Emergency Sign Language Interpreting Services.

V. Each key point of contact in MHRS shall be provided with a roster of linguistically proficient staff/interpreters throughout the Health Care Agency (HCA). This language roster shall be updated annually.

VI. Clinics with deaf or hard of hearing staff are familiar with and able to utilize Video Relay Services (VRS) in order to take calls or make calls to deaf or hard of hearing beneficiaries/clients in Orange County. Any caller using the deaf or hard of hearing's videophone numbers will be automatically connected to VRS.

VII. Initial access logs maintained at the service sites shall indicate whether an interpreter was needed and the response to offers of interpreting services.

VIII. Signage shall be posted at each MHRS County and County Contracted clinic indicating interpreting Services for the Deaf and Hard of Hearing are available free of charge to each beneficiary.

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

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

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

Policy 02.06.02 - Informing Materials for Mental Health Plan Beneficiaries/Clients and Intake/Advisement Checklist

Health Care Agency **Mental Health and** **Recovery 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 Mental Health and Recovery Services	Signature on File	2/22/2023	

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

PURPOSE:

To provide County of Orange Mental Health and Recovery Services (MHRS) beneficiaries/clients 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 beneficiaries/clients of the Orange County Mental Health Plan (MHP) and will be followed by all Mental Health and Recovery Services (MHRS) County and County Contracted staff providing Specialty Mental Health Services (SMHS).

REFERENCES:

MHRS P&P 02.06.01 Advance Directives

MHRS P&P 02.05.01 Notice of Privacy Practices

Title 42, Code of Federal Regulations (CFR),§422.128

FORM:

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

PROCEDURE:

I. All newly admitted beneficiaries/clients 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)

C. The MHP Beneficiary Handbook

D. MHP Provider Directory

II. If, at the time of admission, the beneficiary/client is unable to accept and utilize these materials due to the beneficiary/client's emotional condition, then the information shall be given as soon as the beneficiary/client 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. MHRS Staff shall provide the materials in the appropriate language and/or format to meet the beneficiary/client's needs.

V. MHRS Staff shall actively inquire of each newly admitted consumer whether the beneficiary 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 beneficiary is admitted for mental health services. MHRS Staff shall:

1. Inquire and document the language in which the beneficiary/client would like to receive the informing materials.

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

a) Have the beneficiary/client document by checking "yes" or "no" to this question.

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

a) The MHP Beneficiary Handbook

b) MHP Provider Directory

c) Notice of Privacy Practices (NPP)

d) Completed Receipt of the Notice of Privacy Practices

e) Car Seat Regulation

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

VII. Advance Directives

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

B. All beneficiaries/clients 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 MHRS staff shall place the update in the beneficiary's record (reference MHRS P&P 02.06.01 Advance Directives).

VIII. Signatures

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

Policy 03.01.03 - Trainings Specifically Pertaining to Cultural Competency

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

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

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.

BY LAWS

Orange County Behavioral Health Equity Committee
BYLAWS

Adopted July 2021

ARTICLE I

Name

The name of this board shall be THE ORANGE COUNTY BEHAVIORAL HEALTH EQUITY COMMITTEE, hereinafter referred to as the "BHEC"

ARTICLE II

Section 1:

Authority and Purpose

The BHEC is authorized by the State of California through […] supporting Criterion #4 of the Cultural Competence Plan—

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

Rationale: A culturally competent organization views responsive service delivery to a community as a collaborative process that is informed and influenced by community interests, expertise, and needs. Services that are designed and improved with attention to community needs and desires are more likely to be used by patients/consumers, thus leading to more acceptable, responsive, efficient, and effective care (CLAS, Final Report).

Section 2:

In accordance with applicable federal and state statutory and regulatory requirements, the BHEC shall:

a. Act in an advisory capacity to the Director of Behavioral Health Services, hereinafter referred to as "Behavioral Health Services."
b. Review, evaluate and make recommendations regarding the community's mental health needs, services, facilities, and special problems, keeping the goals of the BHEC as priority.

c. Review and approve the procedures used to ensure diverse stakeholder involvement in all stages of the County's mental health planning process.
d. Provide an annual report to the Director of Behavioral Health Services
e. Develop the Cultural Competence Plan update and oversee its implementation by BHS

Section 3:

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

a) Strategically addressing equity among 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.
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 – both county and contracted programs.

Section 4:

The BHEC will strive to work in a manner that is consistent with the following 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.

ARTICLE III

Membership

Section 1:

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

Section 2:

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.

Section 3:

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.

Section 4:

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.

ARTICLE IV

Officers

Section 1:

a. **Co-Chairs:** There shall be two Co-Chair positions. These shall be one **Behavioral Health Services Co-Chair** position filled by the Behavioral Health Services Director or a designated representative from Orange County Health Care Agency, Behavioral Health Services and one **Community Co-Chair**, selected by the BHEC community members 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 of BHEC community steering committee members 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.

Section 2:

Meetings: Meetings will be co-led by the Co-Chairs with Co-Chairs alternating in facilitating agenda items and jointly developing the agenda prior to the meeting. A consensus process will be used for making decisions as illustrated in Exhibit A. In the event a decision cannot be reached through this process, then a deliberative discussion will be conducted using Rosenberg's Rules of Order as published by the California League of Cities.

Community members will have opportunities to attend quarterly steering committee meetings and participate through polls/chat, and provide public comments as directed by Co-Chairs.

