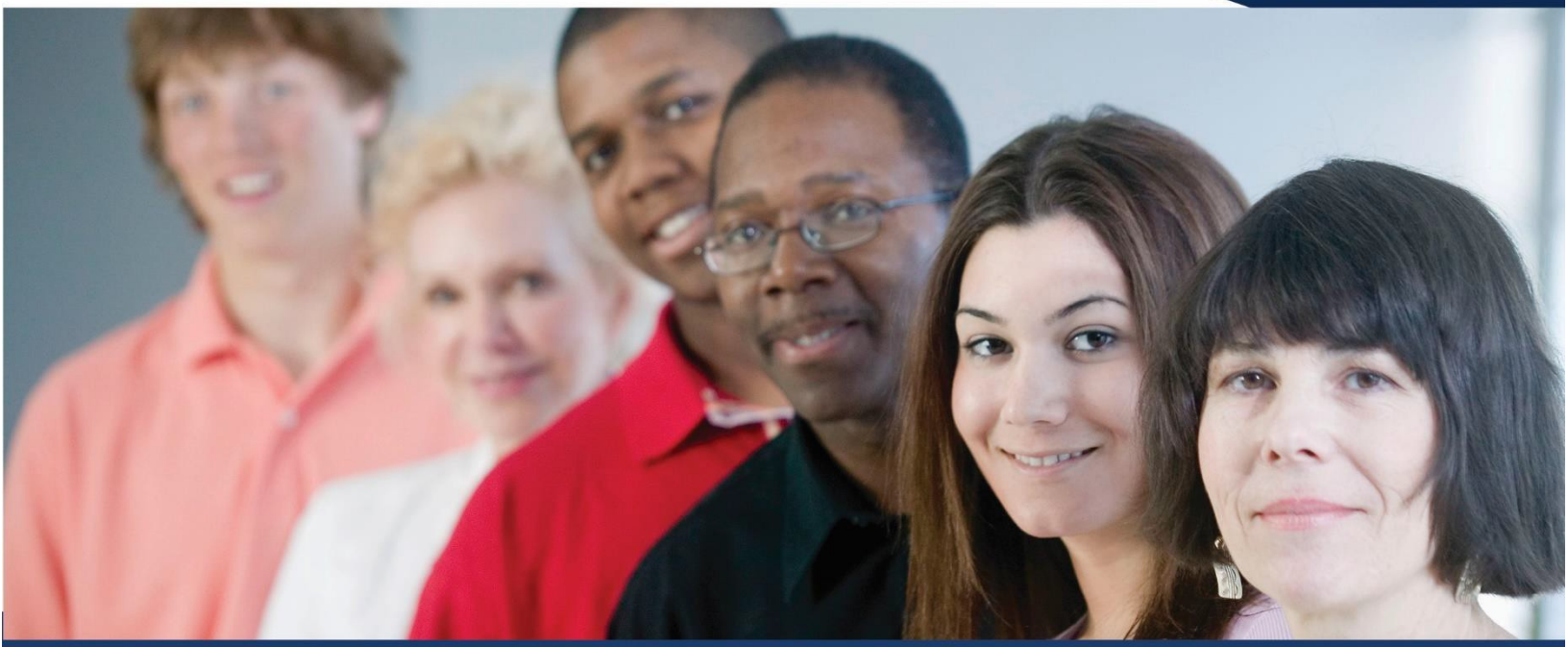
OC health CARE AGENCY



2021 Cultural Competence Plan Update

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DIRECTOR'S MESSAGE

Dear Colleagues and Partners:

2021 is a year that continued to challenge the nation in unprecedented ways. Many are exhausted from the social, financial and emotional impacts of the ongoing COVID-19 pandemic. Public Health data has also demonstrated that communities of color are disproportionately affected by the pandemic creating a call to action to seek health equity. We have also seen significant increases in the utilization of the WarmLine, and of individuals seeking information and referrals through OC Links. Nationwide, healthcare staff are experiencing the secondary effects of the pandemic as well. In response to these conditions, the Health Care Agency has created several programs to address these internal stressors including the Workplace Wellness Advocates program. Due to our commitment to SAMHSA's Trauma-Informed Care principles and the building of resilience among our staff, we plan to continue these programs and principles in the coming years.

The theme of this year's Cultural Competence Plan Update is "Resilience." Since the beginning of the pandemic, our participants and staff have demonstrated remarkable resilience in the face of tremendous challenges. An important part of utilizing trauma-informed principles is to also recognize that innate resilience that can attenuate the effects of complex trauma. To further develop resilience in our participants and community, we assessed the needs of the community and workforce and created the following goals as our focus for this year:

- Continue to develop diversity, equity, and inclusion as core components of the BHS' 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 bi-lingual and bi-cultural staff and seek to racially/culturally/ linguistically match client and therapist according to client preference.
- Operationalize the Cultural Competence Plan Update by sharing the importance of CLAS National standards with line staff and supervisors at every encounter with clients/participants. The reorganization of the Behavioral Health Equity Committee, with its increased representation, will assist in creating greater links with the community and will be able to meet the needs of the community in a more efficacious manner. The commitment to recruit and retain qualified bi-lingual and bi-cultural staff will break down barriers to culturally and linguistically appropriate services for our participants. Finally, we are committed to training staff in CLAS standards so that staff can interact with clients/participants with heightened sensitivity.

Based upon these goals and guiding principles, we present our 2021 Cultural Competence Plan Update. The plan remains grounded in the philosophy of SAMHSA's Recovery Model and seeks to reach out to the community in close collaboration, to assist in building a more resilient and hopeful Orange County. The Health Care Agency continues to believe that individuals with behavioral health conditions have significant innate resilience, can recover from their challenges, and be contributing members of a thriving local and national community. Therefore, it is our hope that this Cultural Competence Plan Update will help move Behavioral Health Services further along the journey toward increased behavioral health equity for those whom we serve.

OC health CARE AGENCY

Jeffrey A. Nagel, Ph.D.
Chief of Mental Health and Recovery Services

INTRODUCTION

Despite the serious disruptions engendered by the global COVID-19 pandemic, the Orange County Health Care Agency (OCHCA) maintained focus on building resilience in its workforce, and in bringing strengths-based care to the population it serves. The pandemic created a significant impact on our clinical teams and drastically changed the way that we delivered behavioral health care. As mentioned in last year's update, the agency took quick action to address and mitigate the worst parts of the pandemic. However, OCHCA, as well as many other agencies throughout the nation are now attempting to cope with a workforce that is exhausted from the severity of the crisis. Therefore, we have taken new steps to increase the support of our workforce by creating the Workplace Wellness Advocates (WWA) program, as well as facilitate a series of Supervisor Focus Groups through our Trauma-Informed Care Workgroup to gather data on how OCHCA Behavioral Health Services can better respond to the extra demands placed upon our supervisory staff. However, this is just the beginning of our efforts to build an agency culture of resilience. We hope to better serve the public by creating and implementing a series of goals to address potential racism within the agency, ensure that the agency meets culturally and linguistically appropriate standards, and increase partnership with community members. We hope that the result will be an increase in participation from unserved and underserved communities and an increased resilience in the populations whom we serve. These goals will be further delineated below.

Yet, how can resilience best be defined, especially as it relates to culture? SAMHSA's TIP 57 defines resilience as follows: "Resilience refers to the ability to bounce back or rise above adversity, as an individual, family, community, or provider. Well beyond individual characteristics of hardiness, resilience includes the process of using available resources to negotiate hardship and/or the consequences of adverse events." SAMHSA also applies the term "resilience" and its processes to individuals across the life span.

When considering the impact of culture on resilience, SAMHSA noted some significant research trends. In TIP 57, the following information was reported, "Connection and Continuity Research suggests that reestablishing ties to family, community, culture, and spiritual systems is not only vital to the individual, but it also influences the impact of the trauma upon future generations. For example, Baker and Gippenreiter (1998) found that families who were able to maintain a sense of connection and continuity with grandparents experienced fewer negative effects than those who were emotionally or physically severed from their grandparents. This research bears careful thought for us as an agency, as it asks us to intervene to help our participants build stronger links to their familial history and cultural history in order to increase resilience. As well, it emphasizes the need for the clinician to consider both internal and external factors of the participant to boost their support.

On Page 55 of TIP 57, SAMHSA noted, "The ability to thrive despite negative life experiences and heal from traumatic events—is related to the internal strengths and environmental supports of an individual. Most individuals are resilient despite experiencing traumatic stress. The ability to thrive beyond the trauma is associated with individual factors as well as situational and contextual factors. There are not only one or two primary factors that make an individual resilient; many factors contribute to the development of resilience. There is little research to indicate that there are specific traits predictive of resilience; instead, it appears that more general characteristics influence resilience, including neurobiology (Feder, Charney, & Collins, 2011), flexibility in adapting to change, beliefs prior to trauma, sense of self-efficacy, and ability to experience positive emotions," (Bonanno & Mancini, 2011).

SAMHSA highlighted the following characteristics that often nurture resilience among individuals from diverse cultural, racial, and ethnic backgrounds:

- Strong kinship bonds;
- Respect for elders and the importance of extended family;
- Spirituality and religious practices (e.g., shrine visitations or the use of traditional healers);
- Value in friendships and warm personal relationships;
- Expression of humor and creativity;
- Instilling a sense of history, heritage, and historical traditions:
- Community orientation, activities, and socialization;
- Strong work ethic; and
- Philosophies and beliefs about life, suffering, and perseverance.

All these characteristics, as well as language orientation are already implicitly a part of the agency's outreach. However, research guidelines merit additional consideration as to whether the agency wants to further define our interventions in this light and this will be discussed in upcoming meetings. To best meet the needs of our service participants this year, the Cultural Competence Plan workgroup, in conjunction with the Behavioral Health Services management, created the following goals to drive our services for the year.

Proposed Goals to Drive Service Delivery

1) Operationalize the Cultural Competence Plan Update at program/clinic level and all parts of BHS system by:

- Training line staff, supervisors, and managers on Culturally and Linguistically Appropriate Service (CLAS) standards implementation at program/clinic level; and
- Utilizing various communication channels to guide and update staff on applications of CLAS.

2) Endorse the work of the Behavioral Health Equity Committee (BHEC) and its workgroups formed in equitable and balanced partnership with members of the community to enhance and deepen relationships with the communities that we serve. Seek ways to utilize the BHEC workgroups to promote community engagement meetings, especially in conjunction with the MHSA office.

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:

- Reviewing all County Policies, Procedures and operating practices to ensure health equity is supported and work to eliminate those policies and practices, if any, that facilitate discrimination against specific populations.
- Recruiting and retaining highly qualified bi-lingual and bi-cultural staff and work to racially/culturally/linguistically match client and therapist according to client preference, if desired.

4) Support the implementation of Anti-racism resolution/statement per the Board of Supervisors (Resolution No. 21-028):

- *"NOW, THEREFORE, BE IT RESOLVED THAT THE ORANGE COUNTY BOARD OF SUPERVISORS declares our 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."*

These goals, in conjunction with the following Mission, Vision and Values Statements will assist us in operationalizing this plan so that the plan becomes a living document through which we can track progress over the coming years. The current goals fall well in-line with each of the three points of our mission statement. We are determined to be successful in operationalizing our goals and will be able to report our progress in next year's plan update.

OCHCA Mission Statement

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

VISION
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.

Agency Philosophy: Dedication to Recovery Principles

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

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

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

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

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

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

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

Summary

The overall theme of this year's Cultural Competence Plan update focuses on "resilience" especially in light of the COVID-19 global pandemic. This seemed an appropriate and strengths-based paradigm through which we will view our challenges and progress. Following upon last year's plan, the CCPU Workgroup decided to create agency-wide goals to assist us in tracking our journey toward greater cultural diversity, equity and inclusion. Last year, our implicit goals were to reduce stigma by increasing community partnership and working toward treating our workforce and our participants with increased dignity, empathy and cultural sensitivity. This year, our clearly stated goals involve reviewing policies, procedures and practices to determine if there are any that may contribute to racism. We also plan to ensure that CLAS standards are actively communicated to clinic staff, enhance the cultural diversity of the staff through the hiring of bi-lingual and bi-cultural clinicians, and align with the goals of the Orange County Board of Supervisors in fighting racism.

The following eight criteria will elaborate our commitment to this process; describe our updated cultural program and activities; review our progress during the year; and make recommendations for on-going improvements over the coming years.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

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

County Mental Health System Commitment to Cultural Competence

Policies, Procedures or Practices

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

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

Behavioral Health Policy	*Policy Details*
BHS Policy 02.01.01.	All of Behavior Health Services (BHS) County and County Contracted providers shall be culturally competent.
BHS Policy 02.01.02.	All Behavioral Health Service (BHS) consumers shall have access to linguistically appropriate services.
BHS Policy 02.01.03.	Behavioral Health Services (BHS) is committed to providing consumers with culturally/linguistically appropriate written materials in all threshold languages or in alternate formats.
BHS Policy 02.01.04.	All beneficiaries receiving behavioral health services from the County of Orange Health Care Agency (HCA) Behavioral Health Services (BHS) will receive and/or have access to a copy of the appropriate Provider Directory.
BHS Policy 02.01.05.	Written materials provided to consumers, family members or significant others of the BHS MHP shall be field tested in the threshold languages to ensure comprehension. Written materials include, but are not limited to: · MHP Consumer Handbook · MHP Provider List · General Correspondence · Beneficiary grievance and fair hearing materials · Confidentiality and release of private health information · MHP orientation materials · SMHS education materials
BHS Policy 02.01.06.	It is the policy of BHS to seek and incorporate input from the service providers and community representatives, consumers and families representing the diverse ethnic and cultural groups of Orange County into service design and implementation.
BHS Policy 02.06.02.	Required distribution of informing materials shall be documented so as to be easily audited. The Advance Directives shall be documented as required in CFR 42, Chapter 4.

*1.1 (Continued) Behavioral Health Services Policies and Procedures (Updated 2020)***

Behavioral Health Policy	Policy Details
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

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

1.2 Program Oversight and Compliance Supporting Documents

Title	Description	Source
BHS Policies and Procedures	List of policies and procedures for operations and client care	https://www.ochealthinfo.com/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/about-hca/behavioral-health-services/authority-quality-improvement-services-division-aqis/drug-0
HCA Organizational Chart	Leadership within organization	https://sp.ochca.com/sites/HCAOrgCharts/_layouts/15/WopiFrame.aspx?sourcedoc=/sites/HCAOrgCharts/Shared%20Documents/1)%20Health%20Care%20Agency/09.2021%20-%20OC%20HCA%20ORG%20CHART.pdf&action=default
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

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

Community Outreach, Engagement and Involvement Efforts

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

The **OC Links Information and Referral** line transitioned to the 24/7 Behavioral Health telephone and online support for anyone seeking information or linkage to any of HCA's BHS County or contracted programs. These services include children and adult mental health, alcohol and drug inpatient and outpatient services, crisis programs, and prevention and early intervention services. BHS recruits and hires bilingual staff. Trained Navigators provide information, referral, and linkage directly to programs that meet the needs of callers, including multi-cultural and bilingual community-based services. OC Links also utilizes an online "Live Chat" feature to address people linking to services when speaking to someone on the phone isn't an option, including deaf and hard of hearing clients. The OC Links phone number is (855) 625-4657 and their website address is www.ochealthinfo.com/oclinks.

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

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

BHS O&E staff also connect with individuals in need by responding to referrals made directly from the community, as well as through regular outreach activities throughout the county. Any individual can request Outreach and Engagement assistance by calling OC Links.

The contracted Outreach and Engagement Collaborative focuses on preventing further development of behavioral health conditions and/or intervening early with the first signs and symptoms to prevent conditions from deteriorating. The program is designed to reach people of all ages who are vulnerable or experience mild to moderate behavioral health conditions. Services are provided in English, Spanish, Vietnamese, Mandarin Chinese, Cambodian, Farsi and Arabic; and include Educational/Skill building workshops, support groups, short-term counseling and case management, and referral/linkage to additional support services.

County Commitment to CLAS standards of Linguistic Diversity within the System

BHS supports a full range of linguistic diverse services for participants including verbal interpretation and translation of documents into the six threshold languages. The forms needed for staff to access language services or request for document translation can be found on the HCA's internet website.

1.3 Language Translation and Interpretation Chart of Forms

Form Name	Form Number	Click Icon to View Form
1) Contact Information - Language Services @ MDP	Information Sheet	
2) Telephonic Interpretation - Request Service	Information Sheet	
3) Onsite Interpretation - Instructions	Information Sheet	
4) Onsite Interpretation - Request Service - Blank Form	Information Sheet	
5) Onsite Interpretation - Request Service - Sample Completed Form	Information Sheet	
6) ASL Interpretation - Instructions	Information Sheet	
7) ASL Interpretation - Request Service	Information Sheet	
8) Document Translation - Instructions	Information Sheet	
9) Document Translation - Request Service Form	Information Sheet	

Cultural/Linguistic Options Available to Clients

The information here is a sample of Orange County's commitment to providing culturally and linguistically appropriate behavioral health services. The documents listed are provided in all six threshold languages as required by the Mental Health Plan. They are available to the beneficiaries electronically and in hard copy.


BHS Medi-Cal Provider Information

Medi-Cal Mental Health Plan - Provider Directory

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

MC MHP Handbook and Provider Directory Lobby Notice

Consumer Handbook - Guide to Medi-Cal Mental Health Services

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

For general information and accessibility issues please call:

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

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

Each County has a Designated Cultural Competence/Ethnic Services Manager (CC/ESM) who is Responsible for Cultural and Linguistic Competence

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

- The CC/ESM will report to, and/or have direct access to the Behavioral Health Director regarding issues influencing mental health concerns related to the identified racial, ethnic, cultural and linguistic populations within the county.
- The County shall include evidence that the County Behavioral Health System has a designated CC/ESM who is responsible for cultural and linguistic competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the County's racial, ethnic, cultural and linguistic populations. This includes written description of the cultural and linguistic competence responsibilities of the designated CC/ESM.
- The current ESM has been in office since September 2017 and holds the position of both Service Chief II of the Multicultural Development Program (MDP) and Ethnic Services Manager (ESM)
- Responsibilities of the MDP Coordinator/ESM include, but are not limited to, the following:
    - Participate in the 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.
    - The CC/ESM reviews and approves all staff trainings for culturally competent content.
- The CC/ESM also oversees the Multicultural Development Program (MDP), which aims to promote health equity by enhancing culturally and linguistically appropriate, responsive, and inclusive behavioral health services for all ethnic and cultural groups through supportive services, training, education, research, and advocacy. The program provides and coordinates language services and cultural trainings. Additionally, it addresses mental health needs of the deaf and hard of hearing community through consultation and training. In addition, consumer/peer supervision, culturally responsive and inclusive clinical consultation, culturally responsive and inclusive community research and advocacy are provided while identifying local and regional behavioral health needs of linguistically and culturally diverse populations as they impact County systems of care. MDP also assists in:

- 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.

Identify Budget Resources Targeted for Culturally and Linguistically Competent Activities

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

HCA BHS currently has two positions dedicated to interpretation and translation services in Vietnamese and Spanish for the Multicultural Development Program (MDP). Within the Behavioral Health Training Services (BHTS) team, MDP has access to additional bilingual staff who assist with translation and interpretation services in Spanish, Farsi, Arabic, Korean and Vietnamese as part of their job responsibilities. Additionally, there are more than 400 BHS bilingual staff who are able to provide interpreter services at either their assigned service site or as needed. In total the MDP program is budgeted for $617,000.

Discussion of Funding Allocations

Interpreter and translation services: Outside interpretation and translation service providers that HCA BHS contracted with during FY 19/20 were Language Line for interpretation (telephonic and onsite) and translation services; and Western Interpreting Network (WIN) for American Sign Language (ASL) services. These services are budgeted based on utilization rates and estimates for each year. A contract for the agency-wide vendor is budgeted for up to $200,000 annually. For American Sign Language services, the budget is up to $300,000 agency wide.

Summary

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

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

To better understand the mission of Orange County Health Care Agency, Behavioral Health Services (BHS), it is necessary to explore Orange County's past and current demographics. Orange County is the third most populous county in California, the sixth most populous in the US, and more populous than 21 US states. Based on data provided by the Department of Finance, the population of the county increased by 6% between 2010 and 2020 (3,010,323 vs. 3,190,832, respectively). The diverse population of Orange County speaks a variety of languages as well. Currently, Orange County provides services in six threshold languages to meet Medi-Cal standards. Though not as diverse as Los Angeles County, with at least 12 identified languages, the breakdown of languages spoken in Orange County provides opportunities for BHS to collaborate with different communities to provide education about behavioral health, recovery, and to bring services to these communities. Additionally, Orange County is a complex, multi-cultural society consisting of many different racial, ethnic and cultural groups. Each of these groups brings a different set of intersecting needs, strengths, values, and abilities to the County. The following sections provide a view of the current demographic statistics in some detail.

General Population

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

2.1 Total Population of Orange County, California

Gender	*Population*	*Percent*
Male	1,588,936	49.8%
Female	1,601,896	50.2%
Total Population	***3,190,832***	
Ethnicity	*Population*	*Percent*
White/Caucasian	1,326,050	41.6%
Hispanic/Latino	1,135,344	35.6%
Asian/Pacific Islander	589,580	18.5%
Black/African American	48,930	1.5%
Native American	6,847	0.2%
Multi Race/Other	84,081	2.6%
Total Population	***3,190,832***	
Age	*Population*	*Percent*
0-5 years	221,000	6.9%
6-17 years	484,558	15.2%
18-59 years	1,775,346	55.6%
60+ years	709,928	22.2%
Total Population	***3,190,832***	

Source: Department of Finance Population Statistics (2020)

Of the 3,190,832 residents in Orange County, 78% (n=2,485,274) were over the age of 18 and 22% (n=705,558) were between the ages of 0-17. A breakdown of the demographics for each of these groups is outlined in tables 2.2 and 2.3 on the following page.

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

Youth Gender	*Population*	*Percent of Total Population*
Male	360,777	11.3%
Female	344,781	10.8%
Youth Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	224,042	7.0%
Hispanic/Latino	318,955	10.0%
Asian/Pacific Islander	118,641	3.7%
Black/African American	9,912	0.3%
Native American	1,402	-*
Multi Race/Other	32,606	1.0%
Youth Age	*Population*	*Percent of Total Population*
0-5 years	221,000	6.9%
6-11 years	233,423	7.3%
12-17 years	251,135	7.9%
Total Youth Population	***705,558***	***22.1%***

**=statistically unstable. Complete data unavailable for these subpopulations.*
Source: Department of Finance Population Statistics (2020)

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

Adult Gender	*Population*	*Percent of Total Population*
Male	1,228,159	38.5%
Female	1,257,115	39.4%
Adult Ethnicity	*Population*	*Percent of Total Population*
White/Caucasian	1,102,008	34.5%
Hispanic/Latino	816,389	25.6%
Asian/Pacific Islander	470,939	14.8%
Black/African American	39,018	1.2%
Native American	5,445	0.2%
Multi Race/Other	51,475	1.6%
Adult Age (18+)	*Population*	*Percent of Total Population*
18-20 years	142,926	4.5%
21-24 years	184,034	5.8%
25-34 years	382,813	12.0%
35-44 years	405,022	12.7%
45-54 years	442,648	13.9%
55-64 years	414,602	13.0%
65+ years	513,229	16.1%
Total Adult Population	***2,485,274***	***77.9%***

Source: Department of Finance Population Statistics (2020)

As of 2019, roughly 47% of Orange County citizens were non-English speakers. This percentage is similar to the California State average (45%), but more than double the National average of 22% (US Census Bureau 1-year Estimates, 2019; see Table 2.4). The US Census Bureau indicated that a quarter (25%) of Orange County residents spoke Spanish at home, while 17% spoke an Asian or Pacific Islander language, and 5% spoke another language at home.

2.4 Language Spoken at Home, Orange County, California

	Children 5-17		Adults 18+		Total	
	Population	Percent	Population	Percent	Population	Percent
English Only	274,362	54%	1,321,245	52%	1,595,607	52%
Spanish	160,119	32%	604,941	24%	765,060	25%
Asian/Pacific Islander Languages	53,008	11%	471,095	19%	524,103	17%
Other Indo-European Languages	13,182	3%	116,195	5%	129,377	4%
All Other Language	3,675	1%	26,540	1%	30,215	1%
Total	***504,346***	17%	***2,540,016***	83%	***3,044,362***	

Source: U.S. Census Bureau (2019). American Community Survey 1-year estimates. Retrieved from Census Reporter Profile page for Orange County, CA <http://censusreporter.org/profiles/05000US06059-orange-county-ca/>

OC, US, and National NUMBERS: https://censusreporter.org/profiles/05000US06059-orange-county-ca/

Orange County Population in Need of Services

Medi-Cal Eligible Population for Mental Health Services

Data was extracted for the number of Medi-Cal eligible residents per month and those who received a service by gender, race/ethnicity, and age from the most recent CALEQRO report for calendar year 2018 (Table 2.5). However, because the California External Quality Review Organization (CALEQRO) report did not provide estimates broken out by primary language, data from the 2018 California Medi-Cal Eligibility Data System (MEDS) and the Orange County Electronic Health Record System are provided in this report to examine penetration rates by primary language (Table 2.6).

In 2019, males and females were equally represented in Orange County. Yet, female residents were more likely to be eligible for Medi-Cal services, as compared to males (54.1% versus 45.9%). Measurable age differences were identified when comparing the County population projections with Medi-Cal eligible populations. As expected, roughly half of the County's Medi-Cal eligible population was between 18 to 59 years of age (49.7%). Residents under the age of 5 and over 60 were less likely to be Medi-Cal eligible (9.9% and 16.4%, respectively). Racial and ethnic differences were also found among Orange County residents. Ethnic minorities were among the residents most likely to be considered Medi-Cal eligible, with the majority being either Hispanic or Latino (46.7%) or Asian and Pacific Islanders (19.3%). While 41.6% of the County's population was projected as being White/Caucasian descent in 2020, very few were eligible for services (16.2%). Additionally, the most common language spoken at home among Orange County residents was English (52.4%). These residents were most likely to be eligible (54.8%), while one-third of Med-Cal eligible residents were Spanish speaking (30.8%).

Medi-Cal Eligible to Beneficiaries Being Served

Based on the number of Medi-Cal eligible residents and the number of beneficiaries with an approved service, the following groups were underrepresented:

- Asian or Pacific Islanders
- Black or African Americans
- Native Americans
- Youth 5 years of age and under
- Adults over the age of 60
- Residents who spoke a language other than English

On average, 19.3% of Asian or Pacific Islander residents were eligible for Medi-Cal services, yet only 8.0% received an approved service. Additionally, the number of Native American residents who were Medi-Cal eligible and had an approved service was extremely low during 2019 (0.2% and 0.3%, respectively). Residents over 60 years of age comprised 16.4% of the Medi-Cal eligible population, yet only 6.1% had an approved service. There was also a noticeable difference for those who speak a language other than English at home. Spanish speakers comprised almost one-third of the Medi-Cal population (30.8%), but only 16.1% 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.

Penetration Rates

Data provided by Behavioral Health Concepts; Inc. during the Mental Health Plan's FY 2019-20 review demonstrated that the State-wide penetration rate was 4.6%.

In Table 2.5, CALEQRO calculated Orange County's penetration rate as being below the State average at 2.7, which is a decrease from last year's report (3.0%). This number was calculated based on the number of Medi-Cal beneficiaries who received an approved service within a calendar year divided by the average number of Medi-Cal eligible beneficiaries in the County per month. CALEQRO did not provide penetration rates for primary language, thus rates were calculated dividing the total number of Medi-Cal beneficiaries served by the total number of residents who were eligible. Using this methodology, the penetration rate calculated for residents who identified their primary language was slightly higher than CALEQRO at 3.7% (Table 2.6).

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

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

	County Population[1]		*Average Number of Medi-Cal Eligibles per Month*[2]		*Medi-Cal Beneficiaries who Received an Approved Service per Year*[2]		*Penetration Rate*[2]
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,588,936	49.8%	395,933	45.9%	11,785	49.6%	3.0%
Female	1,601,896	50.2%	467,410	54.1%	11,954	50.4%	2.6%
Race/Ethnicity							
White/Caucasian	1,326,050	41.6%	140,002	16.2%	5,907	24.9%	4.2%
Hispanic/Latino	1,135,344	35.6%	403,568	46.7%	10,927	46.0%	2.7%
Asian/Pacific Islander	589,580	18.5%	166,862	19.3%	1,910	8.0%	1.1%
Black/African American	48,930	1.5%	14,360	1.7%	877	3.7%	6.1%
Native American	6,847	0.2%	1,304	0.2%	82	0.3%	6.3%
Multi Race/Other	84,081	2.6%	137,247	15.9%	4,036	17.0%	2.9%
Age							
0-5 years	221,000	6.9%	85,778	9.9%	641	2.7%	0.8%
6-17 years	484,558	15.2%	206,958	24.0%	9,740	41.0%	4.7%
18-59 years	1,775,346	55.6%	429,203	49.7%	11,921	50.2%	2.8%
60+ years	709,928	22.2%	141,404	16.4%	1,437	6.1%	1.0%
Total Population	***3,190,832***		***863,343***		***23,739***		***2.7%***

[1] *Source: Department of Finance Population Statistics (2020)*

[2] *Behavioral Health Concepts, Inc., Medi-Cal Approved Claims data for Orange County MHP Calendar year '20, CA EQRO report 2020*

2.6 Medi-Cal Penetration Rates by Primary Language

	County Population[3]		*Number of Medi-Cal Eligibles*[4]		*Medi-Cal Beneficiaries Served*[5]		*Penetration Rate*
	N	*%*	*N*	*%*	*N*	*%*	*%*
Primary Language							
English	1,595,607	52.4%	459,050	54.8%	25,032	92.5%	5.5%
Spanish	765,060	25.1%	258,043	30.8%	4,350	16.1%	1.7%
Asian/Pacific Islander Languages	524,103	17.2%	99,944	11.9%	819	3.0%	0.8%
Other Indo-European Languages	129,377	4.2%	969	0.1%	43	0.2%	4.4%
All Other Languages	30,215	1.0%	19,260	2.3%	423	1.6%	2.2%
Primary Language Total	***3,044,362***		***837,266***		***30,667***		***3.7%***

[3] *Source: U.S. Census Bureau (2019). Age by Language Spoken at Home for the Population 5 Years and Over American Community Survey 1-year estimates. Retrieved from <https://censusreporter.org>*

[4] *Source: CA Medi-Cal Eligibility Data System (MEDS) Extract, June 2020*

[5] *Source: Orange County Health Care Agency (FY 19/20), Electronic Health Record System (IRIS)*

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

Data was extracted for the number of Drug Medi-Cal eligible residents per month and those who received a service by gender, race/ethnicity, and age from the most recent CALEQRO report for fiscal year 2019-20 (Table 2.7). However, because the CALEQRO report did not provide estimates broken out by primary language, this data was not included in this analysis.

In 2019-20, female residents were more likely to be eligible for Drug Medi-Cal services, as compared to males (55.8% versus 44.2%). Measurable age differences were identified when comparing the County population projections with Medi-Cal eligible populations. More than half of the County's Medi-Cal eligible population was between 18 to 64 years of age (68.7%). Residents between the ages of 12-17 and over 65 were less likely to be Medi-Cal eligible (16.2% and 15.1%, respectively). Racial and ethnic differences were also found among Orange County residents. Some ethnic minority groups were among the residents most likely to be considered Medi-Cal eligible, with the majority being either Hispanic or Latino (43.4%), Asian or Pacific Islander (21.9%), or Multi-Racial/Other (15.1%). Additionally, White/Caucasian residents made up 17.7% of the Drug Medi-Cal eligible population in Orange County. Overall, these trends are similar to the statistics reported for Mental Health Plan Medi-Cal eligible residents.

DMC-ODS Eligible Beneficiaries Being Served

Based on the number of Medi-Cal eligible residents and the number of beneficiaries with an approved service, the following groups were underrepresented:

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

On average, 55.8% of Female residents were eligible for Medi-Cal services, yet only 36.6% received an approved service. With regard to age disparities, youth between the ages of 12-17 were 16.2% of the Drug Medi-Cal eligible population, but only 4.7% received services. Residents over 60 years of age comprised 15.1% of the Medi-Cal eligible population, and only 6.1% had an approved service.

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

Penetration Rates

Data provided by Behavioral Health Concepts, Inc. for FY 2019-20 demonstrated that the State-wide penetration rate was 1.1%.

In Table 2.7, CALEQRO calculated Orange County's penetration rate as being slightly below the State average at 0.9%. The penetration rates were higher than the CALEQRO County-wide average for residents who identified as Male, White/Caucasian, Black/African American, Native American, Multi-Race/Other, residents between the ages of 18-64 year-old.

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

	County Population[1]		*Average Number of DMC-ODS Eligibles per Month*[2]		*DMC-ODS Beneficiaries who Received an Approved Service per Year*[2]		*Penetration Rate*[2]
	N	*%*	*N*	*%*	*N*	*%*	*%*
Gender							
Male	1,588,936	49.8%	288,729	44.2%	3,784	63.4%	1.3%
Female	1,601,896	50.2%	364,238	55.8%	2,187	36.6%	0.6%
Race/Ethnicity							
White/Caucasian	1,326,050	41.6%	115,661	17.7%	2,469	41.3%	2.1%
Hispanic/Latino	1,135,344	35.6%	283,582	43.4%	2,012	33.7%	0.7%
Asian/Pacific Islander	589,580	18.5%	143,094	21.9%	183	3.1%	0.1%
Black/African American	48,930	1.5%	11,165	1.7%	160	2.7%	1.4%
Native American	6,847	0.2%	1,189	0.2%	35	0.6%	2.9%
Multi Race/Other	84,081	2.6%	98,279	15.1%	1,112	18.6%	1.1%
Age[3]							
12-17 years	251,135	9.2%	105,934	16.2%	279	4.7%	0.3%
18-64 years	1,972,045	72.1%	448,433	68.7%	5,329	89.2%	1.2%
65+ years	513,229	18.8%	98,600	15.1%	363	6.1%	0.4%
Total Population	***2,736,409***		***652,967***		***5,971***		***0.9%***

[1] *Source: Department of Finance Population Statistics (2020)*

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

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

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

Federal Poverty Line (FLP) data was extracted from the California Health Interview Survey (CHIS, 2019). In total, 483,000 non-Medi-Cal beneficiaries who lived in Orange County were living at or below the 200% FPL in 2019 (see Table 2.8). The majority of these residents were either female, Hispanic/Latino, or between the ages of 18-59 years old.

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

Gender	*Number*
Female	291,000
Male	217,000
Race/Ethnicity	*Number*
White/Caucasian	108,000
Hispanic/Latino	336,000
Asian/Pacific Islander	56,000
Black/African-American	*
Native American	*
Multi Race/Other	4,000
Age	*Number*
0-5 years	0
6-17 years	42,000
18-59 years	357,000
60+ years	84,000
Total	***483,000***

*Data unavailable for this population

Source: California Health Interview Survey (2019)

Table 2.9 compares Orange County's total population with the total number of residents living at or below the 200% FPL. Results indicate that one-quarter of Orange County residents are living at or below the 200% FPL (804,000 compared to 3,190,832). Similar to the results looking at the Orange County population, minus Medi-Cal, the majority of these residents were either female, Hispanic/Latino, or between the ages of 18-59 years old.

2.9 Population Assessment

	County Wide Estimated Total Population[1]		*County Wide Estimated Population Living at or Below 200% FPL*[2]	
	N	*%*	*N*	*%*
Gender				
Males	1,588,936	49.8%	389,000	47.7%
Females	1,601,896	50.2%	426,000	52.3%
Race/Ethnicity				
White/Caucasian	1,326,050	41.6%	147,000	18.1%
Hispanic/Latino	1,135,344	35.6%	496,000	61.1%
Asian/Pacific Islander	589,580	18.5%	141,000	17.4%
Black/African American	48,930	1.5%	15,000	1.8%
Native American	6,847	0.2%	*	*
Multi Race/Other	84,081	2.6%	13,000	1.6%
Age				
0-5 years	221,000	6.9%	23,000	2.9%
6-17 years	484,558	15.2%	164,000	20.4%
18-59 years	1,775,346	55.6%	492,000	61.2%
60+ years	709,928	22.2%	125,000	15.5%
Total	***3,190,832***		***804,000***	

*Data unavailable for this population

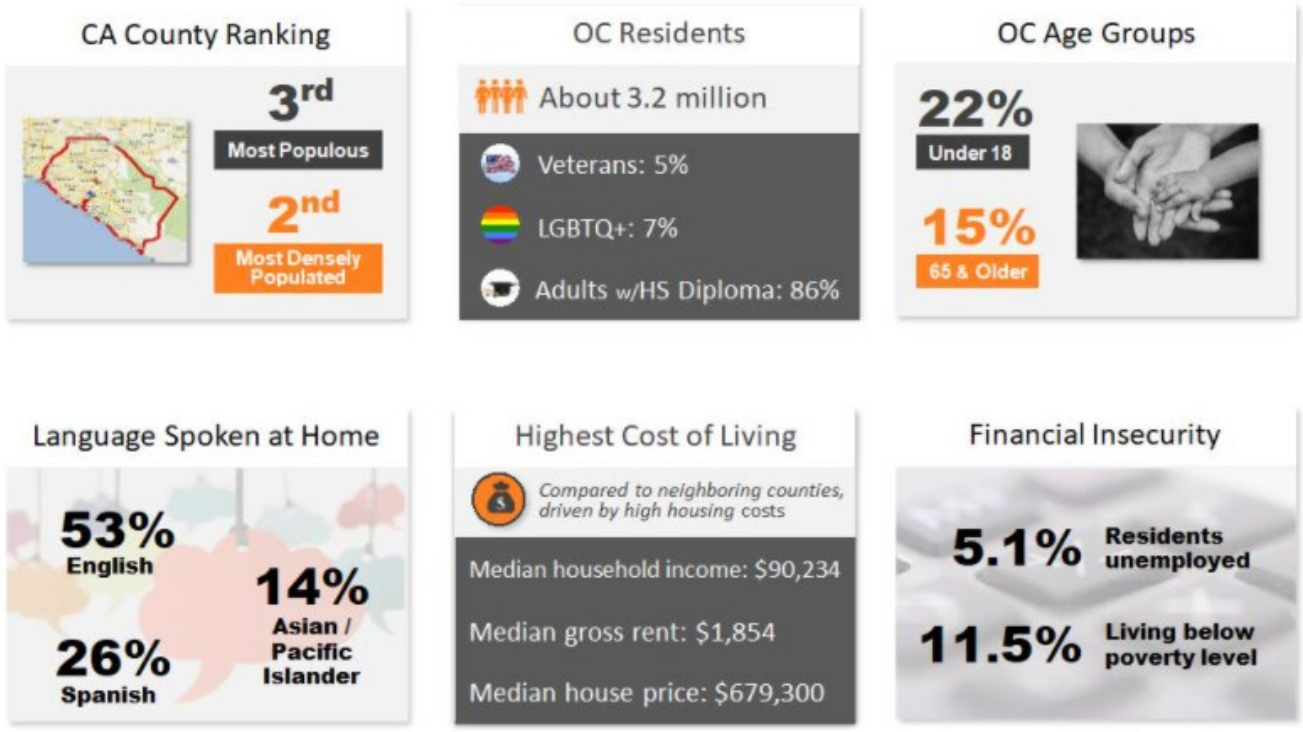
[1] *Source: Department of Finance Population Statistics (2020)*

[2] *Source: California Health Interview Survey (2019)*

MHSA Community Services and Supports (CSS) Population Assessment[1]

The tables below were pulled from the most recent Mental Health Services Act (MHSA) annual update (2021). 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.

Orange County At-A-Glance



CSS/PEI Budgets[2]

FY2020-21 – 2022-2023 Component Budget		
Fiscal Year	**CSS**	**PEI**
Proposed FY 2020-21 Budget	$155,088,175	$47,061,483
Proposed FY 2021-22 Budget	$164,627,171	$49,286,926
Actual FY 2021-22 Budget	$158,758,100	$56,144,101
Proposed FY 2022-23 Budget	$165,320,336	$40,988,101

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

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

Projected Numbers to be Served[3]

OC CENSUS

Orange County Residents by Demographic Characteristic

Age	2019 Census
0-14 yrs	18%
15-24 yrs	13%
26-59 yrs	48%
60+ yrs	20%
2019 Population:	3,175,692

Gender	2019 Census
Female	51%
Male	47%
Transgender	2%
Genderqueer	<1%
Questioning/Unsure	<1%
Another	<1%

Race/Ethnicity	2019 Census
African American/Black	2%
American Indian/Alaskan Native	1%
Asian/Pacific Islander	20%
Caucasian/White	39%
Latino/Hispanic	33%
Middle Eastern/North African	NOT COLLECTED
Two or More Races	4%

CSS/MHSA

Individuals Served in CSS Clinical Services by Demographic Characteristic

Age	Estimated	Actual
0-15 yrs	9%	17%
16-25 yrs	16%	25%
26-59 yrs	63%	47%
60+ yrs	12%	11%
Projected Duplicated:	61,623	
Actual Unduplicated:	14,758	

Gender Identity	Estimated	Actual
Female	42%	48%
Male	56%	52%
Transgender	2%	*0.1%*
Genderqueer	-	*0.1%*
Questioning/Unsure	-	*0.1%*
Another	-	*0.1%*

Race/Ethnicity	Estimated	Actual
African American/Black	7%	5%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	10%
Caucasian/White	42%	35%
Latino/Hispanic	34%	37%
Middle Eastern/North African	1%	1%
Another	5%	11%

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

PEI/MHSA

Individuals Served in PEI Programs by Demographic Characteristic

Age	Estimated	Actual*
0-15 yrs	47%	22%
16-25 yrs	18%	8%
26-59 yrs	25%	53%
60+ yrs	10%	17%
Projected Duplicated:	216,898	
Actual Unduplicated:	178,009	

Gender Identity	Estimated	Actual
Female	54%	51%
Male	42%	49%
Transgender	1%	0%
Genderqueer	-	-
Questioning/Unsure	-	-
Another	2%	-

Race/Ethnicity	Estimated	Actual
African American/Black	7%	13%
American Indian/Alaskan Native	1%	1%
Asian/Pacific Islander	10%	19%
Caucasian/White	42%	38%
Latino/Hispanic	34%	29%
Middle Eastern/North African	1%	0%
Another	5%	-

** Age reflects the age of the person served. These percentages do not reflect the expenditure breakdown, where programs that enroll adult caregivers and guardians in support of their children and youth count as youth-focused programming.*

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

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

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

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

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

The MHSA Office collected responses from a total of 1,136 paper and electronic surveys. Sixty-one percent of respondents identified as consumers and/or family members, all stakeholder groups required by the MHSA were represented among the respondents. Additionally, 16% of respondents were adolescents or Transitional Age Youth (TAY), whose previous participation in community planning had been low to non-existent. In addition, the racial and ethnic diversity of the survey respondents were representative of Orange County diverse population as a whole.

Additionally, because of the Orange County Board of Supervisor's directive to create an Office of Suicide Prevention, PEI funding was set aside for specific strategies to expand support for suicide prevention efforts. Those individuals most vulnerable are included as a priority population.

STRATEGIC PRIORITY: Office of Suicide Prevention

Expand support for suicide prevention efforts

Priority Populations	Board of Supervisors Directive	Proposed Activities

• 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 directed the County Executive Officer and HCA Director to create an Office of Suicide Prevention 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
		• 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 Office and its activities will be a component of the Suicide Prevention Services program in the Orange County MHSA Plan. The Office will be funded through PEI and have a **budget of $1.5 million in FY 2021-22**.

Summary

Population variables were not significantly different from the previous reporting year. The agency's penetration rates were mixed, showing improvement in some areas. This census data provided MHSA with a good benchmark to evaluate the behavioral health needs of the community especially related to the specific populations mentioned in the Prevention and Early Intervention Plan. The outcomes data mentioned above provides a clear focus for the agency to address these at-risk populations in order to reduce the possibility of greater intrapersonal and interpersonal dysfunction. These marginalized groups tend to suffer disproportionate amounts of incarceration, physical health, and mental health challenges. Providing greater access to services through effective outreach, including more thorough staff education on CLAS standards, can reduce barriers to treatment and increase efficacy of outcomes.

We will implement CLAS standards more thoroughly throughout the agency by providing regular training in cultural and linguistic sensitivity, use of translation lines, multimedia presentations and other objective means of staff education. Our Behavioral Health Equity Committee, made up of both BHS employees and community partners, is working to address disparities and increase penetration rates within these populations by creating greater linkages to vulnerable populations and the community in general. Behavioral Health Services (BHS) continues to measure our progress in light of State-wide mandates and the inherent desire to build up the community by reducing mental health stigma, improving access to care, and creating partnerships within the community to further build trust in our services.

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

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

Continuing from last year, our Substance Use Prevention, Education and Disorders program will be included in Criterion 3 for 2021. The addition of this program further clarifies the work of BHS in reaching marginalized communities, such as the homeless, for whom substance use disorders are endemic. We hope to show that the outcomes of all of these programs help to build resilience in the populations served by providing support and intervention, through the utilization of CLAS standards and increased attention to cultural and linguistic awareness.

This year, we have chosen to highlight programs that have specific updates and changes that need to be reported. These may be successes or challenges within program areas. All these programs have worked to meet the needs of the unserved and underserved population of Orange County in a unique and significant way.

Identify Unserved, Underserved, and Inappropriately Served Target Populations

The target populations for each of the programs listed in this criterion include, but are not limited to: racial, ethnic and cultural minorities [e.g., Latino/Latina, Black/African American, Vietnamese, Korean, Iranian, Middle Eastern, the Deaf and Hard of Hearing community, and the Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning (LGBTIQ) community]; people with limited English proficiency; homeless individuals and families; frail, isolated older adults; trauma-exposed people (including veterans); Children and Transitional Age Youth (TAY) involved (or at-risk of becoming involved) in the juvenile justice system, at-risk of school failure, aging out of the foster care system, or in stressed families; and individuals experiencing behavioral health issues. Outcome results for the following programs were extracted from the Orange County Mental Health Services Act (MHSA) Plan Update FY 2019/2020.[6]

Identified Strategies, Objectives, Actions, and Timelines

Strategies to Improve Timely Access to Services for Underserved Populations

Individuals have difficulty linking to services for a variety of reasons. Some examples include homelessness and/or difficulty finding permanent housing; lack of food, transportation, childcare and/or social support; anxiety about their legal status; lack of open program space; stigma related to having mental illness; a tendency to attribute mental health symptoms to previous substance use (theirs and/or their parents'); and previous negative experiences with mental health professionals. Significantly, cultural beliefs can also attenuate the use of public mental health services due to factors such as shame over seeking treatment, belief in the need to manage without assistance, lack of mental health literacy, belief that mental illnesses are spiritually-based and need the intervention of a traditional healer, instead of utilizing both indigenous traditions and modern evidence-based practices. All of these factors tend to increase isolation from available services that could effectively fill a need within the local communities of Orange County. The MHSA Office identified strategies to address access to care as listed below. The progress of each of the strategies is listed as well.