ARTICLE V

Committees

The Co-Chairs shall appoint members of standing committees, such as ad hoc,task force, work group, or other entities as necessary to carry out the responsibilities of the BHEC.

Section 2:

There shall be a Steering Committee comprised of the Co-Chairs, Committee Chairpersons, and others as appointed by the Co-Chairs. The Steering Committee shall carry out any responsibilities delegated to it by the BHEC and act in emergencies in any way it deems necessary when there is not time for the entire BHEC to act.

Section 3:

Committee chairs or their delegates shall report to the BHEC at least once a month.

ARTICLE VI

Meetings

Section 1:

General meetings shall be held each month, the time and place to be announced prior to adjournment of the preceding meeting.

Section 2:

Special meetings may be held by giving 48-hour notice to all members at the call of the Co-Chairs or of a majority of the BHEC.

Section 3:

All meetings will be open to the public as much as possible.

Section 4:

A simple majority of the BHEC shall constitute a quorum and a vote of a simple majority of that quorum shall constitute a vote of the BHEC when a decision cannot be reached by consensus through the process outlined in Exhibit A.

Section 5:

All general meeting Agenda items which require a vote of the BHEC must be submitted to the Chairperson one (1) week in advance of the meeting.

ARTICLE VII

Adoption and Amendment

Section 1:

These Bylaws and amendments thereto shall be recommended to the BHEC by the Steering Committee.

Section 2:

Amendments to the bylaws may be introduced and voted upon by the BHEC at a regular meeting so long as such amendments are e-mailed to all members at least one (1) week in advance of the meeting.

APPENDIX III: SAMPLES OF TRAINING EVALUATION FORMS

Cultural Competence 3.0 Online Training Survey

Orange County Health Care Agency
MHSA Office Division
Behavioral Health Training Services

Training:	**Cultural Competency Training 3.0 - Addressing Unconscious Bias in the Workplace**
Presenter(s):	Various
Date:	Ongoing
Time:	Ongoing
CE or CME Credits:	None

[Adjust instructions as needed depending on if CEs/CMEs are being given]
Instructions: This year's training fulfills the State of California's requirement for a Cultural Competency training to be completed by each County- and Contract-operated BHS staff member. To receive credit for this online training, please complete the mandatory evaluation form. Your input, which shall remain anonymous, will help us determine the effectiveness of this training and improve training program quality. Following the evaluation, you will be directed to a credit documentation form and will then be able to access the certificate.

1. **How much did you learn as a result of this training? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Very Little ☐ 2 ☐ 3 ☐ 4 ☐ 5- Great Deal

2. **How useful was the content of this training for your practice or other professional development? [For trainings where CEs are not provided, change 'CE program' to 'training']**
   ☐ 1- Not Useful ☐ 2 ☐ 3 ☐ 4 ☐ 5- Extremely Useful

3. **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

4. **What changes do you intend to make, if any?**
   _____

5. **What barrier(s) do you expect to encounter in your attempts at change? *Please select all that apply.***
   ☐ No barriers ☐ Not ready to make changes ☐ No time to apply/practice new changes
   ☐ Change is not possible in current condition/system ☐ Other (please specify): _____

6. **Educational trainings should be free of marketing or sales of products or services. This type of *bias* is defined as the promotion or sale of products or services that serves one's professional or financial interests. How much bias was presented during this educational training?**
   ☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very high

7. **What was most useful and/or helpful to you with this training? *Please select all that apply.* [PRE-RECORDED TRAININGS]**
   ☐ The training was easy to follow ☐ The training information ☐ The length of the training
   ☐ The resources provided ☐ Other (please specify) _____

8. **Please rate the quality of today's training: [REQUIRED]**

	Poor	Fair	Good	Very Good	Excellent	N/A
The information discussed during the training.	☐	☐	☐	☐	☐	☐
The training promotional material was informative and accurate (e.g., flyers).	☐	☐	☐	☐	☐	☐
Visuals aids (e.g., slides, handouts, videos, pictures).	☐	☐	☐	☐	☐	☐
Audio/Sound used during the training.	☐	☐	☐	☐	☐	☐

Revised 6-11-2021 AP

PLEASE ALSO COMPLETE THE REVERSE SIDE. Thank you.

The location of the training met my needs.	☐	☐	☐	☐	☐	☐
The location where I took the training was comfortable and accessible.	☐	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐	☐

9. **Based on your experience(s) today, please select how much you agree or disagree with the following statements regarding the quality of the training: [PRE-RECORDED TRAININGS]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
Delivery of information was clear.	☐	☐	☐	☐	☐
The training was engaging/kept my interest.	☐	☐	☐	☐	☐
The online training clearly outlined presenter/staff contact information in case there were follow-up questions.	☐	☐	☐	☐	☐
Information was presented in a fair and balanced manner.	☐	☐	☐	☐	☐
Information presented was current.	☐	☐	☐	☐	☐
Information presented was accurate.	☐	☐	☐	☐	☐
The training was easy to navigate (going from one section of the training to another, being able to go back, if needed).	☐	☐	☐	☐	☐
Enough time was provided to reflect on the topics that were presented.	☐	☐	☐	☐	☐
The presenter(s) communicated knowledge of the subject.	☐	☐	☐	☐	☐

10. **Based on my experience(s) with this training: [REQUIRED]**

	Strongly Disagree	Disagree	Agree	Strongly Agree	N/A
I would recommend this training to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during this training.	☐	☐	☐	☐	☐
Overall, I am satisfied with this training.	☐	☐	☐	☐	☐

11. **Please provide any comment(s) about your experience and/or suggestions for this training.**

_____

PARTICIPANT INFORMATION

1. **Of the Behavioral Health (BH) personal or community roles listed below, which ones do you best identify with? *Please select all that apply.***

- ☐ Advocate for BH clients/services
- ☐ Consumer of BH services
- ☐ Community Member / General Public
- ☐ Caregiver of someone with a BH condition
- ☐ Parent of someone with a BH condition
- ☐ Other Family Member of someone with a BH condition
- ☐ I do not identify with any of these roles

2. **BHTS would like to know why you are attending today's training. Of the licensed or unlicensed occupations listed below, which ones were you seeking professional development for? *Please select all that apply.***

- ☐ Physician (MD)
- ☐ Registered Nurse (RN)
- ☐ Psychologist
- ☐ LCSW
- ☐ LMFT
- ☐ LPCC
- ☐ Case Manager
- ☐ CADC/CATC/RAS
- ☐ Intern
- ☐ Peer Support Worker
- ☐ Faith-based Partner
- ☐ School Counselor
- ☐ Teacher
- ☐ Unlicensed Staff (e.g., Associates)
- ☐ Other Licensed Staff
- ☐ Not a Service Provider

AGE

3. **What is your age?**

☐ 18-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

RACE / ETHNICITY *(Please select ALL of the race and ethnicity categories you identify with.)*

4. **What is your race/ethnicity?**

- ☐ American Indian / Alaska Native
- ☐ African / African American / Black
- ☐ Asian
- ☐ Pacific Islander
- ☐ Latino / Hispanic
- ☐ White / Caucasian
- ☐ Decline to State
- ☐ Other (please specify): _____

LANGUAGE – PRIMARY / PREFERRED

5. **What is your primary language?**

- ☐ Arabic
- ☐ Cantonese
- ☐ Korean
- ☐ Tagalog
- ☐ Armenian
- ☐ English
- ☐ Mandarin
- ☐ Vietnamese
- ☐ ASL
- ☐ Farsi
- ☐ Russian
- ☐ Other _____
- ☐ Cambodian
- ☐ Khmer
- ☐ Spanish
- ☐ Decline to State

GENDER INFORMATION *(Please select ONE that best describes you.)*

6. **What is your current gender identity?**

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State

☐ Questioning or unsure of gender identity ☐ Another gender identity _____

Community & Agency Staff Training (WET) Evaluation Form

Training: Cultural Competency Training 3.0 – Follow Up Form

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

2. **What is your supervisor's name (Last, First)? [REQUIRED]**

3. **What is your supervisor's email address? [REQUIRED]**

4. **Are you currently employed by a County Agency or a Community-Based Organization/Contractor (Please select ONE)? [REQUIRED]**
   - ☐ County Agency **[Complete Question 2-5 as applicable, then Skip to Question 8]**
   - ☐ Community-Based Organization/Contractor **[Skips to Question 6]**
   - ☐ I do not work for a County Agency or a Community-Based Organization/Contractor **[Skips to Question 8]**

5. **[IF *COUNTY* IS SELECTED]: At which County Agency do you currently work? [REQUIRED]**
   - ☐ Orange County CEO
   - ☐ District Attorney
   - ☐ Sheriff-Coroner
   - ☐ Office of Independent Review
   - ☐ Probation
   - ☐ Interim Public Defender
   - ☐ Child Support Services
   - ☐ Health Care Agency
   - ☐ OC Community Resources
   - ☐ Social Services Agency
   - ☐ John Wayne Airport
   - ☐ OC Public Works
   - ☐ OC Waste & Recycling
   - ☐ Assessor
   - ☐ Auditor-Controller
   - ☐ Clerk-Recorder
   - ☐ Treasurer-Tax Collector
   - ☐ Clerk of the Board
   - ☐ County Counsel
   - ☐ Internal Audit
   - ☐ OC Ethics Commission
   - ☐ Registrar of Voters
   - ☐ Other

6. **[IF *HEALTH CARE AGENCY* IS SELECTED]: In which HCA Department do you currently work? [REQUIRED]**
   - ☐ Executive Office
   - ☐ Administrative Services
   - ☐ Mental Health & Recovery Services
   - ☐ Public Health Services
   - ☐ Regulatory / Medical Health Services
   - ☐ Correctional Health Services

7. **[IF *BEHAVIORAL HEALTH SERVICES* IS SELECTED]: What is the name of your division and program? [REQUIRED]**

Name of your Division (e.g., CYBH, P&I)	Open-ended response
Name of your Program (e.g., CAT, CCSS)	Open-ended response

8. **[IF *COUNTY* IS SELECTED]: What is your role within your program? [REQUIRED]**
   - ☐ Manager/Supervisor
   - ☐ Administrative Staff
   - ☐ Direct Service Provider
   - ☐ Office/Support Staff

9. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is the name of the Agency/Program you work for? [REQUIRED]**

   Open-ended response

10. **[IF *COMMUNITY-BASED ORGANIZATION/CONTRACTOR* IS SELECTED]: What is your role within your Agency/Program? [REQUIRED]**
    - ☐ Manager/Supervisor
    - ☐ Administrative Staff
    - ☐ Direct Service Provider
    - ☐ Office/Support Staff

By clicking the statement below, I attest to having viewed/completed: **[REQUIRED]**

- All 14 micro-learnings through Cornerstone Cares
- TED Talk by Verna Myers
- Implicit Association Test
- Article Titled "How to Identify and Mitigate Unconscious Bias in the Workplace"

☐ I understand and agree to the statements above.