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**	• **Work with community to identify and integrate culturally and linguistically responsive strategies and approaches** • Offer telehealth/virtual behavioral health care options for people of all ages living w/significant mental health conditions • Expand school-focused mental health services • Expand transportation services	✔ **Establishing and/or strengthening partnerships with trusted local organizations that serve priority populations** ✔ Made rapid, systemwide transition to various virtual behavioral health services and supports in response to COVID-19 ○ *Continuing to work through challenges in accessing, transitioning to, and using technology by providers and/or clients* ○ *Expanded hours/availability of counseling services* ✔ Launched outreach, peer support, networking and resource activities for K-12 students, college students and TAY ✔ Along with OC Department of Education and OC School Districts, implementing a grant to coordinate referrals and linkages, and to train school staff on mental health topics ⏸ Waiting for State direction on new Medi-Cal program in schools ⏸ Transportation support remains available at reduced levels due to COVID-19 and expansion on pause

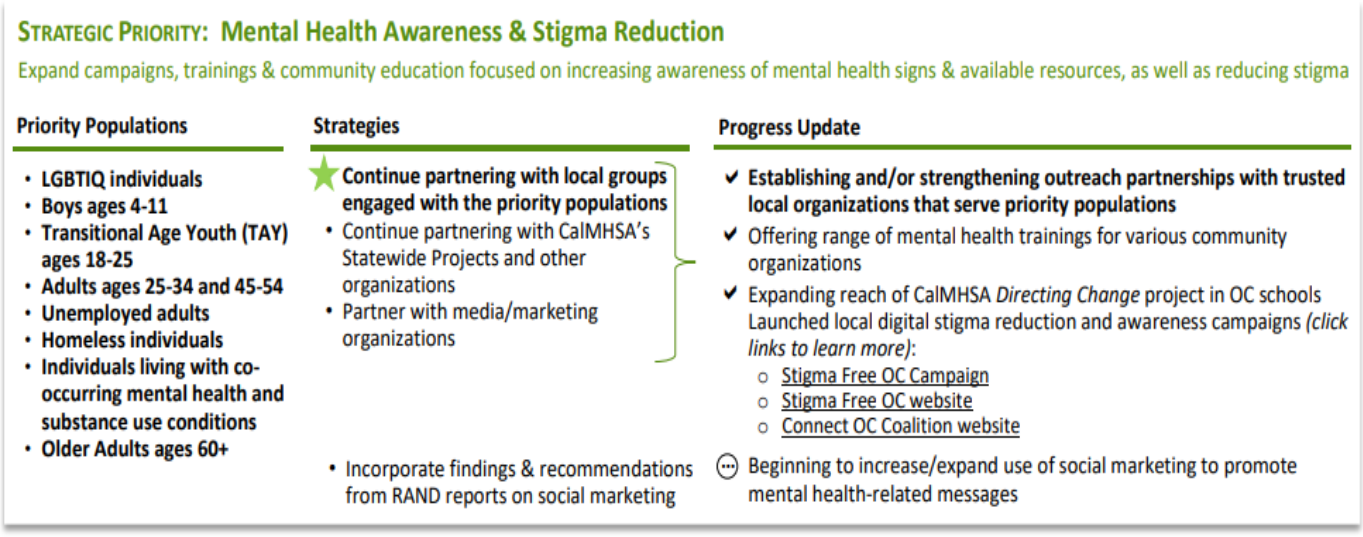
✔ Completed & ongoing ⋯ In progress, some delays due to COVID ⏸ Paused due to COVID

Strategies to Reduce Stigma and Discrimination

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

In addition, all BHS staff are trained yearly in cultural competency. The training provides an overview of how to incorporate culturally responsive approaches in their interactions with participants. The concept of culture, race, ethnicity, and diversity, as well as stigma and self-stigma, are discussed. The training also demonstrates the influence of unconscious thought on judgment as it relates to stereotyping, micro aggression, and racism. Strategies are also provided to recognize diversity and embrace the uniqueness of other cultures beyond mainstream American culture.

From the MHSA Community engagement meetings and responses to surveys, one of the priorities identified was to address stigma specific strategies are listed below along with their progress update.



Behavioral Health Services programs seek to serve clients from a recovery-oriented and person first approach, working to eliminate stigma with each encounter. The following highlight specific programs and ways BHS is outreaching the community and working with clients to promote mental health awareness.

- The Peer Support and Wellness Center (i.e., "The Wellness Center") provides services to walk-in adults, 18 years of age and older, who have been diagnosed with a serious mental illness, may also have a co-occurring substance use disorder, and have demonstrated progress in their recovery. Activities are designed to encourage and empower members to seek interests and passions outside of the adult system of care and offer a pathway for full integration back into the community. Assistance is also offered with employment readiness, job searching and educational opportunities.
- The development and placement of mental health services in locations where the unserved and underserved seek out services is established by working with primary care facilities in Little Saigon, Garden Grove, Santa Ana and Anaheim. It is an ongoing development of networks with other health care practitioners that see those who have mental illness years before they walk through the doors of the county mental health system or other mental health providers in the community.
- Outreach efforts have expanded to utilize the BHEC workgroups, who can assist in the dissemination of Behavioral Health Services materials and information. This type of a partnership with community leaders, clergy, etc., helps increase trust and belief in a behavioral health system that may be foreign to most. Outreach, which includes other forms of media, such as radio stations and non-English language newspapers/periodicals helps assist greatly in the dissemination of information and resources.
- Services must be provided in the languages of the populations served. A large portion of the unserved/underserved populations in Orange County speak a language other than English. In order to better serve these populations, qualified staff are recruited who speak Spanish, Vietnamese, Korean Farsi and Arabic. All written materials used by clients are translated into the threshold languages. Due to the significant shortage of human service professionals who are bilingual/bicultural, additional strategies must be developed to effectively recruit and retain qualified multi-cultural and bilingual staff.

Drug Medi-Cal ODS Services

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

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

Youth under age 21 and pregnant or parenting women are eligible for additional services. For more information about DMC-ODS, visit www.ochealthinfo.com/dmc-ods.

Drug Medi-Cal-ODS Mission

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

Target Population

The Drug Medi-Cal Organized Delivery System (DMC-ODS) County and Contracted providers serve ages eighteen (18) years or older, and/or adolescents ages (12 through-17) who have a diagnosis of substance use disorder as defined in the current Diagnostic Statistical Manual (DSM) and by assessment using all six (6) dimensions of the County ASAM based criteria conducted/reviewed and approved by a LPHA or a physician.

Levels of Care and Services

DMC-ODS providers offer different levels of care based on their assessment and criteria for medical necessity. Both County and Contracted DMC-ODS staff provide a range of outpatient and residential treatment programs designed to work with individuals wanting to reduce or eliminate the abuse of alcohol and other drugs that impair their overall functioning. Outpatient and residential providers provide a structured substance use disorder treatment programs and which includes include intake/assessment, evaluation, individual/group/family counseling, discharge planning, recovery services and case management. Additional referrals/linkages to ancillary services can be provided such as linking to education, vocational training, medical and dental treatment, job search, financial assistance, and other self-help program such as twelve (12) step programs.

Levels of care available within the DMC-ODS plan:

- **Outpatient Drug Free (ODF) – ASAM 1.0:** Less than 9 hours of service/week (adults 21+ years old); less than 6 hours/week (adolescents under 21 years old) of treatment
- **Intensive Outpatient (IOT) – ASAM 2.1:** Minimum of 9 hours with a maximum of 19 hours per week (adults 21+ years old); Minimum of 6 or more hours with a maximum of 19 hours per week (adolescents under 21 years old) of treatment
- **Clinically-Managed Low-Intensity Residential – ASAM 3.1:** 24-hour structure with available trained personnel; at least 5 hours of clinical services/week (adults); at least 5 hours of clinical services/week (adolescents 12 through 17 years old)
- **Clinically-Managed High Intensity Residential – ASAM 3.5:** 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment; at least 5 hours of clinical services/week (adults); at least 5 hours of clinical services/week (adolescents 12 through 17 years old)

- **Clinically Managed Residential Withdrawal Management – ASAM 3.2 WM:** Social Model Detox
- **Medically Monitored Inpatient Withdrawal Management – ASAM 3.7 WM:** Medical Detox
- **Medication Assisted Treatment (MAT):** Opioid Treatment Program (OTP)/Narcotic Treatment Program (NTP) and Vivitrol

In FY 19-20, our DMC-ODS plan consisted of five Outpatient County Operated clinics, five Outpatient Contracted providers with eleven locations and three Outpatient Contracted Medication-Assisted Treatment (MAT) providers with five locations. For residential treatment facilities, there were nine contracted providers and two of these organizations provided residential perinatal treatment. There were two adolescent residential facilities at the onset of FY19/20, however, both facilities closed during the fiscal year. In addition, we had two contracted clinically managed residential withdrawal management and one contracted provider for medically monitored inpatient withdrawal management in two locations located in Los Angeles County. This provider has since terminated their contract so Orange County is currently seeking another 3.7 provider within the county.

Outcomes

During FY 19-20, the Drug Medi-Cal Organized Delivery System (DMC-ODS) continued to offer 24/7 access to addiction treatment services for Medi-Cal beneficiaries. This program was part of a statewide effort to improve access to addiction treatment services, and effectively increased access to Medication Assisted Treatment (MAT) and Intensive Outpatient Treatment (IOT) services. During FY 2019-20, the DMC-ODS system served over 7,000 beneficiaries. This included those served in outpatient programs (5403 adults, 275 adolescents), IOT programs (313 adults, 78 adolescents), residential treatment programs (3190 adults, 78 adolescents), and Narcotic Treatment Programs or other MAT services (2213 clients). The result was an increase of about 20% in the number of beneficiaries served. Since implementation, the DMC-ODS has accomplished the following outcomes:

- Access to treatment: Clients were typically offered an appointment within 2.24 business days of their original request, and usually received a face-to-face appointment within 4.26 business days of their request. For appointments that indicated an urgent need, the first appointment was typically offered within 0.69 days and attended within 3.16 business days
- Re-admission rates: Only 4.74% of clients enrolled in a Withdrawal Management program were re-enrolled in the 30 days following their treatment stay
- Client satisfaction: Treatment perception surveys were conducted with 752 adult beneficiaries across 47 program types and indicated an average satisfaction rate of 4.4 out of 5.0 for adults and 4.3 out of 5.0 for youth. Standout responses in this survey were that clients felt respected (94.3%), understood (93.1%) and welcomed (92.9%).
- Client preparedness and success: Respondents to a treatment discharge survey indicated that clients exceeded national standards for their desire for help, treatment readiness, counseling rapport, treatment participation, peer support, and social support

Challenges/Barriers/Solutions in Progress

Some of the barriers experienced by the DMC-ODS system in FY 19-20 included limited staffing resources due to global pandemic, reorganizations within the Health Care Agency and DHCS, competing priorities established by governing bodies (e.g., 42 CFR, Part 2, DATAR), high rate of clients missing appointments, high incidence of co-morbid post-traumatic stress disorder, and the need for continued development of an internal data team. In addition, our system identified the ongoing need to increase adult residential programs, recovery residences and residential perinatal services to help reduce waiting time and be able to link clients to services immediately. Challenges specific to adolescent services included low family/caretaker engagement in treatment, providers having bilingual Spanish-speaking staff, identifying a DMC certified NTP provider that will serve youth under 18 years old to contract with, and

retaining adolescent residential providers due to facility closures. In June 2020, the County's only adolescent residential DMC program closed. There is currently no adolescent residential program in Orange County. Youth in needed of residential substance use services may receive services through an out of network provider.

Furthermore, we recognized the ongoing need to increase discussion and presentations on the DMC-ODS with our community partners to help them gain a better understanding of the current workflow for referrals to different levels of care and treatment expectations. We also identified a need to increase successful linkages when beneficiaries are moving through the continuum of care by developing a new Peer Mentoring Program. This program will help beneficiaries navigate through our system of care and assist with any linkages and referrals to ancillary services as needed (i.e., physical examination, medical appointments, employment, vocational, accessing benefits, etc.). Adolescents under 18 years old were recently added to the population to be served for this contract in FY20/21, so we are now working with DMC-ODS providers to link youth with Peer Mentors.

In July 2020, the County implemented In-Custody Substance Use Disorder (SUD) Treatment targeting the incarcerated population with SUD treatment needs. The program's goal is to improve recidivism rates for clients who are incarcerated and in need of SUD treatment services. This program provides assessment, individual/group counseling, case management services, pre-release discharge planning, and linkage to SUD services in the community including transportation to post release SUD treatment.

In July 2020, the County launched a new Substance Use Disorder Training and Education Program available to DMC-ODS providers. This training curriculum will include standardization of assessments, additional evidenced-based practices material, increase co-occurring capability and ensure a standardized and integrated approach to SUD services between all levels of care. Other initiatives that are currently under way specific to adolescent services include: seeking opportunities to contract with providers serving adolescents ages 12 through 17 years old in Residential 3.1, 3.3, and 3.5;, Withdrawal Management 3.2, and NTP levels of care; working with providers to increase family engagement in treatment; increasing awareness and linkage of youth to Federally Qualified Health Centers (FQHCs) for MAT services; and, participating in County Touchpoints learning collaborative, which includes SSA, Court, and multiple community stakeholders to ensure Child Welfare families receive the support they need to address opioid use.

The County is continuing to work on adding MAT services to County's SUD Clinics and targeted to launch at Santa Ana SUD Clinic location in 2021. The program goal is to focus on taking direct MAT referrals from clients released from Orange County Correctional Health System and Emergency Departments throughout Orange County. This will serve Medi-Cal beneficiaries and clients without access to a health plan. The overarching program goal is to be able to offer MAT services at all 4 County SUD Clinics and BHS Court Programs.

In efforts to combat opioid overdose related deaths throughout California, all County SUD and Mental Health (MH) clinics and County Contracted providers (Outpatient, Residential, and NTP) are participating in the Naloxone Distribution Project, funded by SAMSHA and administered by the Department of Health Care Services. All county clinics and contract providers now have Naloxone / Narcan on site to utilize in the event of an opioid emergency, as well distributing to at-risk clients and loved ones, to reduce the risk of overdose related deaths. This medication is available to all clients at their first appointment with a clinician.

The COVID-19 global pandemic posed an unprecedented challenge. All County SUD and MH clinics, as well as our contract providers were able to quickly adapt services and continued to offer lifesaving services to our community members, even during the global pandemic. Services added as part of our COVID-19 Response include, telehealth services, take-home MAT, daily MAT dosing continued, and our team inquired with all providers bi-weekly for program modifications, which then were disseminated to all providers within the DMC-ODS network, notifying all of changes/updates in real-time.

Another challenge has been finding a provider that can provide medically supervised withdrawal management. The county had a relationship with a provider for several years, but they were in Los Angeles County. They contracted with the county to provide 3.7 level withdrawal management but due to stressors on staff due to the pandemic, and adjustment to the demand of DMC billing, they made the decision to terminate their contract. Orange County is now seeking another provider. The challenge is finding a 3.7 provider licensed to provide this level of service and willing to serve DMC beneficiaries.

Community Impact

The implementation of the DMC-ODS within our system of care in Orange County has increased the community's ability to access SUD services through a variety of paths including calling in the Beneficiary Access Line (BAL), a 24-hour access line for beneficiaries, or the Member Service Line – OC Links, or through direct contact with any DMC-ODS provider, through County Mental Health Clinics, and through various court programs. In addition, the beneficiaries can access services within a continuum of care and are able to move through services without any treatment interruptions when a client is needing a higher/lower level of care (e.g., moving from residential to outpatient or outpatient to withdrawal management).

We have established several strong partnerships and have sat on several stakeholder committees to increase awareness of these services and ensure that the community is aware of how to access DMC-Services. Our staff are trained to work in collaboration with other county agencies such as Probation Department, Social Services Agency, Courts, and other community-based organizations for continuity of care.

SUD Trends

In FY 19-20, our system continues to see an ongoing increase in the number of beneficiaries with opioid use disorders requesting services. As a result of the COVID-19 pandemic, telehealth capabilities increased for DMC providers. Adolescent-specific trends for FY19/20 included: increased MAT services for youth through FQHCs; most adolescent referrals for DMC services came from other providers rather than being self-referrals; Cannabis Use Disorder was the primary or secondary diagnosis for most adolescents in DMC programs; and, Child Welfare, the courts, and other stakeholders increasing interest in ensuring Child Welfare families receive the SUD services they need.

Orange County has begun a new initiative of collecting data through the Cal OMS called the Cal OMS Dashboard. There was also an initiative to look at service data and the impact of COVID-19. For adult programs, Cal Oms provided data that methamphetamine was the primary drug that is used among participants. People that were homeless at the time of admission were more likely to use methamphetamine. Individuals that used heroine were likely to be in an independent living environment.

Data also showed that clients with a residential stay between 61 to 90 days were most likely to attend a follow-up outpatient appointment 7- and 30-days post discharge. 31.7% of all residential clients stayed in treatment between 61 to 90 days.

SUD Prevention Services

Target Population

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

These images highlight the Orange County Boy Scouts earning their anti-drug Red Ribbon patch and badge, a program coordinated by the Drug Enforcement Administration.

Parents, caregivers, and adult family members are provided services. School staff, from teachers to front office administration, are served. Prevention programming also reaches the business community, specifically alcohol retailers and establishment staff.

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

Services

OCHCA follows its 2018-2023 Strategic Prevention Plan to provide evidence-informed and research-based services throughout its diverse communities. The plan centers around four long-term goals: decrease underage drinking; reduce prescription drug abuse, decrease cannabis/marijuana use among youth; and reduce alcohol and/or drug impaired driving collisions. OCHCA coordinates a comprehensive prevention system, which includes a broad array of prevention strategies directed at those not identified to need substance use disorder treatment. Services are aligned with the strategic plan goals and include providing education; disseminating information/materials; conducting presentations and trainings; collaborating with community partners and stakeholders; implementing media campaigns; and supporting youth-led prevention activities.

Programs are delivered by County staff as well as contracted providers. For example, a provider with the OCHCA is the Orange County Department of Education, which administers two prevention programs - Friday Night Live Partnership, which uses a youth-driven prevention model, and a school-based education program, reaching students, parents, and school staff. Youth education is provided using evidence-based curricula (those which have demonstrated effectiveness in reducing youth substance use), such as Too Good For Drugs and Botvin's Life Skills.

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

Outcomes
Prevention services implemented by Health Care Agency and its providers utilize a systematic approach to evaluation, with both process and outcome objectives. Below are examples of outcomes achieved during FY 2020-2021 in support of the Plan's goals. Outcomes were measured using pre/post or post only surveys.

- Media literacy training was provided to 693 youth, whereby 91% of those surveyed reported increased media literacy.
- Close to 160 youth received training on refusal skills, whereby 81% of those surveyed reported increased confidence to use refusal skills in relation to the prevention of alcohol and other drugs.
- Approximately 150 youth were trained on leadership skills, whereby more than 92% of those surveyed reported increased confidence to use these skills in the implementation of prevention activities.
- Over 500 parents were educated on youth substance use prevention, whereby 88% of those surveyed reported an increase in knowledge of current alcohol and drug trends.
- Orange County youth designed and implemented over 70 alcohol and drug prevention activities in their schools and communities.

Over the past two years, the OCHCA had success in designing, implementing and evaluating an adult opioid prevention media campaign, *Wrong for You*. With the objective to increase awareness of the dangers of misusing prescription opioids, after much research, the target demographics of the campaign were non-Hispanic white males between the ages of 45 – 54 living in the coastal regions of Orange County. Campaign media included digital/social, cable television, radio and print advertising. The campaign originally ran from February through May, 2020 and was relaunched from January through March, 2021. Evaluation metrics from the relaunch include:

- **Cable** (i.e., CNN, ESPN2, Fox Sports, History, TNT): 5,739 Spots Delivered
- **Radio** (KUSC and KPCC): 266 Spots Delivered; 2,518,800 Delivered Impressions
- **OC Register** (newspaper) Digital Banners: 806,696 Delivered Impressions
- **Digital Display**: 30,958,332 Delivered Impressions
- **Social Results** (Facebook/Instagram): 2,709,872 Impressions, 28,422 Clicks
- **Website**: 69,359 Unique Users; Average Time Spent on a Page = 01.47

Challenges, Barriers, Solutions in Progress
Collaboration with schools and districts was greatly impacted by the COVID-19 pandemic. Challenges included schools not permitting outside agencies on campuses, the reluctance to take away from classroom instructional time and the priority to meet educational requirements set forth by the California Department of Education. OCHCA prevention services successfully pivoted to virtual services, using platforms such as Nearpod and Zoom. Trainings, workshops and presentations were reformatted to be virtually interactive, featured learning games and engagement activities and were made available in self-paced recorded videos.

Community Impact
Prevention staff continue strong and productive partnerships with schools, community-based organizations, law enforcement agencies and with the business community. Orange County youth tend to have comparable, and in many cases, much lower rates of alcohol and/or other drug use compared to national and state levels, with just a few exceptions. Although these data are overall favorable, the OCHCA continues to employ evidence-based prevention services in order to improve and sustain health behaviors among the residents of Orange County.

SUD Trends

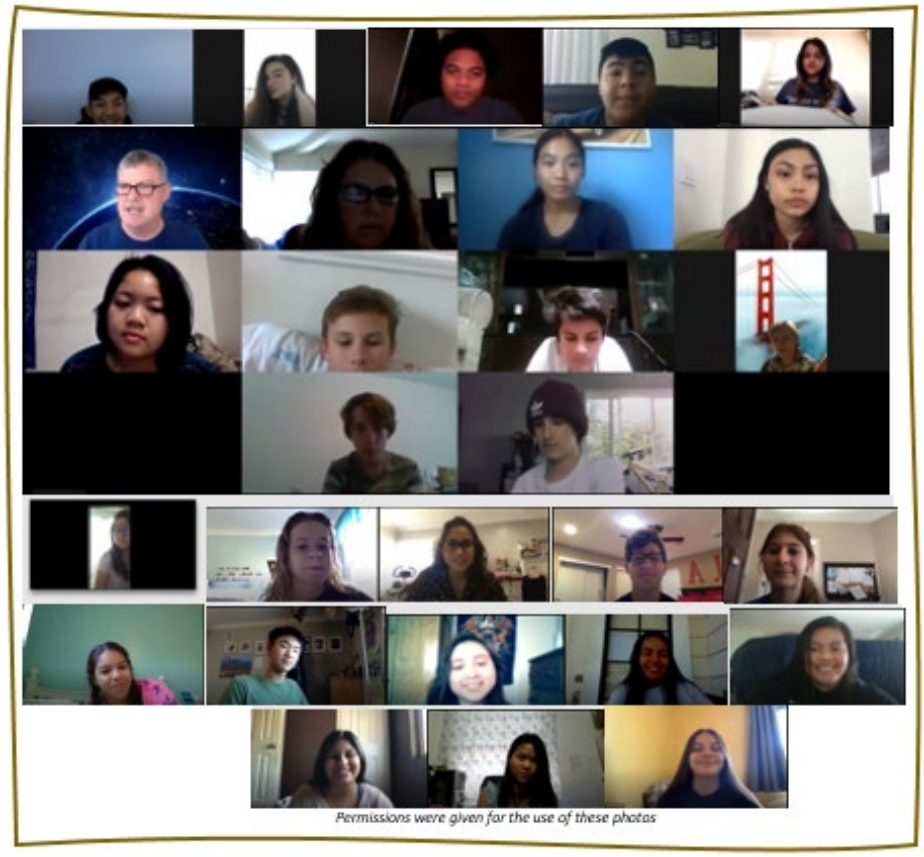
According to results from the California Healthy Kids Survey, past 30-day use rates of the following substances used by Orange County 11th graders have continued to trend downward:

- **Alcohol**: 35% reported in 2007/2009, 14% in 2017/2019
- **Misuse of prescription drugs**: 4% reported in 2013/2014, 1% in 2017/2019
- **Cannabis/marijuana** (smoke, vape, eat or drink): 16% reported in 2013/2015, 12% in 2017/2019

Upcoming

Plans are underway for a youth opioid prevention media campaign**.** According to research, teens misuse prescription drugs because they are easily available and believe these drugs provide a "safe" high. The campaign, targeting youth ages 13 – 18, will focus on increasing awareness of the dangers of prescription painkillers, such as opioids, and will provide productive alternatives. Additionally, the COVID-19 pandemic has taken a toll. The months of isolation have created a heightened vulnerability to substance misuse and an increased need to restore mental health and overall well-being among youth. Media components will be delivered in English due to the target audience of teens. The campaign will be designed to reach youth where they spend much of their time – online and social media platforms (i.e., Instagram, TikTok and Snap Chat). Pre-campaign activities will include key informant interviews, focus group testing and reviewing local data.

These images are a collage of photos from a youth focus group testing in preparation for a youth opioid prevention media campaign.



Mental Health Awareness & Prevention

Start Well / Early Childhood Mental Health Consultation Services (PEI)

Early Childhood Mental Health Consultation Services are provided to Early Childhood and Education (ECE) providers, including licensed providers, license exempt childcare centers, and licensed family childcare homes throughout Orange County. Consultation services are designed to educate and build capacity, increase knowledge and awareness of early childhood educators to provide appropriate behavior support for those exhibiting ongoing challenging behaviors, and promote development of healthy identities in young children. The goal of these services is to improve the mental health outcomes of young developing children, infant to five years old, particularly those exhibiting problematic behaviors and are at risk of mental illness in Early Childhood and Education settings throughout Orange County. Consultation services include consultation, practice-based coaching, direct observation, and follow-up services. (*See Start Well/Early Childhood Flyer in Appendix V*)

K-12 School-Based Mental Health Services (PEI)

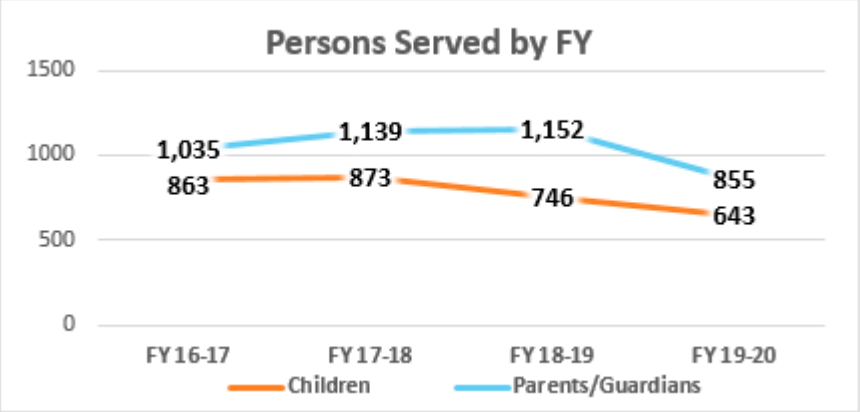
Provides gatekeeper training for students, parents and teachers for identifying the early warning signs of a mental health condition and learning how to engage/support those who are in need of help; provides educational activities, using peer approaches for promoting mental health awareness and for creating supportive environment in schools for students who may be struggling with a behavioral health condition; developing user-friendly mental health resources including a directory; and creating robust community networking opportunities across school districts. (*See School Based MH Flyers in Appendix V*)

TAY and Young Adult Mental Health Services (PEI)

Mental health outreach services, mental health educational activities and community networking services designed to increase help-seeking behaviors and access to behavioral health resources for TAY and young adults with a primary focus on College campuses and institutions for higher education. (*See TAY and Young Adult MH Flyers in Appendix V*)

School Readiness (PEI)

School Readiness serves families with children from birth to age 8 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).

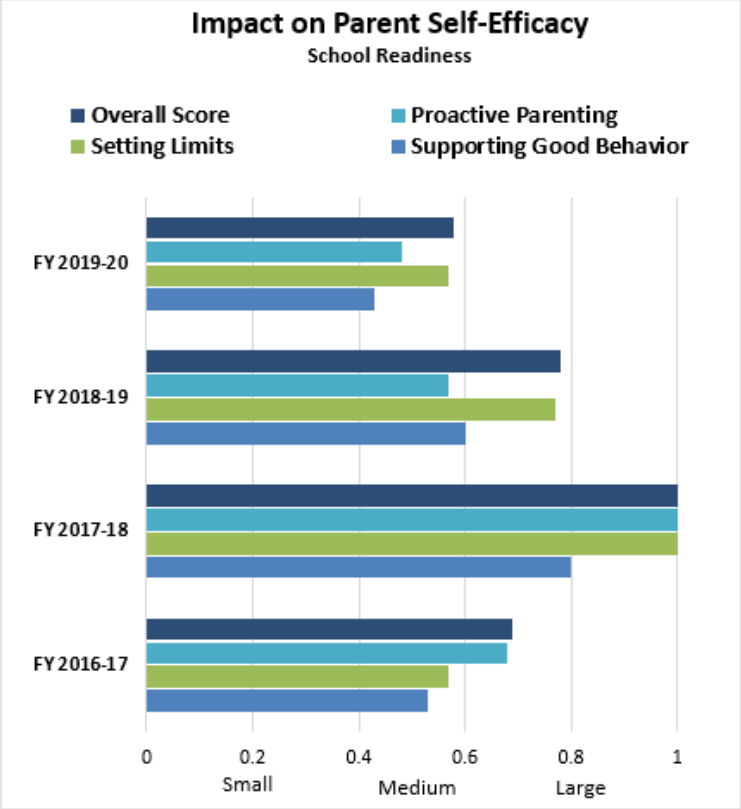


Services

Services for children and their families include developmental screening, child and family needs assessments, parent education/training and coaching using Triple P Positive Parenting Program techniques, case management, and referral and linkage to community resources. The program also goes out into the community to train parents/caregivers, family members, day care staff, early education staff and other professionals working with the target population on how to recognize the early signs of emotional disturbance and behavioral conditions and to be aware of available resources.

Outcomes

To measure the extent to which the program promotes the protective factor of parenting self-efficacy, parents completed the Parenting Children and Adolescents Scale-Self-Efficacy (PARCA-SE) at baseline and follow-up to assess for changes in overall parenting self-efficacy, support of good behavior, limit setting, and proactive parenting. The PARCA-SE is culturally sensitive, as it has been validated for use among diverse racial and ethnic groups (i.e., White, Hispanic, Black, Native American, Asian, Native Hawaiian, Biracial or Other), and is available in multiple threshold languages.



Across all four fiscal years, parents reported medium to large improvements in overall self-efficacy, support of good behavior, limit setting and proactive parenting, with positive impact tending to be somewhat stronger in FY 2017-18 compared to the other fiscal years.

Challenges, Barriers and Solutions in Progress

The challenges encountered by the program in FY 2019-20 were primarily related to planning and coordination around the public health emergency and all the restrictions imposed. Although the school readiness providers were able to pivot their programming on the virtual digital platform, they found conducting screening and assessments and collecting the survey data were a challenge. On the other hand, attendance at trainings was steady; parents and caregivers found it easier to attend the virtual training. Going into FY 2021-22, only one of two provider contracts are being renewed with an increase in the contracted maximum obligation and resulting in a net decrease in the overall program budget and number of participants to be served. The remaining unencumbered program funds (i.e., $600,000) were redistributed to other programs/providers also serving families with young children ages 0-8 (i.e., Parent Education Services; the early childhood provider in the Outreach to Increase recognition of the Early Signs of Mental Illness program).

Community Impact

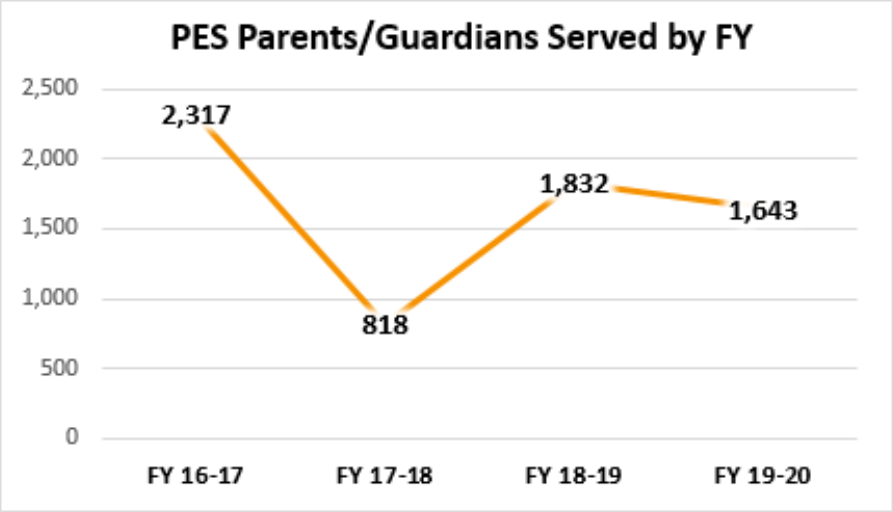
The program has provided services to thousands of participants since its inception in April 2013. Staff regularly work with school and Head Start personnel, physicians and nurses to connect families to services. By helping prepare children to participate in a classroom setting, the program works to decrease the potential for school failure, which can be a risk factor for the development of a mental health condition.

Parent Education Services (PEI)

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.

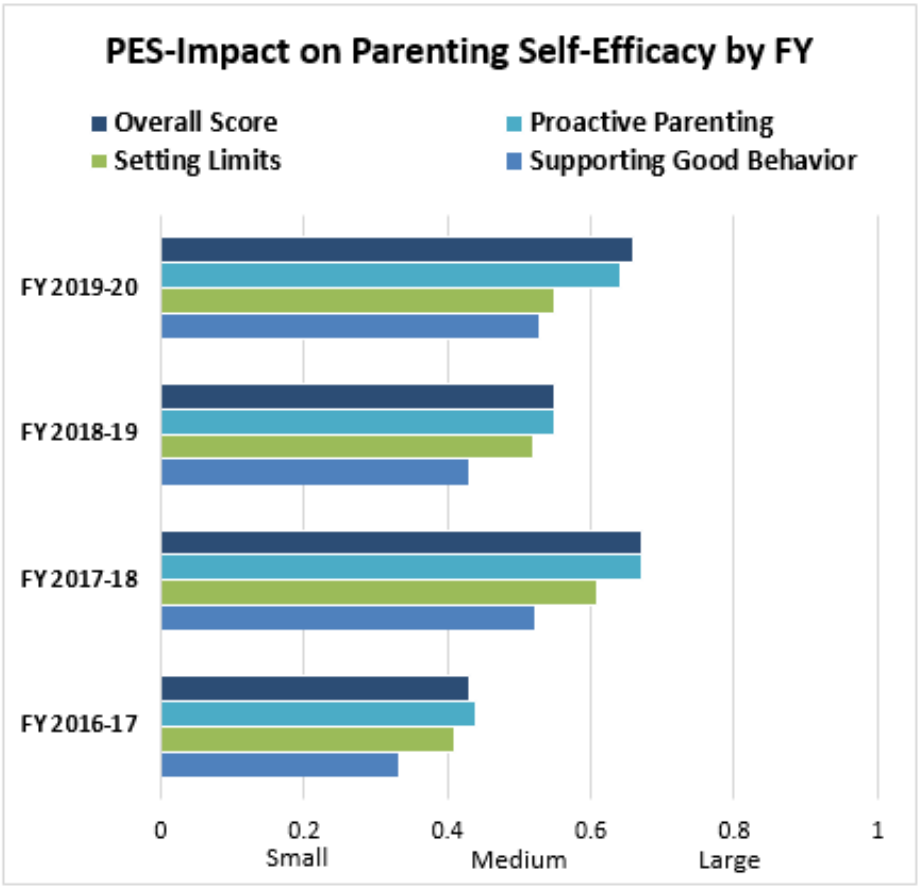
Services

The program's purpose is to prevent the occurrence of, or reduce prolonged suffering due to, negative mental health outcomes in children by promoting protective factors in parents and caregivers. It accomplishes this by providing parenting education classes and individual interventions or additional support when parents need clarification about individual issues or help in understanding the parenting curriculum. The program guides its services through Active Parenting, an evidence-based parent training designed to reduce risk factors and increase family protective factors through practical, easy-to-use skills such as assisting parents in strengthening relationships with their children, reducing problem behaviors exhibited by children and increasing success of children in schools, by increasing cooperation and developing problem-solving skills. To ensure fidelity, all parent trainers are required to attend a comprehensive training prior to conducting classes. Parent trainers are also evaluated in the classroom a minimum of one time per month. In addition, PES provides case management activities, which include engagement, assessment and service coordination and delivery (e.g., navigating and linking to systems, monitoring, advocating for needs).



Outcomes

Program effectiveness for PES was evaluated through an assessment of the protective factor, parenting self-efficacy. Results generally demonstrated that parents not only maintained high levels of parenting efficacy while receiving services, but also made additional small to medium gains, with gains tending to be somewhat larger over the past three years compared to FY 2016-17.



Challenges, Barriers and Solutions in Progress

The program continues to expand its reach in the community to address the needs of the diverse population of the county. Attendance from the LGBTIQ community and the deaf and hard of hearing community continues to grow. In addition, more classes for survivors of domestic violence are being offered and attended

throughout the county, and these classes are formatted as closed sessions, not open to the general public, to protect the identity of the women. Prior to the pandemic, the program was successful in getting access to the Orange County jails to provide classes to incarcerated women and men. Due to the public health emergency, access to the jails was restricted. The program will add more parenting classes specifically for parents with children birth – 8 years of age. Parenting classes for all age groups are provided in multiple languages including Vietnamese, Korean, Farsi, Arabic, in addition to English and Spanish. In response to the pandemic, the program successfully recreated and provided the Active Parenting training remotely to allow access to training during the pandemic shutdown.

Community Impact
Parent Education Services has provided services to 13,067 at-risk children and families since its inception in October 2012. Program staff has worked collaboratively with area school districts, child welfare, juvenile justice, and children's mental health systems throughout Orange County to support at-risk families.

Children's Support & Parenting Program (PEI)

Children's Support and Parenting Program (CSPP) serves a wide range of families from different backgrounds whose stressors make children more vulnerable to developing behavioral health problems. These stressors can include parental history of serious substance use disorder and/or mental health condition; a family member's actual or potential involvement in the juvenile justice system; family members who have developmental or physical illnesses/disabilities; families impacted by divorce, domestic violence, trauma, unemployment and/or homelessness; and families with active-duty military/returning veterans. Families are referred to the program through Family Resource Centers, schools, behavioral health programs and other community providers.

Services
The program provides parent training and family-strengthening programs designed to reduce risk factors and increase protective factors for children and youth. Services include family assessment; group interventions for children, teens and parents; brief individual interventions to address specific family issues; referral and linkage to community resources; and workshops.

CSPP provides these services utilizing evidence-based curricula depending on participant need: Strengthening Families or The Parent Project®. The curricula are delivered in a classroom-type setting in many different types of organizations such as schools, Family Resource Centers (FRC), treatment facilities, juvenile probation offices and the CSPP offices. All staff utilizing an Evidence Based Practices are certified to deliver the curriculum and adhere to it when presenting the material to participants.

Outcomes
CSPP strives to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills. CSPP measured parenting development using the PARCA-SE, which assesses different domains of parenting self-efficacy. Administered at intake, every three months of program participation and at discharge, the PARCA-SE was analyzed for change in scores between intake and the most recent follow-up and reported according to effect size. Results from FY 2016-17 through FY 2019-20 show that parents not only reported maintaining healthy levels of parenting efficacy but also made small additional gains while receiving services.

Challenges, Barriers and Solutions in Progress
Maintenance of program staffing has been challenging in this program as many of the positions are "entry level" in nature and staff quickly promote to other positions. The classification specifications for these programs are being examined to make appropriate changes. In addition, due to the nature of services provided on school campuses or

community sites, with the COVID-19 Pandemic, CSPP services were abruptly halted which affected total number served. Through CARES Act funding, licenses for the Positive Parenting Program (Triple P) online were purchased for caregivers to have remote access to parent education and supports. CSPP staff were made available as parent liaisons for those desiring additional assistance with the curriculum.

School-Based Behavioral Health Intervention & Support (PEI)

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.

Services

SBBHIS provides a three-tiered approach to program services aimed at preventing and/or intervening early among at risk students and their families:

- **Tier 1:** Classroom prevention is a classroom-based approach that utilizes an evidence-based curriculum, Positive Action, with learning modules focused on key learning objectives such as self-concept, life-skills, positive decision-making, respect and bullying prevention. Tier 1 students also have access to an application (app), *You and*, for on-demand digital support for their social and emotional well-being.
- **Tier 2:** Students exhibiting higher-level problem behaviors are provided student-based interventions, which utilize smaller student groups focused on specific areas of concern such as bullying, anger management, conflict resolution, drug prevention and/or self-esteem. Tier 2 students also have access to the *You and* app.
- **Tier 3:** Students who display symptoms indicative of higher-level needs and require more intensive services than provided in Tiers 1 or 2 receive Tier 3, Family Intervention. This tier provides early intervention family services focused on building skills to improve family communication, relationships, bonding and connectedness.

Outcomes

Different measures were used in each tier due to differences in services and level of student need. At each tier, the respective measure was assessed at baseline and program exit, and the change in scores was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students. It should be noted that, due to the large volume of students completing the measures at the start and end of Tier 1 and 2 activities, combined with errors in filling in their identifying information, many surveys were unable to be matched.

- **Tiers 1 and 2**: To measure the extent to which the program increased the protective factor of well-being among Tier 1 and Tier 2 participants, the program began administering the PROMIS Pediatric Global Health-7 (PGH-7) in FY 2018-19. Because one of the providers was unable to separate the outcome data by tiers, analyses combined Tier 1 and Tier 2 PGH-7 data. Self-reported student ratings since FY 2018-19 showed that students maintained adequate levels of positive health while participating in Tier 1/Tier 2 (i.e., average score falling around the 50th percentile, negligible effect size). In earlier fiscal years, program performance was measured with a modified Self-Concept Scale. Self-reported student ratings similarly showed that students maintained positive self-concept during the weeks they participated in Tier 2 programming.
- **Tier 3**: To assess the effectiveness in reducing prolonged suffering among Tier 3 participants, different types of disruptive behaviors were rated by the students' parents on the Child and Adolescent Disruptive Behavior Inventory (CADBI) at baseline and program exit. Change in scores over time is reported according to effect size.

Since 2016-17, parents generally reported that their children showed moderate decreases in disruptive behavior toward both adults and peers, as well as small to moderate decreases in impulsive and hyperactive behaviors.

Challenges, Barriers and Solutions in Progress
In response to the pandemic and school closures, the program was successful in continuing to serve students by recreating their program curriculum and providing it on a virtual platform. In addition, a provider created the "Safer from Home" series for middle school students in response to the pandemic and received outstanding reviews form participants and their teachers. Finally, with the use of CARES Act funding, this same provider developed a computer and mobile interactive app, called "You And," for school age youth designed to maintain social and emotional well-being of students, their mental health, improve resiliency, develop positive coping skills, and stay connected to their peers. The content is tailored to engage four educational groupings: K-2, 3-5, Middle School and High School. Based on requests from individual schools, the provider will integrate the 6-week curriculum within the Tier 1 and Tier 2 services.

Community Impact
The program continues to build capacity in the community through collaboration with community partners and school districts. Since program inception, more than 160,000 students, 10,500 parents/ caregivers and 6,000 school staff have participated.

Violence Prevention Education (PEI)

The Violence Prevention Education (VPE) program aims to reduce violence and/or its impact in schools, local neighborhoods and/or families. The target audience for the program includes students, parents and school staff at participating elementary, middle and high schools throughout Orange County, as well as other community sites such as domestic violence shelters.

Services
The program has five different tracks designed to promote violence prevention. In FY 2017-18 VPE underwent significant change by adding new components (i.e., Boys and Girls Restorative Practices, Threat Assessment Simulation), and tailoring the Anti-Bullying assembly content to different grade levels. Each track uses an evidence-based or practice-based evidence standard geared toward its specific focus, and fidelity to the Evidence-Based Practice (EBP) model is maintained by providing staff with periodic refresher trainings to ensure appropriate implementation.

1- **Bullying/Cyber-Bullying**: Educates students, staff, administrators and parents on bullying and cyber-bullying prevention through: (1) presentations conducted at school assemblies to impact the overall school climate by reducing and/or preventing bullying; and (2) a classroom-based curriculum focused on combating cyber-bullying. From FY 2016-17 through FY 2019-20, most respondents agreed or strongly agreed that they knew or learned about bullying (61-87%) and felt empowered to stand up to bullying behavior (73-83%) after attending a student assembly. In FYs 2018-19 and 2019-20, when the post-training measure was implemented, many students who took part in the cyber-bullying curriculum (72-96%) stated that they had learned a digital literacy skill.

2- **Restorative Practices:** Offers a trauma-informed, research-based training for teachers to promote resilience in youth, particularly those who have been exposed to violence and varying degrees of trauma. Teachers utilize "circle practices" in the classroom to promote healthy relationships and help create calmer, more focused classrooms. The "circle practice" encourages students to strengthen relationships with their peers and teachers, thus, creating a safe and supportive environment for effective communication, expression of emotion, and exploration and acceptance of differences. Teachers who use these methods often find that the

overall portion of time dedicated to managing behavior is reduced, thus freeing up more time for instruction. In FY 2019-20, most students agreed or strongly agreed that they had engaged in healthy habits or accepted others, although fewer girls endorsed having a positive body image or engaging in a meaningful activity.

3- **Safe From The Start**: Educates parents on research demonstrating how exposure to violence, whether through direct physical contact or as a witness, can impact children's neurological development which may, in turn, compromise their cognitive, social and emotional development. Presentations are provided to parents at campus during and after school hours, as well as at shelters. Across the past four fiscal years (FY 2016-17 through FY 2019-20), most respondents reported feeling confident in their ability to better manage emotions and use positive parenting strategies following the training (65-99%).

4- **Threat Assessment:** Provides training to school administrators, teachers, mental health counselors, school resource officers and other school staff to assess threats and respond appropriately, and survey results indicate that those who received the simulation drills (see below) felt more confident in their ability to assess and respond to potential threats. The program consists of three components:

   a. Proactive Threat Assessment Training, a full-day training covering the definition of threat, threat types and levels, how to screen and assess threats, behavioral indicators to look for, a response protocol, addressing stigma and mental health resources; and
   b. Threat Assessment Simulation Drills, covering situational awareness to increase confidence and a sense of empowerment during an emergency, which includes classroom and front office lockdown steps and procedures, and a post-drill debrief to reflect on shared experience, distress reactions, and the importance of self-care.

5- Community Forums, facilitates discussion around the importance of violence prevention and early intervention, shares best practices for school safety, and supports families and community members in identifying ways they can participate in violence prevention efforts, as well as how to support children in times of crisis, and access mental health services and resources.