APPENDIX IV:

List of Culturally Competent Trainings

Training Title	*Date(s)*	*Training Description*
2021 Virtual Meeting of the Minds Mental Health Conference by Various Presenters	17-Jun-21	The Meeting of the Minds Mental Health Conference is dedicated to raising awareness surrounding mental health, amplifying voices of those with lived experiences, increasing cultural sensitivity, and enhancing skills to improve patient care. This conference is also designed to enhance the skills of clinicians in addressing the various needs of the participants they serve—taking into consideration various cultural needs and expectation. The conference also provides people with lived experience a chance to voice their concerns related to their care and to learn the "why" regarding the reasons clinicians work with them.
Adult Mental Health First Aid by Certified Mental Health First Aid Trainers	05-Jun-21 11-May-21 21-Apr-21 27-Feb-21	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.
Building the Beloved Community Through Cultural Humility (CIBHS) by Gloria Morrow	05-Apr-21	Society has been significantly impacted by 4 major pandemics, COVID-19, economic distress, political chaos, and racial injustice. These pandemics taken together have increased the need for behavioral health services, especially for diverse communities. Therefore, it is critical for directors of behavioral health services to understand and embrace their role as leaders by embracing and promoting the 3 pillars of diversity, equity, and inclusion to prepare the environment and workflow for more effectively meeting the behavioral health needs of a diverse clientele. This 2-hour training will help directors of behavioral health services to better understand and accept their role in helping to build the beloved community through cultural humility to promote a culturally responsive environment to promote and celebrate diversity, equity, and inclusion which will ultimately positively impact clients and the workforce.

Clinical Supervision: A Lens on Multicultural Competency by Carol Falender, Ph.D.	10-May-21	Clinical supervision represents an intersection of knowledge, skills, and attitudes, with attitudes having received lesser attention. In this workshop, multicultural humility is the lens through which the competency areas of clinical supervision will be addressed. Focus will be on enhancing competence in light of emerging data that supervisees often perceive clinical supervision as ineffective or even harmful. Emphasis will be on clarity of supervisor roles, self-awareness and knowledge, in the context of racial and cultural personal identities across the supervisory triad (client(s), supervisee, supervisor), balancing hierarchy with collaboration, infusing meta-competence, respectful discourse, ongoing feedback, attention to emotional reactivity, trauma and emotion regulation, and legal and ethical aspects.
Cognitive Behavioral Therapy and Relapse Prevention Strategies by James Peck, PsyD, and Grant Hovik, MA	21-Jul-20 17-Nov-20	The purpose of this three-hour virtual live training is to provide participants with a detailed overview of CBT and relapse prevention (RP) strategies, the available resources and encourage use of these strategies in daily clinical practice.
Confidentiality Issues Facing Substance Use Disorder and Mental Health Providers by Andrew Kurtz, LMFT	15-Jul-20	This interactive virtual training will introduce participants to the subject of ethical principles that underlie the provision of effective and principled substance use disorder and behavioral health treatment. This training will identify and describe issues around boundaries and dual relationships, and challenge participants to think about specific clinical situations that raise ethical dilemmas.
Coping with the Journey of Grief and Mourning by Deborah Silveria, Ph.D.	22-Jun-21	This program is designed to assist clinicians in understanding the psychological, psychophysiological, cultural, and theoretical views of grief and mourning. Four different theories will be discussed. Tools will be provided to clinicians to assist in the grief and mourning process. Special emphasis will be placed on assessing and diagnosing the differences between normal grief and complicated bereavement grief and depression. Self-care will also be highlighted.
Crisis Intervention Training (CIT) by Certified CIT Trainers	Offered throughout FY 20-21	CIT provides behavioral health trainings for first responders in Orange County, including, law enforcement officers, public safety dispatchers, campus safety officers, emergency medical services personnel, firefighters, paramedics, and many more working in the community. CIT introduces first responders to recognize signs and symptoms of mental illness and teaches de-escalation techniques in mental health crises. It also promotes trauma informed care approach

		to better support individuals with living with a mental health condition. CIT was established in 2008 to raise awareness about the mental health needs of the community, and it started with law enforcement officer focused curriculum. Starting in FY 20-21, the contract provider expanded the first responder audience, which now includes first responders mentioned above and others in the community who may encounter someone in a mental health crisis; in response to the community needs, they developed various curriculum tracks for audience, such as Situational Awareness, Trauma Informed Care, Voice Training, Vicarious Trauma and more.
Cultural Competency 2.0 Training by Multiple Presenters	Launched: 01-Jul-20 Closed: 30-Dec-20	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.
Cultural Competency 3.0 Training by Multiple Presenters	Launched: 01-Sep-20	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.
Early Childhood Mental Health: Foundational Principles and Practices by Kristin Reinsberg, MS, LMFT, and Barbara Ivins, PhD	15-Jun-21 02-Jun-21	This 2-day virtual workshop will focus on an introduction to foundational principles and practices in the field of infant/early childhood mental health from pregnancy through the preschool years.
Eye Movement Desensitization & Reprocessing Basic Training Part 2 by Trauma Recovery HAP Trainer	08-Jan-21 through 10-Jan-21	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.
Eye Movement Desensitization & Reprocessing Therapy with Children and Adolescents by Keunho Keefe	14-Oct-20	This training is designed to help clinicians who primarily work with children and adolescents adapt EMDR therapy to their population.
Getting the Best From Yourself and Others: Using MBTI Type to Optimize Leadership Effectiveness (CIBHS) by Patrick L. Kerwin	01-Mar-21	Diversity, equity, and inclusion is not only a business initiative but an ethical imperative. Trust, self-awareness, sensitivity, and collaboration is required to maximize team results. Participants are the key to creating a climate of inclusion and belonging for all healthcare team members, creating space that facilitates the maximum capacity to foster innovation, creativity, and empathy.
Leading and Developing Teams Through a DEI Lens (CIBHS) by Janet Miller Evans, MPA, PCC, EQCC	01-Feb-21	Diversity, equity, and inclusion is not only a business initiative but an ethical imperative. Trust, self-awareness, sensitivity, and collaboration is required to maximize team results. Participants are the key to creating a climate of inclusion and belonging for all healthcare team members, creating space that facilitates the maximum capacity to foster innovation, creativity, and empathy.
Moral Reconation Therapy by Kelly Coburn	01-Oct-20	In this training, participants will learn to conduct/facilitate their own MRT groups. In particular, the presentation combines education, group and individual counseling, and structures exercise designed to foster moral development. The training consists of a lecture, discussion, group work, homework, and individual exercises.
Recovery Based Clinical Practice by Mark Ragins, M.D.	09-Nov-20	This training will focus on how the principles and practices of the Recovery Model can be integrated into clinical practice enhancing clients' engagement, collaboration between providers and clients, and effectiveness of treatment.
Recovery: The Promise of Hope by Keunho Keefe	09-Dec-20	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 then sharing of stories and Q&A.
Self-Care for Holiday Blues and COVID Stress & Anxiety by Belinda McCleese	09-Dec-20	The goal is to provide the guideline on how to effectively maintain well-being during the COVID-19 pandemic and holiday season

Suicide Awareness Training by Deborah Silveria, Ph.D.	16-Mar-21 08-Dec-20	Suicide is the only fatality in the mental health field and its prevalence is increasing worldwide. Evidence based research has led to the finding of specific therapies that are effective at treating both suicidal ideation and behavior. This course will cover the epidemiology, etiology, risk and protective factors for suicide. The course will cover the major theories of why people commit suicide and provide an opportunity for mental health professionals to become familiar with evidence-based screening and assessment tools, safety planning, and treatment modalities for the management of clients at risk for suicide. Countertransference issues and tips to mitigate the risk of malpractice when working with suicidal clients are presented as well as self-care/coping strategies to reduce the risk of burnout and vicarious traumatization. Participants will be provided with online resources and safety planning APPS for clients to use for self-regulation in between sessions.
The Pandemic: What it Reveals About Inequities in Medicine - What if Offers in Systemic Solutions by Sergio Aguilar-Gaxiola, M.D.	03-May-21	This MLTS session will continue the focus on looking at how to infuse equity from a systems-level and Dr. Aguilar-Gaxiola will lead participants through discussions about what local medical leaders can do to strengthen their impact on DEI and Racial Justice at the local and state level.
Translating Culturally Responsive Leadership Into Action by Le Ondra Clark Harvey, Ph.D.	07-Jun-21	Diversity, equity, and inclusion is not only a business initiative but an ethical imperative. Trust, self-awareness, sensitivity, and collaboration is required to maximize team results. Participants are the key to creating a climate of inclusion and belonging for all healthcare team members, creating space that facilitates the maximum capacity to foster innovation, creativity, and empathy.
Trauma and Parenting During a Pandemic by Gabriella Grant, MA	03-Nov-20	There are many causes of trauma in families. The ACE studies reveal 10 common factors that strongly contribute to child maltreatment. And child maltreatment is often caused by parents who were abused or traumatized as children. This training will focus on providing a common definition of trauma, as defined by SAMHSA, review parental trauma and its intergenerational correlates through the research, discuss building safety within the parent-child relationship through secure attachment strategies and will review the effects of trauma on neurobiological development. Concepts from the Polyvagal Theory will be reviewed to highlight the need for activation of the

		social engagement system as a protective factor in healthy socio-emotional development.
Trauma-Informed Care Approaches for Working with Individuals with Substance Use Disorders by Andrew Kurtz, LMFT	18-Aug-20	Training is to introduce participants to the presentation of trauma among clients and the relation between traumatic experience and the development of substance use disorders.
Veteran's Conference - 2020 Annual OC Community Behavioral Health Summit by Various Presenters	28-Aug-20	Although the platform for this event is different this year, we hope the Community Behavioral Health Summit can provide an opportunity to engage in active dialogue on how we can address the needs of our Veterans and their families and seek collaborative support for those needs. We intend to accomplish this goal by discussing ways we work together 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 Veterans Administration.
Youth Mental Health First Aid by Certified Mental Health First Aid Trainers	18-May-21 25-Feb-21 24-Feb-21	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.

APPENDIX V:

NOTICE OF DISCRIMINATION

NOTICE OF NONDISCRIMINATION

AFFORDABLE CARE ACT (ACA) 45 CFR 92 SECTION 1557

The Orange County Health Care Agency complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Orange County Health Care Agency does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Orange County Health Care Agency:

- Provides free aids and services to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

Let our staff know if you need these services.