In FYs 2018-19 and 2019-20, when the training was implemented, the majority of school staff who took part in the training (86-99%) stated that they had learned information on how to identify and/or respond to a potential threat.

- **Crisis Response Network**: A network of crisis responders trained in Crisis Incident Stress Management who mobilize and assist a school or community in times of emergency, need or threat. Pre-incident and crisis management trainings are also provided to the schools and the community. Across the past four fiscal years (FY 2016-17 through FY 2019-20), the majority of respondents agreed or strongly agreed that they learned how to recognize risk factors and practice healthy coping or support behaviors (85-100%).

Challenges, Barriers and Solutions in Progress

In an effort to meet the changing scheduling needs of participating schools and districts, the program had adjusted service delivery or curricula so that trainings and presentations can be held in a single, large-format assembly rather than multiple, smaller classroom sessions. The program faced challenges in providing most of their services due to the public health emergency since March 2019, when schools were on lockdown.

Community Impact

The program has provided services to more than 220,000 students, 32,600 parents and 11,550 school staff since its inception in August 2013. The program has had a strong impact in local communities by increasing awareness about

the risks posed by violence and bullying, providing support in times of crisis, and creating educational opportunities for students, staff, parents and Orange County residents.

Gang Prevention Services (PEI)

Gang Prevention Services (GPS) is a school-based collaboration with the Gang Reduction Intervention Partnership (GRIP) operated by the Orange County District Attorney's (OCDA) Office in conjunction with the OC Probation Department, local police departments and school staff. It provides case management to 4th through 8th grade youth who display signs of being at risk for gang activity which, in turn, places them at an increased risk of violence and of developing mental health conditions, particularly those that are trauma-related. The OCDA Office and the OC Probation Department select schools to participate in the program based on high rates of truancy, discipline issues and gang proximity. The program focuses on being inclusive of all high-risk youth in the identified schools, regardless of their familial affiliations to gang activity or behavior.

Services

At each participating school, staff provides education to students, parents and teachers on gang prevention and offers workshops, structured group interventions, and weekly case management. Staff also works with students and their families to create an individualized action plan that addresses attendance, academic behavior, disciplinary improvement, parenting contracts and an anti-gang dress code plan. The program accompanies law enforcement to provide curfew and truancy sweeps designed to get youth off the streets and back into the classroom.

Students and parents who successfully complete their behavior contracts are provided incentives such as attending a baseball game or other enrichment activities. Many events include law enforcement, which encourages families to see them in a more positive light and as part of a supportive community.

Outcomes

To measure the extent to which GPS increased the protective factor of health and well-being, students completed the PROMIS® Pediatric Global Health at baseline, every three months and at discharge. The change in scores between baseline and the most recent follow-up was analyzed and reported according to effect size, which reflects, in part, the extent to which a change is meaningful for the students served. In all four years, youth not only maintained their global health but also made small additional gains while receiving services. Thus, the program was associated with maintaining and somewhat improving this protective factor. In addition, in FY 2019-20, 64% students increased attendance, 95% decreased truancy and 100% decreased curfew violations.

Challenges, Barriers and Solutions in Progress

In GPS, case managers are constantly encouraging parents to engage with their child by facilitating the establishment of positive social support networks. This is accomplished by creating an open environment with other parents, the school and local law enforcement. The program assists with this coordination by offering parents opportunities to be involved as greeters at their child's school and by encouraging an environment of rapport building with law enforcement. This is an innovative strategy as many communities are often intimidated by law enforcement officials. Youth and their families also meet regularly with case managers to resolve and overcome challenges related to truancy or other school-related behavioral issues to deter future gang involvement. Due to the pandemic and school closures, the program was not able to add new students to the case management services during the latter part of the fiscal year. However, there was an overall need for more case management services for students and families already receiving services.

Community Impact
GPS has provided services to more than 4,700 students and parents since its inception in August 2013. Through its case management services, the program has encouraged youth to avoid high-risk behavior and engage in more positive decision-making. The program has also strengthened relationships with the community by partnering with organizations and businesses such as the Los Angeles Angels. Through these collaborations, agencies can educate and motivate students and to serve as mentors for future career possibilities. The GPS program continues to receive awards for working with Orange County schools on gang suppression, interventions for at risk students, gang information forums and parent/ faculty education.

Family Support Services (PEI)

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.

Services
Services are designed to sustain and/or improve families' overall behavioral health by increasing protective factors through education and social support. The program provides ongoing family education on behavioral health issues to prevent the development of behavioral health problems in other members of the family. FSS includes family-to-family support, behavioral health education and support groups, and delivers a broad range of personalized and peer-to-peer social development services that emphasize behavioral health education, wellness topics and the development of healthy coping tools to support the family. Motivational Interviewing and the Family-to-Family curriculum are two evidence-based practices used by the program to reduce negative outcomes. Family-to-Family serves as the foundation for understanding mental health issues from the perspective of holistic and trauma-informed care, stages of recovery, biopsychosocial elements of mental health conditions, medication, confidentiality and effective communication with individuals living with a mental health condition. Services are delivered through group support, weekly individual peer mentor support, educational workshops, a volunteer family mentor network and family engagement. The program also includes a component on practicing self-care when caring for a loved one with a behavioral health condition within the educational workshops.

Outcomes
FSS aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of Global Health as measured by the PROMIS. The PROMIS was administered at intake (baseline) and program exit (follow-up), and the difference in scores was analyzed and reported according to calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served. In FY 2017-18, FSS services split off from PES. During this transition year, there was a drop in completed outcome measures.

Across 3 of 4 fiscal years, parents consistently reported high levels of global health as they entered the program and made additional, small-to-moderate gains, with the exception of FY 2017-18 when FSS became a standalone program. Thus, FSS appeared to be effective in maintaining and/or enhancing the protective factor of global health among the participants it serves.

Challenges, Barriers and Solutions in Progress
The program faces challenges recruiting participants in the summertime when schools are typically out of session and families may be on vacation or busy with summer activities. To mitigate this challenge, the program partners with local

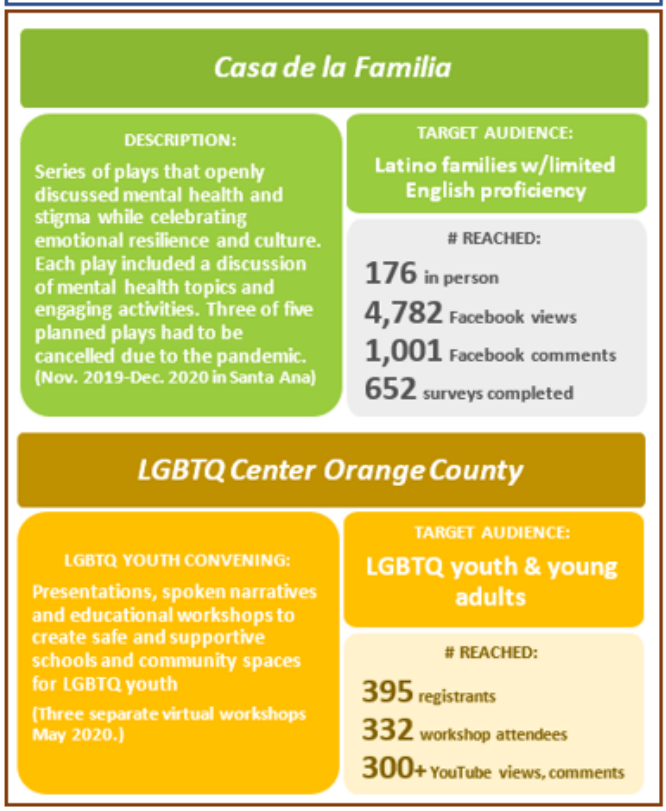
community organizations, including Family Resource Centers, which may have direct contact with potential participants during the summer.

Another significant challenge the program experiences is attendance at the Basics class, a six-week course designed to educate parents of children living with a mental health condition about mental health conditions, parenting skills, caring for siblings, self-care and collaborating with providers and educators. The low attendance is due to difficulties the families have finding appropriate childcare. In response, the provider offers several classes at a time allowing so participants have multiple opportunities to attend, classes are offered throughout Orange County so participants can choose the most convenient location, and childcare is provided onsite.

In response to the pandemic, the program added support groups for first responders through CARES Act funding. Since CARES Act funding expired and these services were identified as a valuable support, they will continue to be provided through MHSA funding.

Community Impact

The program has served 13,692 total families/caregivers since program inception October 2012. FSS collaborates with agencies and community groups to ensure that services are provided throughout Orange County. Services are often held at community locations such as libraries and schools.



Mental Health Community Education Events for Reducing STIGMA & Discrimination (PEI)

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.

Services & Events

Participants are invited to take part in activities designed to help them learn about and/or express their thoughts and feelings about mental health and stigma. Activities can

include viewing or creating artwork, watching performances or presentations, creating videos, storytelling and other forms of self-expression and group-learning. While each event is different, they all provide messaging aimed at educating the public on mental health conditions, the stigma surrounding mental health conditions and the mental health resources available in their communities. The events also seek to educate the public about the abilities and experiences of those living with a behavioral health issue and to instill self-confidence and hope in people living with a mental health condition and their family members.

During FY 2019-20, community-based organizations hosted a series of events. Due to the public health emergency beginning March 2020, all in-person events and activities were put on hold and allowed providers an additional six months to adapt their services to public health guidelines. In addition, the HCA funded four social marketing campaigns focused on mental health awareness, suicide prevention and stigma reduction to address the anticipated increase in need for mental health services and support due to the pandemic.

All providers were contracted to host the event(s) under a provider-specific agreement titled "Mental Health Community Educational Event Services." In FY 2021-22 and 2022-23, the program intends to host events similar to what was offered in FY 2019-20.

Strategies to Promote Recovery/Resilience

The program encourages participants and their family members to attend and participate in stigma reduction activities in their community. Recovery is promoted by tapping into participant's creative energy, encouraging their self-expression to reduce feelings of self-stigma, shame and isolation, and building connections with the larger community through interactive events open to all.

Strategies to Reduce Stigma and Discrimination

The program hosts events that are open to all Orange County residents and are sensitive and responsive to participant's backgrounds. Care is taken to host events in communities of underserved populations where stigma is particularly prevalent. The projects attempt to educate the surrounding community and dispel misperceptions regarding mental health. This strategy is employed because art transcends socioeconomic status, ethnicity, culture, language, mental health condition and other factors that are sometimes a source of discrimination. When art is appreciated, it can open

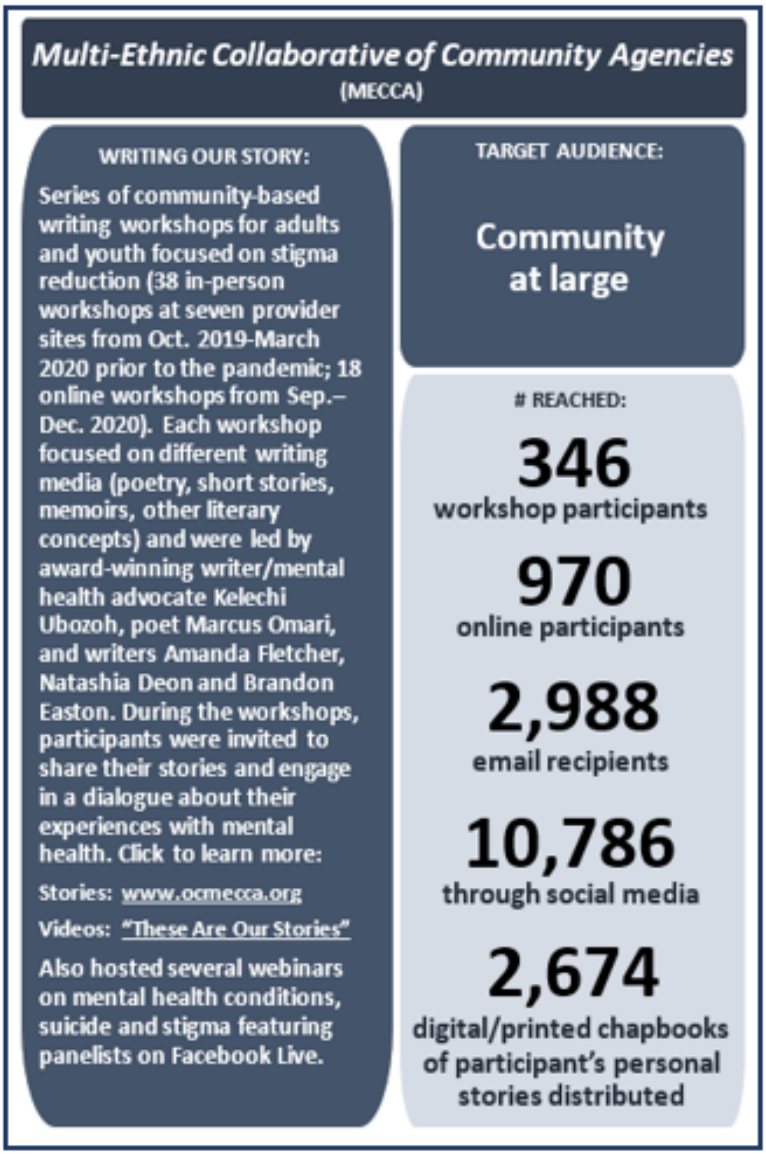
the door to acceptance. Creating and sharing artwork also builds self-esteem and encourages people living with a mental health condition to define themselves by their abilities rather than their disabilities.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment
The program is inclusive of those living with mental health conditions and their loved ones. Community partners who specialize in working with underserved cultural populations are involved to improve community members' access to the events. By having trusted cultural ambassadors host the activities, the program provides an opportunity for these partner agencies to interact with residents living with mental health conditions, thereby encouraging them to seek the agency's services in the future.

Outcomes
HCA has been working on identifying tools and strategies for measuring stigma reduction, which can be challenging, particularly at large-scale events and performances. In FY 2019-20, due to the emphasis on virtual events and digital campaigns, programs tracked number of participants and digital media impressions as outcomes (reported in tables above). The shift to virtual events in FY 2019-20 due to the pandemic introduced challenges with collecting survey outcome data and was unable to be collected in sufficient numbers to report.

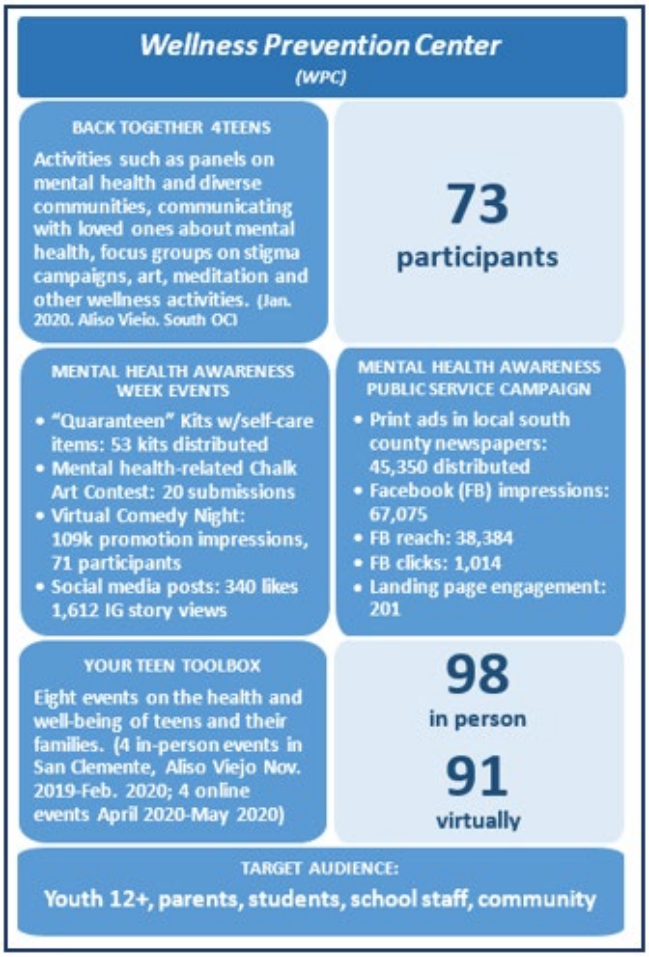
In FY 2018-19, one provider (MECCA) asked event participants to complete a survey on their beliefs and attitudes about mental health:

- **Drawing Out Stigma - Youth Participatory Video Workshops: % "agreed" or "completely agreed" with the following statements** (n=12)
    - **92%** "learned something new about mental health"
    - **92%** stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
    - **100%** "learned ways to prevent discrimination against people with mental health conditions"
    - **58%** "learned where to find more services or programs on mental health"
    - **75%** disagreed or completely disagreed that a "person with a mental health condition is dangerous"
- **Drawing Out Stigma: Adult Participatory Video Workshops** (n=111)
    - **91%** "learned something new about mental health"



- **83%** stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
- **91%** "learned ways to prevent discrimination against people with mental health conditions"
- **84%** "learned where to find more services or programs on mental health"
- **71**% disagreed or completely disagreed that a "person with a mental health condition is dangerous"

- **<u>Community Educational Screenings</u>** (n=517)
  - **88%** "learned something new about mental health"
  - **80%** stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **84%** "learned ways to prevent discrimination against people with mental health conditions"
  - **81%** "learned where to find more services or programs on mental health"
  - **64%** disagreed or completely disagreed that a "person with a mental health condition is dangerous"
- **<u>Multi-Ethnic Mental Health Arts and Festival</u>** (n=383)
  - **86%** "learned something new about mental health"
  - **83%** stated that "viewing the event positively changed [their] perspective about individuals who have a mental illness"
  - **84%** "learned ways to prevent discrimination against people with mental health conditions"
  - **83%** "learned where to find more services or programs on mental health"
  - **50%** disagreed or completely disagreed that a "person with a mental health condition is dangerous"



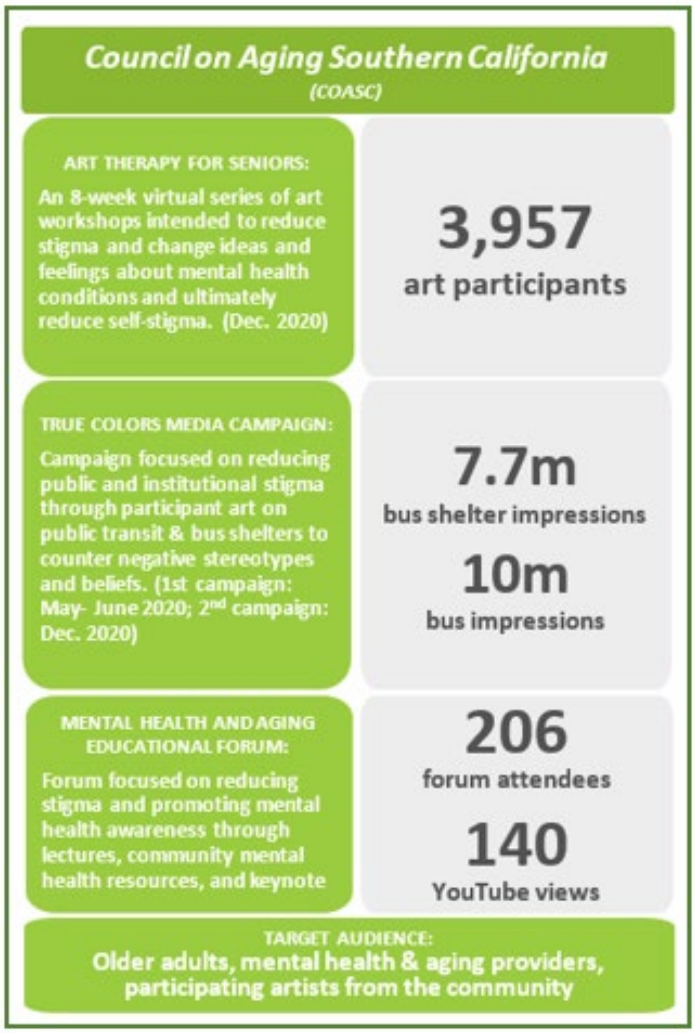
Taken together, the results suggest that these events were particularly effective in promoting positive messages about mental health and people living with mental health conditions among youth and adult participants. Given the nature of the events, it is not surprising that the educational screenings and art event/festival were more effective in informing participants about available services compared to the participatory videos.

Challenges, Barriers and Solutions in Progress

The challenges encountered by the program in FY 2019-20 were primarily related to planning and coordination around the public health emergency and all the restrictions imposed. Although the providers were able to pivot most of their programming in creative ways on the virtual digital platform, they found that participant attendance and collection of surveys was the biggest challenge. Large numbers of participants registered for the events, but fewer attended and almost all were reluctant to complete the surveys.

Community Impact

The program has provided services to nearly 40,000 individuals since its inception in FY 2012-13. Feedback from participants indicates that the arts remain one of the greatest assets in empowering the community while raising awareness and understanding of mental health.



Outreach for Increasing Recognition of Early Signs of Mental Illness (PEI)

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.

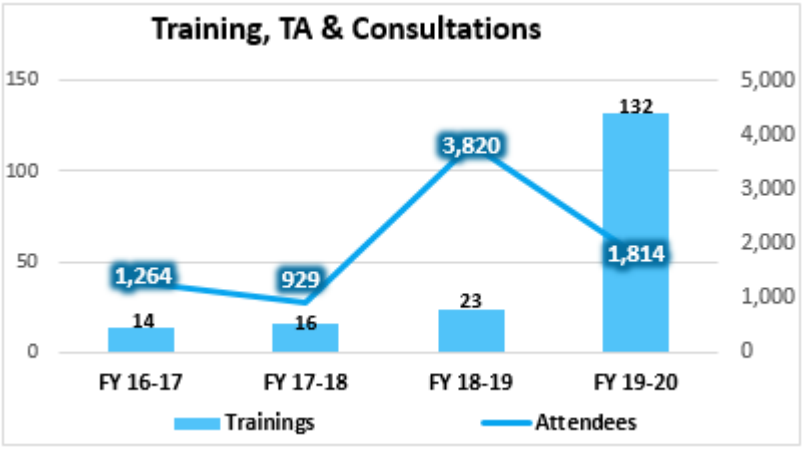
Services

The program aims to better inform and/or prepare a wide range of potential responders on how to: identify behavioral health conditions in all age groups as early in their onset as practicable, assist individuals exposed to trauma and/or living with behavioral health conditions and their families, and increase knowledge on how to access behavioral health services. The program also conducts mental health awareness outreach to individuals of all ages who have had life experiences that place them at risk of developing behavioral health conditions but remain hard to reach in traditional ways because of cultural, linguistic or economic barriers. The program strategies used include 1) training, technical assistance and consultation, 2) educational/informational material development, 3) community events, networking and activation, 4) media campaigns and 5) door-to-door/street outreach. In addition, the content and/or format used within each strategy is tailored for two audience types:

- ***Tier 1*** is for members of the general public seeking information about behavioral health, including individuals such as parents, youth, students, neighbors, etc.
- ***Tier 2*** is for members of professional communities, other than behavioral health, who interact or work with individuals who are experiencing, or at risk of experiencing, a behavioral health issue, including staff from public or private schools, childcare sites, colleges/universities, veteran organizations, law enforcement, probation/parole, housing providers, shelters, religious leaders/faith-based centers, businesses, etc.

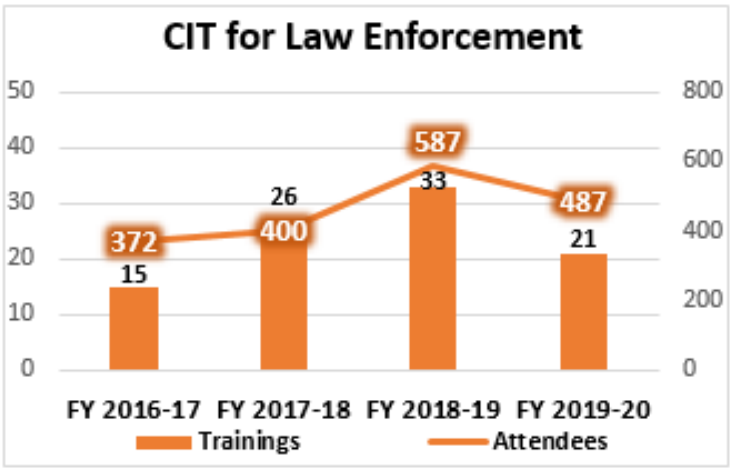
Trainings for behavioral health providers are described in the Workforce Education and Training (WET) section.

Strategy 1: Training, Technical Assistance and Consultations



Trainings, technical assistance (TA) and consultations cover topics such as Identifying and Responding to the Early Signs of Mental Illness, Trauma-Informed Care, Suicide Prevention, Resilience and Well-Being, and other related subjects. In response to community feedback during the Summer of 2018, the Behavioral Health Training Collaborative was formed to provide behavioral health trainings on the signs and symptoms of behavioral health conditions and ways to help. The collaborative began serving the community in December 2019 and, as can be seen in the graph on the left, the number of trainings available for the community substantially increased. In addition, beginning FY 2020-21, Crisis Intervention Training (CIT) for Law Enforcement was moved from WET to PEI.

CIT for Law Enforcement



Crisis Intervention Training (CIT) for law enforcement officers helps to equip and train officers to de-escalate mental health crises to improve the safety of the officers and those individuals with mental health conditions. CIT is a 40- hour curriculum covering topics such as signs/symptoms of behavioral health conditions, dementia and other conditions that older adults may face autism and developmental disorders, and suicide. In previous years, the curriculum was offered in modules to accommodate officer schedules. Beginning FY 2020-21, additional curriculum was developed to train all first responders starting that year. This includes law enforcement (sworn and non-sworn staff), correctional staff, probation staff, dispatchers, and fire/ EMS personnel. Specific curriculum addresses the unique issues each first responder may encounter. Starting FY 2021-22, the law enforcement curriculum will be provided in one week over 40 hours at the request of local law enforcement agencies. See graph for CIT activity since FY 2016-17.

TIER 1: Trainings for Community Members*

Early Signs of Mental Illness	Trauma-Informed Care	Suicide Prevention	Resilience & Well-Being
• Multi-Cultural Mental Health Training • What is Mental Health	• Adverse Childhood Experiences	• Means Restrictions • CalMHSA Know the Signs	• Resilience • 40 Developmental Assets • Healthy Coping Skills • Virtual Engagement Best Practices • NAMI Family-to-Family • NAMI Peer-to-Peer • Pathways to Permanence

** Open to the general public, including parents, youth, students, neighbors, etc. and who are seeking information about behavioral health.*

TIER 2: Trainings for Non-Behavioral Health Professionals*

Early Signs of Mental Illness	Trauma-Informed Care	Suicide Prevention	Resilience & Well-Being
• CalMHSA Each Mind Matters and related areas (i.e., *How to Have Conversations About Mental Health*, Strategies to Collaborate with Native Communities, *etc.)* • Crisis Intervention Training (CIT) for Law Enforcement • Screening and assessing for challenging behaviors in young children • Mental Health First Aid • Paraprofessional Training Modules I and II	• Critical Incident Stress Management training (see Crisis Services section for description) • Disaster Preparedness for Disaster Service Workers • Vicarious Trauma: Impact and Skills to Help You Cope • Training Qualified Educators in Understanding ACEs • Building Trauma-Informed School Communities	• Means Restrictions • CalMHSA Know the Signs • Kognito online trainings • Collaborative Safety Planning • Suicide Prevention & Assessment • Responding to Crisis Calls and Messages	• Positive Behavioral Interventions • Unconditional Pride: Creating Affirming Spaces for Trans and Queer Youth • Talking About Bullying • Self-Care, Self-Control & Preferred Self • Mindfulness • Virtual Engagement Best Practices • Assessing Student's Well-being During Virtual Instruction

** Open to non-mental health professionals who interact with/provide services to Orange County residents who may be experiencing a mental health issue; this can include teachers, childcare providers, veteran organizations, law enforcement, housing providers. religious/faith leaders, businesses, etc.*

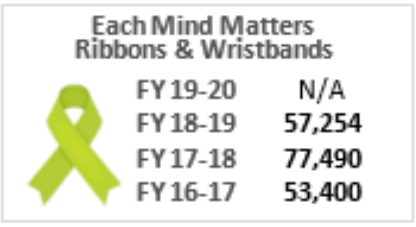
For a list of all trainings offered in FY 2019-20, go to: https://www.eventbrite.com/o/behavioral-health-training-collaborative-27819159453

Online resources are available for select trainings so that students and families can access information after a training has been completed: ocstudentmentalhealth.org

Strategy 2: Educational/Informational Materials

Culturally responsive educational and informational materials for potential responders and members of the PEI Priority Populations are available in print, podcast or online. Materials address one or more of the following topics and are tailored for both Tier 1 and Tier 2:

- Identifying and Responding to Early Signs of Mental Illness, Suicide Prevention, Outreach to Unserved and Underserved Cultural Communities
    - i.e., "OC Links Talking Cards: How to Initiate a Conversation About Mental Health," CalMHSA/Statewide Projects Toolkits and Tipsheets on Stigma Reduction, Mental Health Awareness and Suicide Prevention, "Mental Health Support Guide" in English, Spanish, Korean and Vietnamese, "Be True and Be You Mental Health Guide" for LGBTQ+ youth, "Aging and LGBT Mental Health Support Guide," Latinx LGBTQ+ Immigrant Youth Provider Fact Sheet, etc.



- Trauma-Informed Care
- RESET Toolbox: A collection of trainings designed to increase developmental assets, protective factors and mental health resilience among children, developed by Western Youth Services in collaboration with CHOC Children's Hospital and Orange County Department of Education. The toolbox also equips parents, educators, school/district administrators and leaders of youth-serving collaborative agencies with multi-modal tools to mitigate the effects of toxic stress due to isolation in the wake of the COVID-19 pandemic

Strategy 3: Community Events, Networking and Activation Efforts

Community events, networking and activation efforts for potential responders and members of a PEI Priority Population include one or more of the following methods, strategies and approaches:

- Events: Tier 1
- In-person and virtual art exhibits showcasing artwork crated by program participants that promote mental health awareness, suicide prevention, stigma reduction, etc.: examples: Send the Silence Packing suicide prevention exhibit, local arts and photographic displays, etc.
- Performances: Tier 1
    - In-person and virtual professional theatre performances that highlight mental health topics and are followed by panel discussions facilitated by mental health professionals.
- Conferences and Forums: Tiers 1, 2
    - In-person and virtual events such as book clubs, Salon, story-telling events, pop-up talks, resource and/or wellness fairs, Teen Toolbox (events for teens and parents), Youth Convening to empower LGBTIQ youth, etc.
- Community Networking: Tiers 1, 2
    - In-person and virtual Informational and networking forums for schools, school districts, colleges and universities, providers and other community organizations to learn from each other about evidence-based, practice-based and community-defined best practices, etc.
- Community Activation
    - Tier 1: Virtual and on-campus clubs and promotion of student-led activities on mental health, i.e., Active Minds, NAMI on Campus, Lesbian Gay Bisexual Transgender Intersex Questioning (LGBTIQ) clubs, Friday Night Live, Peer Assistance Leadership groups, Associated Student Body, etc.

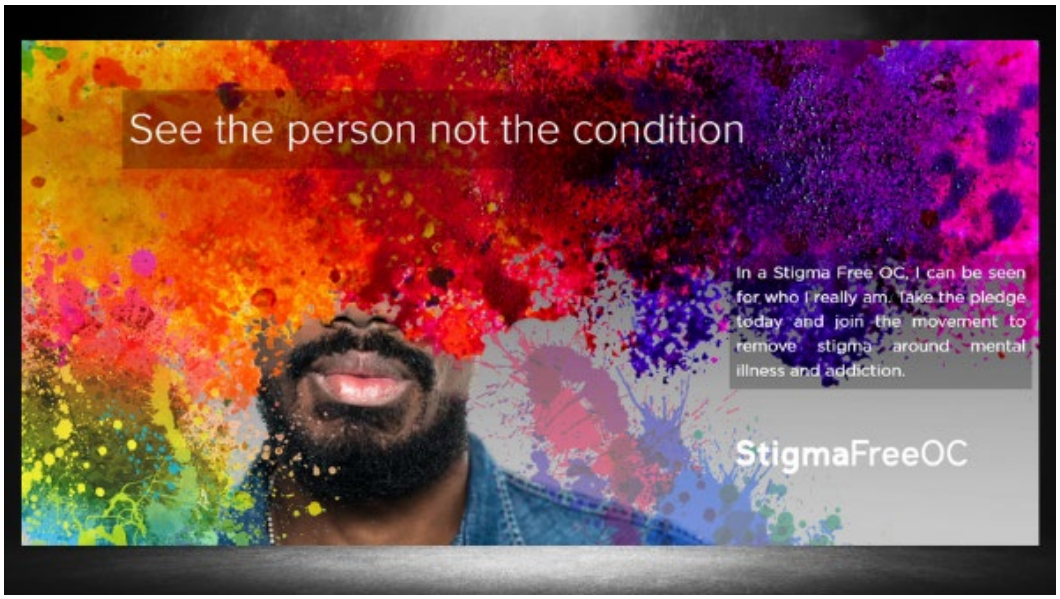
- Tier 1, 2: Community collaborations, coalitions or partnerships aimed at expanding behavioral health knowledge and awareness, etc.

FISCAL YEAR	# SUBMISSIONS Statewide	# SUBMISSIONS from OC	DIRECTING CHANGE HIGHLIGHTS View winning films from Orange County: https://www.directingchangeca.org/films-by-county/#Orange
FY 19/20	1,080	78 237 OC youth	**Regional Competition Winners**: • 3 Orange County films in the *"Mental Health Matters"* category • 2 Orange County films in the *"Suicide Prevention"* category • 1 Orange County film in the "Animated Shorts" category **Honorable mentions**: • 1 *"Through the Lens of Culture"* category • 7 *"Mental Health Matters"* category • 6 *"Suicide Prevention"* category • 2 *"Sana Mente"* category • 1 *"Animated Shorts"* category • 2 "Walk in Our Shoes" category
FY 18/19	1,063	84 210 OC youth	**Regional Competition Winners**: • 3 Orange County films in the *"Mental Health Matters"* category • 3 Orange County films in the *"Suicide Prevention"* category **Honorable mentions**: • 3 Orange County films in the *"Through the Lens of Culture"* category • 10 *"Mental Health Matters"* category • 9 *"Suicide Prevention"* category • 1 *"Sana Mente"* category • 2 *"Animated Shorts"* category
FY 17/18	742	134 342 OC youth	**Regional Competition Winners**: • 3 Orange County films in the *"Mental Health Matters"* category • 3 Orange County films in the *"Suicide Prevention"* category • 1 Orange County film in the *"Through the Lens of Culture"* category
FY 16/17	456	46	**Regional Competition Winners**: • 3 Orange County films in the *"Mental Health Matters"* category • 2 Orange County films in the *"Suicide Prevention"* category

- Creative Self-Expression: Tiers 1, 2
  - "Life Stories," a 10–12-week evidence-based program designed for self-expression through the creation of original dramatic works where participants use their own life experiences as inspiration for others; "Directing Change," a statewide video competition where students create public service announcements focused on educating the broader community on stigma and suicide prevention (see table below); etc.

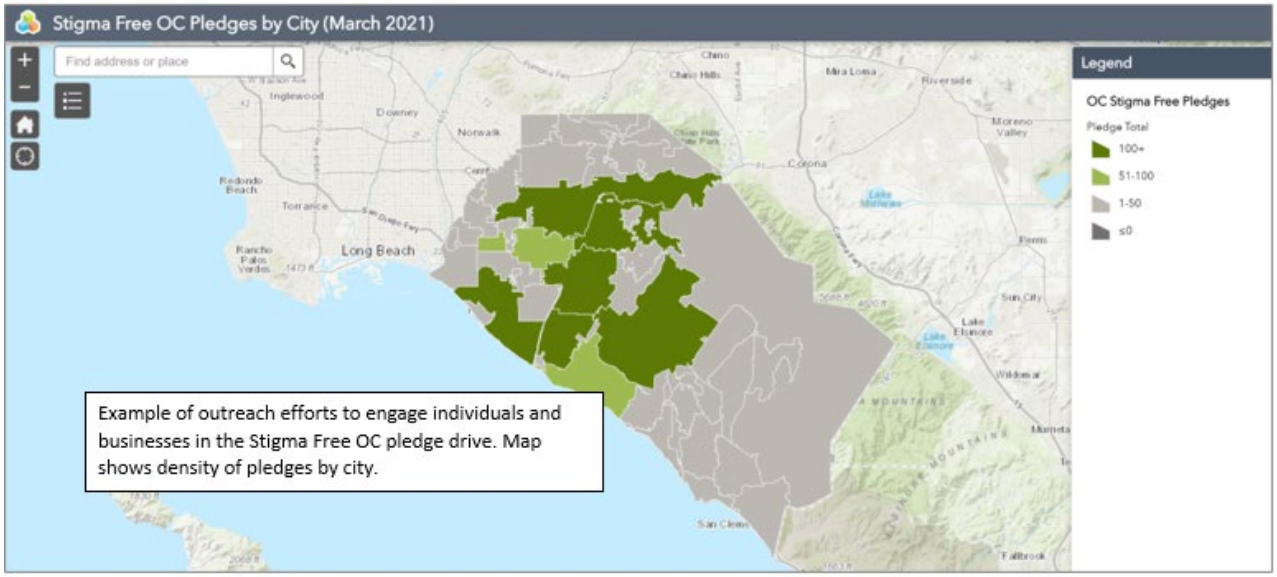
Strategy 4: Media Campaigns (i.e., culturally responsive/tailored print, radio, television, internet, social, etc.):

- *Each Mind Matters* public service announcements (PSAs)
- *Sana Mente PSA "Cuidate"* (i.e., "Take Care"), targeting the Spanish-speaking community between the ages 25-29
- *Know the Signs* suicide prevention
- *Stigma Free OC* launched October 2019 and the website was revamped and a new promotional campaign, "See the Person, not the Condition," was relaunched in November 2020



Strategy 5: Door-to-Door/Street/Event-Based Outreach (Tiers 1, 2)

- Door-to-door, street, virtual and telephone outreach conducted by provider staff, who are often trusted members of the community. Staff canvas neighborhoods and make phone calls to raise awareness, educate the community about mental health topics and provide them information about available services and resources. This is achieved by building rapport and trust with the community, especially with those who may be unaware of available resources and how to access them.
- Other outreach strategies include making in-person and online presentations and providing information via resource tabling at small- or large-scale community events such as health fairs, conferences, church events, 5k races, etc.



Location of Outreach Trainings, Activities and Events (see table below for more details): These outreach strategies and methods are provided at locations convenient for the different potential responders and can include early childcare facilities (licensed and licensed exempt, family and faith-based childcare programs, non-state/non-federally

funded programs); K-12, college and university campuses and District Offices; faith institutions; Juvenile Hall, Orange County Courts, law enforcement/police departments, hospitals, first responder stations/locations; community-based organizations; Social Services Agency; shelters, Family Resource Centers, parks, older adult community centers, wellness centers, residential treatment facilities and recovery homes; Mexican Consulate Office; the HCA Behavioral Health training facility; and other community locations convenient for target population to be trained.

Location of Outreach Trainings and Events									
SETTINGS	POTENTIAL RESPONDERS								
Where Potential Responders Were Engaged	Tier 2						Tier 1		
	Teachers, School Staff, Administrators	Staff Working w/ At-Risk, Unserved	Law Enforce. (i.e., police, probation, etc.)	First Responders (i.e., paramedics, fire, etc.)	Hospital, Medical, Nursing Staff	Religious Leaders	Youth/ Students	Family Members	Other Community Members
Childcare Facilities	x	x						x	
School and College Campuses, District Offices	x	x					x	x	
Faith Institutions		x				x	x	x	x
Criminal Justice Settings (i.e., Juvenile Hall, Courts, Sheriff/Probation/police, etc.)		x							
First Responder Locations (i.e., fire departments, etc.)		x		x					
Hospitals/Medical Offices		x			x				
Residential Treatment Facilities, Recovery Homes		x							
Community-Based Organizations	x	x	x	x	x	x	x	x	x
Social Services Agency Sites		x							
Shelters		x						x	x
Family Resource Centers		x					x	x	x
Older Adult Community Centers		x						x	
Wellness Centers		x						x	x
Mexican Consulate		x							
Parks, Fairgrounds, Public Events		x	x		x	x	x	x	x
HCA Behavioral Health Training Facility	x	x	x	x	x	x	x	x	x
Other Locations							x	x	x

When working to provide outreach directly to unserved and underserved target populations, program staff work with partner agencies such as LGBTIQ alliances, social services agencies and cultural ambassadors from trusted community-based organizations.

In addition, informational resources, educational materials, and promotional and behavioral health-related advertising campaigns can also be provided at community events (e.g., NAMI walk, events at County parks, health fairs, community festivals, sporting events, etc.) and/or in public locations (e.g., sporting venues, bus stops, billboards, etc.) where potential responders and members of PEI priority populations may frequent, as well as through door-to-door outreach and a variety of online forums and presented as described throughout the document.

Strategies to Promote Recovery/Resilience

The program uses different strategies to promote recovery and resilience. For providers, the program offers trainings in critical incident stress management. For parents and family members, the program offers peer support and skill-building. For consumers, resilience is fostered by building on protective factors, addressing risk factors and providing peer support.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment
When appropriate, staff provides referrals to treatment and/or support services for individuals of any age who need additional services and/or supports. Referrals are determined based on the individual's needs, with greater levels of support provided to those who face greater challenges and barriers to accessing care. In addition, the program leverages opportunities through CalMHSA Statewide Projects, such as competitive mini-grants awarded to local agencies, so that they may create tailored outreach materials and social marketing campaigns designed to improve timely access of their services.

Strategies to Reduce Stigma and Discrimination
Reducing stigma and discrimination related to mental health conditions is central to the outreach materials, events and training. Providers employ bilingual staff to meet the program's multicultural and language needs and materials are designed to be culturally and linguistically responsive and tailored to reach Orange County residents of all ages from diverse backgrounds and cultures. Providers also adopt a collaborative approach across agencies and systems of care and utilize evidence-based best practices that are culturally and linguistically responsive.

Challenges, Barriers and Solutions in Progress
To mitigate the impact of limited resources and reach a larger geographic area, the program successfully collaborated with community partners to build a network that expanded the program's reach in Orange County. In addition, the stand-alone, PEI-funded School-Based Stress Management Services (SMS) program was discontinued beginning FY 2020-21 following the retirement of the contracted subject matter expert who oversaw this program. School-based/student-focused mindfulness trainings will continue to be offered through this outreach program.

Community Impact
The consolidated program continues its mission of increasing awareness of mental health, early signs of mental health challenges, and available resources; providing support in times of crisis; and creating educational opportunities for students, staff, parents and other Orange County residents. Through a network of providers, the program can provide effective outreach and training to diverse communities throughout the county. In addition, several new activities (i.e., resource fairs, networking events, etc.) have been added to or expanded in the Three-Year Plan in response to community requests.

Outpatient Treatment: Early Intervention

School-Based Mental Health Services (PEI)

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

Services
SBMHS provides a range of services to develop protective factors and create resilience in youth to better meet new academic and social challenges. This includes educating parents about these challenges and how they can assist their transitioning youth. Services include assessment, individual counseling, group interventions, case management, and referral and linkage to community resources. It uses evidenced-based curricula such as Cognitive Behavioral Intervention for Trauma in Schools (C-BITS), Coping Cat and Seeking Safety, as well as Eye Movement Desensitization and Reprocessing (EMDR).

Outcomes
Beginning in FY 2017-18, SBMHS assessed reductions in, or prevention of, prolonged suffering via the YOQ® 30.2, which was administered at intake, every three months and at discharge. Results indicate that program services are associated with preventing symptoms of a mental health condition from becoming severe and disabling for most students served across the past three years.

Challenges, Barriers, and Solutions in Progress
In FY 2019-20, the program expanded services to new districts (n=6 schools) and was on track to meet their target enrollment goal. However, due to the COVID-19 pandemic, Orange County schools began distance learning in March of 2020 and SBMHS clinicians had to creatively engage students via phone or telehealth since they could not go on campus. Many participants declined telehealth services because they did not want to be seen from home, or they didn't have access to technology and/or privacy. As a result, the program was unable to continue group interventions. During this period the program also experienced a significant drop in referrals as school partners shared their own difficulties in engaging students to attend regular classes. Additional program challenges included staff vacancies and limited access to students during instruction time since clinicians could no longer pull students out of class for counseling sessions as they had done prior to the pandemic. To increase access to students and address barriers to telehealth, the program has extended their business hours and offers to engage students outside of the school setting. SBMHS became Medi-Cal certified to further expand staffing and increase capacity to serve additional students.

Community Impact
The SBMHS program has provided services to more than 15,338 students since its inception in August 2011. In FY 2020-21, the program will collaborate with the Orange County Department of Education's (OCDE) Mental Health Student Services Act (MHSSA) Regional Mental Health Coordinators to meet the need for mental health services in schools throughout Orange County

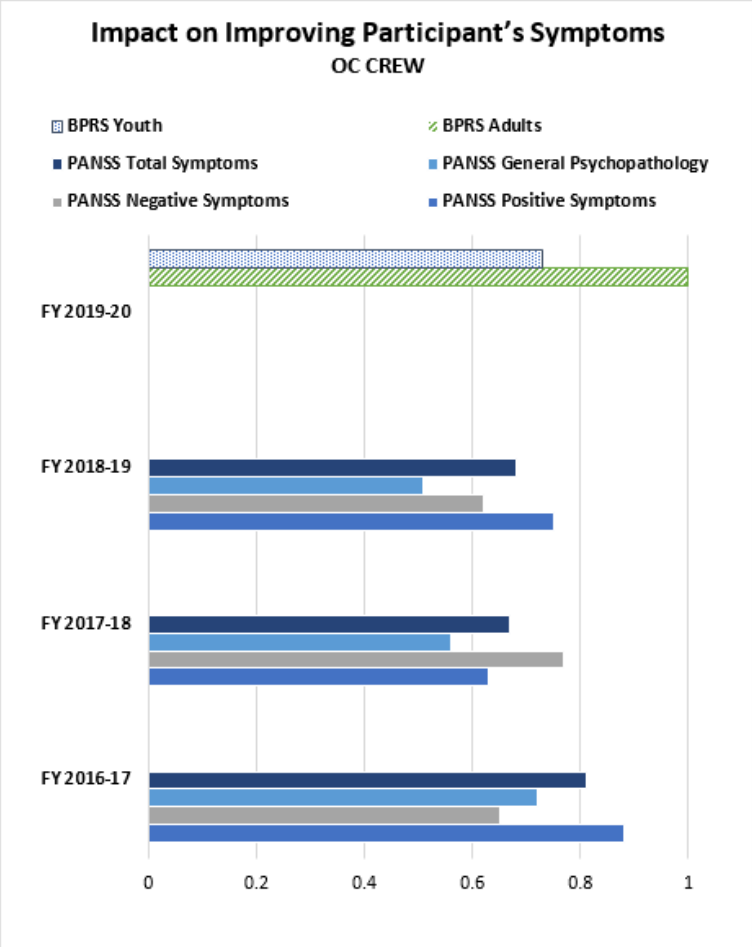
First Onset of Psychiatric Illness (OC CREW) (PEI)

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

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

Outcomes
The goal of OC CREW is to reduce prolonged suffering from an untreated mental health condition. From FYs 2016-17 to 2018-19, this was measured using psychiatrists' ratings on the Positive and Negative Syndrome Scale (PANSS). In FY 2019-20, OC CREW began using the Brief Psychiatric Rating Scale (BPRS). Both are widely used measures that assess the frequency and/or severity of psychiatric symptoms, particularly schizophrenia. The 24-item BPRS was used for

adults and the 21-item was used for youth ages 12-17 with each item rated on a 7-point scale ranging from 'not present' to 'extremely severe.'