If you have any difficulty obtaining these services, believe you have been discriminated against, or wish to file a grievance related to any of these services or policies, you can file a grievance in person or by mail, fax or email at the contact information listed directly below. Kelly K. Sabet, Civil Rights Coordinator at Orange County Health Care Agency, is available to help you as needed.

Orange County Health Care Agency
Attn: Kelly K. Sabet, Civil Rights Coordinator, Office of Compliance
405 W. 5th Street, Santa Ana, CA 92701
714-568-5787, 711 (TTD), 714-834-6595 (Fax)
officeofcompliance@ochca.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

APPENDIX VI:

INTERPRETATION SERVICES AVAILABLE

INTERPRETATION SERVICES AVAILABLE

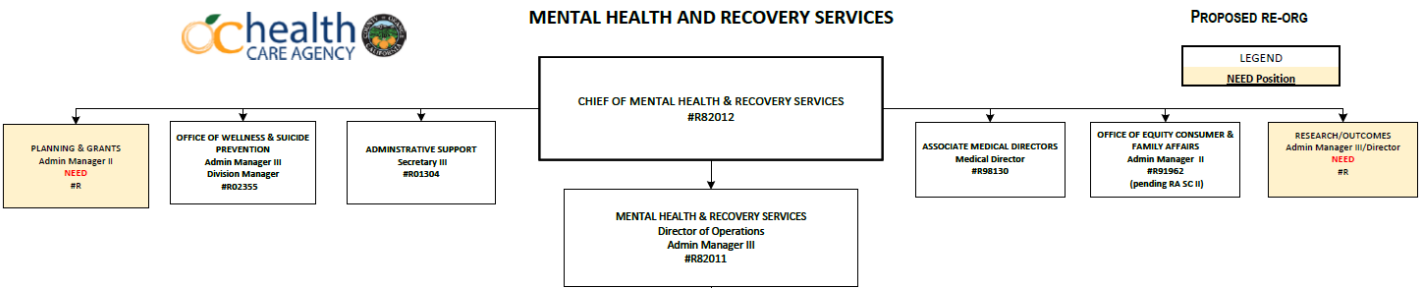
You have the right to an interpreter at no cost to you. Ask at the front desk.

Arabic	لك الحق في الحصول على مترجم فوري بدون تحمل أي رسوم من تجاهك. اسأل في مكتب الاستقبال.
Armenian	Դուք իրավունք ունեք անվճար թարգմանչի ծառայություն ստանալ: Հարցրեք գրանցման սեղանի մոտ:
Cambodian	លោកអ្នកមានសិទ្ធិទទួលបានអ្នកបកប្រែផ្ទាល់មាត់ម្នាក់ដោយឥតគិតថ្លៃ។ សូមសាកសួរនៅតុទទួលភ្ញៀវ។
Cantonese	您有權免費獲得一位口譯人員。請在前臺諮詢。
Farsi	شما این حق را دارید که بطور رایگان از خدمات یک مترجم استفاده کنید. در مورد این خدمات از کارکنان جلوی دفتر یا پشت پیشخوان جویا شوید.
Hindi	आपको निःशुल्क दुभाषिया प्राप्त करने का अधिकार है। फ्रंट डेस्क पर पूछताछ करें।
Hmong	Koj muaj cai tau txais ib tug kws txhais lus pub dawb. Nug ntawm lub rooj ua haujlwm nyob sab ntawm xub thawj.
Japanese	あなたには無料で通訳者のサービスを受ける権利があります。フロントデスクにお尋ねください。
Korean	당신은 통역사를 무상으로 이용할 권리가 있습니다. 프론트 데스크에 문의하세요.
Lao	ທ່ານມີສິດມີວ່າມ.ຕປພາສາໂດຍບໍ່ເສຍຄ່າ. ຖາມຢູ່ໂຕະຕ້ອນຮັບ.
Mandarin	你有权利免费获得翻译服务。请问前台。
Punjabi	ਤੁਹਾਡੇ ਕੋਲ ਬਿਨਾਂ ਕਿਸੇ ਖ਼ਰਚ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈਣ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਇਸ ਬਾਰੇ ਫਰੰਟ ਡੈਸਕ ਤੋਂ ਪੁੱਛੋ।
Russian	Вы имеете право на получение бесплатных услуг переводчика. Спросите на стойке регистрации.
Samoan	E iai lau aiia tatau mo se fa'amatalaupu e leai se totogi. Fesisli i le tagata oi le laulau i luma.
Spanish	Usted tiene el derecho a un intérprete sin costo alguno para usted. Pregunte en la recepción.
Tagalog	Mayroon kang karapatan sa isang tagapagsalin nang walang bayad. Magtanong sa front desk.
Thai	คุณมีสิทธิเป็นล่ามได้โดยที่คุณไม่ต้องมีค่าใช้จ่าย สอบถามได้ที่แผนกต้อนรับ
Vietnamese	Quý vị có quyền yêu cầu một thông dịch viên miễn phí. Xin hỏi ban tiếp tân.

**Translation services are also available in other languages, free of charge.
If another language is needed, please inquire at the front desk.