Clinicians provided PANSS and BPRS ratings at intake, every six months and at program exit, and the difference between intake (baseline) and the most recent follow-up was used to determine whether there was a reduction of prolonged suffering. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the youth served in the program. Effect sizes are standardized and are interpreted the same way across different measures. Medium to large reductions in symptoms were consistently observed across all years, suggesting that OC CREW reduces prolonged suffering from an untreated mental health condition and is effective in helping to prevent first episode psychosis from becoming severe, persistent and disabling.

Challenges, Barriers and Solutions in Progress

In March 2020, the program filled several vacant positions: Service Chief, Mental Health Specialist, and two Behavioral Health Clinicians, with the psychiatrist position still vacant. Filling the positions was anticipated to increase the number of youths enrolled in the program, however that same month coincided with the start of the COVID-19 pandemic. In response, OC CREW revamped its internal enrollment process and the way it provided its services. The program temporarily transitioned from clinic- and field- based services to a largely telephone- and telehealth-based platform, with in-person appointments still available as clinically indicated. With the new team members and treatment platform, efforts were focused on training staff to increase engagement of telehealth services and to provide quality care to the community. Public health restrictions due to the COVID-19 pandemic led to a reduction in group services, community outreach to increase awareness of psychosis and the numbers of First Break of Psychosis presentations. As COVID-19-related restrictions are lifted over the course of the next fiscal year, the goal is to increase the coordinated specialty care services provided to better serve the community.

In addition, the program continues to participate in the Early Psychosis Learning Health Care Network (EPLHCN) Statewide Collaboration. The Medi-Cal certification process is complete, and the program is now billing Medi-Cal. As a Medi-Cal Certified program, OC CREW can look to expand staffing and increase their capacity to serve additional participants as the need arises.

REFERENCE NOTES

Brief Psychiatric Rating Scale (BPRS):

Children:
FY 2019-20: Baseline M=57.0, SD=18.02; Follow-up M=48.9, SD=21.17; t(8)=-2.11, p>.05; Cohen's d=0.73

Adult:
FY 2019-20: Baseline M=54.3, SD=18.17; Follow-up M=42.3, SD=12.57; t(17)=-3.90, p<.01; Cohen's d=1.00

PANSS:

Positive Symptoms:
FY 2018-19: Baseline M=16.7, SD=6.68; Follow-up M=11.7, SD=5.94; t(54)=5.53, p<.001; Cohen's d=0.75
FY 2017-18: Baseline M=16.1, SD=7.0; Follow-up M=10.8, SD=7.9; t(50)=4.47, p<.001; Cohen's d=0.63
FY 2016-17: Baseline M=15.9, SD=7.0; Follow-up M=9.0, SD=7.7; t(50)=6.33, p<.001; Cohen's d=0.88

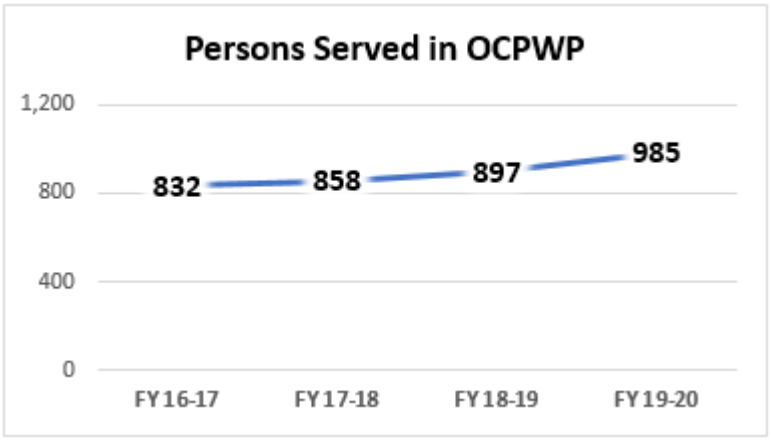
Negative Symptoms:
FY 2018-19: Baseline M=19.0, SD=7.66; Follow-up M=14.0, SD=7.2; t(54)=4.62, p<.001; Cohen's d=0.62
FY 2017-18: Baseline M=17.9, SD=7.1; Follow-up M=12.0, SD=7.4; t(48)=5.42, p<.001; Cohen's d=0.77
FY 2016-17: Baseline M=17.2, SD=8.3; Follow-up M=11.5, SD=8.3; t(50)=4.63, p<.001; Cohen's d=0.65

General Psychopathology:
FY 2018-19: Baseline M=34.9, SD=11.40; Follow-up M=27.8, SD=10.65; t(54)=3.75, p<.001; Cohen's d=0.51
FY 2017-18: Baseline M=33.5, SD=11.6; Follow-up M=24.7, SD=14.2; t(50)=3.95, p<.001; Cohen's d=0.56
FY 2016-17: Baseline M=32.2, SD=11.9; Follow-up M=22.2, SD=13.1; t(50)=5.14, p<.001; Cohen's d=0.72

Total Symptoms:
FY 2018-19: Baseline M=70.6, SD=23.29; Follow-up M=53.0, SD=21.15; t(54)=5.06, p<.001; Cohen's d=0.68
FY 2017-18: Baseline M=68.2, SD=24.0; Follow-up M=48.6, SD=29.6; t(50)=4.72, p<.001; Cohen's d=0.67
FY 2016-17: Baseline M=65.3, SD=25.0; Follow-up M=42.7, SD=27.4; t(50)=5.74, p<.001; Cohen's d=0.81

OC Parent Wellness Program (PEI)

The Orange County Parent Wellness Program (OCPWP) has been expanded to include the former Stress Free Families and Connect the Tots programs and 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.



Referrals come from a variety of sources including self-referrals, hospitals, schools, behavioral health outpatient facilities, and the Social Services Agency (SSA). Eligibility criteria for families referred by SSA is that the most recent child abuse and/or neglect allegation(s) was found to be inconclusive, unfounded or unsubstantiated.

Services

The expanded OC Parent Wellness Program provides early intervention outpatient treatment that includes screening and needs assessment, clinical case management, individual counseling, parent education, psychoeducational support groups, wellness activities, referral and linkage to community resources, and community outreach and education.

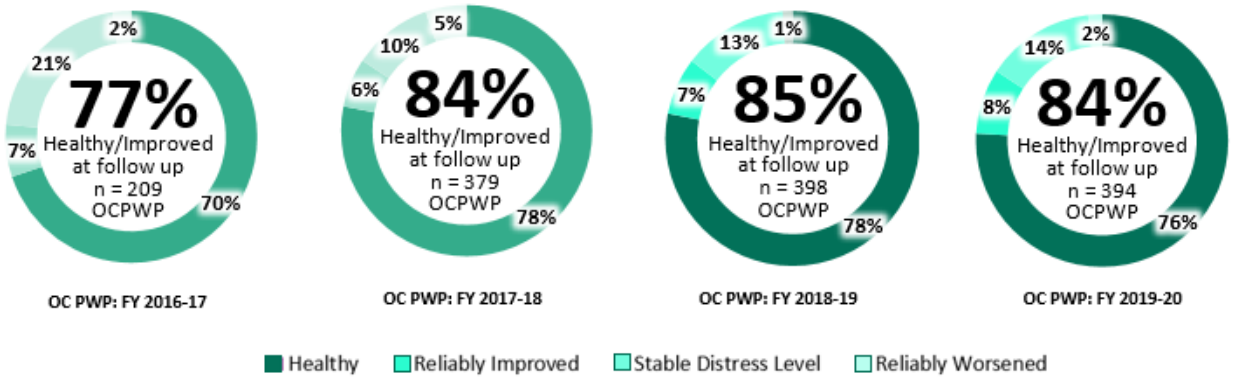
The counseling approaches used by clinicians include Cognitive Behavioral Therapy (CBT) and Eye Movement Desensitization and Reprocessing (EMDR) when clinically indicated. The program also utilizes the evidenced-based curriculum, Triple P (Positive Parenting Program) and Mothers and Babies (MB), with staff having been recently trained more intensively to ensure they follow the fidelity of these models and remain current on best practices when working with trauma-exposed individuals.

Outcomes

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

Across the four fiscal years, anywhere from 78% to 90% of enrolled parents reported healthy or reliably improved levels of distress, as measured by the OQ®, since starting services. Thus, services were associated with preventing symptoms of a mental health condition from becoming severe and disabling for the overwhelming majority of parents served.

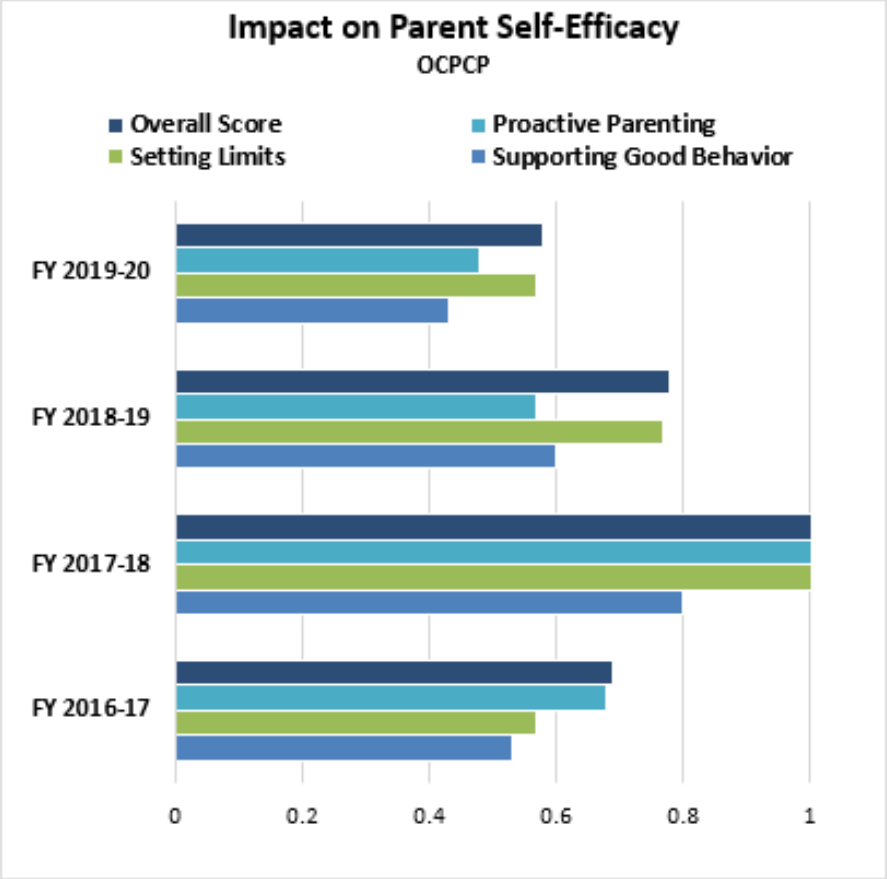
For the parents who report a significant worsening in their distress, program staff have been streamlining procedures to quickly identify these individuals earlier during treatment, modify the treatment plan to include increased face-to-face time, or, when appropriate, refer them to a higher level of care with warm handoffs to behavioral health clinics, contract providers, or psychiatrists. For parent participants with young children, the program also aims to prevent the development or worsening of mental health conditions by maintaining and/or strengthening the protective factor of effective parenting skills, which was assessed using the PARCA-SE. Across the four years, parents consistently reported increased levels of confidence in their parenting skills between intake and follow up. Thus, services appeared to be effective in maintaining and/or enhancing the protective factor related to parental self-efficacy among those parents in the at-risk families served in the program.



Challenges, Barriers and Solutions in Progress

In FY 2019-20, OCPWP received an increase in referrals following implementation of the state law requiring practitioners who see women before and after pregnancy to screen for maternal mental health conditions. This necessitated the restructuring of the intake process. The program implemented 25 intake slots on a weekly basis which

led to individuals being enrolled for program services more quickly thus decreasing the duration of untreated mental health conditions. Additionally, staff received formal training and post training consultation groups on the Mothers and Babies Course, an evidence-based curriculum focused on both the prevention and treatment of major depression during the prenatal and postpartum periods. This intervention is offered in both group and individual settings to enrolled participants. Furthermore, the program continues to make strides toward becoming more father-inclusive by employing a male provider to outreach and engage expectant and new fathers. OCPWP continues to maintain its strong collaborative relationships with community partners and with the increase in referrals, the program required two mental health specialists to shift from their role as case carrying providers to Intake Coordinators (IC). As the IC's, they conduct screenings to determine if program referrals meet the basic criteria for suitability and, when appropriate, to immediately schedule an initial Intake session with a therapist to ensure timely access to care. This IC system improves overall efficiency as staff are simultaneously screening for all three specialty areas thus reducing the wait time and increasing linkage to the appropriate level of care. Lastly, the COVID-19 pandemic transformed the program service provision from in-person care to virtual visits that include telehealth and telephonic services. Despite this, staff provided 4,498 face-to-face contacts and 3,456 telephonic correspondences.



Community Impact

Since inception of its respective services, OC Parent Wellness has worked with more than 3,992 new and expecting parents, 1,054 families referred by Child Protective Services/SSA, and 2,139 families with young children at risk of not being ready for school. Clinicians work directly with parents and caregivers and program staff provide consultation to various community partners and County agencies on the early signs of mental health symptoms, program eligibility and referral processes, thus increasing families' access to timely and appropriate behavioral health services.

Community Counseling and Supportive Services (PEI)

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. Participants are referred to the program by family resource centers, medical offices, community-based organizations, County-operated and County-contracted programs and self-referral.

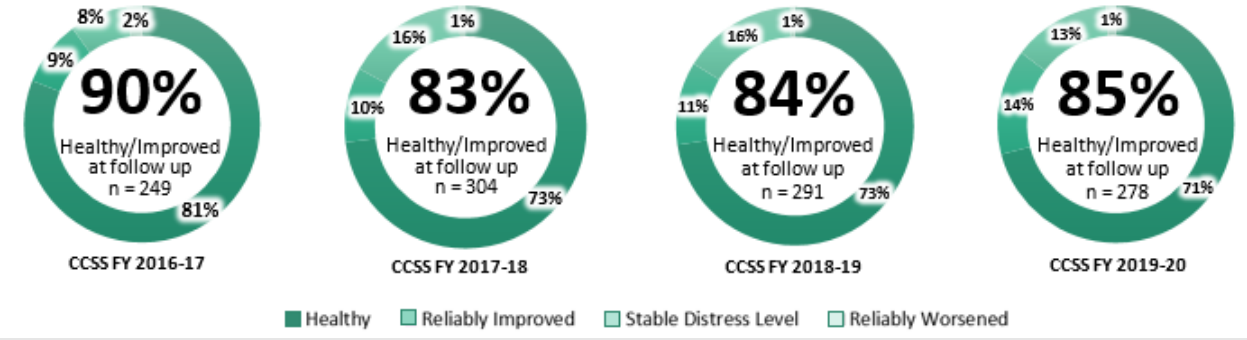
Services

CCSS provides face-to-face individual and collateral counseling, groups (i.e., psychoeducational, skill-building, insight oriented, etc.), clinical case management, and referral and linkage to community services. Clinicians utilize evidence-based practices such as Eye Movement Desensitization and Reprocessing (EMDR), Motivational Interviewing (MI), Cognitive Behavioral Therapy (CBT) and Seeking Safety while working with program participants. In addition, peer specialists provide social, educational and vocational support and offer targeted case management to help individuals access needed resources or meet other goal-specific needs. Services are tailored to meet the age, developmental and cultural needs of each participant.

Outcomes

The program aims to measure reductions in, or prevention of, prolonged suffering through an age-appropriate form of the OQ® (YOQ® 30.2 for youth, OQ® 30.2 for adults). Participants completed the measure at intake, every three months of program participation, and at discharge. Scores were compared to the measure's clinical benchmarks to determine program effectiveness at improving symptoms and reducing prolonged suffering. This measure reflects cultural competence as it is available in all threshold languages and contains a wide range of symptoms, including somatic symptoms, which may be experienced and/or reported by people from different cultural backgrounds.

Across all four fiscal years, most participants (83-90%) reported healthy or clinically improved levels of distress at the most recent follow up.



Overall, this improvement in scores between intake and follow up suggests that the services of CCSS were associated both with preventing symptoms of a mental health condition from becoming severe and disabling, as well as with a meaningful reduction in suffering among those who had reported clinically elevated distress levels upon enrolling. In addition, because it was also noted that LGBTQ+ participants tended to report higher levels of distress based on the OQ scores at baseline and follow up in comparison to cisgender/straight participants, the program implemented procedures to identify those with greater needs and refer them to programs that serve individuals with more severe mental health conditions.

Challenges, Barriers and Solutions in Progress
In fiscal 2019-20, as a result of the COVID-19 pandemic, in person services were halted and the program transitioned to a virtual and telephonic platform. The pandemic had a significant impact on the number of referrals received. In response to this challenge, several measures were taken. The program created a dedicated Outlook inbox and modified their referral forms so that they could be completed electronically and securely emailed from community agencies to CCSS. In response to the behavioral health needs of "first responders," business hours were extended to late evenings to accommodate their schedules. In addition, the number of bilingual clinicians in the program was increased- now over 90% of clinicians are bilingual in two of the County's threshold languages thereby increasing the program's ability to serve monolingual communities. Furthermore, all clinicians have received specialized training in a variety of modalities to better serve participants in the treatment of complex trauma, Post Traumatic Stress Disorder (PTSD), anxiety & depression. An area for further development is to increase outreach efforts in south Orange County, where a satellite CCSS office is open.

In anticipation of the consolidation of CCSS and OC ACCEPT to one CCSS, OC ACCEPT made several adaptations to their screening and intake processes to align practices with CCSS. This included staff training, outreach to new referral sources, clarification of eligibility criteria, and outcome data collection. In FY 2019-20 the program was progressing positively with numerous outreach and training in the community. Additionally, the number of enrollments increased, and the program was enrolling more participants by November 2019 compared to the previous fiscal year. However, by January 2020 when the COVID-19 pandemic started, the program was significantly impacted by a significant reduction in outreach and enrollment. In March 2020, OC ACCEPT stopped outreach and trainings to collaborative partners and community members as the program transitioned to a virtual platform. Since that time, referrals have significantly decreased leading to low enrollment numbers for the remainder of the fiscal year.

Community Impact
CCSS collaborates with community-based organizations to provide culturally responsive services to ethnic minorities, deaf-and-hard-of hearing, and LGBTIQ communities. Since inception, the expanded program has provided services to more than 2,593 individuals, 510 of whom were part of its LGBTIQ service. Additionally, in FY 2019-20, 743 individuals (of 913 referred to the program), were screened by the Intake Coordinator. The Intake Coordinator position has reinforced the program's ability to accurately identify and enroll participants into services that fall within the mild to moderate spectrum. Conversely, participants presenting with higher severity symptoms are referred and linked to the appropriate level of care that addresses their specific need in a timely manner. The expanded program has also provided valuable education and resources to various unserved and underserved populations with mental health needs to promote awareness of, and encourage use of, its services. In this FY, the program provided 26 community education presentations and trainings to over 386 attendees, raising awareness and reducing stigma about the LGBTIQ population.

OC4VETS (PEI)

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. Referrals into the programs come from established collaborative relationships with outside community programs supporting Orange County veterans, veteran groups within the county, the Veterans Affairs Administration, Veterans Resource Centers at local community colleges, the Veterans Service Office (VSO), and directly from the veterans and family members looking for support.

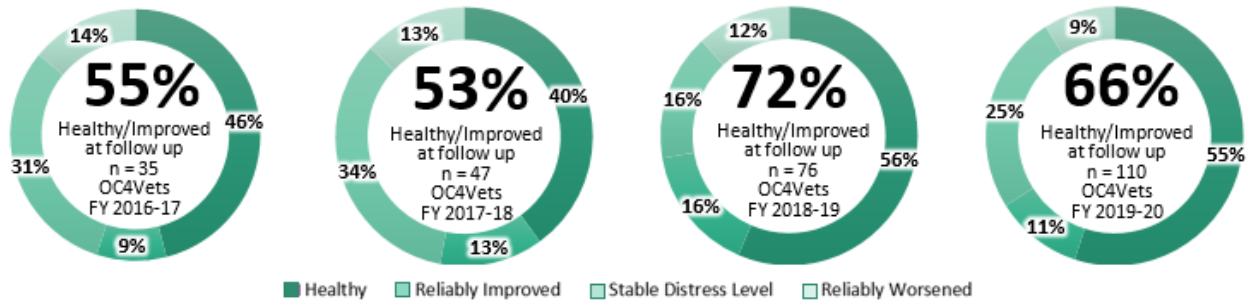
Services

OC4Vets has five distinct service delivery options for the veteran community, each with a distinct referral path that offers a wide range of services and supports for veterans, military-connected individuals and their families. The array of services are tailored to meet the needs of the individuals and/or the families and can include peer support, community outreach, housing navigation and assistance, employment support, behavioral health screening and assessment, referral and linkages to community and behavioral health resources, clinical case management, individual counseling, family counseling, group counseling, domestic violence support, workshops and educational support groups for families, and legal support and advocacy services. Each referral path is described in more detail below:

- **Referral Path 1**: Adult veterans who have not yet integrated into the Department of Veterans Affairs (VA) system, do not have access to the VA system, are unaware of their need for behavioral health services, or are seeking alternative services to the VA system.
- **Referral Path 2**: Veterans and military connected adults who would benefit from partnering with peer navigators. Peer navigators understand military culture and are veterans themselves who work with program participants to identify their behavioral health needs, overcome barriers that may limit access to care and connect to ongoing treatment.
- **Referral Path 3**: Veterans and military connected adults engaged with the Orange County Courts (i.e., Veterans Treatment, Military Diversion, Family), many of whom exhibit mental health symptoms related to trauma exposure.
- **Referral Path 4**: Military connected students in local community colleges who would benefit from a military connected behavioral health clinician located on campus. The clinician also provides outreach and engagement on Orange County campuses using veteran-specific events and support groups to encourage discussion of barriers to a successful transition to college and civilian life. Services are provided on campus, in areas that are comfortable and accessible to the veterans, such as the campus Veterans Resource Center and virtually for groups and individual services.
- **Referral Path 5**: Military connected families who would benefit from working with trained clinicians and peer navigators with experience and knowledge of military culture to address mental health concerns encountered by veterans that may affect the whole family, such as Post Traumatic Stress Disorder (PTSD), traumatic brain injury (TBI), substance use and other conditions. Services are inclusive of the entire family unit, which allows for more effective family communication, functioning and support. Services can be provided via telehealth.

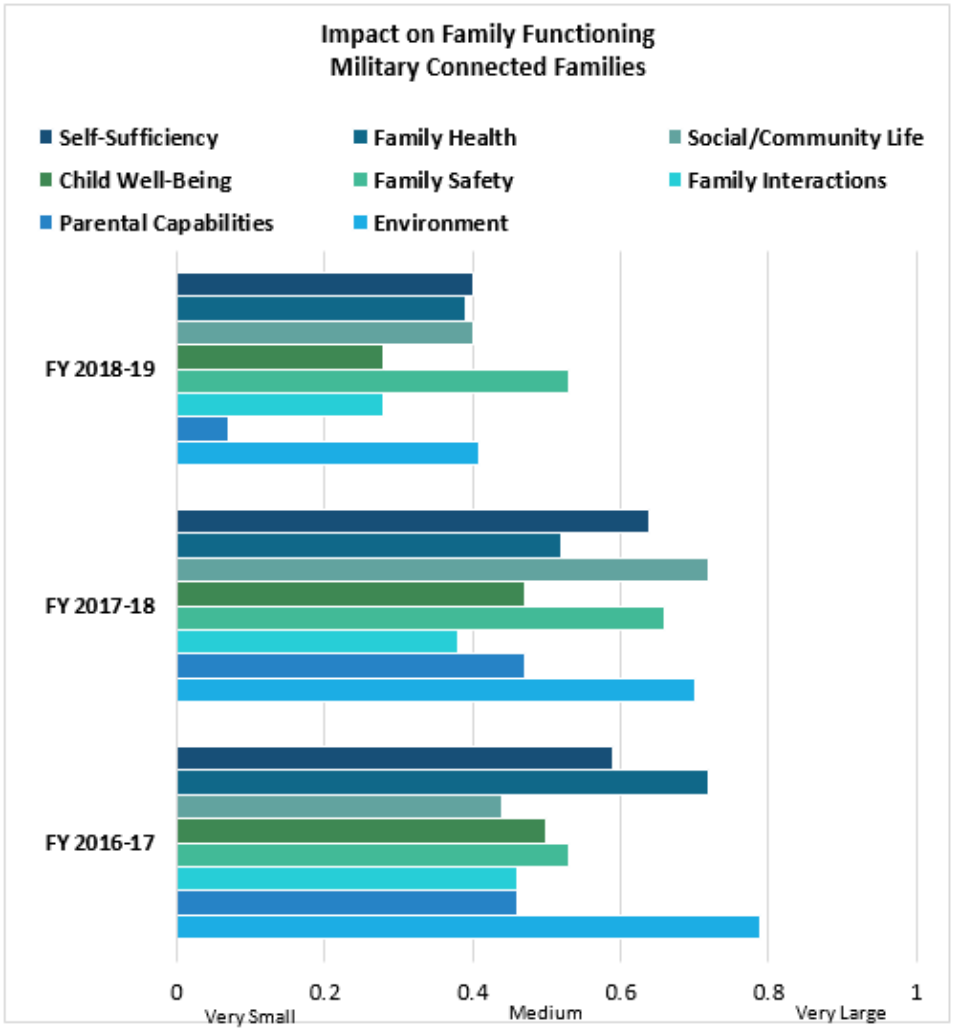
Outcomes

Depending on a participant's age, they completed the age-appropriate OQ at intake, every one to three months of program participation, and at discharge (YOQ® 30.2 for youth, OQ® 30.2 or OQ® 45.2 for adults). Scores were compared to the measure's clinical benchmarks to determine program effectiveness at reducing prolonged suffering. Because the OQ® is a measure of symptom distress and a tool to help inform care planning, beginning in FY 2018-19 the programs began to administer the OQ® to participants who were enrolled in individual counseling. Additionally, since some programs provide clinical interventions to single individuals within a family unit or the family as a whole, the OQ® was administered to participants depending on which family members were identified as the primary participant(s).



After noting the low completion rate of measures in FY 2016-17, OC Health Care Agency (HCA) staff provided guidance and course corrective actions to providers to ensure data were collected reliably and consistently. Steps have been taken to encourage more timely completion of forms, including providing training on administration timing and procedures, how to incorporate the results into care planning, and continuous support and follow up. As a result, an increasing number of completed forms have been returned over the past few years (i.e., 35, 47, 76 and 110 from FY 2016-17 through FY 2019-20, respectively).

Overall results from the OQ® suggest that OC4Vets services help prevent participant's symptoms from becoming severe and disabling, with the proportion of OC4Vets participants reporting a healthy or reliably improved level of distress at follow up increased from 40-46% in FYs 2016-17 and 2017-18 to 55-56% in the past two fiscal years. Moreover, this is largely accounted for by more veterans enrolled in community-based programs reporting healthy distress levels at follow up (64% community-based veterans compared to 26% of college student veterans).



Before FY 2019-20, the onset and/or worsening of mental health conditions specifically among military connected families was assessed using the North Carolina Family Assessment Scale (NCFAS). Ratings were made at intake and program exit, and the difference in scores was used to analyze whether there was improvement in, or maintenance of, healthy family functioning. Results were reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time was clinically meaningful for the families served in the program.

Depending on the construct measured, program services were associated with small to medium/large improvements, with larger improvements generally noted in environment (e.g., housing stability, personal hygiene), family safety, self-sufficiency (e.g., family income, food), and family health (e.g., physical and mental health), and greater effects observed in FY 2016-17 and FY 2017-18 compared to FY 2018-19. The difference in effects observed in FY 2018-19 compared to previous fiscal years may be due to capacity issues, including understaffing within agencies and staff turnover, as well as reduced leverage funding from partners, resulting in increased referrals outside of the project to link families to needed support. Beginning in FY 2019-20, military connected families began to complete the OQ® to 1) standardize data collection and reporting across program referral paths and 2) allow for more direct assessment of clinical improvement given that this is an early intervention program.

For program participants who primarily receive case management rather than therapy services, information on referrals and linkage to needed resources is provided in the "Summary of MHSA Strategies used by Early Intervention Programs" at the end of this section.

Challenges, Barriers and Solutions in Progress

As noted above, the programs are working to improve their OQ administration procedures and use as a clinical tool. They are also implementing changes with the hopes of expanding their reach and serving larger numbers of veterans in Orange County. For example, in the first half of the FY, the County worked on streamlining intake procedures, engaging participants through phone check-ins, coordinating peer follow-ups, increasing community partnerships, coordinating with Veterans Affairs services, and increasing outreach efforts to engage those who are more difficult to reach.

The military culture tends to enhance the stigma associated with seeking support and their cultural beliefs often deter veterans from asking for help. In many cases, veterans do not seek out help until their behavioral health conditions have severely affected their ability to function at work, school or within their relationships. To address these barriers, the program is designed to support timely access to services by co-locating services in non-mental health settings already frequented by veterans (i.e., college campuses, VSO, Court).

Although providers experienced some barriers to success as a result of COVID-19, they were able to adjust their service delivery models rapidly to help overcome these barriers. The primary barrier was the closure of the community settings in which they typically engaged with the veterans and family members. This eliminated the opportunity for the programs to outreach to and provide services for veterans as had been done in the past. Most providers were also unable to offer face-to-face therapy sessions for student participants. To overcome these obstacles, Outside the Wire worked with the colleges to help develop new strategies to reach out to veterans for nearly half of the FY. To overcome the barriers the veterans faced in accessing care, the programs transitioned to a telehealth model of service delivery. While they saw a reduction in referrals and enrollments and a significant reduction in group therapy attendance, providers were able to continue providing individual and family therapy to veterans and started to offer virtual outreach events. The programs also saw an increase in the clinical needs of many enrolled participants related to COVID-19 stressors and impacts; as there was a reduction in new enrollments, providers were able to increase the frequency and duration of treatment for participants to ensure that the intensity of treatment met the increased need for intervention.

Community Impact

OC4Vets has provided services to more than 840 veterans and military connected adults in the community since July 2012, more than 340 veterans in college since its inception in October 2011, and more than 1,206 individual family participants since July 2015. Program staff has developed strong collaborations with a number of agencies that serve Orange County's veteran population, including the Veteran's Service Office with OC Community Resources (OCCR), Workforce Investment Office with OCCR, Office on Aging, Veterans Affairs Administration, the Tierney Center at

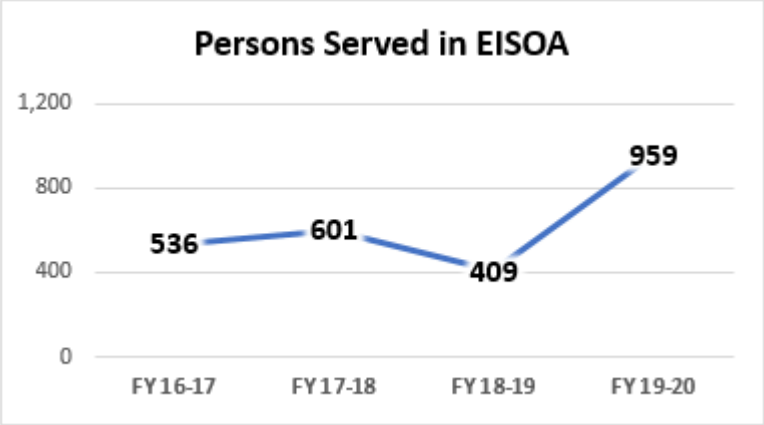
Goodwill, and the Los Alamitos Joint Forces Training Base OC Superior Courts, OC Family Court, Veterans Resource Centers at local community colleges, and Orange County schools to best meet the needs of Orange County's veterans and their families.

Early Intervention Services for Older Adults (PEI)

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.

Services

Program staff conducts a comprehensive in-home evaluation that includes psychosocial assessment, screening for depression, and measurement of social functioning, well-being and cognitive impairment. Using these results, staff then connects older adults to case managers who develop individualized care plans and facilitate participant's involvement in support groups, educational training, physical activity, workshops and other activities. A geropsychiatrist is also available to provide a psychiatric assessment of older adults who may have undiagnosed mental health conditions, as well as medication monitoring and management.

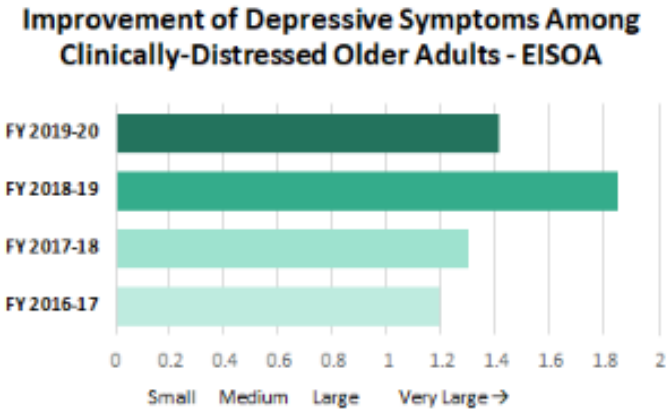


EISOA utilizes the evidence-based practice Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) which employs a systematic, team-based approach to identifying and reducing the severity of depressive symptoms in older adults via case management, community linkages and behavioral activation services. To ensure fidelity, the program provides staff with comprehensive training on the Healthy IDEAS model, program goals and deliverables, evidence-based interventions, education on mental health and theories of aging, behavioral activation techniques, ethical and legal considerations, cultural competence and humility, field safety, assessment tools and outcome measures, care planning, and effective communication strategies when working with older adults. In addition, the program conducts staff development workshops and in-service trainings.

Outcomes

Larger numbers of older adults were served in FY 2019-20 relative to previous years due to an increase in funding allocation for these services. The dip in older adults served in FY 2018-19 was due to a change in the program's admission and discharge criteria that occurred in the second half of FY 2017-18 and affected participant recruitment and engagement the following fiscal year.

Mental health functioning was assessed through the Patient Health Questionnaire (PHQ-9), a commonly used measure of depressive symptom severity. Measures were completed at intake, every three months and at discharge. Change in scores among participants who scored in the clinical range at intake (i.e., score > 10) was evaluated to assess the program's effectiveness at reducing depression symptoms. Clinically distressed older adults have consistently reported substantial declines in depressive services while enrolled in program services. These findings suggest that the program is effective at reducing prolonged suffering and/or preventing mental health symptoms from becoming severe and persistent.



Challenges, Barriers and Solutions in Progress

Due to the increased risk that COVID-19 pandemic posed for the older adult population, additional supports were provided through CARES Act funding during the 2020 calendar year. Rental assistance and essential items such as masks, toiletries, cleaning supplies, nutritional drinks, clothing, prepared meals, fresh food and pet supplies were delivered, allowing participants to remain safely in their homes while still ensuring their basic needs were met. Program staff remained in contact with the participants telephonically to provide emotional support during this time, and computer devices, hot spots/Wi-Fi and training were provided to those who did not have access to technology.

Prior to the COVID-19 pandemic, transportation had been identified as a barrier to accessing services as the older adults served tend to have limited income and some are unable to pay for public transportation. To overcome this barrier, most program services are provided in the community (i.e., homes, apartment complexes, senior centers, etc.). To encourage self-reliance, the program provided bus vouchers and taught participants to utilize the bus system. For older adults who were hesitant to take the bus, staff traveled with them and taught them how to ride a bus, or seasoned bus riders were paired with new bus riders. Program staff also facilitated carpools between participants. Finally, to help alleviate remaining transportation barriers, EISOA expanded transportation services for its participants with time-limited, PEI carryover funds.

Community Impact

The program has experienced positive participant outcomes that include improved mental health status, enhanced quality of life, increased social functioning, more effective management of behavioral health and chronic conditions, enhanced ability to live independently, increased community involvement and development of a supportive network. By providing services in Spanish, Vietnamese, Korean, Khmer, Mandarin, Arabic and Farsi, the program can reach, serve and impact non-English speaking older adults through its self-stigma reduction activities, effective outreach and early intervention services.

Access & Linkage to Treatment/Services

Programs that fall within the Access and Linkage to Services/Treatment function are designed to link individuals of all ages who are living with a mental health condition to an appropriate level of care and needed supportive services. Orange County offers several programs in this category, although only BHS Outreach and Engagement is subject to PEI regulations. The remaining programs are funded by CSS and tailored to meet the needs of specific unserved populations living with SMI or SPMI (i.e., individuals who are homeless, discharging from jail or a hospital, etc.).

OC Links (PEI)

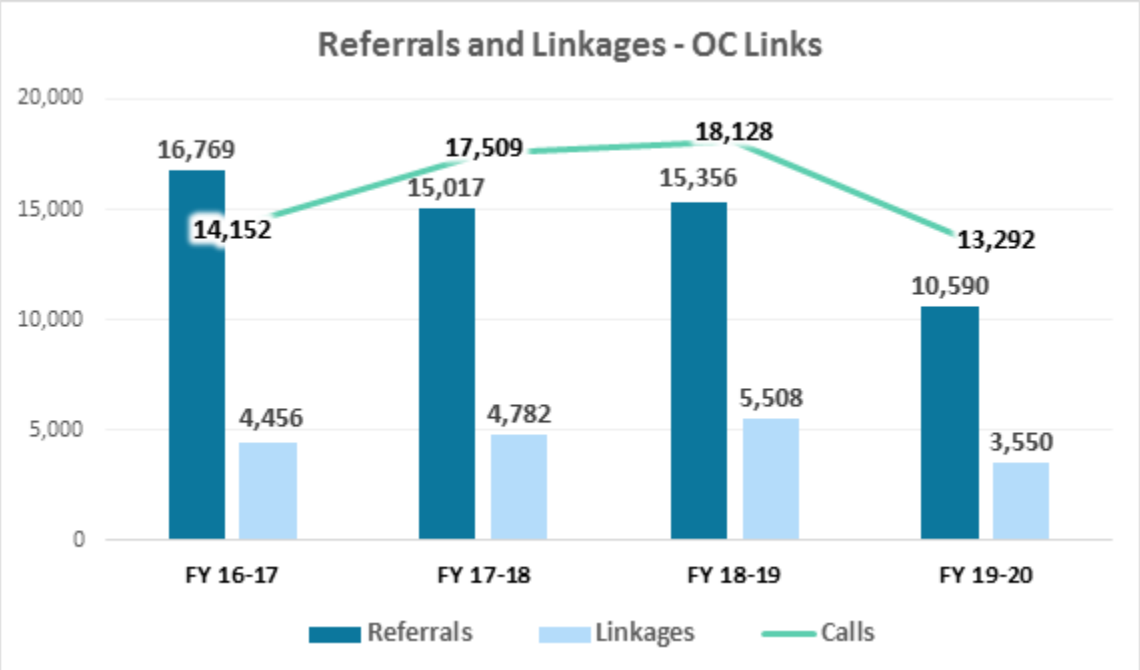
OC Links is the Behavioral Health Services (BHS) line that provides information and linkage to any of the OC Health Care Agency's Behavioral Health Services, including crisis services, via telephone and online chat. Because the navigators who staff the line are clinicians, they can work with callers and chatters experiencing any level of behavioral health issue, ranging from prevention through crisis identification and response. Beginning February 2021, OC Links began operating 24 hours a day, 7 days a week. Since that time, their calls/chat have quadrupled.

Services & Outcomes

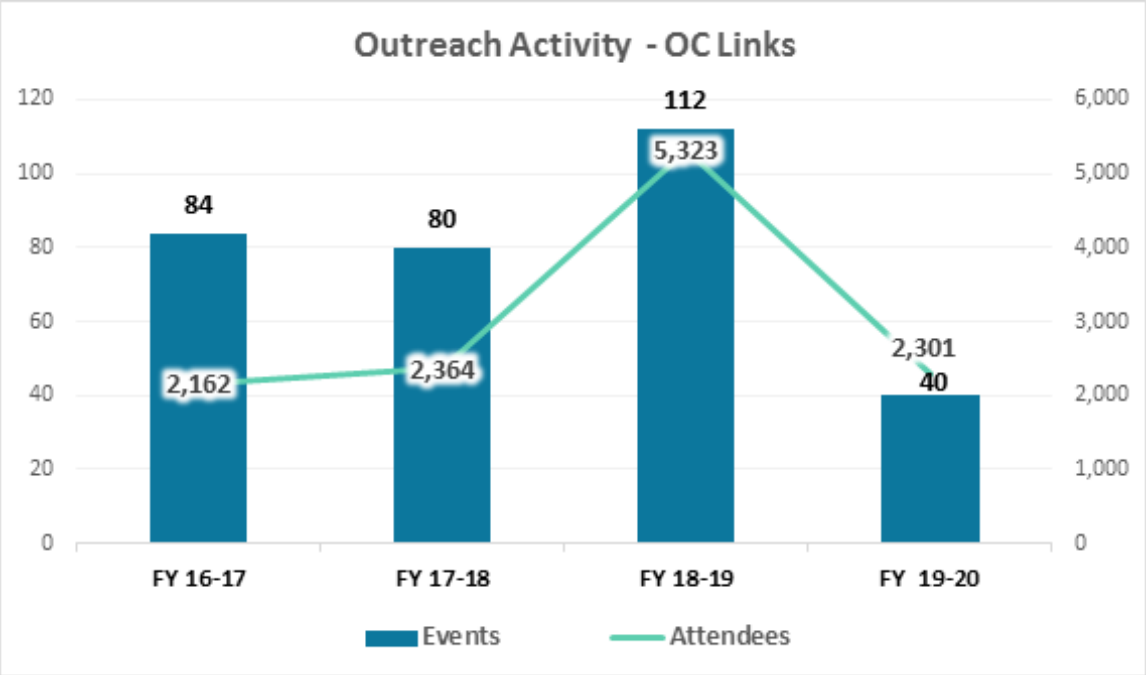
Serving as the single access point for the HCA BHS System of Care, OC Links provides telephone and internet, chat-based support for any Orange County resident seeking HCA Behavioral Health services. OC Links now operates 24 hours a day, 7 days a week, year-round. Callers may access navigation services through a toll-free phone number (855-OC-Links or 855-625-4657) or a live chat option available on the OC Links webpage (www.ochealthinfo.com/oclinks). Individuals may also access information about BHS resources on the website at any time (http://www.ochealthinfo.com/bhs/).

During a call or live chat, trained navigators provide screening, information, and referral and linkage directly to BHS programs that best meet the needs of callers. Navigators make every attempt to connect callers directly to services while they are still on the line. Once the caller is scheduled for their first appointment, the navigator offers a follow-up call within the next 1-2 days to ensure a linkage has occurred (see Referral and Linkages graph).

Most Common Linkages Made
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE PROGRAMS; PREVENTION AND EARLY INTERVENTION SERVICES



In addition, staff attends numerous community events each year where they provide outreach and education on mental health awareness and the availability of OC Links. The number of referrals, linkages and outreach activity was somewhat lower in FY 2019-20 compared to recent years, likely due to the impact of COVID-19 (see Outreach Activity graph).



Challenges, Barriers and Solutions in Progress

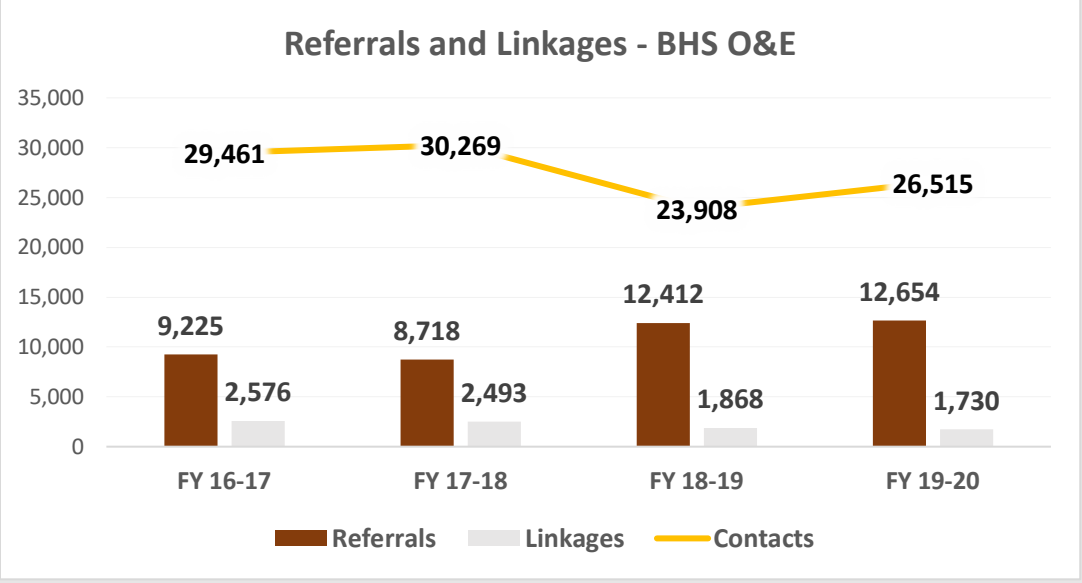
Increasing community awareness about OC Links and the services available through the County of Orange is a constant challenge that must continually be addressed. To better educate the public about OC Links on an ongoing basis, the team participates in community events and offers presentations to service providers and community groups. The program also provides OC Links informational cards to locations throughout the community in the threshold languages to promote services. As utilization has increased, the program has noted an increasing need for bilingual speakers. Thus, OC Links continues its recruitment efforts to hire bilingual clinicians who are knowledgeable about the County BHS. Challenges that arose due to COVID-19 impacted the daily work shifts and the type of outreach OC Links was able to perform. In response to the pandemic, hours of operation were expanded to cover from 8 a.m. to 8 p.m., and then in February 2021 the program permanently shifted to operate 24/7. Community outreach in the form of tabling events were also suspended. There was a small impact felt by callers who identified specifics issues relating to COVID-19 and these issues were addressed by shifting work schedules to cover the additional hours. Local organizations that requested presentations were able to be accommodated by using meeting software platforms.

Community Impact
The program has responded to more than 90,000 participants since opening in the Fall of 2013. OC Links serves Orange County residents by helping callers navigate a large and complex system of care and linking them to the County and/or County-contracted services best suited to meet their behavioral health needs.

BHS Outreach and Engagement (O&E) (PEI/CSS)

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

Services & Outcomes
To promote awareness of, and increase referrals to its services, BHS O&E performs outreach at community events and locations likely to be frequented by individuals the program intends to serve and/or the providers that work with them in non-mental health capacities (i.e., street outreach, homeless service provider locations, etc.). When a person is referred to the program, staff screens them in the community or over the phone to determine the individual's needs. Once their needs are identified, staff employ various strategies to link individuals, such as personalized action plans aimed to decrease barriers to accessing services and evidence-based psychoeducational groups for those who have experienced trauma and/or substance use. Staff utilizes motivational interviewing, harm reduction, and strength-based techniques when working with participants and assists them in developing and practicing coping skills. All outreach services are focused on making referrals and ensuring linkages to ongoing behavioral health and support services by assisting with scheduling appointments, providing transportation to services, addressing barriers, and offering ongoing follow-up (see Referrals and Linkages graph).



Challenges, Barriers and Solutions in Progress
Lack of affordable housing continues to be a barrier, especially for individuals who are homeless, and the program continues to collaborate with agencies to improve access to affordable housing opportunities. To address some participant's reluctance to provide personal information or enroll in engagement services, the programs have reached out to work with trusted community agencies/organizations. Through these partnerships, O&E staff have demonstrated the ability to follow through on commitments to address participant's needs and assist individuals with

accessing referrals, thereby building trust and rapport with participants. Once rapport and some success in linking to resources have been established, participants have been more receptive to engaging in ongoing services. BHS O&E has been called upon to engage individuals at homeless encampments across the county in partnership with cities and local law enforcement agencies many times over the past few years. After the large-scale riverbed engagement three years ago, the community saw the impact of the Outreach Team engaging and linking homeless individuals to treatment, shelter and services. Due to their cultural competence working with this population, many cities and police/sheriff departments have requested BHS O&E support for one-time and ongoing engagement projects in communities across the county. This has necessitated increases in staffing and working hours/days resulting in the program now being active six days per week including Saturdays.

The onset of the COVID-19 pandemic had a significant impact on the elderly homeless population and those with high-risk conditions. BHS O&E was tasked with helping to identify those at high risk for serious COVID-19 infection and referring them to Project Room Key (PRK) for further assistance and care. More specifically, PRK was a program that placed high-risk homeless individuals into motel settings. BHS O&E staff took referrals, conducted outreach and offered services to those with the highest of needs.

Most Common Linkages Made
OUTPATIENT MENTAL HEALTH AND SUBSTANCE USE PROGRAMS, INTENSIVE OUTPATIENT PROGRAMS, HOUSING SUPPORT, MEDICAL SERVICES

Another challenge the BHS O&E encountered was the lack of available shelter beds due to the COVID-19 pandemic. During this time, shelters were required to have social distancing protocols in place resulting in fewer available beds. O&E team members researched and advocated for their participants to find shelter options.

Community Impact

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

Multi-Service Center for Homeless Adults (CSS)

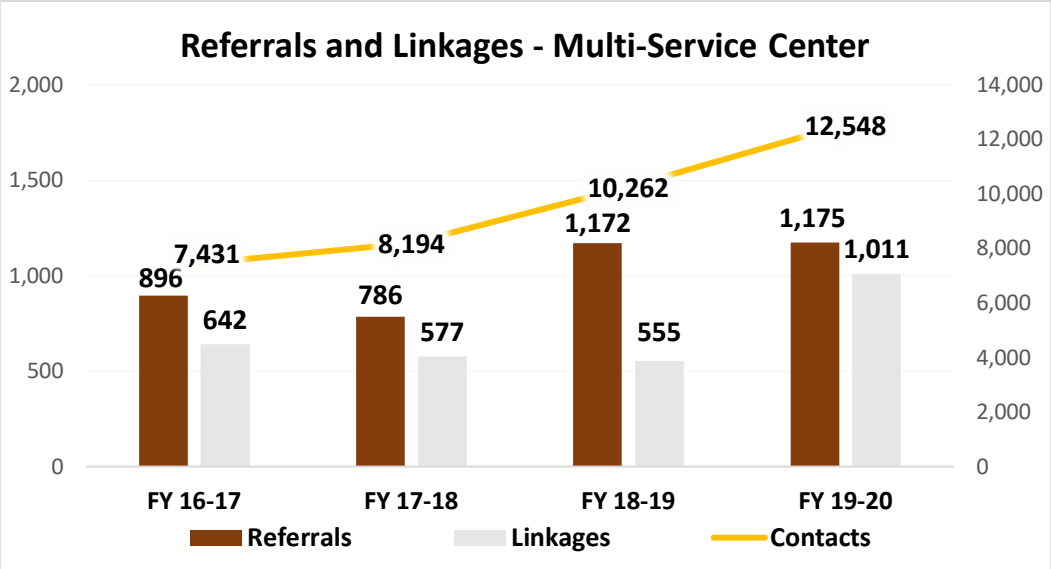
The Multi-Service Center for Homeless Mentally Ill Adults (MSC) program, formerly called Courtyard Outreach, serves residents ages 18 years or older who are experiencing homelessness and living with a serious mental illness and/or co-occurring substance use disorder. The outreach team links individuals receiving supportive services at the Multi-Service Center to mental health and/or substance use services.

Services & Outcomes

The MSC outreach workers assess residents' strengths and resources to determine their level of psychosocial impairment, substance use, physical health problems, support network, adequacy of living arrangements, financial status, employment status and basic needs. They facilitate linking participants to the most appropriate services for each individual (i.e., case management, outpatient mental health, medical appointments, housing, employment, SSI/SSDI and additional services such as obtaining identification or other personal documents, etc.). The team can

transport, or facilitate the transportation of, residents to those services as needed. As can be seen in the graph below, the number of contacts has increased by approximately 41% and the number of referrals has increased by approximately 31% from FY 2016-17 to FY 2019-20. This upward trend is most likely a result of stable staffing. In addition, program staff rebounded with an improved linkage rate in FY 2019-20 compared to FY 2018-19, when it had dropped compared to the prior two fiscal years.

Challenges, Barriers and Solutions in Progress



The Courtyard shelter in Santa Ana, the original location of Courtyard Outreach services, moved locations in February 2021, and the new shelter is offering these same services under a different (non-MHSA) funding stream. To avoid duplication of effort, and to enable the provider at the new shelter to fulfill its contractual obligations, the MSC program team will continue to serve the same population at a different location in Santa Ana where there is a need for these services. The program strives to build stronger partnerships with the collaborative agencies and community groups focused on integrating the program participants into permanent housing. Communication among community partners is not only necessary but ideal to meet the immediate needs of the residents. The MSC program team acts as the liaison with these other agencies and attends meetings with the collaborative ensuring that outcomes data are collected properly and presented in a timely manner.

Community Impact

The MSC team collaborates with a variety of human services and nonprofit providers to help its participants meet basic needs and obtain access to behavioral health services, housing, employment, public benefits and personal identification documents. By partnering with the collaborative agencies and program participants, the MSC team shares in the goal of helping break the cycle of homelessness among those living with serious mental illness.

Most Common Linkages Made
BASIC NEEDS; EDUCATION; MHA MULTI-SERVICE CENTER; INFORMATION AND REFERRAL SOURCES; EMPLOYMENT SERVICES

CHS Jail to Community Re-Entry (CSS)

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

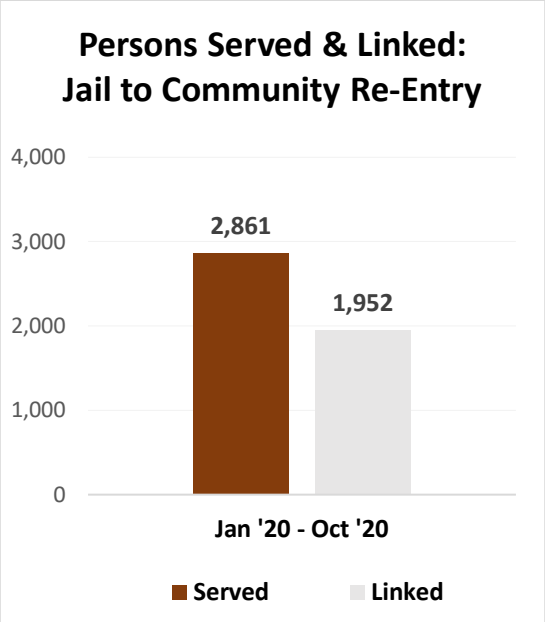
Services & Outcomes

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

Services also include facilitation of linkage to a range of services upon release, such as counseling, medication support, housing, Medi-Cal enrollment and essential needs such as clothing and transportation. Connections with family and support systems such as peer support mentors is also facilitated. JCRP staff work in collaboration with other stakeholders, including the Orange County Probation Department, Orange County Public Defender, Social Services Agency, Regional Center of Orange County, Orange County Housing Authority and other ancillary agencies to identify gaps in service delivery and solidify linkage with external stakeholders for a smooth transition from jail to the community. JCRP has established a 7-day release process which provides face-to-face contact and re-entry resources for all inmates leaving the Central Jail Complex and the Theo Lacy Facility. Additionally, the JCRP is now able to make direct referrals to the HCA Residential Treatment programs and assist with facilitating transitions for clients requiring residential in-treatment services.

Beginning January 2020, JCRP established a process of measuring referral and linkage outcomes. Due to the challenges brought about by the pandemic, the program had to readjust services depending on the available services and programs in the community.

From January 2020 to October 2020, 2,861 inmates who received mental health services while incarcerated were released from Orange County jails. Of these inmates served, 1,952 were referred to external programs by the JCRP team. The individuals who were not referred either had directly declined or had a previous established transition arrangement. Linkage outcome data is limited to the programs that confirm that our clients have linked to their programs once they have been released. The programs include Opportunity Knocks, North/South HCA Open Access clinics, Assisted Outpatient Treatment (AOT) program and a community based mental health service provider, APAIT (Asian Pacific AIDS Intervention Team).



Challenges, Barriers and Solutions in Progress

The COVID-19 pandemic impacted in-reach in the jail facilities and supportive programs available for patients transitioning from incarceration. Although the JCRP operation tempo increased due to a higher than normal number of inmates released during the beginning of the pandemic (i.e., January, February and March) community provider service availability decreased and linkage outcomes were impacted. The quick decision to control the spread of COVID-19 by decreasing the jail population similarly impacted the ability of the JCRP staff to link and refer clients. The JCRP program has been faced with various challenges. Some challenges have involved the pandemic and others are associated with changing the traditional approach for assisting individuals who have been incarcerated and released. Challenges have included finding appropriate placement and transporting clients during this challenging time. Although some of these services have resumed, JCRP continues to work with programs to reintegrate the linkage process.

Community Impact

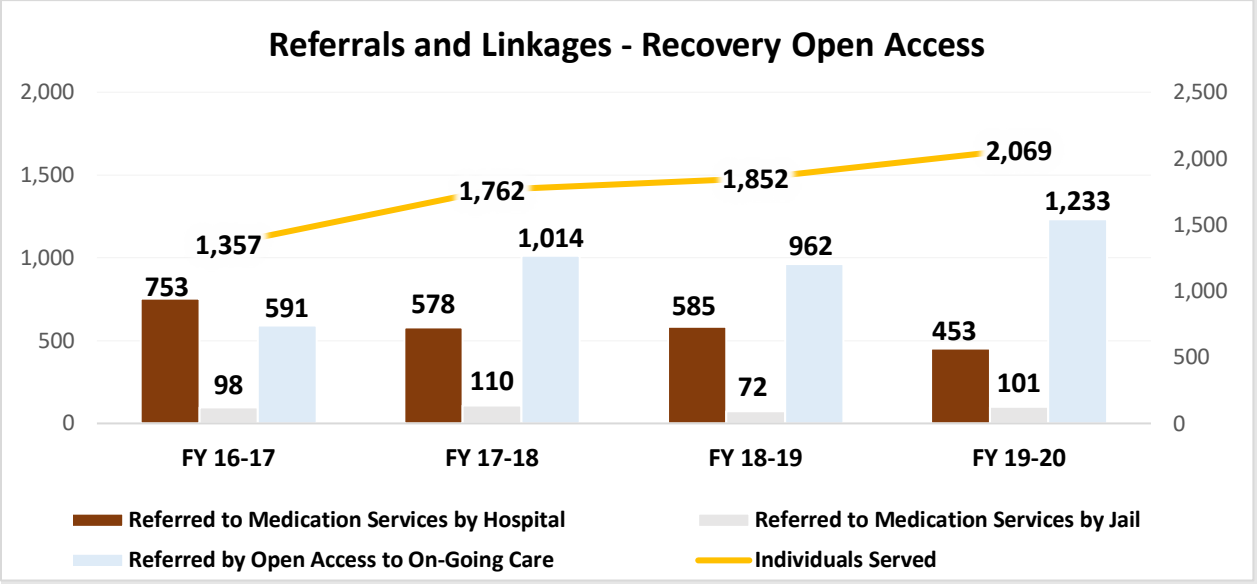
On July 1, 2020 JCRP expanded services to the Theo Lacy Facility. The Release Team replicates the services provided at the Intake and Release Center. This includes a Release Clinician who reviews all documents for patients scheduled for release and confirms discharge plans have been established. Currently the team is pending the addition of a dedicated nurse and, while awaiting this addition, coordination is made with the nursing team when patients require medical attention and education regarding their discharge plans.

Recovery Open Access (CSS)

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

Services

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

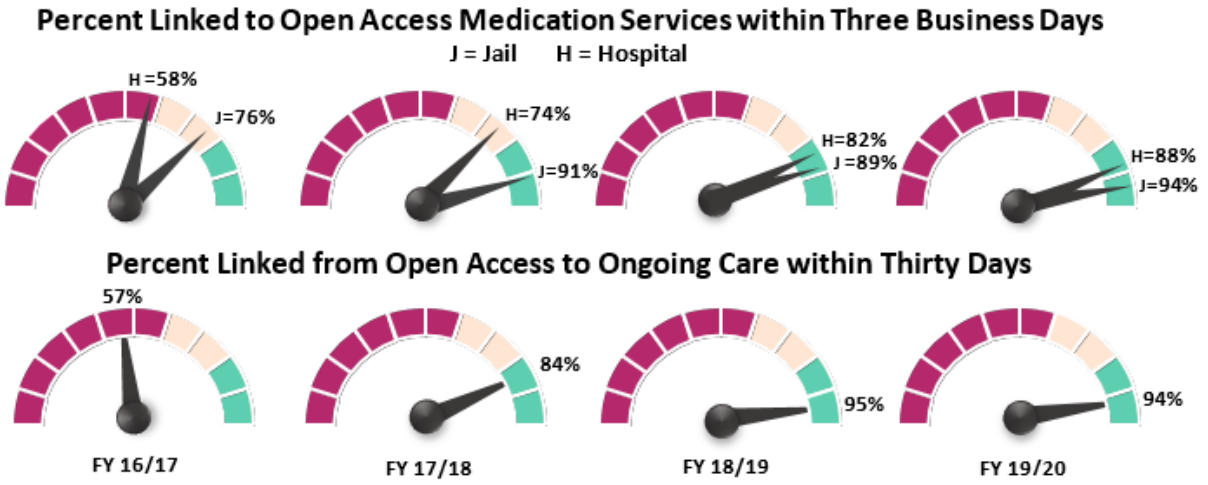


Outcomes

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

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

The program continued to meet its targets in FY 2019-20 after clarifying service benchmarks with program staff at the end of FY 2016-17. Additional staff has resulted in smaller caseloads, and this has allowed staff to monitor linkages more closely and follow up on missed appointments. These improvements, in addition to the implementation of a Performance Improvement Project (PIP) in October 2018 that focused on linking hospitalized clients to Open Access and outpatient services, may have contributed to the upward trend in linkages since 2016-17.



Challenges, Barriers and Solutions in Progress

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

Community Impact

Recovery Open Access has provided services to more than 6,400 individuals since its inception through the end of FY 2018-19. The program collaborates with a variety of community partners, including hospitals, jails, homeless shelters, substance use programs, community health clinics, mental health clinics, OC Probation and Social Services Agency to help individuals receive needed behavioral health care.

Summary of MHSA Strategies Used by Access and Linkage to Treatment Programs

Strategies to Promote Recovery/Resilience

Access and Linkage to Treatment (ALT) programs work with some of the most marginalized and unserved populations in the county, including those who are homeless and/or involved in the criminal justice system. These individuals may have previously experienced trauma or, particularly among the homeless population, are currently experiencing daily trauma and are struggling to meet their basic needs, leaving them feeling disenfranchised or stigmatized. In order to engage individuals successfully, staff integrates a consumer-centered, strength-based approach that works with individuals in their current stage of recovery and acknowledges and builds upon their existing coping skills. They also use harm reduction techniques, provide unconditional positive regard, help to reduce barriers and offer supportive services while working to link individuals to treatment. Staff use recovery principles and techniques such as motivational interviewing to help engage individuals in their recovery journey.

Strategies to Reduce Stigma and Discrimination

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

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

ALT program staff, particularly OC Links and BHS O&E, also provides hundreds of outreach trainings throughout the county at community events, resource fairs, law enforcement departments, etc. With this increased presence in the community, programs hope to reduce the stigma and discrimination attached to those attempting to reach out for behavioral health services.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment

The Navigation program, OC Links, encourages timely access by promoting its services among unserved and underserved populations in Orange County. For example, the program displays its information and phone number on rotation every day at the Civic Center Plaza message board; has advertised on Public Access Cable Television Community Resource displays; and has posted advertisements on Facebook and Twitter that direct people to the OC Links website where they can obtain information and connect to Live Chat with the navigators. Information cards in all threshold languages are also handed out at many locations throughout the county, including schools, colleges, community organizations, businesses, court houses, libraries and resource fairs. Once an individual connects with OC Links, they can work with a navigator who speaks English, Spanish, Vietnamese, Korean, Arabic or Farsi. The program also has access to a language line translation service to meet the language needs of any caller and offers a Telecommunications Device for the Deaf (TDD) number (714-834-2332) for deaf and hard of hearing callers.

In addition, the ALT programs provide face-to-face services to increase unserved individuals' willingness to enroll in needed services and facilitate linkage to appointments in as timely a manner as possible. Staff stay up-to-date on available resources, network and collaborate with other providers, assist with decreasing barriers to accessing services as they are identified, and provide transportation and warm handoffs to ensure linkage to ongoing care. Staff are bilingual/bicultural and a language translation service is available when needed. In addition, BHS O&E is staffed with peers who share their own lived experience as a way to build the rapport and trust necessary to engage homeless individuals. Open Access improves access to care by expediting urgent care needs and by facilitating quicker and smoother linkages to behavioral health treatment for those discharging from inpatient and jail settings.

In addition, all ALT programs have developed collaborative relationships with outside agencies that come into frequent contact with the programs' respective target populations and, in turn, these agencies provide referrals to ALT services. The types of agencies with which the programs have established strong working relationships include community-based organizations, homeless service providers, housing programs and shelters, schools, places of worship, law enforcement agencies, hospitals, social service agencies, juvenile justice, the OC Probation Department, the Orange

County Fire Authority, veteran's services, community centers, motels, shelter staff, apartment complexes, and other behavioral health service agencies.

Crisis Prevention and Support Services

WarmLine (PEI)

The WarmLine provides 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. Beginning July 2020, the WarmLine began providing services 24 hours a day, seven days a week, year-round.

Services

The WarmLine plays an important role in Orange County's Crisis and Suicide Prevention continuum by providing non-crisis or crisis prevention support over the phone or through live chat, for anyone struggling with mental health and substance use issues. Upon connecting with the WarmLine, individuals are screened for eligibility and assessed for needed mental health information, support and resources. Staff draw upon their lived experience to connect with callers and provide them with emotional support and referrals to ongoing services as needed. Callers who are experiencing a behavioral crisis are immediately referred to the Crisis Prevention Hotline.

Active listening, a person-centered motivational interviewing skill, is effective in establishing rapport and demonstrating empathy, and can be especially useful with callers in the pre-contemplative or contemplative stages of change. The WarmLine also uses Positive Psychology, a resilience-based model that focuses on positive emotions, traits and institutions. This model trains mentors to focus on the positive influences in callers' lives such as character, optimism, emotions, relationships and resources in order to reduce risk factors and enhance protective ones.

Outcomes

The WarmLine continues to demonstrate an increasing number of callers and amount of activity. The majority of calls were from individuals who had used the WarmLine before and calls typically lasted 20 minutes or less.

The WarmLine aims to reduce prolonged suffering from behavioral health problems, which was measured through changes in ratings on the Profile of Mood States (POMS). Callers were asked at the beginning of the call whether they felt different emotions (i.e., worried, uncertain, etc.) and then asked at the end of the call whether they felt better, the same or worse. The evaluation reflects cultural competence in that it assessed for the presence of, and changes in, a range of negative mood states to ensure that different cultural expressions of distress were reflected.

While the extent of improvement varied across specific mood states, overall results across fiscal years show that most callers reported feeling better at the end of the call, with the highest rates of improvement observed for callers feeling anxious, overwhelmed or helpless, and the lowest rate for those feeling agitated. Thus, the program appears to be successful in reducing emotional distress through the support and services provided during the telephone contact.

Challenges, Barriers, and Solutions in Progress

An ongoing challenge for the program has been the continuing increase in calls year after year. This increase has created longer wait times as staff are not always available to answer incoming calls immediately. The program has adjusted staff shifts to accommodate when call volume is highest and is always identifying and recruiting new volunteers to try and accommodate the increasing demand for services. The program also received increased funding for FY 2018-19 and, through the community planning process, was identified as a program that can receive additional carryover funds over the course of this Three-Year Plan if demand for services exceeds its recently augmented budget. The provider is also exploring other strategies to adapt to the increased volume, including methods to enhance their

technology. In addition, as a result of the recent hiring of bilingual staff, the program's voicemail system was expanded from English and Spanish to include Farsi and Vietnamese language voicemail options. Callers who speak these languages can now leave a voicemail requesting support from a staff who speaks their preferred language as soon as they become available rather than having to make repeated calls to the line in hopes of connecting with a bilingual staff by chance.

Community Impact
The WarmLine has provided services to more than 122,000 individuals since its inception in August 2010. The provider also actively collaborates within the community to break down stigma, raise awareness and educate the community about available services.

Suicide Prevention Services (PEI)

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 will now also be supported by a new Office of Suicide Prevention, which was established in the HCA's Behavioral Health Services area upon the direction of the Orange County Board of Supervisors in 2021.

Services
The program currently offers a range of services that use Applied Suicide Intervention Skills Training (ASIST), which provides practical suicide intervention training for clinicians, first responders, medical providers and caregivers seeking to prevent the immediate risk of suicide. During the COVID-19 pandemic, ASIST trainings were temporarily paused since they are required to be done in person; the provider offered other virtual trainings in its place.

- **Telephone Hotline Support:** Trained counselors provide immediate, confidential, over-the-phone/text/chat assistance and initiate active rescues when necessary. For callers who give their consent, counselors conduct follow-up calls to ensure continued safety and reduce the likelihood of attempts and emergency room visits. Callers who are not experiencing a crisis are triaged and offered access to the WarmLine or other appropriate resources. The toll-free suicide prevention service is available to anyone in crisis or experiencing suicidal thoughts or to someone who is concerned about a loved one attempting suicide.

TELEPHONE HOTLINE CALL VOLUME	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Callers	6,807	9,200	10,137	9,886
Calls	8,475	11,607	13,536	13,613

- **Face-to-Face Services:**
  - **Individual Counseling for Survivors after Suicide:** Children, adolescents, adults and older adults who are coping with the loss of someone to suicide can receive time-limited individual counseling. Short-term bereavement counseling is also available to families who want to improve their functioning and communication after the loss of a family member.
  - **Survivors after Suicide Bereavement Groups:** Two different bereavement groups are offered for anyone who is coping with the loss of someone to suicide. The first is an eight-week, closed format group, co-facilitated by a therapist and a survivor. The goal is to establish a safe place without stigma

for survivors to share experiences, ask questions, and express painful feelings so they can move forward with their lives. The second group is a drop-in bereavement group designed to help individuals receiving individual counseling (described above), and program alumni so that they continue the healing process in the months and years following their losses.

- **Survivors of Suicide Attempts (SOSA) Support Group**: The program offers closed groups that provide a safe, non-judgmental place for people who have survived a suicide attempt to talk about the feelings that led them to attempt suicide. The goal of this group is to support their recovery and provide them with skills for coping with deep hurt. The program also provides individuals with culturally appropriate follow-up care and education.

INDIVIDUALS SERVED IN FACE-TO-FACE SERVICES			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
132	148	140	156

TOTAL NUMBER OF INDIVIDUAL SESSIONS			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
511	559	678	745

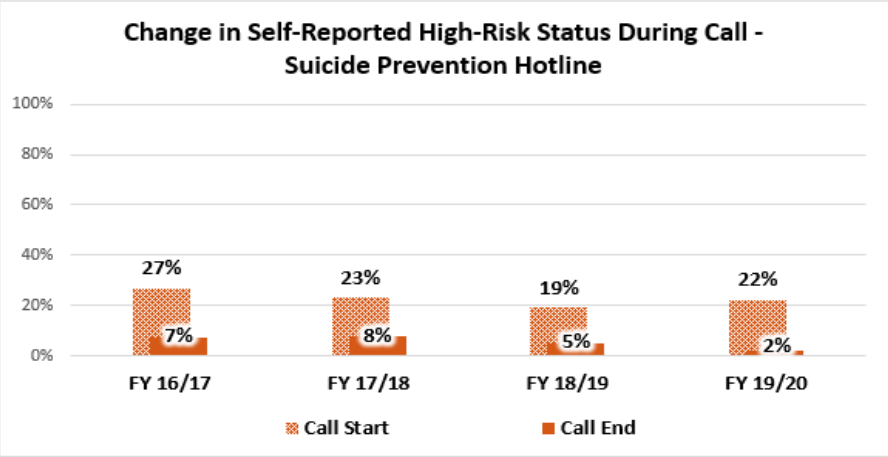
TOTAL NUMBER OF SAS & SOSA GROUPS			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
59	64	91	104

Community Training/Outreach

Consistent with PEI regulations, the program trains potential first responders in ASIST and SafeTalk so that they are 1) better able to recognize signs of depression, suicidal ideation and other mental health conditions, and 2) informed about myths associated with talking about suicide, strategies on how to listen to and aid someone in distress, and awareness of the Suicide and Crisis Prevention Services program. Audiences include nurses, physicians, teachers and school personnel, law enforcement and other Orange County community members. Program staff also provides informational/program promotional material through information tables at events and speaking engagements throughout the county.

Outcomes

Corresponding to increased outreach efforts, the hotline has seen a steady increase in the number of individuals served. Outcomes for the different types of services are summarized below.

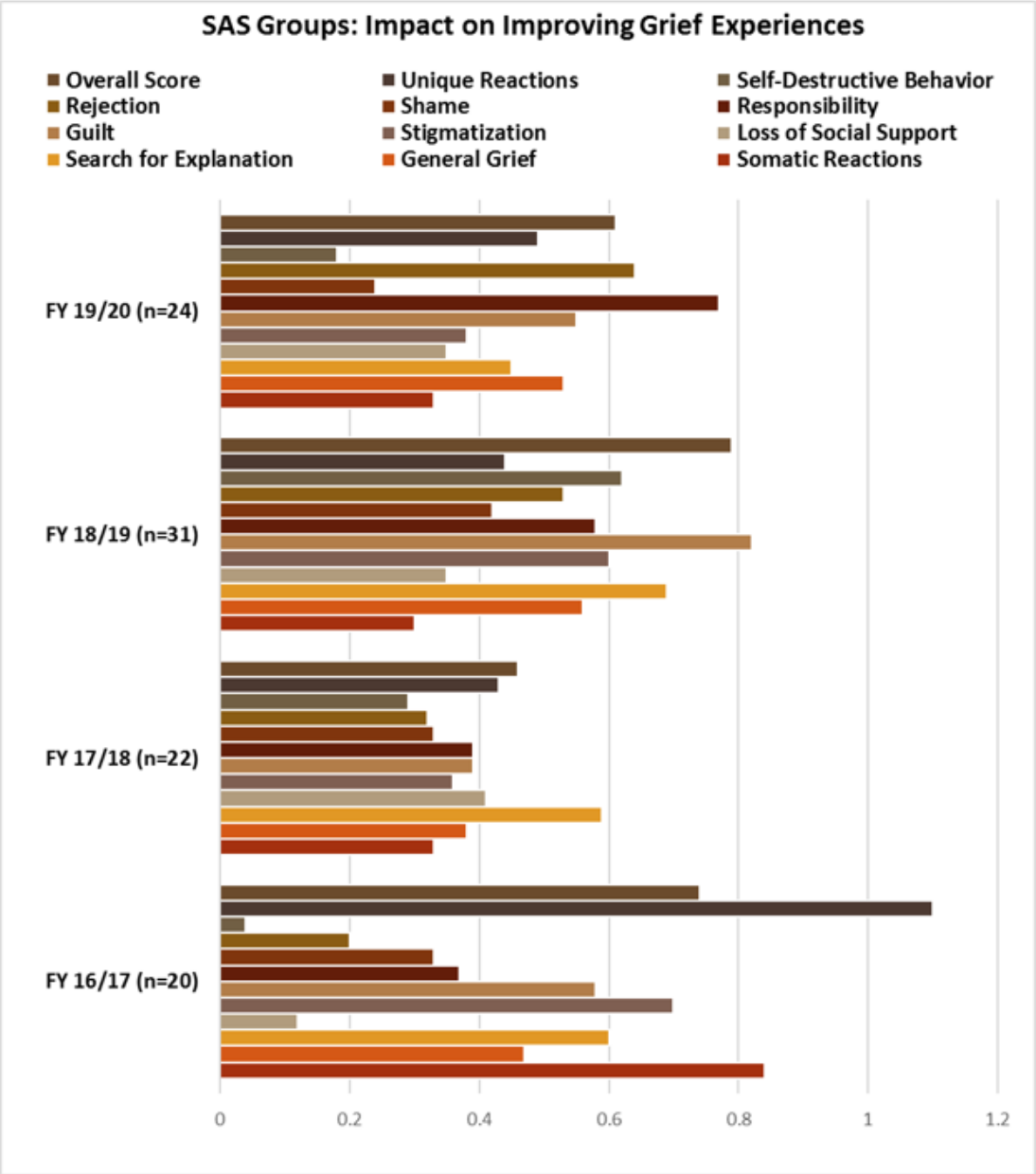


Telephone Hotline Support: To assess the hotline's effectiveness in reducing prolonged suffering, callers were asked to complete a Self-Rated Intent (SRI) on a 5-point scale at the beginning and end of the call. Risk of suicidal behavior was rated low if a caller reported their suicidal intent as a score of 1 or 2, medium if they reported a score of 3, and high if they reported a 4 or 5. A score that moved to a lower risk category by the end of the call or remained in the low-risk category for the duration of the call suggests that services effectively stabilized or decreased suicidal intent. The proportion of high-risk callers has consistently dropped by the end of the call. Thus, Crisis Prevention Hotline counselors helped reduce suicidal intent and prevented the worsening of crisis symptoms.

Face-to-Face Services: The program also provides in-person services, which have remained relatively consistent in the numbers of people served over the past few years, and a trend towards more individual counseling sessions and fewer support groups.

To measure the reduction in prolonged suffering in a culturally competent manner, individuals participating in individual or group counseling were asked to complete measures specific to their experience. Measures were administered at intake and program exit, and the difference between scores was used to analyze whether there was a significant reduction of prolonged suffering after receiving program services. Results are reported according to the calculated effect size, which reflects, in part, the extent to which a change in scores over time is clinically meaningful for the individuals served in the program.

- **Survivors of Suicide Attempts (SOSA)**: SOSA participants (FY 2019-20 n=2; FY 2018-19 n=10; FY 2017-18 n=14; FY 2016-17: n=13) completed the Beck Hopelessness Scale, Beck Scale for Suicidal Ideation and Interpersonal Needs Questionnaire to assess for pessimism and negativity they felt about their future; their thoughts, plans and intent to commit suicide; and their perceived burdensomeness and thwarted belongingness, respectively. Due to the small sample size of participants who completed both a baseline and follow-up of these measures, data were not statistically analyzed. However, clinicians monitored scores over the course of treatment to track participant's progress and adjust care plans as needed. The HCA is currently identifying ways to improve collection and/or measurement of performance outcome for this group.
- **Survivors of Suicide (SAS)**: Based on individuals' responses on the Grief Experiences Questionnaire (GEQ), services were generally associated with a meaningful lessening of grief following the loss of a loved one to suicide. Although degree of improvement varied across subscales and fiscal years, given the small sample sizes, it cannot yet be determined whether these differences reflect a change in the impact of services, the nature of the individuals served or other factors. The HCA will continue to monitor these outcomes to see if a trend can be identified.



Challenges, Barriers and Solutions in Progress

Similar to the WarmLine, the crisis hotline has seen a steady increase in calls over the past several years, which exceeded its staffing capacity. In response, the program received increased funding beginning FY 2018-19. Through the recent community planning process, the integrated Suicide and Crisis Prevention Services program was also identified as a program that can receive additional carryover funds over the course of this Three-Year Plan if demand for services exceeds its recently augmented budget. The program recently relocated to a new building with more space to accommodate additional staff and volunteers, and the facility is equipped with updated, state-of-the-art technology. Stigma regarding suicide continues to be a barrier to seeking services, which the program is addressing by conducting more community outreach and presentations, especially in different ethnic communities, and the program has hired bilingual staff who speak Korean and Spanish. In addition, the program has incorporated a workshop model to conduct outreach. This strategy has been especially successful in the Spanish-speaking community, as noted by an increase in Spanish-speaking participants. In addition, the program conducts outreach in Arabic, Farsi, Urdu and Hindi languages

through its partnership with a community agency serving the Middle Eastern and North African communities. The increased outreach efforts have been successful, and the program is seeing an increase in demand for individual sessions, especially from Survivors of Suicide Attempts (SOSA) and Survivors after Suicide (SAS) participants. However, stigma continues to be a barrier for participating in group sessions, especially for SOSA groups. Recognizing that a survivor of a suicide attempt may need additional time to engage in groups, the program periodically reaches out to the individual to assess their readiness for services. The program is working to collaborate with hospitals, such as Hoag and Mission Hospital, in hopes of increasing referrals for SOSA groups.

Community Impact
The integrated program has answered more than 88,000 calls and provided face-to-face services to more than 1,000 since services launched in August 2010. One of the key components of the program's success is its collaboration with community partners and agencies that serve ethnic communities. This partnership promotes awareness, breaks down stigma related to mental health, and educates communities about available resources.

Mobile Crisis Assessment (CSS)

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 or ride along with assigned law enforcement officers to address behavioral health-related calls in their assigned city. PERT provides all the same services as CAT and initiates involuntary hospitalizations as necessary.

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

The Children's team provides ongoing trainings and education to schools, school districts, hospitals, police departments and other community stakeholders upon request to increase collaboration and support for children and youth experiencing a behavioral health crisis event. PERT clinicians similarly educate police on behavioral health issues and provide officers with tools that allow them to assist individuals living with behavioral health issues more effectively.
There are currently 27 clinicians on the children's crisis assessment team (CAT) serving youth under age 18, and 41 clinicians on the TAY/Adult/Older Adult team serving individuals ages 18 and older. The teams are also staffed with Service Chiefs who are responsible for overseeing the day-to-day operations of the program. The HCA currently has 17 PERT collaborations across Orange County, including the Orange County Sheriff's Department and police departments in the cities of Anaheim, Buena Park, Costa Mesa, Fullerton, Fountain Valley, Garden Grove, Huntington Beach, Irvine, Laguna Beach, Newport Beach, Orange, Santa Ana, Seal Beach, Tustin, University of California at Irvine and Westminster.

The Children's team experienced a decrease in total calls received in FY 2019-20. A contributing factor to the decrease in calls was the impact of the COVID-19 public health emergency. The program demonstrated a drop in totals call starting in March through the end of the fiscal year. Schools are one of the main referral sources for the Children's team and the program saw a decrease in calls that correlates with the closing of in-person school services for children and youth.

Outcomes

The program is evaluated by the timeliness with which the teams can respond to calls, with the goal of a dispatch-to-arrival time that is 30 minutes or less at least 70% of the time. The Children's and TAY/Adult/Older Adult team meet this goal for FY 2019-20. While the TAY/Adult/Older Adult team has continued to meet this goal, this was the first time in the last four fiscal years that the Children's team reached this goal. The re-location of the Children's team to a new facility, combined with reduced traffic during the COVID-19 public health emergency, contributed to the Children's program reaching the goal for FY 2019-20.

In addition to dispatch-to-arrival times, the teams examine the rate at which individuals are psychiatrically hospitalized as a way of monitoring the severity of the presenting problems experienced by the individuals served and the availability of safe alternatives to inpatient services. Consistent with prior years, individuals continued to be hospitalized less than half the time (44%, 40% and 42% in FYs 2016-17 through 2018-19 for children; 48%, 45% and 46% in FYs 2016-17 through 2018-19 for TAY, adults and older adults).

Challenges, Barriers and Solutions in Progress

As an essential service, both Adult and Children's CAT continued to respond to calls throughout the COVID-19 pandemic and were required to implement new processes to keep our clients and clinicians safe. All clinicians started responding to calls with Personal Protective Equipment (PPE), including but not limited to masks, gloves and face shields. Both teams started the process of having clinicians dispatching from home to reduce the number of clinicians in the office. While maintaining social distancing guidelines, evaluating clients in the field/home added a layer of complexity. Targeted training was provided for CAT to ensure PPE was being put on, worn and taken off in the appropriate manner.

While the increasing calls from law enforcement, schools and the community are ultimately a reflection of the program's positive impact in Orange County, this growing demand nevertheless poses challenges. As PERT continues to expand, the TAY/Adult/Older Adult team experiences decreased staffing due to the transition of CAT staff to the new PERTs. To accommodate increasing call volume, the TAY/Adult/Older Adult teams have increased the number of positions, however hiring remains difficult due to the inherent challenges in staffing a 24/7 program. Hiring bilingual staff is also difficult as clinicians who speak languages other than English frequently receive competing job offers for positions that offer a more traditional schedule. The HCA is working to overcome these challenges by offering pay differential for bilingual staff and for those who work the night shift. To address increasing volume during daytime hours, CAT has also been supported by Lanterman-Petris-Short (LPS)-designated clinicians from County-operated outpatient clinics and, for the Adult team, clinicians from the Program for Assertive Community Treatment.

While the Children's team has continued to evaluate the impact of call location on response time, current COVID-19 impact has led to a decrease in calls for evaluation, freeing up staff to respond more quickly and improve response time. The HCA will continue to monitor call volume and the impact on response time.

Crisis Residential Services (CSS)

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 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 4 sites located throughout Orange County.

CRS has several sites across the county tailored to meet the needs of different age groups:

- **Children** ages 12 to 17 receive services at three sites operated by Children Youth and Behavioral Health (CYBH; i.e., Laguna Beach, Huntington Beach, Tustin) with a total of 16 beds. Services generally last for three weeks, although children can remain in treatment for up to six weeks if needed. Additional sites are being added to address the needs of dependents as part of Continuum of Care (CoC) Children's Crisis Residential Program (CCRP) services and/or DHCS' Psychiatric Residential Treatment Facilities (PRTF).
- **TAY** between the ages of 18-25 receive services at a site operated by CYBH with six beds. Services generally last for three weeks, although youth can remain in treatment for up to six weeks if needed. TAY may also receive services at the TAY/Adults sites operated by Adult and Older Adult Behavioral Health (AOABH).
- **TAY/Adults** ages 18 and older receive services at three sites operated by AOABH (2 sites in Orange, 1 in Mission Viejo) with a total of 36 beds, four of which are Americans with Disabilities Act (ADA)-compliant. Stays last an average of 7 to 14 days.
- **Older Adults** ages 50 and older receive services at a newly renovated Older Adult CRS operated by AOABH in Anaheim (6 beds, 2 of which are ADA-compliant). Stays last an average of 7 to 14 days.

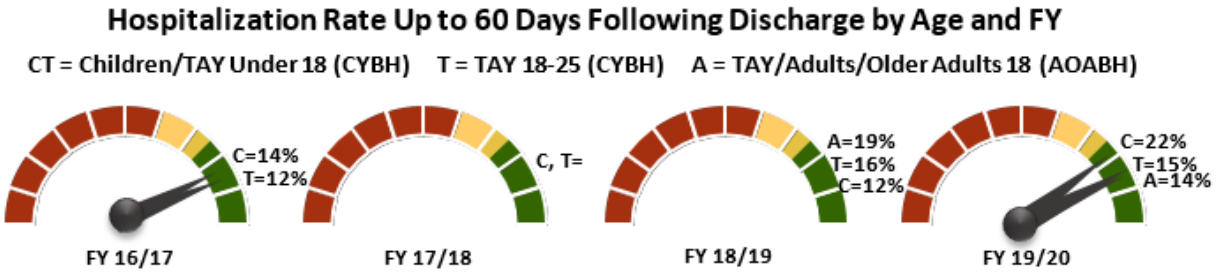
Services

The residences emulate home-like environments in which intensive and structured psychosocial, trauma-informed, recovery services are offered. Depending on the individual's age and their or their family's/significant other's needs, services can include crisis intervention; individual, group and family counseling/therapy; group education and rehabilitation; assistance with self-administration of medications; training in skills of daily living; case management; development of a Wellness Recovery Action Plan (WRAP); prevention education; recreational activities; activities to build social skills; parent education and skill-building; mindfulness training; narrative therapy, reminiscence groups, educational and didactic groups specific to older adults, issues associated with aging, stigma associated with aging, safety issues, adaptive equipment, fragility issues and "silver" fitness groups, outings and activities, and nursing assessments. The evidence-based and best practices most used include cognitive behavior therapy, Dialectical Behavioral Therapy (DBT), and trauma-informed care. Programs also provide substance use disorder education and treatment services for people who have co-occurring disorders.

To integrate the individual back into the community effectively, discharge planning starts upon admission. A key aspect of discharge planning involves linkage to community resources and services that build resilience and promote recovery (i.e., FSPs and other ongoing behavioral health services; victim's assistance; local art, music, cooking, self-protection classes; animal therapy; activity groups designed to support the individual; etc.). Children also have the option to participate in a weekly graduate drop-in group. As an essential service the CRPs remained fully operational throughout the COVID-19 pandemic and implemented new practices to keep clients and staff safe, including the use of PPE, COVID-19 testing and reducing the census as necessary to allow for isolation and quarantine

Outcomes

The goal of the program is to help the person manage their behavioral health crisis and make positive gains in recovery, which is quantified as achieving a psychiatric hospitalization rate of 25% or less from the time the individual is enrolled in the program through 60 days post-discharge. The program met this goal with hospitalization rates ranging from 14-22% across all fiscal years and age groups.



Challenges, Barriers and Solutions in Progress

An ongoing, primary challenge has been the increased demand for Crisis Residential Services, with the community identifying a particular need for a facility specifically geared towards older adults. The HCA is actively working on addressing this service gap and opened the Silver Treehouse on September 1, 2021, that exclusively addresses the needs of older adults in behavioral health crisis. TAY continue to face challenges with the lack of stable housing available when youth are ready for a lower level of care, and children periodically showed an increased demand for services throughout the past two calendar years and, at times, either had to be placed on a waitlist or diverted to other crisis services such as in-home crisis. The HCA is examining these trends to determine projected need for Children's Crisis Residential Services over the course of the next three-year period. As part of this, the HCA is considering how the new State requirement for a CCRP level of care and facility type will affect the children's crisis residential needs moving forward to ensure enough beds are available for youth determined to need this level of care.

In-Home Crisis Stabilization (CSS)

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

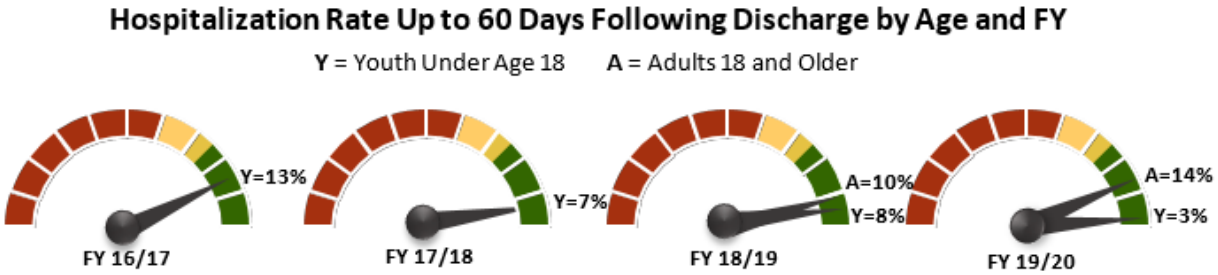
Services

Individuals and their families or identified support networks (i.e., "family") are typically referred to IHCS after a clinician has evaluated an individual for possible hospitalization and determined that, while they may not meet criteria for hospitalization, they and their family would safely benefit from supportive services. The evaluator calls the crisis stabilization team to the site of the evaluation and the team is required to respond in person within two hours, immediately working with the individual and their family or identified support network to develop a stabilization plan. After triggers have been identified and a safety plan is in place, additional in-home appointments are made for the next day.

The IHCS teams utilize strategies such as crisis intervention, assessment, short-term individual therapy, peer support services, collateral services and case management to help the individual and their family establish a treatment plan, develop coping strategies and ultimately transition to ongoing support. Length of stay in the program is usually three weeks but can be extended based on clinical need and the amount of time it takes before an individual is linked to long-term services. All IHCS services are mobile and, whenever possible, provided in the home, at the identified residence of individuals who are experiencing homelessness, and/or in any community setting that the individual or family feels comfortable. As an essential service, the IHCS Teams continued to remain fully operational throughout the COVID-19 pandemic and were required to implement new processes to keep both clients and clinicians safe, such as the use of telehealth and PPE.

Outcomes

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



Challenges, Barriers and Solutions in Progress

The Children's team strives to stay within the three-week timeframe to address crisis events for children and youth. The program has made progress in maintaining the three-week structure of the program. The program is continuing to focus on the discharge process and working to link children and their families as early as possible during the treatment period. Linking children with private insurance has continued to be a challenge for the Children's team. The program continues to address this by increasing outreach to private insurance providers to educate about its program services and increase collaboration for linkages to covered outpatient or other appropriate services.