APPENDIX VII:

MENTAL HEALTH AND RECOVERY SERVICES RE-ORGANIZATION CHART



APPENDIX VIII: ACCESS CRITERIA FOR SPECIALTY MENTAL HEALTH SERVICES

Policy 01.03.06

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.06 ☒New ☐Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	9/14/2022

SUBJECT: Access Criteria for Specialty Mental Health Services

PURPOSE:

To describe the County of Orange Mental Health Plan (hereby referred to as Orange MHP) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to Specialty Mental Health Services (SMHS) in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing SMHS throughout the Orange MHP.

REFERENCES:

Behavioral Health Information Notice (BHIN) 21-073 Criteria for beneficiary access to Specialty Mental Health Services (SMHS), medical necessity and other coverage requirements

Early and Periodic Screening, Diagnostic, and Treatment | Medicaid

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

DEFINITIONS:

Specialty Mental Health Services (SMHS) - Medi-Cal mental health services available to children, youth, and adults. SMHS include medically necessary services to correct or ameliorate impairments and mental illnesses or conditions available through the Medi-Cal Early and

Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. This benefit is available to beneficiaries under the age of 21 who are eligible for full scope Medi-Cal. These services may include crisis counseling, individual/group/family therapy, medication management, targeted case management, psychological testing, psychiatric inpatient hospitalization, and recovery services.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) - The federally mandated Medi-Cal benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medi-Cal service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

Involvement in Child Welfare System - The beneficiary has an open child welfare service case, or the beneficiary is determined by a child welfare service agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the beneficiary is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

Juvenile Justice Involvement - The beneficiary (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Beneficiaries who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Beneficiaries on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

Homelessness - The beneficiary meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act.15 Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

Trauma Screening Tools - The trauma screening tools referenced are screening measures that have been approved by DHCS to aid in determining whether a beneficiary has met the access criteria. MHPs are not required to implement screening tool(s) until DHCS issues additional guidance regarding approved trauma screening tool(s) for the purposes of SMHS access criteria.

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. This section requires provision of all Medi-Cal coverable services necessary to correct or ameliorate a mental illness or condition discovered by a screening service, regardless of whether such services are covered under the State Plan. Services that sustain, support, improve, or make more tolerable a mental health condition are considered to ameliorate the mental health condition are thus medically necessary and covered as Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

- Services provided to a beneficiary must be medically necessary and clinically appropriate to address the beneficiary's presenting condition.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the SMHS Delivery System

A. For beneficiaries 21 years of age or older, SMHS shall be provided for beneficiaries who meet both of the following criteria in 1 and 2 below:

1. The beneficiary has one or both of the following:

a) Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities.

b) A reasonable probability of significant deterioration in an important area of life functioning. AND

2. The beneficiary's condition as described above in 1 is due to either of the following:

a) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

b) A suspected mental disorder that has not yet been diagnosed.

II. Criteria for Beneficiaries under Age 21 to Access the SMHS Delivery System

A. Beneficiaries under 21 years of age shall be provided all medically necessary SMHS required pursuant to Title 42 U.S.C.§1396d(r). Covered specialty mental health services shall be provided to enrolled beneficiaries who meet either of the following criteria in 1 or 2 below.

1. The beneficiary has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool approved by the department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. OR

2. The beneficiary meets both of the following requirements in a) and b) below:

a) The beneficiary has at least one of the following:

i) A significant impairment

ii) A reasonable probability of significant deterioration in an important area of life functioning

iii) A reasonable probability of not progressing developmentally as appropriate.

iv) A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide. AND

b) The beneficiary's condition as described in 2 above is due to one of the following:

i) A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Statistical Classification of Diseases and Related Health Problems (ICD).

ii) A suspected mental health disorder that has not yet been diagnosed.

iii) Significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

3. If a beneficiary under age 21 meets the criteria as described in 1 above, the beneficiary meets criteria to access SMHS. It is not necessary to establish that the beneficiary also meets the criteria in 2 above.

III. Additional Coverage Requirements

A. Criteria for a beneficiary to access the SMHS delivery system (except for psychiatric inpatient hospital and psychiatric health facility services) set forth above shall not be construed to exclude coverage for, or reimbursement of, a clinically appropriate and covered mental health prevention, screening, assessment, treatment, or recovery service under any of the following circumstances:

1. Services were provided prior to determining a diagnosis, including clinically appropriate and covered services provided during the assessment process.

2. The prevention, screening, assessment, treatment, or recovery service was not included in an individual treatment plan.

3. The beneficiary has a co-occurring substance use disorder.

B. All Medi-Cal claims, including SMHS claims, are required to include a CMS approved ICD-10 diagnosis code.

APPENDIX IX: ACCESS CRITERIA FOR DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM

Policy 01.03.07

Health Care Agency **Mental Health and** **Recovery Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Care and Treatment Access 01.03.07 ☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	1/30/2023

SUBJECT: Access Criteria for Drug Medi-Cal Organized Delivery System

PURPOSE:

To describe the County of Orange Drug Medi-Cal Organized Delivery System (DMC-ODS) access criteria for Medi-Cal beneficiaries residing in Orange County to comply with the California Advancing and Innovating Medi-Cal (CalAIM) initiative to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes.

POLICY:

Orange County Health Care Agency (OCHCA) adheres to California state regulations and guidelines for providing access to DMC-ODS in accordance with California Advancing and Innovating Medi-Cal (CalAIM) initiative.

SCOPE:

The provisions of this policy are applicable to all County and County contracted staff providing DMC-ODS and Substance Use Disorder (SUD) services throughout Orange County.