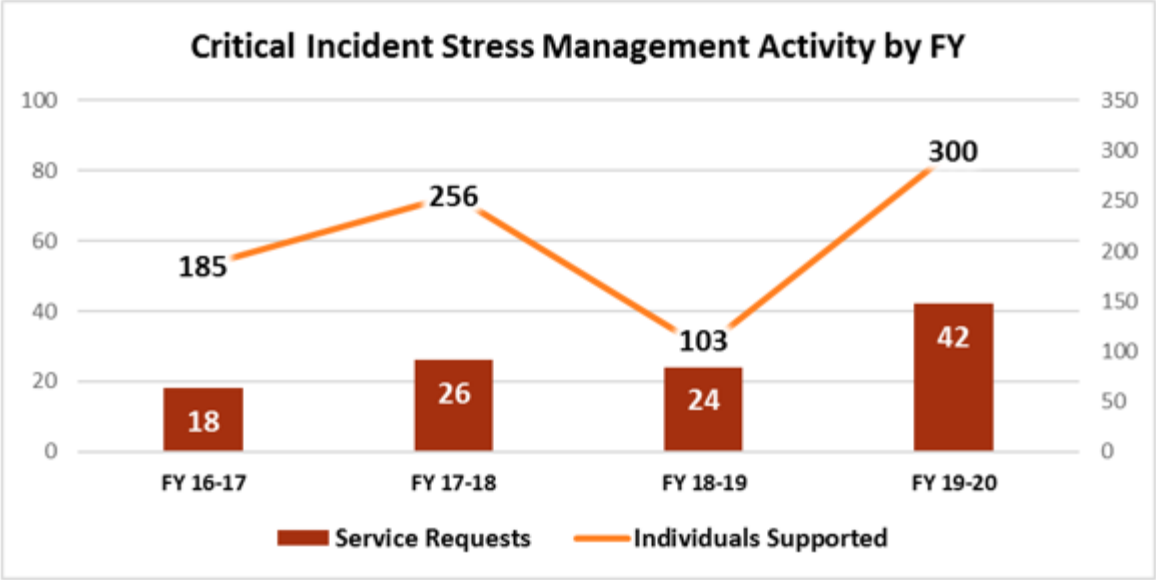
BHS Disaster Response (PEI)

The Behavioral Health Services Disaster Response (BHSDR) program is a mobile team of BHS clinicians who receive specialized training in Critical Incident Stress Management (CISM). The team is on-call to provide support to residents with the goal of minimizing lasting, negative impacts from critical, traumatic and/or disruptive events. The team responds anywhere in Orange County or surrounding areas. It is part of the PEI-funded program, Outreach for Increasing Recognition of Early Signs of Mental Illness and is described here due to its specific focus on crisis response.

Services

BHSDR provides Critical Incident Stress Management (CISM) group debriefings, CISM one-on-one debriefings, CISM briefings and education on grief, stress reactions and self-care. In addition, the team provides Psychological First Aid training to community members. The number of requests for services and/or individuals supported varies based on the number and/or magnitude of critical incidents that may occur in any given year.

Notably, during FY 2019-20 several scheduled meetings, exercises, activities and trainings were canceled during the last quarter due to the COVID-19 crisis. BHSDR shifted its focus to assist with many activities to support the County's response to the pandemic.



More specifically, the team helped with:

- Coordination of Personal Protective Equipment (PPE) distribution
- Redeployment of team members to homeless shelters (i.e., Salvation Army in Santa Ana for three weeks in April 2020; Joplin Youth Center in May 2020), where they provided outreach and engagement, case management, crisis intervention and referral and linkage to supportive services
- Coordination and oversight of supportive services provided to the vulnerable homeless population residing in motels during the COVID-19 crisis
- Development of a debriefing process for hotline workers at the Loma Ridge Emergency Operations Center (EOC)
- Facilitation of 12 trainings to 346 individuals throughout FY 2019-20, including Psychological First Aid (PFA); Disaster Preparedness for Disaster Service Workers (DSW); Vicarious Trauma: Impact and Skills to Help You Cope; and a new training focused on Grief and Loss that reached approximately 272 community partners from Waymakers, Social Service Agency, HOPE Animal Assisted Crisis Response, HCA Public Health Nursing and several Community Emergency Response Teams (CERT)

In addition, 27 BHSDR Team members received training in Grief Following Trauma through the International Critical Incident Stress Foundation (ICISF).

Community Impact
BHSDR staff served a critical role in responding to the COVID-19 pandemic, supporting both essential workers and vulnerable individuals. The team continues to work tirelessly to support County clients and staff during this unprecedented time, and recently received recognition from the HCA BHS Director's office for their efforts.

Office of Suicide Prevention

On October 6, 2020, the Board directed the County Executive Officer and HCA Director to create an Office of Suicide Prevention to:

1. Reach out to high-risk populations to find and engage those in need
2. Maintain contact with those in need and support continuity of care
3. Improve the lives of those in need through comprehensive services and supports, and
4. Build community awareness, reduce stigma and promote help-seeking

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.

Innovation Projects

Help@Hand (INN)

Help@Hand (formerly Tech Suite) is a statewide project comprised of 14 counties and cities that leverages interactive technology-based mental health solutions (i.e., internet-based and/or mobile applications) to help improve access to care and outcomes for people across the state. The project seeks to understand how technology is introduced and works within the public behavioral health system of care. Help@Hand aims to provide diverse populations with access to mobile applications ("apps") designed to educate users on the signs and symptoms of mental illness, improve early identification of emotional/behavioral destabilization, connect individuals seeking help in real time, and/or increase user access to mental health services when needed.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	**$6,000,000**
FY 2021-22	**$3,100,000**
FY 2022-23	***above carryover***

Services

Orange County was approved to join this Innovation project in April 2018 and began project implementation planning immediately. The HCA originally applied as a four-year project and was recently approved by the MHSOAC for a one-year, no-cost extension. Thus, the project will end for Orange County in April 2023. The primary purpose of this project is to increase access to mental health services to underserved groups, 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.

Help@Hand consists of several main components of which participating counties have chosen to opt in or out, based on their local needs. Orange County was approved to implement all project components, which includes:

- Technology Apps (3):
  A. 24/7 Peer chat, which will offer around-the-clock, anonymous peer chat support to an individual
  B. Therapy Avatar, which will offer virtual manualized evidence-based interventions delivered via an avatar in a simple, intuitive fashion (e.g., mindfulness exercises, cognitive behavioral or dialectical behavior interventions)
  C. Customized Wellness Coach, which will utilize passive sensory data to engage, educate and suggest behavioral activation strategies to users
    - Marketing and Outreach
    - Evaluation

Peers are integral to Help@Hand, and the vision of the peer role is to incorporate peer input, expertise, knowledge and lived experience at all levels of the project, and to support the use of identified apps through peer outreach and training. The peer component of the project holds significant importance as it:

- Creates transparency around basic cautions, clarity about user choice, and highlights that technology does not replace in-person mental health services

- Provides clarity on the project definition of peers, roles, and serves as an example of a peer staffing ladder
- Supports collaboration of peer leads across the state important to project learning, connection, and problem-solving
- Responds to county/city community stakeholder specific needs by developing digital mental health literacy curriculum that will support project learning and stakeholder's ability to make informed choices
- Trains the peer workforce to facilitate digital mental health literacy sessions that will keep learning at the local level and sustainable
- Trains project partners on peer culture, experience, and history supporting better project integration
- Integrates consumer expertise and voice in evaluation thus enhancing the work
- Incorporates lived experience and perspective on how possible future technology can help the project be responsive to consumer needs

During FY 2019-20, Orange County continued its planning efforts to launch Mindstrong, a technology app that fits within the Customized Wellness Coach component. This app is a service that provides access to round-the-clock telehealth support augmented by a new form of digital mood and cognitive measurement. Mindstrong telehealth services are delivered by a team of licensed psychiatrists and licensed or supervised therapists who can help maintain well-being between appointments or after office hours. While telehealth services are an established behavioral health practice, the Mindstrong automatic notifications (i.e., biomarkers) are a new and emerging approach to care and derived from the touches, scrolls and taps a person makes throughout the day as they use their phone. These notifications may provide an early indication of changes in the moods and symptoms associated with an individual's condition that may help facilitate earlier access to care and support. The health app and services will only be available to eligible participants within specific partnered programs within Orange County.

In preparation for the app launch, the project team visited the pilot site to learn about staffing, services and workflows. This allowed the staff to understand and better streamline how Mindstrong would integrate into daily operations. Project activities also focused on identifying eligibility criteria, developing implementation materials (i.e., referral tracking log, communication templates, brochures, OC Help@Hand website content) and drafting an informed consent form. The development of an informed consent form involved extensive conversations with peers, Mindstrong and HCA Compliance. The Mindstrong pilot launched in May 2020. In response to the COVID-19 pandemic and stay home orders, project staff focused their efforts in digitizing all content, including the development of an outreach video and plans for a digital informed consent. Project staff also partnered with a video production company for the digitization of the consent form and project materials.

In addition to preparing for local implementation, project staff also participated in collaborative activities and priorities. Details about the Help@Hand Collaborative activities during FY 2019-20 are available in the MHSA INN Annual Project Report.

Outcomes

Help@Hand will examine the following learning objectives:

A. Detect and acknowledge mental health symptoms sooner
B. Reduce stigma associated with mental illness by promoting wellness
C. Increase access to the appropriate level of support and care
D. Increase purpose, belonging and social connectedness of individuals served
E. Analyze and collect data to improve mental health needs assessment and service delivery

Since the pilot launch in May, 5 participants were enrolled in Mindstrong services. Because outcome metrics take time to yield results after deployment and utilization of the technology, a formative evaluation will provide a look beyond

performance outcomes to examine the progress of the project and offer suggestions along the way. Outcomes related to the Mindstrong pilot, and the overall project formative evaluation will be reported in future Plan Updates and/or project reports.

Challenges, Barriers and Solutions in Progress

The 14 participating cities/counties are at the forefront of innovation to understand how technology is introduced and works within the public behavioral health system of care. When faced with challenges or barriers, the collaborative offers the benefit of a shared learning experience that accelerates learning.

Throughout this process, the most significant lesson learned is that the primary focus of Help@Hand is not the implementation of apps, but rather the development of a sustainable digital mental health system of care for California (i.e., infrastructure building). As such, initial efforts should prioritize system preparation; user, program and agency readiness for change; and implementation planning. An effective work plan and checklist of pre-launch activities are essential to prioritize the necessary and required preconditions prior to the launch of an app (i.e., roadmap of involved parties and logical order/priorities for Information Technology (IT), data sharing, Compliance, clinical integration, etc.). The initial planning phase should also include strategies for an effective communication and decision-making process. System readiness requires collaboration and ongoing communication with program managers and staff in programs where an app will be launched. It is critical to obtain feedback from clinicians and peers early on to assess interest and/or readiness to use the app services. Equally as critical is communication with vendors, checking in to ensure information, messaging and shared vision is accurate. The public behavioral health system and the private industry have their own language and communication style. As a result, it is important to frequently define terms to ensure shared understanding. Furthermore, existing technology is not necessarily geared with the County mental health plan consumer in mind, so when exploring and procuring technology, it is important to be clear in including the type of technology the target population will likely have access to, as well as language capabilities.

With regard to the planning, development and implementation of apps, it is essential for this process to be streamlined and sustainable in the future. This includes the involvement of County Counsel, Compliance and IT teams throughout the process. Additional considerations include outlining a process for procuring and learning about new apps/vendors, creating a systematic process for testing apps, and addressing potential safety, risk and liability concerns. Project staff identified additional lessons learned that are highlighted in the Orange County Spotlight.

Behavioral Health System Transformation (INN)

The Behavioral Health System Transformation (BHST) project is an INN 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. Orange County's BHST project proposal was approved by the MHSOAC in May 2019 and local project start up began in October 2019.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$9,477,500
FY 2021-22	$5,355,250
FY 2022-23	*above carryover*

Services

Unlike most INN projects that tend to focus on new or modified approaches to service delivery, the BHST project will strive to transform the behavioral health system of care by identifying strategies to braid public and private funding; creating a value-based system; and improving navigation of and access to needed resources. Project activities are divided into two parts:

BHST Part 1, Performance and Value-Based Contracting, addresses the plan to create a value-based system that braids public and private funding. Key steps and activities include:

- Establishing community-defined values and metrics
- Identifying braiding strategies for public and private funding
- Aligning community-defined outcomes with legal, fiscal and regulatory requirements
- Developing new provider contract templates
- Providing technical assistance to assist providers

BHST Part 2, Digital Resource Navigator and Overall Project Evaluation, involves the development of a digital navigation tool, as well as the evaluation of the overall BHST project (i.e., Part 1 & digital resource navigator). The features, functionality and list of resources in the digital resource navigator will be developed through a participatory process that involves community members, including consumers, family members and behavioral health providers. Core features of the directory will include an optional social determinants survey, curated list of resources prioritized based on an individual's needs, and ability for providers to update resource information in real-time. Key steps and activities include:

- Identifying directory resources, features and functionality
- Directory development and testing
- Continuous review and refinement
- Project evaluation and lessons learned

Due to its focus on identifying methods to change processes and integrate policies across the public and private sectors, this project will utilize a formative evaluation. One of the key goals of a formative evaluation is to identify influences – both potential and real – on the progress and/or effectiveness of a project's implementation. Information is collected at all phases of execution and is used as part of a continuous feedback loop to improve the ultimate likelihood of successful project implementation.

Through focus groups, interviews, observational studies, and surveys of stakeholders, subject matter experts and meeting participants, the evaluation will allow Orange County to identify successful and unsuccessful strategies employed throughout the various project activities, including inter-agency and inter-departmental meetings and workgroups. Similarly, the formative evaluation will determine whether Orange County is able to identify ways to engage a diverse group of community stakeholders successfully and elicit meaningful participation, guidance and feedback.

Outcomes

The BHST project does not provide direct services, as a result, there are no outcomes to report. However, during FY 2019-20, BHST Part 1 and Part 2 made significant progress in their respective key steps and activities. A full report of all project activities can be found in the https://www.ochealthinfo.com/sites/hca/files/2021-11/OC_BHST_INN_Project_Annual_Report_FINAL.pdf

Early Psychosis Learning Health Care Network (INN)

The Early Psychosis Learning Health Care Network (LHCN) is a multi-county Innovation (INN) project led by the University of California, Davis. The project aims to evaluate early psychosis (EP) programs across the state with the primary purpose of increasing the quality of mental health services, including measurable outcomes, and the goal of introducing a mental health practice or approach that is new to the overall mental health system, including, but not limited to, prevention and early intervention. The aim of the EP LHCN is to standardize the evaluation of EP programs across participating counties; establish shared learning; and provide an opportunity to improve OC CREW outcomes,

program impact and cost-effectiveness. This INN project does not provide direct services and will not require that OC CREW change the clinical services that it provides.

Orange County's participation was approved by the Mental Health Services Oversight & Accountability Commission (MHSOAC) in 2018 and local project start up began in January 2020. At present, a total of 5 counties are participating, including Orange County with its First Onset of Psychiatric Illness program (i.e., OC CREW). OC CREW participants and their families will have the option of participating in the INN project while they are enrolled in OC CREW and/or for the length of this INN project, whichever is shorter.

Services
During the initial year of implementation, OC CREW program staff, participants and family members participated in voluntary focus groups to provide feedback on the selection of EP outcome measures. Focus group results from all participating counties, as well as a detailed description of project activities within the first year of implementation are available in the MHSA INN Annual Project Report.

As selected outcome measures are administered, ongoing focus groups with OC CREW staff, participants and their families will be facilitated to gather feedback on the use of measures. Outcome measures and focus group data will be analyzed to assess the impact of the LHCN on consumer- and program-level metrics, as well as utilization and cost rates of EP programs (see diagram of the implementation and evaluation process below). This will provide counties the opportunity to adjust program operations and/or services, if appropriate, based on lessons learned through multiple research approaches.

Outcomes
This first year of this project focused on the process of selecting appropriate measures, so there are no outcomes to report at this time. Outcomes will be reported in future Plan Updates.

Continuum of Care for Veterans and Military Families (INN)

The Continuum of Care for Veterans and Military Families Innovation project integrates military family culture and services into Families and Communities Together (FaCT) Family Resource Centers (FRCs) located throughout Orange County. It seeks to expand general service providers' knowledge of how to best meet the needs of military-connected families so that they feel competent and willing to identify and serve this currently hidden population. The target population served includes active service members, reservists, veterans (regardless of their discharge status) and their children, spouses, partners and loved ones.

Services
Peer Navigators with lived military experience are co-located within FRCs to provide two key functions: (1) provide case management and peer support to referred participants, and (2) provide military family culture awareness trainings for FRC staff so that they are better able to identify, screen and serve military-connected families. The project is also staffed with clinicians who, with the ongoing support of peer navigators, provide counseling and trauma-informed care utilizing evidence-based practices. Additional services include referral and linkage to County and community programs.

Continuum of Care for Veterans and Military Families was implemented July 1, 2018. The primary purpose of this project is to increase access to mental health services, with a goal of making a change to an existing practice in the field of mental health, including but not limited to, application to a different population. Innovation funds for this project will end in March 2023.

Outcomes

In FY 2019-20, program staff integrated into all 15 FaCT FRC sites throughout Orange County. However, community outreach events were significantly impacted due to stay home orders and social distancing requirements in response to the COVID-19 pandemic. Staff conducted 17 community outreach events, compared to the 37 events held in FY 2018-19. In FY 2019-20, Peer Navigators, clinicians and collaborative partners provided 256 trainings related to military family culture to FRC staff, which included specialty trainings on military legal issues, domestic violence and housing. This is an increase from the 151 trainings provided in FY 2018-19. In the upcoming year, the program will further expand on trainings to include e-Learns, brief microlearning sessions that will be available online to FRC staff.

In FY 2019-20, 47 military-connected families (n=175 individual family members) were served, which is an increase from FY 2018-19 (37 military-connected families; n=140 individual family members). A total of 1,728 case management session were provided to families, in contrast to the 475 sessions provided in FY 2018-19. Due to their lived experience and extensive training, the Peer Navigators were able to identify needs and appropriately refer military-connected families to resources, thereby increasing the likelihood that families would receive needed services in a timely manner.

Challenges, Barriers and Solutions in Progress

A significant challenge in this program involves the collaboration with FRCs due to their unique population needs and variation in operations across the different sites. FaCT FRCs include over 100 funded and unfunded community partners, adding complexity to the collaboration, training and partnership elements of this program. To address this challenge, program staff continue to attend FRC meetings and work closely with FRC staff to learn about the unique culture and needs of each site. The program is also currently developing brief online trainings on various topics to increase FRC staff's access to information about military family culture, based on their specific needs.

Community Impact

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

Clinic Expansion

Children and Youth Clinic Services (CSS)

The Children and Youth Clinic Services program serves youth under age 21 who meet the following eligibility criteria and their families/caregivers: Living with serious emotional disturbance (SED) or serious mental illness (SMI) and a) qualifies for Specialty Mental Health Services as part of the Pathways to Well-Being subclass (formerly known as "Katie A"); b) is in foster care, at risk of foster care involvement, and/or eligible for mental health services under the State-mandated program Therapeutic Foster Care (TFC) and referred by the Social Services Agency (SSA); c) has Medi-Cal and qualifies for Specialty Mental Health Services; d) has been screened for trauma in primary care settings through the ACES Aware Initiative and referred for mental health services; or e) is struggling in school due to their SED/SMI and not already receiving or eligible for mental health services through the school or other provider.

Services
Youth can be referred by community agencies, other behavioral health providers, pediatricians, SSA, school personnel, general community, families, etc. Outpatient services provided through this program are tailored to meet the needs of the youth and their family, and can include screening/assessment, individual and family outpatient therapy, group therapy, crisis intervention and support, case management, referral and linkage to supportive services, and/or medication management, if needed. Services are linguistically and culturally competent and provided in the clinic, out in the community or at a school (with permission) depending on what the youth/family prefers. For youth enrolled under Pathways to Well-Being, services will comply with program requirements, including those for Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS) and Child and Family Teams.

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

Challenges, Barriers and Solutions in Progress
The Children and Youth Expansion Services program will face a variety of challenges in FY 2021-22. Increased incidents of depression and anxiety are being identified by providers at all the clinics throughout Orange County. As children and youth deal with the adverse impact of the COVID-19 pandemic, providers are seeing more mental health problems with high acuity requiring more intensive levels of intervention. Overcoming barriers to access that children and their parents face such as childcare, public transportation, unemployment, and hybrid school schedules will be of paramount importance to the program. Some of the solutions providers have developed include implementation of audio/video technology to provide telehealth services for children and their families who cannot, or who do not yet feel safe to receive services in the clinics. Another solution providers are using is to make changes to both clinic procedures and the physical environment that allows for adequate social distancing, screening for health symptoms, and increased outreach to clients by providing resource information on children's mental health and daily living needs such as where and how to obtain vaccinations, transportation, housing and food.

Full-Service Partnership Programs (CSS)

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. Thus, 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). 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. The most common age groups spanned are Children/TAY and Adult/Older Adult, although there are some exceptions (see tables below). All FSP services – even those affiliated with the Courts and OC Probation – are voluntary.

Services
The FSP programs use a coordinated team approach to provide "whatever it takes," including 24/7 crisis intervention and flexible funding to support people on their recovery journeys. They follow the Assertive Community Treatment (ACT) model of providing comprehensive, community-based interventions, linguistically and culturally competent services, and around-the-clock crisis intervention and support by coordinated, multidisciplinary teams. The teams can

include Marriage and Family Therapists, Clinical Social Workers, Personal Services Coordinators, Peer Mentors, Youth Mentors, Parent Partners, Housing Coordinators, Employment Coordinators, Clinical Dietitians, Licensed Clinical Supervisors, Psychiatrists and/or Nurses who are committed to the recovery model and the success of their participants. Working together, the teams provide intensive services that include counseling, case management and peer support, which are described in more detail below.

With regard to clinical interventions, the FSP provides individual, family and group counseling and therapy to help individuals reduce and manage their symptoms, improve functional impairments and assist with family dynamics. A wide array of evidence-based practices are available and, depending on the age and needs of the individual, can include Motivational Interviewing, Cognitive Behavioral Therapy (CBT), Trauma-Focused CBT, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavior Therapy, Integrated Treatment for Co-Occurring Disorders, Parent Child Interaction Therapy (PCIT), Seeking Safety, Illness Management and Recovery, Moral Reconation Therapy (MRT), Program to Encourage Active Rewarding Lives for Seniors (PEARLS), behavioral modification and others. Individuals enrolled in an FSP program also receive psychiatric care, medication management, psychoeducation, co-occurring substance use disorder services, mindfulness training, crisis intervention and/or 24/7 support as needed.

Personal Services Coordinators (PSCs) provide intensive case management to help individuals access crucial medical care, educational support, social and recreational opportunities, mental health rehabilitation, benefits acquisition, transportation resources, basic needs and other resources available in the community. PSCs and/or other FSP staff also help individuals develop skills to manage problematic behaviors or impairments and work with significant others and caregivers, when available, to support them in learning and practicing the new skills.

Some providers also have employment and/or housing coordinators who assist and support their participants in these essential elements of recovery. Employment coordinators, or when dedicated coordinators are not available, PSCs and other staff, lead numerous workshops and classes to teach and hone prevocational and vocational skills such as resume writing, interviewing skills, computer skills, etc. FSP housing coordinators (and/or PSCs) also assist individuals with finding and maintaining safe, suitable housing, as reducing homelessness is one of the target outcomes for the FSPs.

Peer Recovery Specialists/Coaches and Parent Partners are key members of the FSP teams and play an integral role in promoting wellness and resilience. By sharing their lived experience and learned skills, peer staff support recovery, empowerment and community integration. In addition, Parent/Family Partners work closely with parents, legal guardians, caregivers, significant others and other family members to provide suggestions on how they can best support the participant. Parent Partners also assist with the psychoeducational process to close the generational gap and shift how parents and caregivers view mental health, as well as provide respite care.

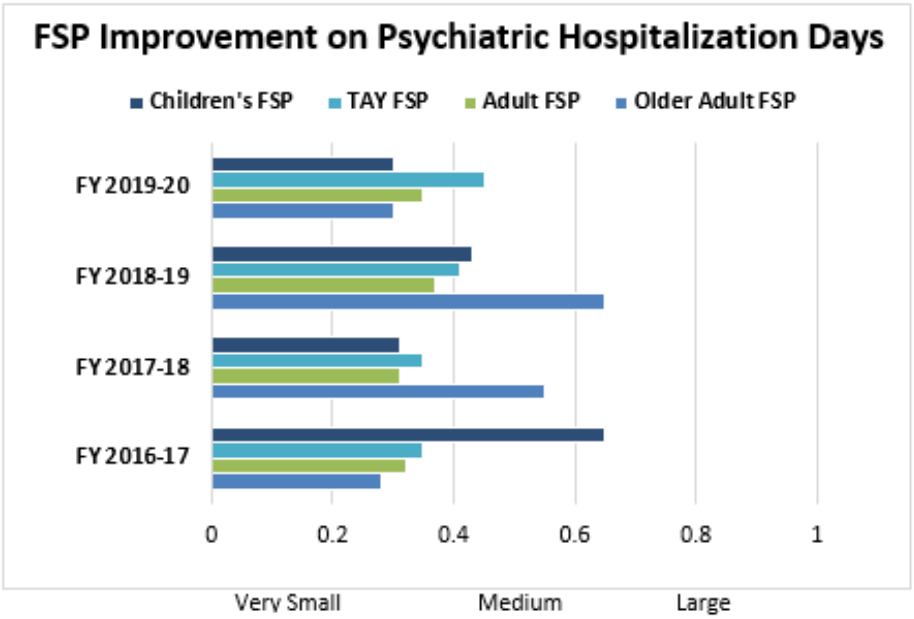
Family involvement in treatment and services can be critical to supporting and maintaining an individual's recovery and has been central to the Children and TAY FSP program providers' approach to service and care planning. In addition, the Adult FSP program providers have been working on increasing family inclusion at all levels of treatment and at social events, and several providers offer a monthly family support group to provide families with information, education, guidance and support for their own needs, as well as to enable them to assist their family member's recovery.

Outcomes

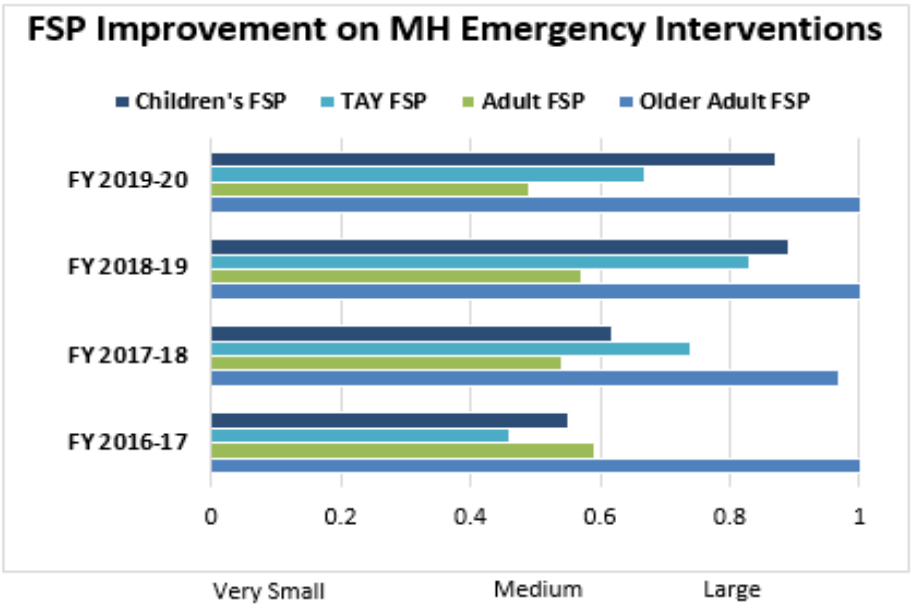
The programs evaluated changes on outcomes related to mental health recovery, living situation, legal involvement, employment and/or school performance by comparing functioning in the 12 months prior to enrolling in the FSP to functioning during the fiscal year being evaluated. With the exception of school performance, all results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the FSP program.

Mental Health Recovery: Mental health recovery was evaluated through changes in two measures: (1) number of days the individual had been psychiatrically hospitalized, and (2) the number of times the individual experienced a mental health emergency intervention (defined as a hospitalization episode, crisis residential placement, emergency room/CSU visit, crisis assessment/WIC 5585 evaluation or police response due to a mental health crisis).

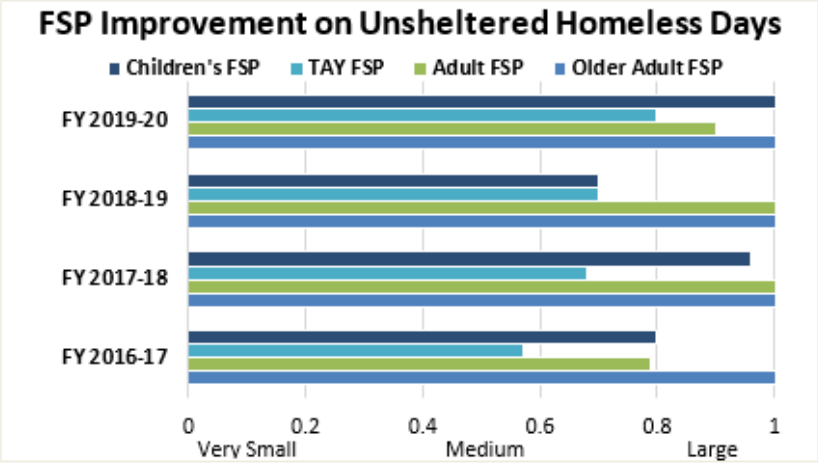
Across fiscal years, the FSPs generally made a small impact on decreasing the amount of time participants spent in a psychiatric hospital, with TAY, adult and older adult participants having spent, on average, about 4-5 weeks in the hospital during the year prior to enrolling in an FSP compared to about 1-2 weeks in the hospital after enrolling. Relative to the other FSP participants, children spent considerably less time in the hospital both prior to and after enrolling in an FSP (i.e., 1-1.5 weeks an average prior; 2-4 days an average after). Overall, this suggests that participants experienced somewhat less disruption in their daily lives by spending less time in the hospital while receiving FSP services.

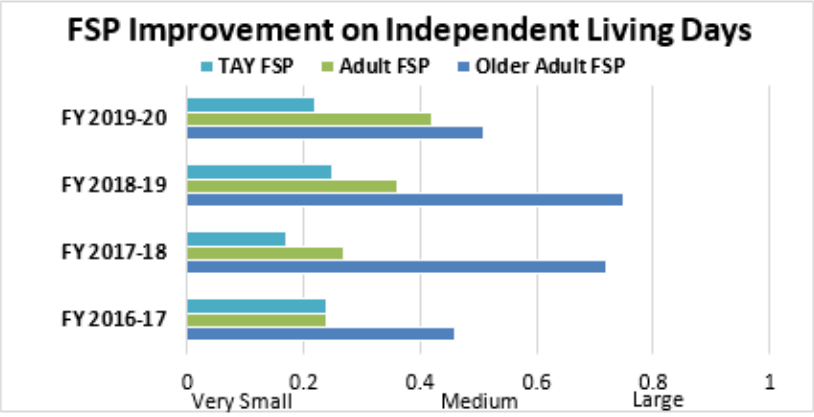


In addition, FSPs demonstrated medium to large decreases in the average number of mental health-related emergency interventions that participants experienced across each of the fiscal years, further suggesting that they experienced recovery while receiving FSP services. This effect was particularly pronounced for older adults, with the average number of events essentially dropping to zero.



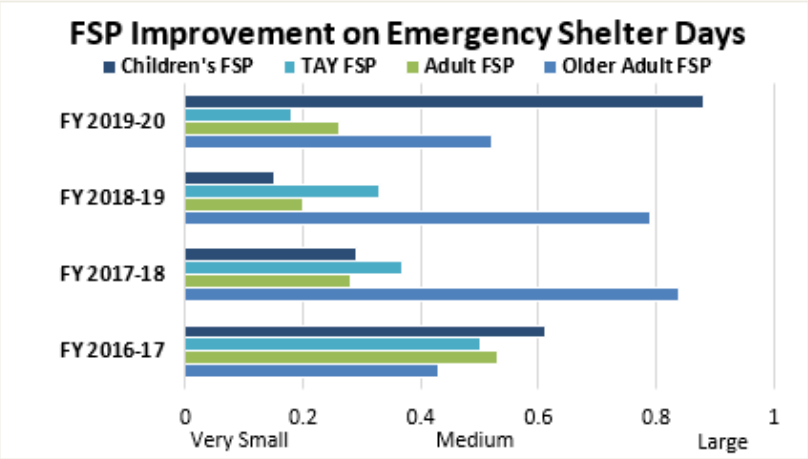
Homelessness and Living Situation: Another goal of the FSPs is to prevent and reduce unsheltered homelessness, emergency shelter stays and, for children, out-of-home placements. For TAY, Adults and Older Adults, the FSPs also strive to increase the number of days they are able to live in the community independently (i.e., live safely in an unsupervised setting and perform their own activities of daily living).





The FSP programs continued to improve the housing circumstances of their participants as evidenced by the generally large reduction (moderate for TAY) in the average number of days spent homeless during each of the past FYs. Improvements were most pronounced for adult and older adults, who typically experienced greater homelessness prior to FSP enrollment. Unsheltered homelessness was defined as a residence not intended for human habitation, such as a car, abandoned building, the street, etc.

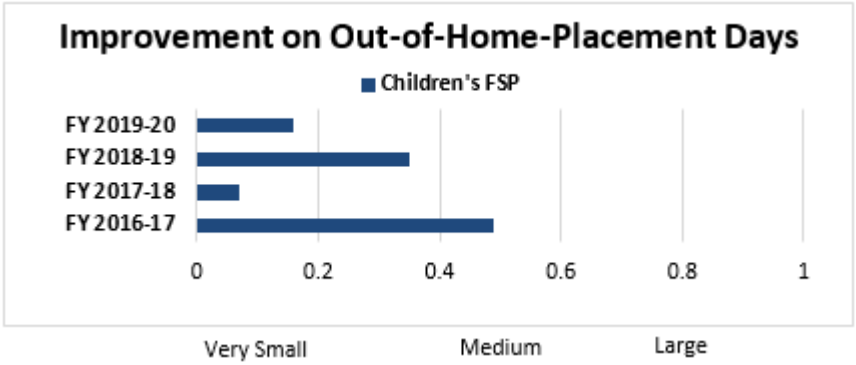
The impact of FSPs on reducing days spent in emergency shelter varied across age group and fiscal year. Children, TAY and adults generally experienced small to moderate decreases while enrolled in the FSP over the past several FYs. Efforts to relocate a large number of homeless adults living in the Flood Control Channel and Santa Ana Civic Center area during FYs 2017-18 and 2018-19 likely contributed to the reduced impact on this outcome as the TAO Central FSP provider worked to place adults living in these areas in emergency shelters temporarily. In support of this speculation, when homeless adults served by this provider are removed from the analysis, the remaining adults experienced moderate reductions (0.48) in emergency shelter use during FY 2018-19, which is consistent with findings from FY 2016-17. In contrast, older adults FSP demonstrated the opposite pattern (i.e., shifting from a moderate impact in FY 2016-17 to a large impact in the past two FYs), which may be attributable to a few participants who had very long emergency shelter motel stays while receiving services in FY 2016-17 before transitioning to permanent living placements in FY 2017-18. Finally, while fewer children served in FY 2019-20 had stayed in emergency shelters prior to enrolling in the FSP compared to prior fiscal years, those that had reported unusually long shelter days, resulting in a large decrease once the FSP was able to provide housing for these children and their families.



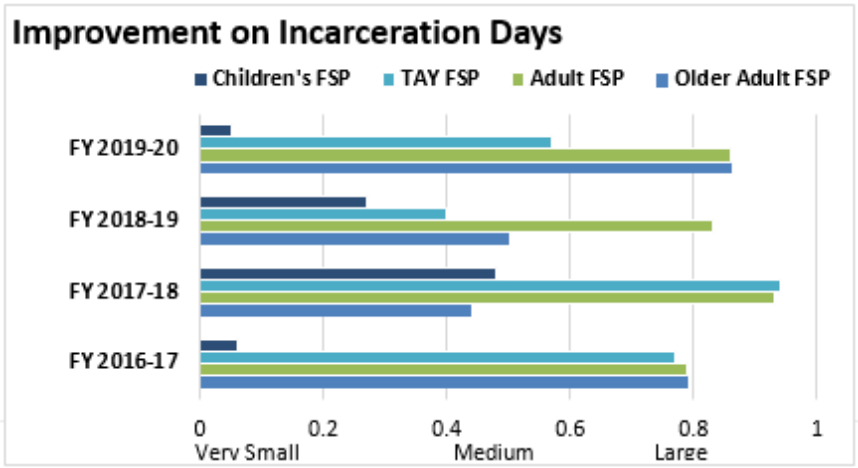
Thus, unique factors across the past four FYs may account for the fluctuating impact on emergency shelter use rather than true changes in the FSPs' ability to improve this outcome.

While TAY and adults experienced a small increase in the average number of days spent living independently across FYs, older adults demonstrated moderate to large increases. Thus, the Older Adult FSP appears to be relatively effective at helping support independent living, which is defined as living in an apartment or single room occupancy as opposed to any type of supervised residential placement. These improvements appear to be the result of changes implemented in FY 2017-18 when the increased impact was first observed. During this time the provider implemented a more collaborative, structured approach where the treatment team collectively discussed and problem-solved ways to engage members who were at high risk of hospitalization and/or incarceration. In addition to weekly contact with personal service coordinators, teams increased contact with the older adults by including visits with life coaches, therapists or housing coordinators or members of the medical team. In addition, staff has worked diligently to increase the number of groups offered and created new and more interesting group topics and events based on client interests and needs. As a result, the program has seen a significant increase in group participation over the past fiscal years. These improvements are thought to have positively impacted overall functioning and not just independent living, as evidenced by improvements across all outcomes during the past two FYs relative to FY 2016-17.

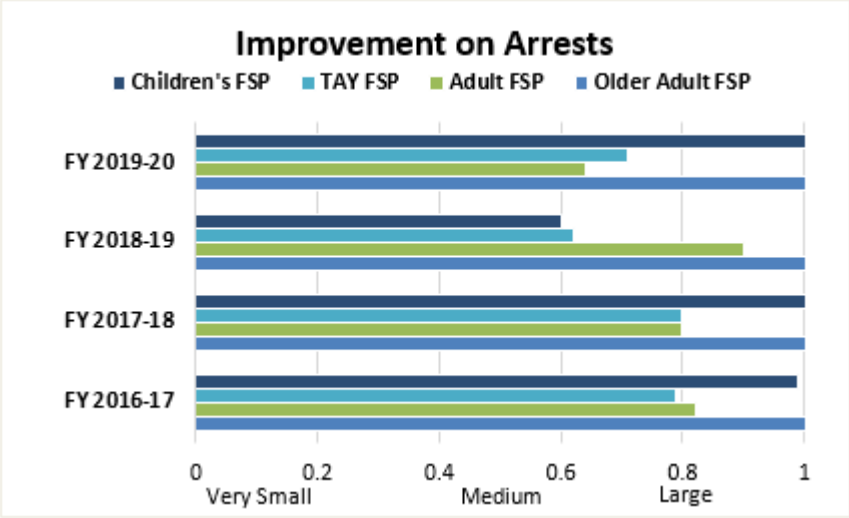
Finally, for children the goal is to reduce out-of-home placements, which are defined as placement in a group home or residential treatment facility. It should be noted that a very small number of children are affected by an out-of-home placement either prior to enrolling in the FSP or during the fiscal year being evaluated (i.e., n= 20 in FY 2016-17, n= 14 in FY 2017-18, & n= 17 in FY 2018-19). Thus, it is difficult to draw firm conclusions on the overall efficacy of FSPs in reducing out-of-home placements for children, although the average number of days children were placed out-of-the-home did decrease during all three fiscal years when compared to the year prior to their enrollment in the FSP.



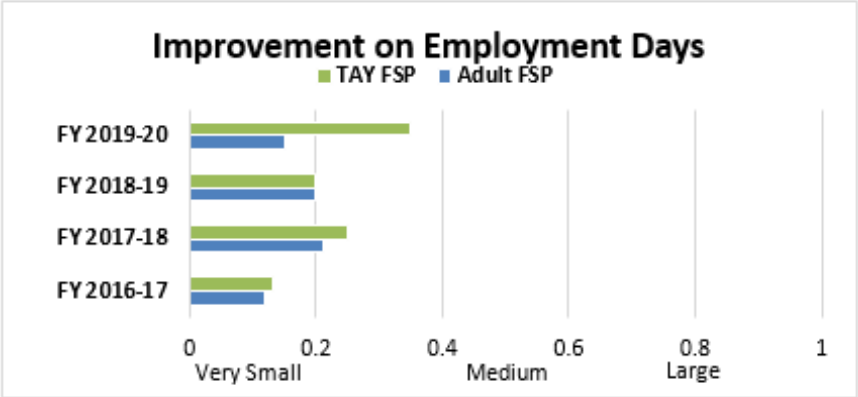
Legal Involvement: Outcomes related to decreasing individuals' involvement with the legal system were tracked using two measures: number of arrests and days incarcerated in jail or prison. Participants of all ages generally experienced large to very large decreases in arrests during all fiscal years compared to the year prior to FSP enrollment, with the exception of moderate to large reductions experienced by children and TAY in FYs 2018-19 and 2019-20.



There was variability across age groups and fiscal years with regard to the impact on days spent incarcerated. Adults showed consistently large decreases in days incarcerated across all four fiscal years, and TAY and older adults tended to show moderate-to-large decreases. Over the past four FYs, children have shown large fluctuations in incarceration outcomes. The HCA is currently exploring possible underlying reasons for these shifts in incarceration patterns among TAY and children.

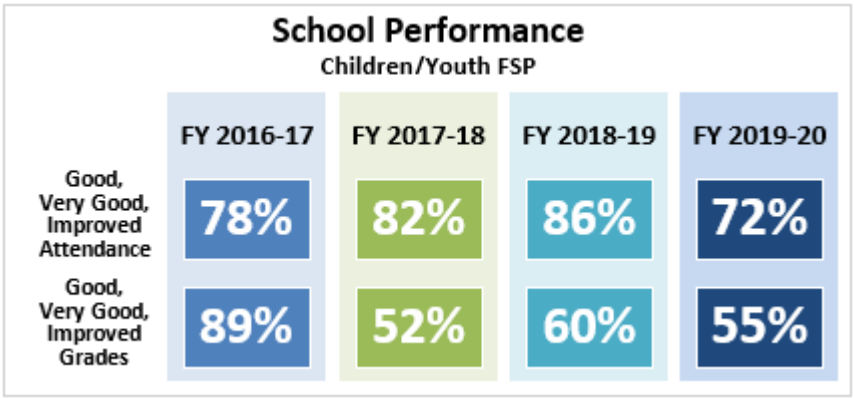


Employment: The TAY and Adult FSPs also examined days employed, which is vital to recovery but can be difficult to attain for those struggling with the combination of serious mental illness, substance use disorders, homelessness and/or a legal history. Per guidelines established by the County Behavioral Health Directors Association of California (CBHDA), employment was defined as competitive, supported or transitional employment, as well as paid in-housework, work experience, non-paid work experience and other gainful employment activity.



Compared to the year prior to FSP enrollment, the FSPs had no impact in FY 2016-17 and a small impact in FYs 2017-18 and 2018-19 on employment for adults and TAY who were at least 16 years old at the start of the fiscal year (and therefore eligible to work the duration of the reporting period). Thus, increasing employment activity in a meaningful way continues to be a particularly challenging area for the FSPs.

School Performance: The Children's FSPs examined the proportion of children who (1) maintained good/very good school attendance or grades and/or who (2) improved their attendance or grades while enrolled in the FSP. Although the majority of children reported good/improved attendance across both fiscal years, the proportion reporting good/improved grades fell from 89% in FY 2016-17 to 52% in FY 2017-18. Thus, while the findings generally suggest that the FSPs are successful in maintaining or improving school performance among the children served, the HCA will continue to monitor the FSPs' impact on grades to determine whether or not the FY 2017-18 results are an anomaly.



Challenges, Barriers and Solutions in Progress

Finding safe, affordable and permanent housing in the neighborhoods in which the individuals/families have support networks and/or the children are enrolled in school has continued to be challenging. To address immediate concerns with supply, FSP housing specialists work to build relationships in the community and develop housing resources for their participants. Once participants have been placed in housing, FSPs utilize a housing assistance strategy in which the individual/family becomes increasingly responsible with meeting costs so that, when clinical goals are met, the individual/family is able to maintain housing independently. This strategy creates stability so that clinical advances can be maintained upon discharge from the program. The HCA is also in the process of creating an FSP track that will assist individuals and families who are living in permanent housing but struggling to maintain their housing and are at risk of becoming homeless. To address the shortage of permanent supportive housing, the HCA along with the support of the Orange County Board of Supervisors, is continuing to identify and fund new housing development opportunities. In addition, the HCA has partnered with Orange County Community Resources, housing developers and other community partners to apply for federal and state housing funding, including No Place Like Home.

Employment has also continued to be an ongoing and significant challenge despite the recovering job market. FSP programs can encounter difficulties identifying employers who are flexible enough to employ individuals (or their parents/guardians) who may need time away from work to support their (child's) recovery. Yet employment serves as a critical component of recovery by helping increase peoples' connection with their community, providing a sense of purpose and increasing self-sufficiency. Drawing upon these principles, as well as CBHDA's expanded definition of employment, the programs are working to increase individuals' participation in meaningful, employment-related activities such as volunteer work and enrollment in educational/ training courses as a way to enhance vocational skills, gain experience, and increase their confidence in being able to succeed in the workforce. Over the past year, the Adult FSP program has worked to secure additional community opportunities and created internal opportunities for volunteer work. Nevertheless, more than any other target outcome, the program continues to struggle with supporting individuals in sustaining employment in a consequential way. Over the next year, FSP program staff will review referrals and linkages to employment services to see if opportunities exist to increase referrals and better support linkage to these services.

In addition, the Older Adult FSP program has noted that its participants do not always attend groups consistently. The provider has made an increased effort to recruit potential participants by engaging them in conversation about the groups and benefits of attending, placing reminder calls, increasing socialization among group participants and assisting with and/or linking to transportation so that they may attend groups. Feedback from older adults served is also elicited regularly so that improvements to the groups' content and/or structure can be made on an ongoing basis.

To address an increase of co-occurring substance use issues among TAY and adult participants, the FSP programs are offering more co-occurring groups; working to partner with community substance use treatment programs to expand resources, including residential programs that specialize in co-occurring treatment; and creating their own co-occurring supports and interventions to fill identified service gaps. FSP staff also works collaboratively with Housing and Supportive Services staff to help individuals with co-occurring issues maintain their housing. The Adult FSP providers that serve justice-involved individuals are working to have more staff trained in MRT in order to provide more MRT groups and have increased collaboration with Correctional Health Services to support linkage by providing in reach services and coordinating for transportation upon release.

The Adult FSP program provider for Assisted Outpatient Treatment (AOT) focused services actively continues to address misunderstanding within the community about what their program can and cannot do in relation to its implementation of AOT by virtue of being MHSA-funded and therefore required to be voluntary in nature.

The Adult Housing FSP provider began providing services in Fall 2020. The provider effectively engages individuals who have come from homelessness and provides intensive and comprehensive treatment and support that focuses on preventing loss of housing while increasing housing sustainability.

Finally, the Children's Project RENEW provider was expanded in FY 2020-21 to serve 20 additional children/youth placed in Intensive Services Foster Care (ISFC) homes. ISFC is a placement model of home-based family care for eligible children/youth whose needs for safety, permanency and well-being require specially trained resource parents and access to intensive supportive services.

Community Impact

Since program inception dates, the FSPs have served more than 2,100 children (approximately 18%), nearly 4,000 TAY (approximately 35%), more than 4,600 adults (approximately 40%) and nearly 700 older adults (approximately 6%). The FSP programs provide a strong base in participant-driven services that build on individual strengths using a "whatever it takes" approach and field-based services that break down barriers to accessing treatment. With the continued implementation of co-occurring services, the programs have increased their collaboration with community substance use programs, residential substance use treatment programs and/or detoxification centers. In addition, providers that work collaboratively with the Courts, Probation Department, Public Defender's Office, District Attorney's Office, and/or County Counsel continue to prioritize developing treatment approaches that reduce recidivism in the criminal justice system.

The FSP programs also work closely with various providers and other community groups to support participants on their recovery journeys. This includes the Social Security Administration, Social Services Agency, primary care physicians and other medical providers, hospitals, board and care homes, room and boards, recovery residences, housing providers, shelters, Family Resource Centers, legal resources, food banks, vocational trade programs, LGBTIQ centers, Salvation Army, Goodwill, Wellness Centers, NAMI, immigration services, thrift shops, faith-based leaders, school districts, policymakers, community based organizations and community clinics. By establishing such depth and breadth to their network of collaborators, the FSPs continue to be a leading force for mental health recovery in the community.

REFERENCE NOTES

Psychiatric Hospitalization Days:

Children:
- FY 2019-20: Prior M=14.8, SD= 37.7; Since M= 4.5, SD 12.5; t(82)=2.4, p<.02, Cohen's d= 0.30, -70%
- FY 2018-19: Prior M=9.9, SD= 11.6; Since M=3.8, SD 7.0; t(90)=4.0, p<.001, Cohen's d=0.43, -62%
- FY 2017-18: Prior M= 7.7, SD= 6.7; Since M=3.8, SD= 8.9; t(75)=2.67, p<.01, Cohen's d=0.31, -51%
- FY 2016-17: Prior M=10.8, SD=13.6; Since M=1.8, SD=4.6.1; t(70)=5.05, p<.001, Cohen's d=0.65, -83%

TAY:
- FY2019-20: Prior M=17.2, SD=23.8; Since M=5.2, SD=17.6; t(245)=-7.0, p<.001, Cohen's d=.45, -70%
- FY 2018-19: Prior M=23.0, SD=42.1; Since M=6.7, SD=19.8; t(265)=-6.14, p<.001, Cohen's d=0.41, -71%
- FY 2017-18: Prior M=28.6, SD= 52.1; Since M=8.6, SD=26.8; t(274)=5.59, p<.001, Cohen's d=0.35, -70%
- FY 2016-17: Prior M=39.8, SD=76.6; Since M=14.8, SD=38.3; t (246)=-5.03, p<.001, Cohen's d=0.35, -63%

Adults:
- FY2019-20: Prior M=37.7, SD=65.9; Since M=13.8, SD=31.6; t(599)=8.06, p<.001, Cohen's d=.35, -63%
- FY 2018-19: Prior M=36.7, SD=65.1; Since M=13.2, SD=29.7; t(556)=8.08, p<.001, Cohen's d=0.37, -64%
- FY 2017-18: Prior M=34.0, SD=59.7; Since M=14.4, SD=31.9; t(559)=6.92, p<.001, Cohen's d=0.31, -58%
- FY 2016-17: Prior M=34.2, SD=64.3; Since M=13.1, SD=30.4; t(542)=6.78, p<0.001, Cohen's d=0.32, -62%

Older Adults:
- FY 2019-20: Prior M=36.3, SD=67.9; Since M=8.7, SD=24.4; t(55)=2.89, p <.05, Cohen's d=.43, -76%
- FY 2018-19: Prior M=37.2, SD=70.4; Since M=7.6, SD=24.0; t(52)=3.53, p <.001, Cohen's d=0.65, -80%
- FY 2017-18: Prior M=39.4, SD=76.1; Since M=5.0, SD=12.8; t(57)=3.41, p<.001, Cohen's d=0.55, 87%

FY 2016-17: Prior M=28.1, SD=59.7; Since M=11.7, SD=26.7; t(58)=1.84, p=0.07, Cohen's d=0.28, -58%

Mental Health Emergency Interventions:

Children:
FY 2019-20: Prior M=2.1, SD=2.0; Since M=0.3, SD=1.0; t(169)=11.8, p<.001, Cohen's d=0.87, -86%
FY 2018-19: Prior M=1.8, SD=1.7; Since M=0.3, SD=.78; t(241), p<.001, Cohen's d=0.89, -83%
FY 2017-18: Prior M=1.8, SD=1.9; Since M=0.5, SD=1.1; t(158)=7.61, p<.001, Cohen's d=0.62, -72%
FY 2016-17: Prior M=1.8, SD=2.6; Since M=0.4, SD=0.7; t(82)=4.57, p<.001, Cohen's d=0.55, -78%
TAY:
FY 2019-20: Prior M=2.4, SD=3.4; Since M=0.3, SD=1.0; t(460)=13.3, p<.001, Cohen's d=0.67, -88%
FY 2018-19: Prior M=2.6, SD=3.3; Since M=0.3, SD=.7; t(500)=15.12, p<.001, Cohen's d=0.83, -88%
FY 2017-18: Prior M=2.7, SD=3.6; Since M=0.4, SD=3.6; t(365)=12.14, p<.001, Cohen's d=0.74, -85%
FY 2016-17: Prior M=2.3, SD=3.3; Since M=0.6, SD=1.7; t(295)=7.7, p<.001, Cohen's d=0.46, -74%
Adults:
FY 2019-20: Prior M=2.3, SD=2.3; Since M=0.81, SD=2.0; t(700)=13.00, p<.001, Cohen's d=.49, -65%
FY 2018-19: Prior M=2.5, SD=2.4; Since M=0.8, SD=1.7; t(658)=14.43, p<.001, Cohen's d=0.57, -67%
FY 2017-18: Prior M=3.2, SD=3.7; Since M=1.0, SD=2.0; t(809)=14.88, p<.001, Cohen's d=0.54, -68%
FY 2016-17: Prior M=2.4, SD=2.6; Since M=0.7, SD=1.5; t(629)=13.10, p<.001, Cohen's d=0.59, -69%
Older Adults:
FY 2019-20: Prior M=2.5, SD=2.4; Since M=0.01, SD=0.12; t(73)=8.68, p<.001, Cohen's d=1.35, -100%
FY 2018-19: Prior M=2.1, SD=1.7; Since M=0, SD=0.0; t(66)=10.25, p<.001, Cohen's d=1.77, -100%
FY 2017-18: Prior M=3.2, SD=4.6; Since M=0, SD=0.0; t(121)=7.58, p<.001, Cohen's d=0.97, -100%
FY 2016-17: Prior M=1.7, SD=1.6; Since M=0.2, SD=0.5; t(79)=8.07, p<.001, Cohen's d=1.02, -89%

Homeless Days:

Children:
FY 2019-20: Prior M=81.5, SD=109.3; Since M=0.0; SD=0.0; t(17)= 3.2, p<.006, Cohen's d=1.10, -100%
FY 2018-19: Prior M=56.0, SD=94.7; Since M=1.9; SD=7.1; t(25)=2.87, p<.001, Cohen's d=0.70, -97%
FY 2017-18: Prior M=88.8, SD=101.8; Since M=7.3, SD=19.7; t(23)=3.86, p<.01, Cohen's d=0.96, -92%
FY 2016-17: Prior M=96.4, SD=129.7; Since M=17.1, SD=51.7; t(19)=-3.0, p<.01, Cohen's d=0.80, -82%
TAY:
FY 2019-20: Prior M=77.8, SD=91.4; Since M=11.7, SD=41.3; t(132)=8.4, p<.001, Cohen's d=.80, -85%
FY 2018-19: Prior M=92.8, SD=113.9; Since M=15.1, SD=33.2; t(146)=8.51, p<.001, Cohen's d=0.70, -84%
FY 2017-18: Prior M=101.6, SD=118.8; Since M=21.9, SD=46.1; t(168)=8.13, p<.001, Cohen's d=0.68, -78%
FY 2016-17: Prior M=102.3, SD=124.93; Since M=26.3, SD=55.79; t(154)=-6.69, p<.001, Cohen's d=0.57, -74%
Adults:
FY 2019-20: Prior M=159.8, SD=127.8; Since M=30.9, SD=71.3; t(669)=22.4, p<.001, Cohen's d=.90, -81%
FY 2018-19: Prior M=179.9, SD=134.1; Since M=30.6, SD=70.0; t(640)=25.4, p<.001, Cohen's d=1.05, -83%
FY 2017-18: Prior M=178.7, SD=132.0; Since M=25.2, SD=60.7; t(666)=26.17, p<.001, Cohen's d=1.07, -86%
FY 2016-17: Prior M=145.7, SD=122.56; Since M=36.9, SD=73.42; t(611)=18.68, p<.001, Cohen's d=0.79, -75%
Older Adults:
FY 2019-20: Prior M=204.9, SD=133.8; Since M=25.7, SD=70.4; t(119)=13.3, p<.001, Cohen's d=1.28, -87%
FY 2018-19: Prior M=216.4, SD=140.0; Since M=27.8, SD=76.1; t(124)=13.89, p<.001, Cohen's d=1.31, -87%
FY 2017-18: Prior M=217.5, SD=136.2; Since M=27.7, SD=67.2; t(128)=14.99, p<.001, Cohen's d=1.42, -87%
FY 2016-17: Prior M=205.4, SD=138.5; Since M=37.6, SD=84.5; t(134)=12.14, p<.001, Cohen's d=1.06, -82%

Emergency Shelter Days:

Children:
FY 2019-20: Prior M= 88.2, SD=112.9; Since M=7.7, SD=20.6; t(22)=3.4, p=.003, Cohen's d=0.88, -91%
FY 2018-19: Prior M= 43.8, SD=79.6; Since M=25.4; SD=45.1; t(83)=1.7, p=.094, Cohen's d=0.19,-37%
FY 2017-18: Prior M=62.4, SD=100.4; Since M=27.5; SD=55.7; t(48)=1.99, p=.05, Cohen's d=0.29, -56%
FY 2016-17: Prior M=72.9, SD=108.9; Since M=14.8; SD=35.4; t(31)=-2.97, p<.01, Cohen's d=0.61, -80%
TAY:
FY 2019-20: Prior M= 54.2, SD=85.7; Since M=32.6, SD=75.3; t(205)=2.6, p<.011, Cohen's d= 0.18, -40%
FY 2018-19: Prior M= 96.0, SD=109.5; Since M=28.7, SD=57.2; t(215)=-.041, p<.05, Cohen's d=0.61, -51%
FY 2017-18: Prior M=69.3, SD=101.3; Since M=29.2, SD=54.5; t(155)=4.38, p<.001, Cohen's d=0.37, -58%
FY 2016-17: Prior M=82.9, SD=117.2; Since M=22.5, SD=51.3; t(162)=-5.90, p<.001, Cohen's d=0.50, -73%
Adults:
FY 2019-20: Prior M=66.5, SD=102.6; Since M=32.6, SD=67.0; t(385)=5.03, p<.001, Cohen's d=.26, -51%
FY 2018-19: Prior M=62.7, SD=103.3; Since M=36.8, SD=63.9; t(406)=4.01, p<.001, Cohen's d=0.20, -41%

FY 2017-18: Prior M=68.4, SD=102.6; Since M=33.9, SD=53.6; t(430)=5.66, p<.001, Cohen's d=0.28, -50%
FY 2016-17: Prior M=83.2, SD=112.6; Since M=20.5, SD=53.4; t(341)=9.18, p<.001, Cohen's d=0.53, -75%

Older Adults:

FY 2019-20: Prior M=118.2, SD=130.8; Since M=40.0, SD=73.6; t(109)=5.27, p<.001, Cohen's d=.52, -66%
FY 2018-19: Prior M=138.1, SD=139.4; Since M=25.2, SD=60.6; t(87)=6.89, p<.001, Cohen's d=0.79, -82%
FY 2017-18: Prior M=120.2, SD=136.9; Since M=12.8, SD=34.4; t(95)=7.27, p<.001, Cohen's d=0.84, -89%
FY 2016-17: Prior M=99.4, SD=126.7; Since M=39.5, SD=81.5; t(102)=3.96, p<.001, Cohen's d=0.43, -63%

Independent Living Days:

TAY:

FY 2019-20: Prior M=8.5, SD=43.3; Since M=25.23, SD=77.2; t(910)=-6.4, p<.001, Cohen's d=-0.22, 196%
FY 2018-19: Prior M=10.2, SD=49.0; Since M=33.1, SD=89.6; t(787)=-6.69, p<.001, Cohen's d=-0.25, 225%
FY 2017-18: Prior M=14.6, SD= 60.8; Since M=29.9, SD=81.2; t(743)=-4.57, p<.001, Cohen's d=-0.17, 105%
FY 2016-17: Prior M=17.9, SD= 65.01; Since M=43.4, SD=96.66; t(747)=-6.46, p<.001, Cohen's d=-0.24, 142%

Adults:

FY 2019-20: Prior M=34.5, SD=89.4; Since M=94.9, SD=136.7; t(1187)=-13.9, p<.001, Cohen's d=-.42, 175%
FY 2018-19: Prior M=38.3, SD=95.2; Since M=89.8, SD=133.4; t(1111)=-11.81, p<.001, Cohen's d=-0.36, 134%
FY 2017-18: Prior M=38.7, SD=95.8; Since M=75.7, SD=127.1; t(1144)=-9.01, p<.001, Cohen's d=-0.27, 96%
FY 2016-17: Prior M=46.6, SD=105.5; Since M=86.8, SD=139.1; t(1153)=-9.10, p<.001, Cohen's d=-0.24, 86%

Older Adults:

FY 2019-20: Prior M=55.4, SD=113.9; Since M=145.3, SD=161.9; t(199)=-7.12, p<.001, Cohen's d=-.51, 162%
FY 2018-19: Prior M=58.6, SD=116.1; Since M=190.1, SD=156.2; t(181)=-9.95, p<.001, Cohen's d=-0.75, 224%
FY 2017-18: Prior M=70.0, SD=125.3; Since M=198.1, SD=152.3; t(190)=-9.82, p<.001, Cohen's d=-0.72, 183%
FY 2016-17: Prior M=76.2, SD=129.2; Since M=170.9, SD=160.3; t(219)=-7.41, p<.001, Cohen's d=-0.46, 124%

Out-of-Home Placement Days:

Children:

FY 2019-20: Prior M=45.5, SD=95.1; Since M=27.4; SD=50.9; t(9)=0.50, p=.63, Cohen's d=0.16, -40%
FY 2018-19: Prior M=92.8, SD=135.44; Since M=55.2, SD=93.1; t(16)=1.38, p=.19, Cohen's d=0.35, -41%
FY 2017-18: Prior M=51.8, SD=74.3; Since M=44.0, SD=66.2; t(13)=0.27, p=.79, Cohen's d=0.07, -15%
FY 2016-17: Prior M=72.9, SD=102.2; Since M=55.9, SD=104.1; t(19)=.643m, p=0.53, Cohen's d=0.49, -23%

Arrests:

Children:

FY 2019-20: Prior M=2.0, SD=1.7; Since M=0.2, SD=.5; t(28)=6.5, p<.001, Cohen's d=1.60, -90%
FY 2018-19: Prior M=2.3, SD=.4; Since M=0.4, SD=.8; t(61)=3.69, p<.001, Cohen's d=0.60, -83%
FY 2017-18: Prior M=2.5, SD=2.6; Since M=0.1, SD=0.4; t(24)=4.48, p<.001, Cohen's d=1.04, -72%
FY 2016-17: Prior M=2.9, SD=4.1; Since M=0.0, SD=0.0; t(6)=1.86, p=.11, Cohen's d=0.99, -78%

TAY:

FY 2019-20: Prior M=2.5, SD=3.6; Since M=.3, SD=.8; t(308)=10.3, p<.001, Cohen's d=0.71, -88%
FY 2018-19: Prior M=2.1, SD=3.0; Since M=0.4, SD=.84; t(220)=7.9, p<.001, Cohen's d=0.62, -81%
FY 2017-18: Prior M=2.2, SD=3.1; Since M=0.1, SD=0.5; t(216)=9.81, p<.001, Cohen's d=0.80, -95%
FY 2016-17: Prior M=2.1, SD=3.0; Since M=0.4, SD=.83; t(270)=10.21, p<.001, Cohen's d=0.79, -81%

Adults:

FY 2019-20: Prior M=2.1, SD=3.0; Since M=.4, SD=0.9; t(613)=13.72, p<.001, Cohen's d=.64, -81%
FY 2018-19: Prior M=2.0, SD=1.7; Since M=0.4, SD=0.8; t(554)=19.84, p<.001, Cohen's d=0.90, -82%
FY 2017-18: Prior M=1.9, SD=1.9; Since M=0.3, SD=0.8; t(586)=18.26, p<.001, Cohen's d=0.80, -84%
FY 2016-17: Prior M=2.0, SD=2.2; Since M=0.3, SD=0.8; t(598)=17.58, p<.001, Cohen's d=0.82, -86%

Older Adults:

FY 2019-20: Prior M=1.6, SD=1.5; Since M=0; SD=0.0; t(43)=7.0, p<.001, Cohen's d=1.49, -100%
FY 2018-19: Prior M=1.3, SD=0.6; Since M=0, SD=0.0; t(39)=14.58, p<.001, Cohen's d=3.26, -100%
FY 2017-18: Prior M=1.4, SD=0.7; Since M=0, SD=0.0; t(32)=12.34, p<.001, Cohen's d=3.03, -100%
FY 2016-17: Prior M=1.4, SD=0.8; Since M=0, SD=0.0; t(31)=10.71, p<.001, Cohen's d=2.68, -100%

Incarceration Days:

Children:

FY 2019-20: Prior M=33.3, SD=47.8; Since M=37.7; SD=76.1; t(22)=-.25, p=.81, Cohen's d=-.05, 13%
FY 2018-19: Prior M=43.0, SD=69.4; Since M=22.1; SD=42.6; t(52)=1.93, p=.059, Cohen's d=0.27, -48%
FY 2017-18: Prior M=75.4, SD=97.4; Since M=29.8; SD=42.6; t(21)=2.07, p=.05, Cohen's d=0.48, -60%

FY 2016-17: Prior M=28.7, SD=39.1; Since M=34.2; SD=67.9; t(9)=.194, p=.851, Cohen's d=-0.06, 19%

TAY:

FY 2019-20: Prior M=83.5, SD=96.6; Since M=24.4, SD=48.2, t(290)=9.3, p<.001, Cohen's d=0.57, -71%

FY 2018-19: Prior M=99.7, SD=102.4; Since M=44.9, SD=82.5, t(215)=5.9, p<.001, Cohen's d=0.4, -55%

FY 2017-18: Prior M=114.1, SD=107.4; Since M=22.5, SD=42.9, t(210)=12.19, p<.001, Cohen's d= 0.94, -80%

FY 2016-17: Prior M=95.3, SD=102.3; Since M=19.9, SD=39.1, t(217)=10.31, p<.001, Cohen's d=0.77, -79%

Adults:

FY 2019-20: Prior M=117.9, SD=107.0; Since M=26.0, SD=49.9; t(620)=20.04, p<.001, Cohen's d=.86, -78%

FY 2018-19: Prior M=105.6, SD=102.2; Since M=24.5, SD=48.3; t(555)=18.03, p<.001, Cohen's d=0.83, -77%

FY 2017-18: Prior M=103.8, SD=97.6; Since M=17.3, SD=38.3; t(585)=20.38, p<.001, Cohen's d=0.93, -83%

FY 2016-17: Prior M=99.6, SD=94.5; Since M=20.4, SD=41.7; t(623)=19.24, p<.001, Cohen's d=0.79, -80%

Older Adults:

FY 2019-20: Prior M=106.9, SD=111.1; Since M=12.6, SD=44.1; t(32) = 4.54, p<.001, Cohen's d=0.86, -88%

FY 2018-19: Prior M=71.4, SD=91.2; Since M=19.3, SD=48.9; t(37)=2.98, p<.05, Cohen's d=0.5, -73%

FY 2017-18: Prior M=46.6, SD=75.0; Since M=11.5, SD=39.5; t(29)=2.28, p<.05, Cohen's d=0.44, -75%

FY 2016-17: Prior M=72.6, SD=90.6; Since M=8.4, SD=24.7; t(29)=3.72, p<.01, Cohen's d=0.79, -88%

Employment Days:

TAY:

FY 2019-20: Prior M=28.2, SD=75.3, Since M=68.2, SD=114.7; t(897)=-10.2, p<.001, Cohen's d=-0.35, 142%

FY 2018-19: Prior M=39.8, SD=87.3; Since M=62.9, SD=109.5; t(848)=-5.74, p<.001, Cohen's d=-0.20, 58%

FY 2017-18: Prior M=40.5, SD=89.5; Since M=70.8, SD=115.3; t(764)=-6.88, p<.001, Cohen's d=-0.25, 75%

FY 2016-17: Prior M=46.6, SD=95.4; Since M=63.6, SD=110.0; t(624)=3.30, p<.001, Cohen's d=-0.13, 36%

Adults:

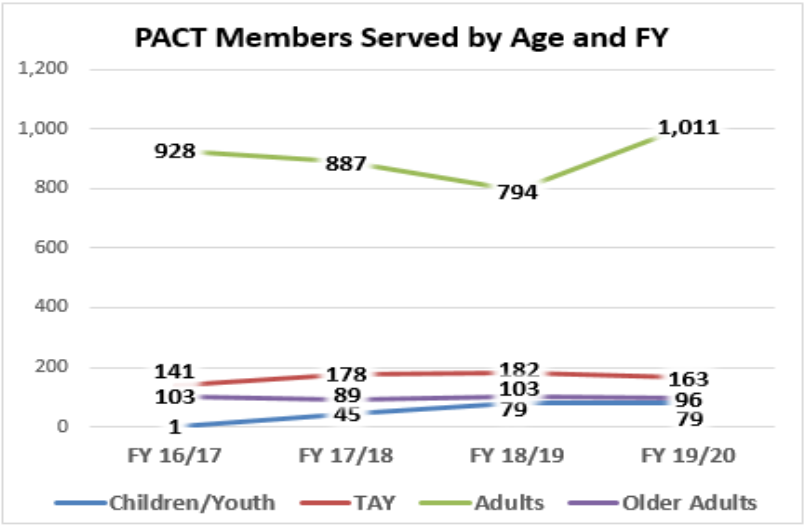
FY 2019-20: Prior M=28.6, SD=76.4; Since M=45.5, SD=103.6; t(1181)=-4.92, p<.001, Cohen's d=-.15, 59%

FY 2018-19: Prior M=26.6, SD=74.4; Since M=49.4, SD=106.0; t(1111)=-6.50, p<.001, Cohen's d=-0.20, 85%

FY 2017-18: Prior M=25.8, SD=70.9; Since M=50.5, SD=108.2; t(1144)=-6.91, p<.001, Cohen's d=-0.21, 96%

FY 2016-17: Prior M=28.8, SD=75.8; Since M=44.1, SD=97.5; t(1150)=-4.58, p<.001, Cohen's d=-0.12, 53%

Program of Assertive Community Treatment (PACT) (CSS)



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.

Services

The PACT is staffed by multidisciplinary teams that provide an individualized treatment approach offering intensive, age-appropriate services out in the community. The teams include Mental Health Specialists, Clinical Social Workers, Marriage and Family Therapists, Peer Specialists, Psychiatrists and Supervisors who work together to provide clinical interventions such as individual and group therapy, crisis intervention, substance use services and medication services. The most commonly used evidence-based and best practices include Assertive Community Treatment, Seeking Safety and Trauma-Focused Cognitive Behavioral Therapy. Children and TAY, in particular, also require intensive family involvement. Thus, collaboration with family members, which can include family therapy, is provided.

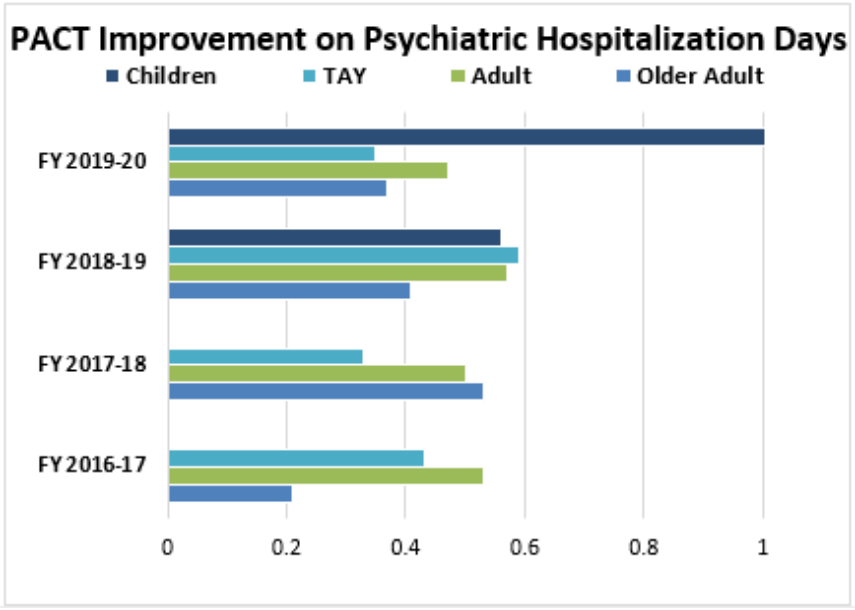
The PACT also provides intensive case management. Team members offer peer and/or caregiver support, vocational and education support, assistance with benefits acquisition, money management, advocacy and psychoeducation on a number of topics. Participants are also referred and linked to a number of community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

As needed, the PACT uses flexible funding to support the needs of participants and/or their families and is intended to cover the costs of services and supports not otherwise reimbursable, as well as items such as incentives, stipends, tickets/admission fees, food, refreshments, and ancillary supports such as child care or family involvement, etc. so that the participant may fully engage in the recovery-focused activity.

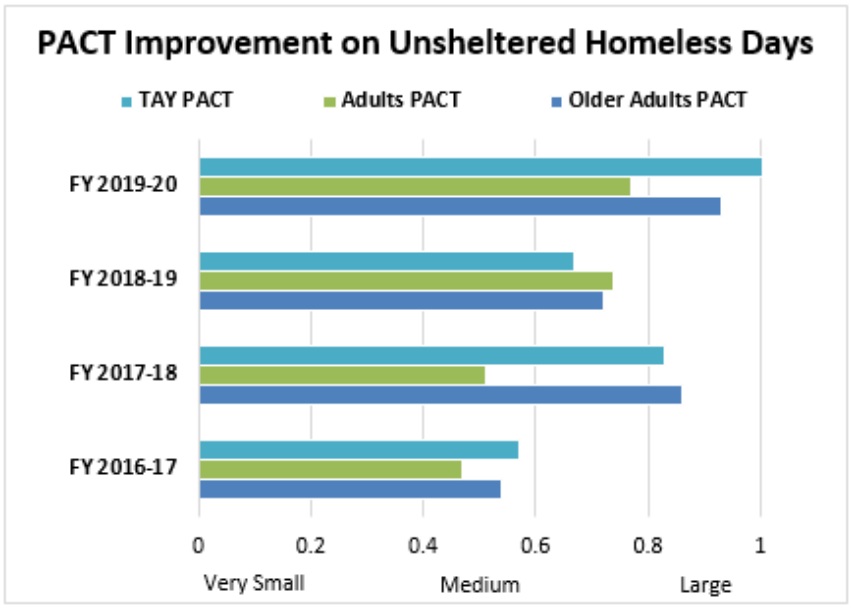
Outcomes

Using the same approach as the FSPs, the PACT evaluated performance through several recovery-based outcome measures related to life functioning: days spent psychiatrically hospitalized, homeless, incarcerated and, for TAY and adults, employed. For children/youth under age 18, the PACT also evaluated grades and school attendance. Program effectiveness was measured by comparing differences in functioning during the 12 months prior to enrolling in the PACT to the fiscal year being evaluated. Results were statistically analyzed and reported according to the calculated effect size, which reflects, in part, the extent to which a change in functioning over time is clinically meaningful for the individuals served in the PACT. For all functional measures other than employment or education, only individuals who reported that they experienced the functional outcome (i.e., hospitalization, homelessness, incarceration) either before or after enrollment were included in the outcomes analysis. All TAY and adults were included in the employment analysis and all children/youth were included in the school attendance/grades evaluation.

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

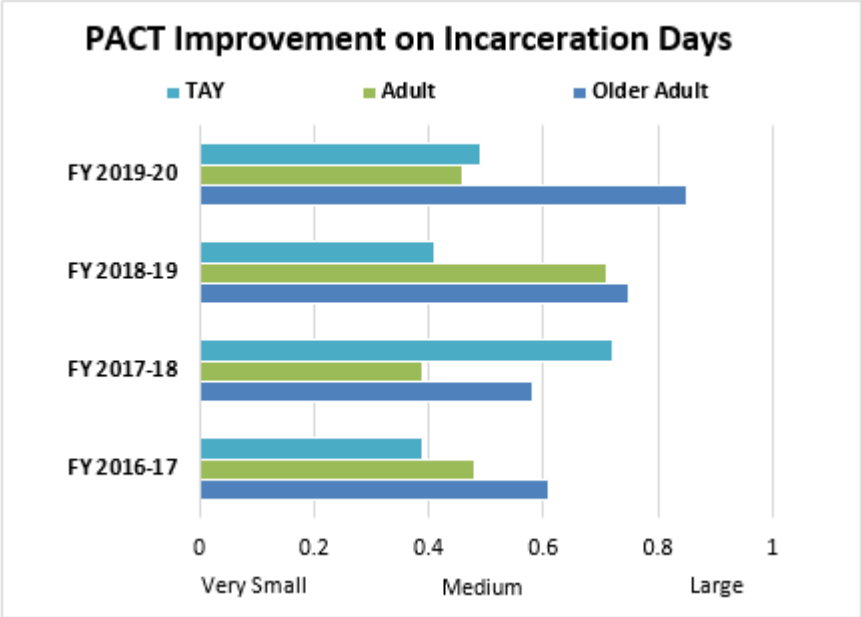


Homelessness: Because individuals who are homeless and living with SED/SMI are largely referred to FSP services, the number of individuals in the PACT who experience unsheltered homelessness tends to be lower than those who are in an FSP. Consistent with this, no children/youth reported experiencing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

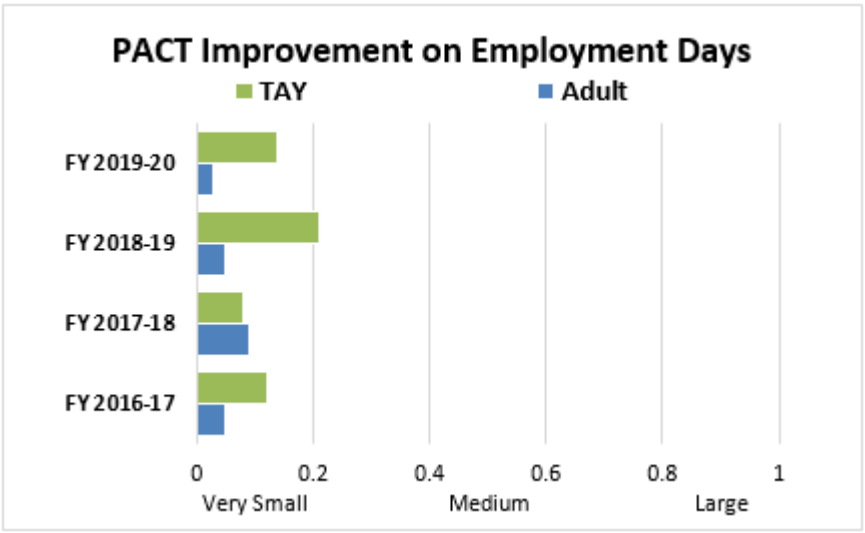


TAY, adults and older adults experienced moderate to large decreases in days spent homeless over each of the past four fiscal years (i.e., average days spent homeless while enrolled in the PACT generally ranged from 1.5-2.5 weeks for TAY except FY 2019-20 which averaged 30 days; 7-9 weeks for adults, 7-10 weeks for older adults). The number of TAY and older adults affected by homelessness tends to be much lower than the number of adults affected, thus the differences across the age groups may reflect unique characteristics of the TAY or older adults served in any given year rather than a change in overall program efficacy. The HCA will continue to monitor trends in homelessness for the PACT participants over time.

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

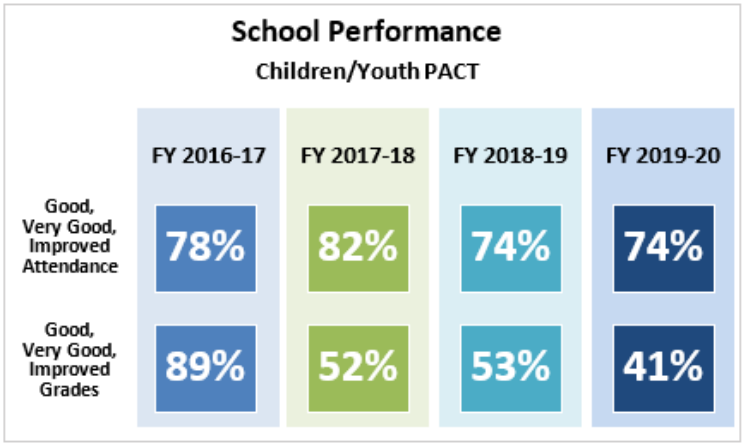


Very few children/youth reported incarcerations prior to or during enrollment in the PACT. During FY 2019-20, two clients were incarcerated prior to enrollment for a total of 168 days (one for 28 days, one for 140 days). There were no incarceration days during enrollment in the PACT. In FY 2018-19, the first year in which the child/youth team was fully implemented, 2 of the 79 children/youth experienced incarceration (one for 121 days prior to enrollment and no days in FY 2018-19; the other reported for 30 days prior to enrollment and 19 days after).



Employment: Across all fiscal years, the PACT showed minimal to no impact on improving employment, with an exception in 2018-19 where a small increase was noted for TAY. As with the FSP programs, the PACT continues to struggle with making progress on this functional domain.

Education**:** Across the past four fiscal years, the majority (74-82%) of children/youth demonstrated good, very good or improved school attendance while enrolled in the program compared to prior to enrollment. During the three most recent fiscal years, about half (41-53%) of youth showed good, very good or improved grades while enrolled in the PACT, which is a decline from a high of 89% observed in FY 2016-17. These findings are consistent with educational outcomes among FSP participants.



Challenges, Barriers and Solutions in Progress

The Children/Youth team is frequently at capacity, resulting in waitlists. With a small number of staff in the program, enrolling new clients can take longer. Another ongoing challenge has been the reluctance of the children/youth to use existing work/vocational programs. Instead, they prefer to seek employment on their own with coaching from program staff. In the two years since the program began, many clients have obtained employment, suggesting that this challenge may decrease as clients stabilize and take advantage of the vocational support provided by the program. In the future, the HCA would like to offer services to children/youth and their families in additional threshold languages but will need staff that speak the languages to meet this need.

The TAY, Adult and Older Adult teams have experienced some new challenges during the COVID-19 pandemic. While the teams never stopped providing services to the clients, the methods of delivery were constantly changing to maintain safety for the clients and the staff providing the services. The programs have been able to increase their use of telehealth services through WebEx to continue face-to-face services for clients who have adequate technology. For clients who do not have access to technology, the programs have received telepresence machines where the participant is able to come into the program and be in one room while their clinician is in another room. Some older adults are not comfortable using telehealth services as they feel it is not a trustworthy way of talking to their clinician. They are able to access services over the phone or in person.

Finding safe and affordable housing continues to be a challenge for the Older Adult PACT due to clients having limited supplemental Social Security Income and housing resources. This issue has increased especially during the COVID Pandemic as most shelters, Assisted Living Facilities, and Board and Care facilities are closed or are not accepting new clients. Most Older Adult PACT clients are scared and fearful of going to shelters as they are more vulnerable and are at higher risk in regard to COVID-19. There has been an increase in Older Adult PACT referrals for individuals who are homeless, at risk of evictions, and struggling to find placement which often exacerbates their mental health condition resulting in frequent hospitalizations. The PACT clinicians are addressing these challenges by increasing their visits with clients to provide additional support and continue to utilize life coaches and peer mentors to expand the list of available housing resources.

The challenges of medication adherence and follow through with medical and other appointments have improved by utilizing peer mentors and life coaches to assist with appointments. The Older Adult PACT clinicians are also using County resources such as iPhones to assist clients in connecting with their primary care doctors and psychiatrists during the COVID-19 Pandemic to address their physical and mental health needs.

New challenges that Older Adult PACT participants face during the COVID-19 pandemic are social isolation, food insecurity, and a lack of sanitizing supplies that can have a tremendous impact on their mental and physical health. The

Older Adult team has addressed these issues by increasing the frequency of case management visits and bringing clients food and supplies from the food bank.

Community Impact

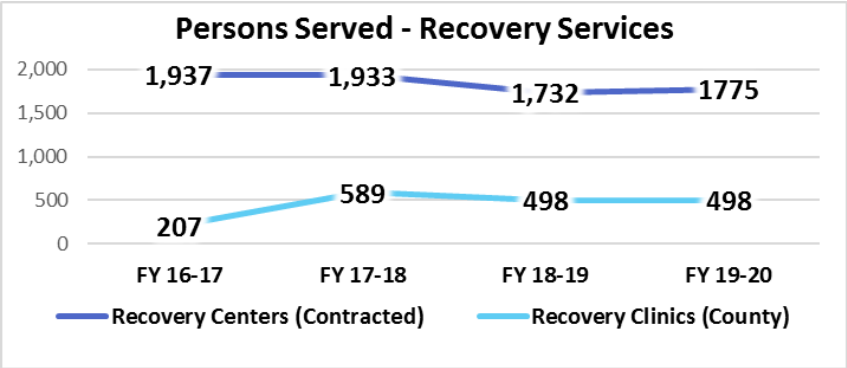
The PACT teams in Orange County target high-risk underserved populations, which include monolingual Asian/ Pacific Islanders, Latino youth and their families, and TAY, adults and older adults living with serious mental illness. The program has shown a modest reduction in psychiatric hospitalization and incarceration days, thereby reducing the need for high-cost crisis services for these individuals.

Outpatient Recovery (CSS)

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

Services

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

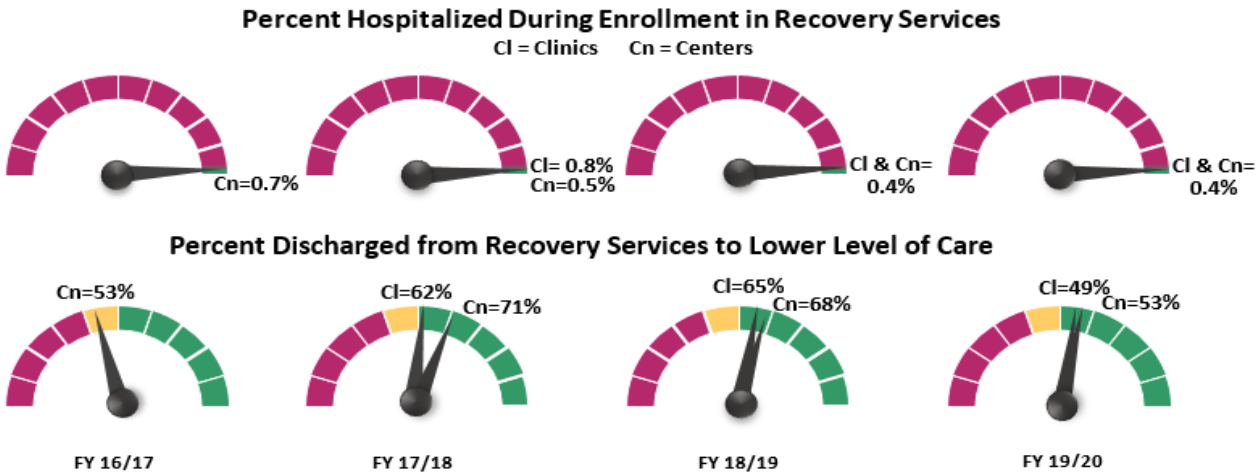


Outcomes

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

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

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



Challenges, Barriers and Solutions in Progress

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

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

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

Community Impact

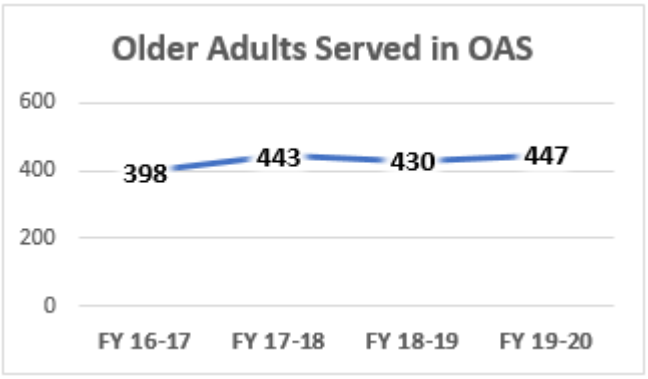
The needs of the individuals accessing the Recovery Centers and Clinics are uniquely met through services focused on reintegration into the community and overall independence. Individuals and their families are educated about the system of care, exposed to community resources and encouraged to set and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

Older Adult Services (CSS)

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

Services

OAS provides case management, referral and linkages to various community resources, geriatric psychiatry, vocational and educational support, substance use services, nursing services, crisis intervention, medication monitoring, peer counseling, therapy services (individual, group, and family), and psychoeducation for participants, family members and caregivers. Evidence-based practices include Cognitive Behavioral Therapy, Motivational Interviewing, Eye Movement Desensitization and Reprocessing (EMDR), Dialectical Behavioral Therapy (DBT), problem-solving therapy, solution focused therapy, harm reduction, Seeking Safety and trauma-informed care.



Outcomes

One of the program's goals is to help participants maintain their independence and remain safely in the community by increasing access to primary care, which is quantified as the number of nursing assessments completed. Of the older adults served each fiscal year, 49%, 19%, 21% and 26% had an assessment completed in FYs 2016-17 through 2019-20, respectively. This reduction since 2016-17 is partly due to an increase in client no-shows after the office had to be evacuated in early April 2018 due to a leak in the roof. As a result, staff were spread out over multiple offices, which affected program operations and service delivery. The program moved to a new location in March 2019 and nursing assessments increased. However during COVID-19, nursing assessments were abbreviated due to the lack of face-to-face interviews with participants. The nurse was not able to obtain vital signs and interviewed new participants on the phone prior to the appointment with the psychiatrist for past medical conditions, current and past medications, education on diet and nutrition, sleep hygiene, PCP information, labs and allergies.

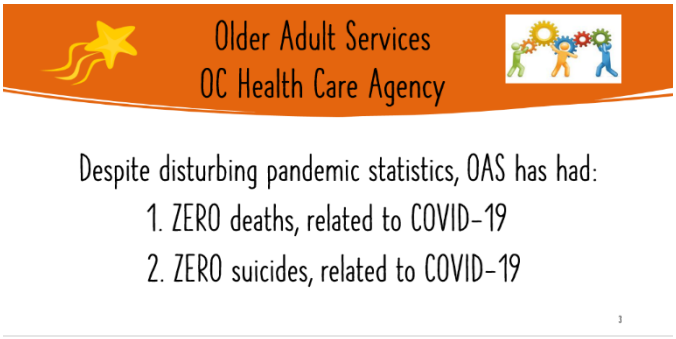
Challenges, Barriers and Solutions in Progress

OAS continues to encounter ongoing issues collecting outcome measures that evaluate the program's performance (i.e., selection of a feasible measure of symptom reduction, adequate completion rates, etc.). Program staff has continued meeting to identify metrics appropriate for the target population being served. Future plan updates will report these outcomes once implemented. With the move to a new location, OAS staff plan to offer evidence-based practice groups and education for participants and their family members in a clubhouse atmosphere. During COVID-19, however, older adults became even more vulnerable since they were sheltering at home. Even though there were options for assistance during the pandemic, many of our clients were unable to access these resources. The Meals on Wheels Program was overwhelmed with new participants and many of their drivers were no longer available due to their age and vulnerability to covid. So, many of our clients lost that face-to-face contact from someone dropping off a meal. Food pantries had very long lines and many times would run out of food. Our clients have limited transportation and physically could not wait in long lines. Grocery stores did provide early morning hours for seniors but our clients we serve have a difficult time getting up early in the morning and accessing transportation. Another factor was we all were under stay-at-home orders. Many of our clients are already isolated. A Kaiser study reported

that pre-covid, 1 in 10 older adults reported anxiety or depression. During COVID, 1 in 4 reported anxiety or depression. Our geriatric psychiatrist also noted an increase in clients asking for medications to ease their worry and anxiety.

Older Adult Services was able to access some of the CARES Act funding for food and essential items. OAS developed an assessment tool for each clinician to fill out with their client. This alone increased the number of direct service hours for our clients. We were able to provide groceries / healthy home delivered meals, covid sanitation supplies, hygiene items, toilet paper, adult diapers, warm clothes, denture care, water, nutrition drinks and pet food for companion animals. Staff worked together as a team to put together the items that each client needed and delivered them to where they were living. Staff were also excited and energized by this project to assist their clients and worked together as an efficient team. Staff would make multiple trips to visit clients and drop of essential items. This allowed the clinician to see the client face to face and provide support and mental health services. OAS staff made a total of 539 deliveries! In addition, 1,620 healthy meals were delivered. During this time, data showed that case management services doubled, individual counseling increased by almost 30% and crisis intervention services decreased by half. Our geriatric psychiatrist also noted that clients were making positive comments regarding the fact they felt very cared about and clients stopped asking for medications to assist with anxiety. The food for companion animals was very important. Sometimes a pet is the only companion in an older person's life. Studies have shown that pet owners are less likely to suffer from depression. The Council on Aging reports that pets fulfill the basic human need for touch and rapidly calm and soothe

you when you are stressed or anxious. OAS was able to provide multiple services to 486 clients with the CARES Act funding. As a result, OAS had zero deaths related to COVID, and zero suicides related to COVID.