REFERENCES:

Behavioral Health Information Notice (BHIN) 23-001 Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements for the Period of 2022 – 2026

Behavioral Health Information Notice (BHIN) 21-071 Medical Necessity Determination and Level of Care Determination Requirements for Drug Medi-Cal (DMC) Treatment Program Services

The ICD 10-CM Updates and Information

Welfare and Institutions Code (WIC) §14184.402

Welfare and Institutions Code § 14059.5

Title 42 of the United States Code § 1396d(r)(5)

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DEFINITIONS:

Medical Necessity or Medically Necessary –

- Pursuant to Welfare and Institutions Code section 14184.402(a), for individuals 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain as set forth in Welfare and Institutions Code section 14059.5.

- For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards covered under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) mandate.

PROCEDURE:

I. Criteria for Adult Beneficiaries to Access the DMC-ODS

A. For beneficiaries 21 years of age or older, DMC-ODS services shall be provided for beneficiaries who meet one of the following criteria in 1 and 2 below:

1. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance Related Disorders, OR

2. Have had at least one diagnosis from the DSM for Substance- Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

B. Narcotic Treatment Programs (NTPs) conduct a history and physical exam by an LPHA pursuant to state and federal regulations. This history and physical exam done at admission to a NTP qualifies for the purpose of determining medical necessity under the DMC-ODS.

II. Criteria for Beneficiaries under Age 21 to Access the DMC-ODS

A. Beneficiaries under 21 years of age shall be provided all medically necessary DMC-ODS services required pursuant to Title 42 U.S.C.§1396d(r).

B. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan.

C. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs.

D. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

III. Level of Care Determination

A. In addition to being medically necessary, all SUD treatment services provided to a DMC-ODS beneficiary must be clinically appropriate to address that beneficiary's presenting condition.

B. In accordance with Welfare and Institutions Code (WIC) §14184.402(e), providers must use the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC-ODS beneficiaries.

1. However, a full assessment utilizing the ASAM criteria is not required for a DMC-ODS beneficiary to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

2. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

C. For DMC-ODS beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with a licensed professional of the healing arts (LPHA) or registered/certified counselor.

D. For DMC-ODS beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM criteria shall be completed within 60 days of the DMC-ODS beneficiary's first visit with an LPHA or registered/certified counselor.

E. If a DMC-ODS beneficiary withdraws from treatment prior to completing the ASAM assessment and later returns, the time period starts over.

1. The assessment time period re-sets in cases where the Episode of Care (EOC) has been closed, as open EOC must follow established timelines.

IV. Additional Coverage Requirements

A. Consistent with WIC §14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, treatment, and recovery services are covered and reimbursable Medi-Cal services even when:

1. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met, as described above.

2. Services are provided during the assessment process and if is later determines through the assessment that the beneficiary does not meet criteria for DMC-ODS services.

3. The prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

4. The beneficiary has a co-occurring mental health condition.

    a) Reimbursement for covered DMC-ODS services provided to a beneficiary who meets DMC-ODS criteria and has a co-occurring mental health condition shall not be denied as long as DMC-ODS criteria and requirements are met.

B. All Medi-Cal claims, including DMC-ODS claims, are required to include a CMS approved International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), or current version, diagnosis code.

APPENDIX X: TEST CALL PROCEDURE FOR MONITORING ADMINISTRATIVE SERVICE ORGANIZATION (ASO) ACCESS QUALITY AND COMPLIANCE

Policy 06.02.01

Health Care Agency	Section Name:	Quality Improvement
Mental Health and	Sub-section Name:	Access
Recovery Services	Section Number:	06.02.01
Policies and Procedures	Policy Status:	☐New ☒Revised

	SIGNATURE	DATE APPROVED
Director of Operations Mental Health and Recovery Services	Signature on File	2/14/2023

SUBJECT: Test Call Procedure for Monitoring Administrative Service Organization (ASO) Access Quality and Compliance

PURPOSE:

To establish a Policy and Procedure for monitoring the Administrative Service Organization (ASO)'s compliance to County of Orange Mental Health Plan (MHP) (hereby referred to as Orange MHP) Access Line requirements.

POLICY:

The Orange MHP will monitor the ASO in order to assure that the ASO is complying with the MHP's Access Line regulations.

SCOPE:

The procedure is applicable to the ASO.

REFERENCES:

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(d)

California Code of Regulations, Title 9, Chapter 11, Section 1810.405(f)

DEFINITIONS:

Test calls to the MHP's ASO are made in order to test the Orange MHP's Access Line in the following areas:

- Responsiveness of the Access Line 24-hours a day, seven days a week;
- Access to afterhours care;
- Knowledge and helpfulness of the access line staff; and

- Recording of the call on the Telephone Access Log. Calls made in threshold languages are to test response capability to non-English languages.

PROCEDURE:

I. Once per quarter the Adult and Older Adult (AOA) ASO contract monitor will arrange, with the assistance of Authority and Quality Improvement Services (AQIS), to make a minimum of four test calls.

II. AOA will maintain a desk procedure for test calls to the ASO and provide a worksheet and call scenarios for test callers to utilize in order to monitor the ASO's Access Line for access, quality, and compliance. AQIS will collaborate with AOA to modify procedures per State requirements and as needed.

III. Worksheets will be compiled and the results in the form of a Test Call Summary will be shared at the Quality Improvement ASO quarterly management meetings with a request for ASO follow-up and correction.