Community Impact

Health Services Senior Health Outreach and Prevention Program (SHOPP), Council on Aging, Social Services Agency (Adult Protective Services), community senior centers, adult day health care, Alzheimer's Association, Ageless Alliance, local police departments, OC Probation Department, hospitals and residential programs, etc. These relationships are important to address the many complicated issues that Orange County older adults face, which can include ensuring the safety of seniors, reaching out to homebound seniors in need of mental health services, coordinating joint home visits with the HCA Public Health nurses to ensure that participant's mental and physical health needs are addressed, and providing educational events for older adults and professionals on issues relevant to seniors, such as medication management, health- and mental health-related matters and community services.

Telehealth/Virtual Behavioral Health Care (CSS)

The Telehealth/Virtual Behavioral Health Care program was new to the Three-Year Plan and intended to provide telehealth and/or virtual behavioral health care options for individuals 13 years and older living with serious mental health conditions, and for parents and caregivers of children of all ages. Due to the use of CARES Act funding that supported the transition of many MHSA-funded programs into providing telehealth and virtual mental health services, program implementation was paused in FY 2020-21.

BUDGETS & PROJECTED #'s TO BE SERVED FROM 3YP BY FY

Fiscal Year	Program Budget	Unduplicated # to be Served
FY 2020-21	-	-
FY 2021-22*	$2,500,000	TBD
FY 2022-23	$3,000,000	TBD

Services

Through one or more applications and/or telehealth providers, this program is intended to offer a range of tele-mental health care including, but not limited to, individual therapy, crisis intervention, telepsychiatry and/or peer support. Digital solutions that offer psychoeducation, navigation to needed resources, and training and coaching in relaxation skills, meditation, mindfulness, etc. may also be identified. This program may offer standalone services to individuals and/or provide adjunctive supports to individuals engaged in face-to-face behavioral health services. The services provided through this program will be evidence-supported or established practices. In contrast, the Help@Hand Innovation project will support 1) the identification, development and/or evaluation of new and/or emerging technologies, and 2) the identification and development of administrative processes necessary to create a 'digital mental health system of care' capable of responding to rapid changes in technology and/or its regulatory environment.

In response to considerable feedback from consumers, clients, family members and service providers during the 2021 CPPP, this program will also address a key barrier to engaging in virtual care, namely gaps in understanding how to use technology safely, efficiently and effectively. As such, this program will also include a robust training and technical assistance (TA) piece that will include, but not be limited to:

- Needs assessment to determine whether/how to replace/upgrade outdated provider devices
- Development of tip sheets, brief video tutorials available on-demand online, drop-in scheduled "Appy Hours," and multi-session courses on digital literacy and digital mental health literacy topics
- Partnership with local agencies and community organizations as needed to develop and adapt materials and training that are culturally responsive and linguistically appropriate
- Accelerated development and implementation of in-person training and TA for consumers, family members, prioritizing in-person training/TA for those most in need
- Ongoing market surveillance scan of digital MH solutions

In response to community feedback, the HCA will also strive to provide training on digital literacy basics to individuals and groups most in need of in-person training by the end of Summer 2021. This would allow those with the greatest gaps in digital knowledge an opportunity to receive hands-on assistance while in-person gatherings and meetings are permitted since it is still unknown whether there will be new safer-at-home orders in the fall/winter.

Supportive Services: General Support

Transportation (PEI)

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 BHS treatment provider, following an assessment of their transportation needs and history of scheduled appointments missed due to transportation issues. Based on the community planning process for the Three-Year Plan, this program was to be expanded to support participants with additional transportation needs. However, due to the lingering impact of COVID-19, exploration of expanding services to youth and families with children, including those who must be transported in child safety seats, and to support services that help address social determinants of health, may be postponed.

Services

Individuals are provided curb-to-curb service or door-to-door service if they are living with physical disabilities that may require additional assistance entering or exiting the vehicles. All that is required for the person to do is schedule the appointment in advance and 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 may be used to link participants being discharged from the County's Crisis Stabilization Unit to their follow-up appointments at either of the County's Open Access clinics.

Outcomes

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

Challenges, Barriers and Solutions in Progress

One of the biggest challenges for this program is for participants to remember to schedule their transportation service 24-hours in advance of their appointment times. The purpose of this is to allow the transportation provider to schedule

its fleet of drivers the night before for their appointments the next day. With the high demand for transportation services on a daily basis (Monday-Friday), in all regions of the county, it has been very challenging for drivers to get to their scheduled pick-up/drop-off locations on time without the 24-hour notice. In an effort to ensure drivers can be at the right place at the right time, the transportation provider has identified the highest utilized areas, and increased its driver fleet in those areas during known times when there is a high need, which has resulted in minimizing any delays for pick-ups/drop-offs. To assist with the high demand for these services, additional drivers have been added to the taxi fleet that has enabled the transportation provider to meet the high demands despite not always getting a 24-hour notice for service. Finally, BHS programs will continue to identify ways to leverage transportation assistance provided by other partners and agencies (i.e., CalOptima, etc.) so that efforts are not being duplicated unnecessarily.

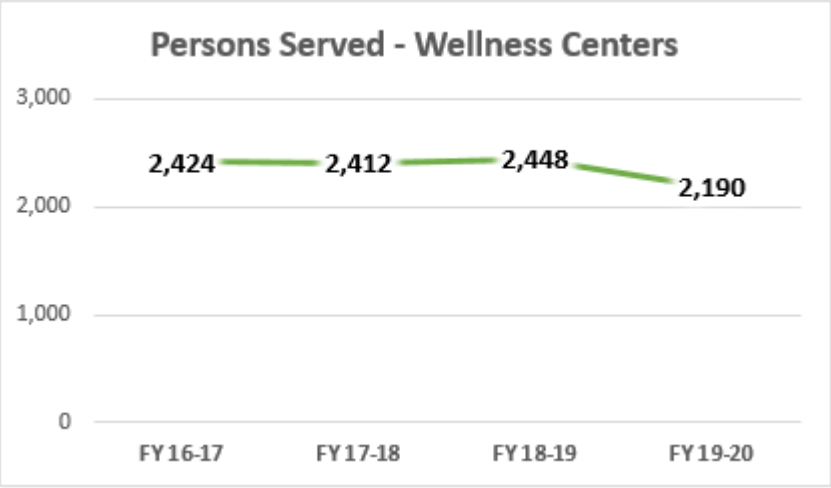
Supportive Services: Peer Support

Wellness Centers (CSS)

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.

Services

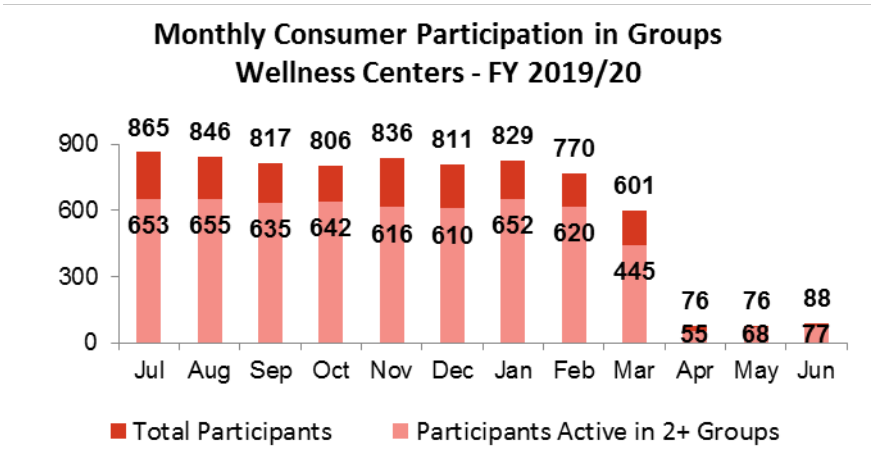
Wellness Centers are grounded in the Recovery Model and provide a support system of peers to assist members in maintaining their stability while continuing to progress in their personal growth and development. The programs are culturally and linguistically appropriate while focusing on personalized socialization,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



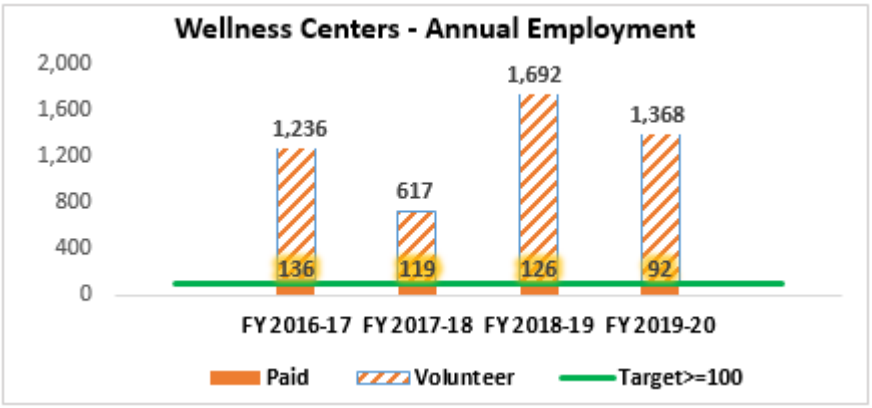
Recovery interventions are member-directed and embedded within the following array of services: individualized wellness recovery action plans, peer supports, social outings, recreational activities, and linkage to community services and supports. Services are provided by individuals with lived experience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

Outcomes

The Wellness Centers monitor their success in supporting recovery through two broad categories: social inclusion and self-reliance. Social inclusion is evaluated in two interrelated ways. First, the Wellness Centers encourage their members to engage in two or more groups or social activities each month. As can be seen in the graph, the Centers met this goal with 72-89% of members participating in two or more groups/activities each month during FY 2019-20. This is comparable to FY 2016-17 through FY 2018-19.



Second, of the various social activities offered, the Centers particularly encourage their members to engage in community integration activities as a key aspect of promoting their recovery. In FY 2019-20, 1,638 adults (75%) participated in community integration activities, which is lower than the rates in FY 2016-17 through FY 2018-19, (84%, 84% and 97%, respectively) and was likely attributable to the COVID-19 pandemic that began in the last quarter of the fiscal year.



The Wellness Centers also strive to increase a member's self-reliance, as reflected by school enrollment and employment rates. A total of 153, 219, 146 and 141 adults enrolled in education classes in FY 2019-20, FY 2018-19, FY 2017-18, and FY 2016-17, respectively. Thus, school enrollment remains a challenging area and HCA staff will continue to work with the providers to strategize new ways to increase interest and enrollment in classes. To assist members in furthering their education in ways that may not require a long-term school commitment, members are encouraged and have been completing online courses that are shorter in duration and which issue a certificate of completion at the end of the course. This has been well received by members and serves to build confidence by achieving shorter term goals and often leads to more interest by members in furthering their education.

In contrast, 1,460 adults in FY 2019-20, 1,818 adults in FY 2018-19, 736 adults in FY 2017-18, and 1,372 adults in FY 2016-17 were involved in employment, primarily due to the large proportion in volunteer positions. The programs will continue their efforts to engage members in employment-related activities and work toward increasing the number who obtain paid positions.

Challenges, Barriers and Solutions in Progress

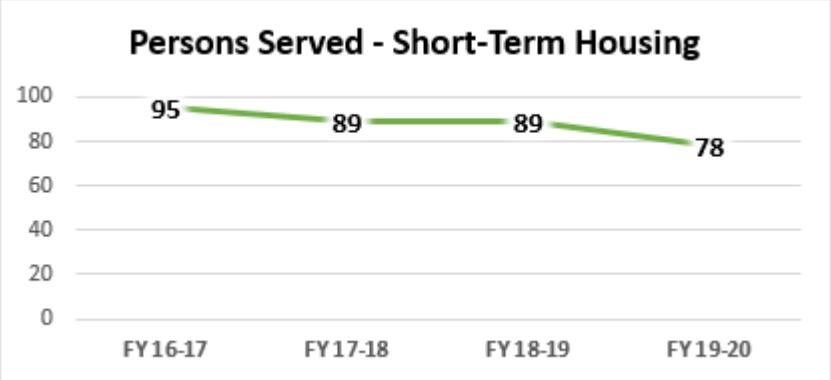
A continuing challenge for accessing the Wellness Centers is transportation, which can take from 45 minutes to 2 hours each way on public transportation. Each of the Wellness Centers strives to offer activities in different community settings that allow access in members' own neighborhoods without the 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.

Community Impact
Since their respective programs' inceptions, over 6,300 adults have received services at Wellness Center Central, with an average daily attendance of 66 members, six days per week; more than 850 adults at Wellness Center South, with an average daily attendance of 29 members, six days per week; and nearly 1,800 members at Wellness Center West, with an average daily attendance of 47 members per day, six days per week.

Supportive Services: Housing Support

Year-Round Emergency Shelter (CSS)

Housing Support programs serve Orange County adults who are experiencing homelessness and living with a serious mental health condition. They range from providing short-term emergency shelter to permanent supportive housing and are designed to meet individuals where there are at and support them in their recovery. Year-Round Emergency Shelter (formerly called Short-Term Housing Services) serves adults experiencing homelessness with serious mental illness who may also have a co-occurring substance use disorder and are in need of immediate shelter. Individuals referred to the program are actively participating in services at an Adult and Older Adult Behavioral Health County or County-contracted outpatient clinic, PACT or Assembly Bill (AB) 109 program.



Services
This program has MHSA-dedicated beds within five existing shelters. In addition to daily shelter, the program provides basic needs items (i.e., food, clothing, hygiene goods), as well as case management and linkage to services designed to assist individuals in their transition out of the shelter and into a more stable housing situation. The estimated length of stay for each episode of shelter housing is 120 days. Extensions are considered on a case-by-case basis.

Outcomes
As reported below, the program has been successful in reaching its goals:

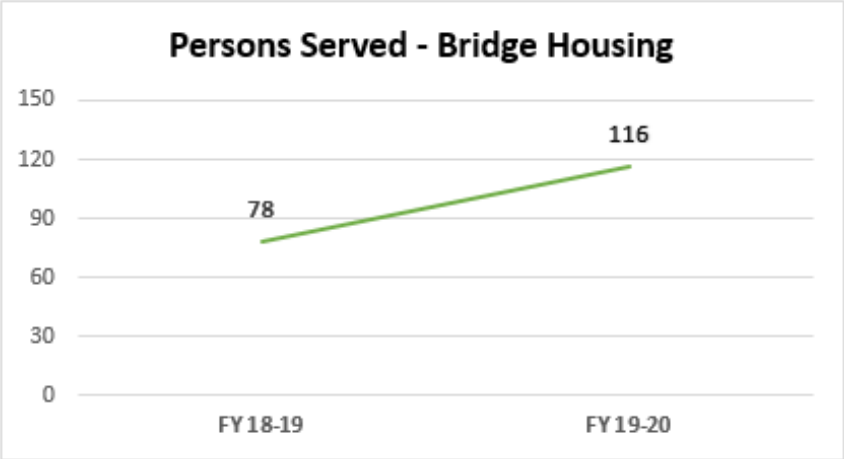
Short-Term Housing Services Metrics	FY 2017-18	FY 2018-19	FY 2019-20
Average Length of Stay (ALOS) is 120 Days or Less	ALOS = 82 days	ALOS = 58 days	ALOS= 80 days
% Who Found Permanent or Transitional Housing within 120 Days is > 25%	40%	33%	53%

Challenges, Barriers and Solutions in Progress

Due to COVID-19 and the stay home orders, the facilities did not allow in-and-out day access which was a difficult adjustment for participants who are not used to a shelter environment. The program provided the participants with support and virtual activities to increase receptiveness to staying in the shelter. The program addressed other important needs, including supportive services such as transitional or permanent housing assistance and linkage to needed community support services in coordination with the Plan Coordinator from the outpatient clinic. Some facilities allowed pets and partners to stay in the shelter with participants and permitted BHS Outreach and Engagement staff into the shelter. This allowed participants to receive support from the outreach worker with whom they had already built rapport, which could help facilitate their engagement into behavioral health services now that they were in a more stable environment.

Bridge Housing for the Homeless (CSS)

Bridge Housing for the Homeless offers interim housing for adults who have received a certificate from the Orange County Housing Authority for the Continuum of Care (CoC) Program but have been unsuccessful at finding a rental unit. The program also serves adults experiencing homelessness who have not yet received a certificate but are beginning the process. Adults (including couples) are eligible if they are homeless, are living with a serious mental illness, and may have a co-occurring substance use disorder. Referrals for the Homeless Bridge Housing Services are accepted on an ongoing basis by Adult and Older Adult Behavioral Health (AOABH) Housing and Supportive Services. Participants can only be referred to the Homeless Bridge Housing Services if they are actively participating in treatment at an AOABH outpatient clinic.



Services

The program provides housing coordination and navigation to assist participants in acquiring permanent housing. The provider also provides life skills and independent living skills training to support the participant's transition to independent living. The provider assists participants in obtaining housing opportunities that include Continuum of Care certificates, housing vouchers, locating rental units, negotiating leases and securing other housing options. The estimated length of stay is 18 months. Participants who are not able to find housing within the 18-month period are able to stay in Bridge Housing Services and continue to look for permanent housing as long as they are actively working towards their housing goals.

Outcomes
Bridge Housing for the Homeless tracks a number of measures to monitor its performance in supporting adults living with serious mental illness find permanent housing. During FY 2018-19, its first year of operation, the program successfully reached all measurable targets during that year.

Bridge Housing for the Homeless Metrics	FY 2018-19	FY 2019-20
Average # of potential landlords contacted per month (Target: > 15)	27	39
% of participants with CoC certificates who moved into permanent housing within 1 year (Target: > 50%)	100%	74%
% of participants w/out CoC certificates who moved into permanent housing within 18 months (Target: > 50%)	In progress* (16% housed in 12 months)	41%
% of participants who secured work or entitlements w/in 6 months of intake (Target: > 50%)	60%	78%
Persons Served – Bridge Housing	78	116

MHSA/CSS Housing Program (CSS)

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

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

Original funding allocations for this program included:

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

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

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

MHSA Special Needs Housing Program (SNHP)

When the MHSA Housing Program concluded in May 2016, the state created the Local Government Special Needs Housing Program (SNHP). Local stakeholders identified an ongoing and persistent need for housing for individuals living with serious mental illness and who are homeless or at risk of homelessness. As such, multiple CSS transfers to the SNHP operated by the California Housing Finance Agency's (CalHFA) occurred over several years totaling $95.5 million:

- $5 million in FY 2016-17 following local community planning input
- $35 million total in FY 2017-18 upon directive by the Board of Supervisors
- $25 million total in FY 2018-19
- $30.5 million total in FY 2019-20

On December 12, 2019, the Board approved allocating $10 million to the 2020 Supportive Housing Notice of Funding Availability (OCCR 2020 NOFA) and the remaining $20.5 million to the Orange County Housing Finance Trust (Trust).

Project	Year	MHSA Units	Total Units	Total
Santa Ana Arts Collective	2020	15	58	$4,724,430
Hero's Landing	2020	20	76	$2,912,000
Casa Querencia	2021	28	57	$7,035,800
Total		63	191	$14,672,230

Challenges, Barriers and Solutions in Progress

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

Community Impact

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

Housing Project Pipeline Using MHSA Funding								
Project	City	Estimated Completion	SNHP Units	NPLH Units	Trust	OCCR 2020 NOFA	Total MHSA Units	Total Units
Jamboree PSH (Buena Esperanza)	Anaheim	2021	35	0	0	0	35	70
Altrudy Seniors	Yorba Linda	2021	10	10	0	0	10	48
Francis Xavier	Santa Ana	2022	13	9	0	0	13	17
Legacy Square	Santa Ana	2022	10	16	0	0	16	93
Westminster Crossing	Westminster	2021	20	0	0	0	20	65
Villa St. Joseph	Orange	2022	18	18	0	0	18	50
The Groves Senior Apartments	San Juan Capistrano	2022	10	0	0	0	10	75
Mountain View	Lake Forest	2023	12	12	0	0	12	71
Casa Paloma	Midway City	2022	24	0	0	0	24	49
Airport Inn Apartments	Buena Park	2021	28	0	0	0	28	58
Orchard View Gardens	Buena Park	2023	8	13	5	0	13	66
Santa Angelina Senior Community	Placentia	2023	16	21	5	0	21	65
Center for Hope	Anaheim	2022	0	34	16	4	34	72
Cartwright Family Apartments	Irvine	2023	10	10	0	0	10	60
Lincoln Avenue Apartments	Buena Park	2022	10	0	0	0	10	55
Westview	Santa Ana	2023	0	26	0	26	26	85
North Harbor Village	Santa Ana	2022	0	0	14	0	14	90
Huntington Beach Senior Housing	Huntington Beach	2023	0	21	0	21	21	43
Paseo Adelanto	San Juan Capistrano	2023	0	0	0	24	24	41
TOTAL			224	143	40	75	359	1,173

SUMMARY of MHSA Strategies Used by Supportive Services Programs: Supportive Housing Services

Strategies to Promote Recovery/Resilience

These programs address the basic needs of adults experiencing homelessness, such as food, shelter and physical safety. This creates a safe environment in which participants can make progress toward their recovery while securing and/or

maintaining permanent housing. Staff uses Motivational Interviewing to engage participants and help them identify their own needs and challenges. This evidence-based therapeutic approach facilitates independence through self-discovery, and helps individuals become more ready for independent or supportive housing.

Strategies to Reduce Stigma and Discrimination
While in the shelter or bridge housing, staff works with residents to prepare them to accept permanent housing so they can smoothly transition to housing from the streets and end their episodes of homelessness. Program staff also conducts community outreach to educate and engage prospective landlords with the goals of improving access to housing options, reducing misconceptions about people living with a mental health disorder, reducing the possibility of discrimination from landlords, and helping to facilitate acquisition of permanent housing.

Strategies to Increase Access to Services: Timely Access for Underserved Populations and Linkage to Treatment
Staff works with treatment providers to link individuals to services, if they are not already engaged in treatment. Bicultural/bilingual staff ensure availability of services in a variety of languages. Behavioral health programs provide their services on-site or off-site, promoting easy access to services. In addition, most housing sites are located near public transportation routes to enhance residents' access to transportation, as many residents do not own a car.

Whole Person Care Pilot (PEI)

Whole Person Care (WPC) is the coordination of physical, behavioral, health and social services in a person-centered approach with the goal of improving health and well-being through comprehensive, streamlined service delivery. WPC services are for Medi-Cal beneficiaries living with serious and persistent mental illness (SPMI) and struggling with homelessness.

BHS had been leveraging a total of $856,600 in MHSA funds per year to draw down Whole Person Care federal match dollars, resulting in over $30 million over five years.

BHS is continuing to provide some services through an extension of the WPC pilot, which was originally set to expire on December 31, 2020:

- The BHS Outreach and Engagement expansion team uses MHSA funds to identify individuals eligible for WPC and engage them into needed services ($475,927 in MHSA per year).
- Recuperative/Respite Care provides recuperative care beds for homeless adults who are recovering from an acute illness or injury, are no longer in need of acute care but are unable to sustain recovery if living on the street or other unsuitable place (funded by WPC).

The following services concluded December 31, 2020 as originally planned:

- Peer Mentoring expansion, which provided housing and tenancy-sustaining services to help WPC participants be successful in their housing placements.
- Housing Navigators, who addressed barriers preventing BHS participants from making successful housing placements and worked to increase the inventory of available units for homeless adults living with SPMI.

Workforce Education & Training (WET)

Workforce Education and Training (WET) is intended to address community-based occupational shortages in the public mental health system. This is accomplished by training staff and other community members to develop and maintain a culturally and linguistically competent workforce that includes consumers and family members and that is capable of providing consumer and family-driven services.

WET Component Overview

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

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

WET programs continue to reach a large audience; however, compared to last fiscal year, WET saw a decrease in the number of trainings and attendees. This was largely due to the impact of the COVID-19 global pandemic. In FY 2019-20, approximately 6,740 individuals and/or community members attended WET trainings and activities.

The WET component currently funds the following major training and program areas:

- Workforce Staffing Support
- Training and Technical Assistance
- Mental Health Career Pathways
- Residency and Internship Programs
- Financial Incentive Programs

STATEWIDE WET PROGRAM

The FY 2019-20 state budget included approximately $40 million to fund county MHSA WET programs statewide. To secure these funds, county behavioral health agencies must collectively provide a 33% match or $13.2 million by 2025. County contributions must also be transferred to a third-party entity and used for WET purposes to fund pipeline/career awareness, scholarships, stipends, and loan repayment programs. The County Behavioral Health Directors Association (CBHDA) has proposed that CalMHSA act as this entity and ensures contributions are returned to the county for WET purposes. In addition, CBHDA was authorized by its Board to calculate a suggested contribution for each county based on the current MHSA allocation formula. Based on the current MHSA allocation formula, the suggested contribution for Orange County's share of the match is **$904,713**. Orange County transferred the full amount of its suggested contribution in FY 2020-21.

Workforce Staffing Support

The Workforce Staffing Support (WSS) program performs three functions: (1) Workforce Education and Training Coordination; (2) Consumer Employment Specialist Trainings and One-on-One Consultations; and (3) the Liaison to the Regional Workforce Education and Training Partnership. WSS services are provided for the Orange County behavioral health workforce, consumers, family members and the wider Orange County community. In FY 2019-20, WSS provided trainings to a total of 2,073 individuals including County staff, County-contracted staff and general community members. This was a decrease from previous fiscal years where over 3,000 individuals were provided trainings. This is mostly attributed to the impact of the COVID-19 global pandemic. Very few trainings were facilitated between March and June 2020 while all in-person learning was shifted to virtual platforms.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,710,584
FY 2021-22	$1,761,902
FY 2022-23	$1,814,758

Staffing Descriptions & Outcomes

Workforce Education and Training Coordination: Orange County regards coordination of workforce education and training as a key strategy to promoting recovery, resilience and culturally competent services. Multidisciplinary staff members design and monitor WET programs, research pertinent training topics and content, and provide and coordinate trainings. As noted in the table, WET provided a large number of in-person professional development trainings between FYs 2017-18 and 2018-19. Toward the latter half of FY 2019-20, all trainings had to shift to virtual platforms to accommodate the restrictions associated with in-person trainings due to the COVID-19 pandemic. Training topics included Law and Ethics, 5150/5585 Involuntary Hospitalization and Designation, Patients' Rights Respect and Dignity, Rights for Individuals in Inpatient and Outpatient Mental Health Facilities, Developing and Enhancing Competence in Clinical Supervision, Group and Individual Crisis Response, Housing Placement, Raising Awareness About First Episode of Psychosis, Response to Active Shooters, Meeting of the Minds, Continuum of Care, and Understanding American Society of Addiction Medicine (ASAM) Criteria in the Context of the California Treatment System.

In FY 2015-16, WET launched online training that offered Continuing Education (CE) and Continuing Medical Education (CME) credits for County and County-contracted providers who could not attend a live training. In the first two years after launch, nine trainings were offered annually. In FY 2018-19 only one pre-recorded on-demand online training was offered as the OC Health Care Agency (HCA) transitioned to a new Learning Management System (LMS) where employees have access to over 70 online trainings annually. Moreover, in FY 2019-20, live virtual instruction trainings were offered due to the global COVID-19 pandemic. Some of these trainings were recorded and offered to staff at a later date.

Consumer Employment Specialist Trainings/One-on-One Consultations: As part of WSS, Consumer Employment Support (CES) Specialists work with Behavioral Health Services, contract providers and community partners to educate consumers on disability benefits. One of the Consumer Specialists provides educational and outreach services exclusively in American Sign Language (ASL). The specialists provided training on topics such as Ticket to Work, Reporting Overpayment, and Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI). One-on-one SSI/SSDI Work Incentive consultation was also provided to consumers who requested more in-depth guidance. Additional services for those who are deaf and hard of hearing include advocacy/education, group or individual consultations, and information/referral to resources.

Multicultural Development Program: The Multicultural Development Program (MDP) consists of staff with language proficiency and culturally responsive skills who support the workforce by providing trainings on various multicultural issues. The MDP also coordinates requests and provides translation/interpretation services through in-house staff and

a contracted provider. During FY 2019-20, 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.

MDP staff and Language Line services also translated, reviewed and field-tested a total of 277 documents into the threshold languages of Spanish, Vietnamese, Farsi, Korean and Arabic in FY 2019-20, which was level from the previous fiscal years. 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 2019-20, the Ethnic Services Manager and staff continued organizing the Cultural Competence Committee (CCC) meetings.

The CCC consists of multi-ethnic partners and multi-cultural experts in Orange County 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. Although the count of unduplicated participants declined in FY 2019-20 compared to prior years, this was likely due to meeting cancelations.

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

Training and Technical Assistance

The Training and Technical Assistance (TTA) program offers trainings on evidence-based practices, the consumer and family member perspective, and 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 continuing education units to other departments in the HCA requesting trainings for their clinical or medical staff. Examples of requested trainings include Psychological First Aid, Raising Awareness about First Episode of Psychosis, Rights for Individuals in Inpatient Settings, and Rights for Individuals in Outpatient Settings. In FY 2019-20, TAA provided a total of 78 trainings for 3,642 attendees, which are described in detail below.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,223,390
FY 2021-22	$1,282,434
FY 2022-23	$1,241,794

Training Descriptions & Outcomes

Evidence-Based Practices: Trainings on Evidence-Based Practices were conducted to help behavioral health providers stay current on best practice standards in their field. County and contracted staff, community partners, consumers and their family members attended evidence-based training on topics such as Mental Health First Aid, Eye Movement Desensitization and Reprocessing (EMDR), Nonviolent Crisis Intervention Training, Motivational Interviewing, Children Adolescent Needs and Strengths (CANS), a Trauma-Informed Care series, Trauma Focused Cognitive Behavioral Therapy, Treating Trauma and Substance Use, and Dialectical Behavioral Therapy. During FY 2018-19, more requests

were submitted by HCA staff and/or community members for trainings focused in different Evidence-Based Practices, compared to previous years.

Consumer and Family Member Perspective: Consumers and their family members sat on a panel where they shared their lived experience with County and County-contracted behavioral health personnel. Panel members presented on their lived experiences to help reduce stigma and raise awareness of behavioral health conditions. Over the past three years, fewer requests have been made for these trainings. During FY 2019-20, WET included consumer and family member perspectives through the use of peer specialists and highlighted key principles of recovery which includes the consumer perspective. These concepts were interwoven into most trainings.

Cultural Competence: Culturally responsive trainings were conducted to raise cultural awareness and humility among behavioral health providers and community partners. Topics included Caring for Gender Nonconforming and Transgender Youth, Clinical Considerations when Working with Patients and Families from the Sikh Faith, Mindful Listening, Role of Forgiveness in Psychotherapy, Spirituality and Therapy, and Bio-Spiritual Focusing. Beginning in FY 2018-19, WET established an online Cultural Competency training for all BHS staff. Each year, new and ongoing staff are required to take this training as part of their professional development and per state regulations. Due to the establishment of this new annual training, the total number of attendees increased.

Crisis Intervention Training (CIT), which is now being funded through PEI, is reported in *Outreach to Increase Recognition of the Early Signs of Mental Illness.*

Mental Health Career Pathways

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.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$1,046,663
FY 2021-22	$1,046,663
FY 2022-23	$1,046,663

Program Description & Outcomes

Similar to previous fiscal years, in FY 2019-20 REI provided a total of 153 trainings to 499 active students. Of the 210 newly enrolled students, 76% identified themselves as living with a behavioral health condition, 10% identified themselves as a family member of someone living with a behavioral health condition, and 13% identified as both. These percentages are similar to what was reported in previous fiscal years. In FY 2018-19, REI provided a total of 161 trainings to 567 active students. Of the 274 newly enrolled students, 72% identified themselves as living with a behavioral health condition, 10% identified themselves as family members of those living with a behavioral health condition and 18% identified as both. In FY 2017-18, REI provided 156 trainings to 535 active students. Of the 292 newly enrolled students, 71% identified themselves as living with a behavioral health condition, 13% identified themselves as family members of those living with a behavioral health condition and 17% identified as both.

REI also employs academic advisors and peer success coaches to mentor and tutor students. REI enrolled 210 new students in FY 2019-20, and more students engaged in Academic Advisement and Success Coaching sessions. Due to the COVID-19 global pandemic the program provided more accessibility to resources. REI distributed Chromebooks to students to enable them to utilize online courses and academic advisement sessions. Students had immediate access to advising sessions, rather than having to travel to campus to seek guidance. Also, another shift was offering monthly

course schedules, rather than semester-based schedules. Therefore, students had up-to-date information regarding advisement hours and workshop courses that were available.

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

REI also offers a series of pre-vocational workshops to prepare students to enter the workforce. These workshops include job search techniques, resume building, interview skills, and dressing for job interviews. In addition, REI offers ESL and General Education Development classes for students to benefit their employment. opportunities.

In addition, REI contracts with Saddleback College to offer a Mental Health Worker Certificate program that prepares students to enter the public mental health workforce. Students gain knowledge and skills in the areas of cultural competency, the Recovery Model, co-occurring disorders, early identification of mental health conditions and evidence-based practices to name a few. To receive certification, students must complete nine 3-unit courses and a 2-unit, 120-hour internship. In addition, REI/Saddleback College added courses in alcohol and drug studies that integrates theory and practical experience to develop the skills necessary to work with individuals living with substance use disorders. Students who complete all required courses also receive a certificate in Alcohol & Drug Studies (see "College Credit Course" below). During FY 2019-20, fewer students completed the certificate programs than the previous fiscal year due to the COVID-19 global pandemic. Students were not able to complete the internship portion of the program, and many decided to postpone their certificate completion to later academic years.

REI Workshops and Courses	FY 2019-20
Workshops & Classes	**83 offered** **96% completion rate**
Pre-Vocational Courses	**43 offered** **93% completion rate**
Extended Education[4]	**10 offered**
College Credit Course	**17 offered** **81% completion rate**

[4] In FY 2019-20, WET discontinued calculated Completion Rates for Extended Education courses. Since the Extended Education courses are structured in an open entry and exit format, there is no specific "Completion" date for these courses. Students can join or exit a course at any point during the semester, for any reason. Therefore, completion rates were not calculated for Extended Education courses.

Residency and Internship Programs

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 behavioral health program during FY 2019-20, with three students being placed at WET's Neurobehavioral Testing Unit (NBTU) and two placed at Children Youth Behavioral Health (CYBH) sites.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$170,000
FY 2021-22	$5,000
FY 2022-23	$170,000

Program Description & Outcomes

In collaboration with the Psychiatry Department at the University of California-Irvine (UCI) School of Medicine, supervised trainings were provided in the program to teach the recovery philosophy; enhance cultural humility and understanding from the consumer and family perspectives; and recruit talented psychiatry residents and fellows into the public mental health system. The funded positions and training are one strategy the County uses to address the shortage of child and community psychiatrists working in community mental health. FY 2019-20 CAPIC students completed fewer clinical internship hours compared to previous years. This decrease was due to one student exiting the program early as well as the inability to conduct in-person testing due to the restrictions imposed because of the global pandemic of COVID-19.

In spring 2020, WET distributed an online survey to all FY 2019-20 CAPIC interns, as well as psychiatry residents and fellows to examine their experiences during the program. The two CAPIC interns who responded to the survey were very satisfied with their experience, were provided ample support and mentorship from their supervisor, and received professional development opportunities to refine their skills (e.g., hands on experience, working with clients, utilizing clinical skills, etc.). Similarly, all psychiatry resident and fellow interns who responded (n=9) were satisfied with their experiences during the program. The clinical supervisors were perceived as knowledgeable, supportive, and positive. All of the interns also felt they gained the skills necessary to perform their tasks in the field (e.g., hands on experience, working with clients, utilizing clinical skills, etc.).

Financial Incentive Programs

The Financial Incentives Program (FIP) 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 Orange County public mental health system. The WET office collaborates with numerous colleges and universities to offer stipends and encourage students to work for County or County-contracted agencies upon graduation. 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.

PROPOSED BUDGETS FROM 3YP

Fiscal Year	Program Budget
FY 2020-21	$526,968
FY 2021-22	$646,968
FY 2022-23	$526,968

Program Description & Outcomes

Similar to previous years, in FY 2019-20, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (70%), followed by Caucasian (20%), and Asian (10%) descent. The primary languages spoken were English (50%) and Spanish (50%). In FY 2018-19, over half of all those receiving BA/MA stipends self-identified as Mexican/Hispanic (64%), followed by Caucasian (24%) and Asian (12%) descent. The primary languages spoken were English (35%) and Spanish (35%). Roughly one-quarter said they spoke multiple languages (29%). In FY 2017-18, stipends were provided to 22 staff. More than half of staff self-identified as Mexican/Hispanic (54.6%), followed by Asian (27.2%) or Caucasian (18.2%) descent. While over one-third indicated their primary language was English (36.3%), a large proportion indicated they spoke more than one language (45.5%).

During FY 2019-20, WET conducted an online survey with all staff who participated in FIP during FY 2019-20. Out of the 20 staff enrolled in the program, nine responded to the online survey (45% response rate). Of those who responded, the majority of participants self-identified as female (63%) and were between the ages of 26-59 (89%). A large proportion indicated their racial or ethnic background as being either Mexican/Other Latino (67%), Caucasian/White (22%), or Asian (11%). All staff indicated they were employed with the County and worked at several behavioral health locations including OC ACCEPT, Community Counseling and Supportive Services, Outreach & Engagement, Clinical Evaluation Guidance Unit (CEGU), Children's Support and Parenting Program, Assisted Outpatient Treatment (AOT), or Inpatient/Residential Services.

Staff were asked to identify their organizational roles prior to and after participating in FIP. Prior to enrolling in the FIP program, 89% of staff indicated they were direct services providers, while 11% identified as support staff. One (n = 1, 11%) staff indicated that after participating in the program they advanced to a new role of Administrative or Manager and the remaining participants were still in their same roles. In addition, staff were asked if they earned an advanced degree as a result of their participation in FIP. All staff said that FIP helped them to earn a higher educational degree or level of schooling, as well as assisted them with achieving their educational goals (100%). More specifically, prior to participating in FIP, participants either had some college experience (11%) or earned a bachelor's degree (89%). After engaging in FIP, 44% of staff had advanced their education by earning a master's level degree.

The majority of staff said that FIP helped them to advance in their careers (89%). When asked to list all the ways FIP helped them, a large percentage stated the program helped them to advance their education (89%), invested in their abilities (78%), helped them develop new skills (78%), increased their earning potential (78%), and increased their awareness of cultural and linguistically diverse services (78%). Other ways in which FIP helped staff included networking with other professionals (67%), helped them increase motivation related to their job (67%), provided opportunities to develop leadership skills (56%), and helped them to step out of their comfort zone (44%).

In the future, staff would like to see specific changes made to FIP to improve its effectiveness. Specifically, staff would like to see more support provided during the program (44%), the establishment of a mentorship/transition program for after graduation (44%), more resources to help apply knowledge and skills in the workforce (22%), and a streamlining of the application process (11%). While staff had recommendations for program improvements, overall, all staff who responded to the survey were satisfied with their FIP experiences, felt they were treated with courtesy and respect by staff, and would recommend the program to their colleagues. The majority also felt the program was very or extremely effective in developing a bilingual/bicultural workforce (22% and 44%, respectively). The remaining responses indicated the program was somewhat effective (33%) in developing a bilingual/bicultural workforce.

Summary

Despite the overwhelming impact of COVID-19, the agency continued to serve the community in the best way possible. It did so at a significant cost to employees and staff. Individuals and families seeking services increased dramatically over the year with staff needing to cope with the increased use of services while often working in clinics with high vacancy rates. BHS programs are both small and large. They serve small groups such as Veterans matriculated at colleges as well as the thousands of people who call the OC Links Program for referrals and linkage to BHS programs. Overall, mostly all programs indicated success in their outcomes. Many programs reported that participants demonstrated improved mental health status, enhanced quality of life, increased social functioning, more effective management of behavioral health symptoms and other chronic conditions, as well as enhanced ability to live independently. Services were provided in all the threshold languages as well as a few others such as Khmer. All these factors helped the community build resilience, and be more able to respond to future crises, especially the possibility of natural and man-made disasters and other threats.

The partnership between public and private agencies continued in full force this past year with HCA building many more linkages with the community. We partnered with private behavioral health systems, faith-based groups, and other community organizations to reach out to the community both as a listener and as a provider. We expect that this will continue in the coming years.

Of note was the work of the Behavioral Health Services Disaster Response Team (BHSDR). The team was instrumental in serving the community during the Covid-19 pandemic. From providing behavioral health interventions to the homeless at free standing shelters, to assisting at a refurbished former youth facility designed to serve the medically fragile in a safe and contained wooded area, to providing hundreds of hours of behavioral health support at the vaccine distribution centers (PODs). BHSDR served approximately 27,000 people during the year with behavioral health interventions. Most of the clinicians volunteered their time with the approval of their programs. Many were bi-lingual or multi-lingual. Overall, the work of BHSDR was a great success, and was a happy counterpoint to the other stresses of the pandemic.

Looking forward to 2022, we fully intend to integrate CLAS standards and health equity more strongly into each of the divisions. Similarly, we intend to hire more bi-lingual staff to meet ever increasing needs within the community. But many internal decisions will need to be made to increase staff retention and offer incentives for hiring.

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

The County has a Cultural Competence Committee, or Other Group to Address Cultural and Linguistic Issues and has Participation from Cultural Groups, which is Reflective of the Community

Behavioral Health Equity Committee (BHEC) formerly known as the Cultural Competence Committee (CCC)

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

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

BHEC's vision as defined by the Governing Structure states that: *Our efforts are focused on the promotion of behavioral health equity for unserved and underserved racial and ethnic communities, as well as lesbian, gay, bisexual, transgender, questioning/queer and intersex (LGBTQI), Veterans, deaf and hard of hearing and other cultural groups.* In accordance with the Governing Structure a Steering Committee and several Work Groups were formed in the first quarter of 2021. The BHS appointed Bijan Amirshahi, the current ESM, as the Co-Chair on its behalf and the community members of the Steering Committee elected Iliana Soto Welty as the community Co-Chair.

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

Cultural Competence Committee Summary of Accomplishments -FY 2019-20:

- From its inception in May 2016, through June of 2021, BHEC (CCC) held 52 meetings (9 meetings in 2019-2020). The meetings were held virtually since May 2020.
- More than 30 organizations/contract providers/county departments and programs were represented at BHEC meetings. Average number of attendees per meeting was 20 during FY 2019-2020. The average number of attendees at BHEC meetings held virtually since May 2020 increased to more than 30 per meeting. The membership roster is shown in the table below.
- Several presentations were made for/by the members covering the following topics:
  - Lunar Year
  - National Women's History Month
  - Vernal Equinox – Nowruz: Persian New Year

    - Women's Equality Day
    - Eid Al-Adha
    - International Week of the Deaf
    - Hispanic Heritage Month
    - Indigenous/Columbus Day
    - Martin Luther King Day
    - Black History Month
    - Asian American and Pacific Islander Heritage Month
    - Mental Health Matters Month
    - Memorial Day
    - National Minority Mental Health Awareness Month
    - Advance OC
- BHEC members represented at MHSA Steering Committee meetings.
- Members participated in end of the year holiday celebration by sharing ethnic food and stories in 2016, 2017, 2018 and 2019. The multicultural Potluck held virtually in December 2020 attracted more than 20 attendees. Three members made virtual presentations about a meal from a culture they identified with.
- Increased awareness of cultural practices/traditions among BHEC members/organizations through the 15 presentations listed above.
- Increased BHEC members' involvement in field testing and developing mandatory annual training.
- CLAS – Cultural and Linguistically Appropriate Services (CLAS) Standards were reviewed.
- The online 2020 Cultural Competence Training 3.0 benefited from feedback and cooperation from BHEC members. The online training was launched on September 2020 and within three months was completed by over 2,500 BHS staff and employees of contracted providers.
- The idea of Culture Corner, a video series about different cultures intended to help clinicians and staff better understand and connect with the participants we serve and enhance the quality of behavioral health services was generated from the BHEC meetings and the first video about Jewish Holidays was launched in September 2018. A second Culture Corner video about celebration of Kwanzaa in Black/African American communities was produced and launched in December 2020.
- Cultural Competence Communication Partnership (CCCP) idea was developed at BHEC, presented to the agency management in 2019 and taken on the road to several programs. The objective of CCCP was to decentralize and standardize access to language services throughout the agency. Presentations were made at BHS programs' monthly meetings attended by over 80 managers, service chiefs and program supervisors.
- Multilingual Afterhours Greeting project was developed at BHEC and was presented to the BHS top management. Implementation of the pilot for this project at one of the programs is foreseen in 2021-2022 FY.

BHEC Members 2021

Adelekan, Patricia	Community
Amirshahi, Bijan	Orange County Health Care Agency
Anguiano, Lloraley	Orange County Health Care Agency
Arnot, Michael	Children's Cause OC
Aziz, Sumar	Orange County Social Services
Banicki, Wendy	Orange County Health Care Agency
Brack, Yvonne	Orange County Health Care Agency
Burney, Lenora	Orange County Health Care Agency
Chiu, Irene	OCAPICA

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
Gibbs Danny	Orange County Health Care Agency
Gibbs, Daniel	Orange County Health Care Agency
Grande, Andre	ICNA Relief
Hanifzai, Wali	Access CA
Helmy, Deana	Orange County Health Care Agency
Hernandez, Elizabeth	Orange County Health Care Agency
Kalk, Karin	Orange County Health Care Agency
Kellman, Allison	Orange County Health Care Agency
Kim, Yuri	Orange County Social Services
Lu, Pham	Orange County Health Care Agency
McCleese Belinda	Orange County Health Care Agency
Merritt, Alex	Orange County Health Care Agency
Mugrditchian, Annette	Orange County Health Care Agency
Mullard, Michael	Orange County Health Care Agency
Nagel, Jeff	Orange County Health Care Agency
Ngo, Hannah	Orange County Health Care Agency
Nguyen, Hugh	Orange County Health Care Agency
Nguyen, Kelvin	Viet-care
Nguyen, Nicki	Orange County Health Care Agency
Nguyen, Tricia	Southland
O'Brien, Brett	Orange County Health Care Agency
Ortega, Christy	Orange County Health Care Agency
Peong, Vattana	Cambodian Family
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
Rowe, Cheryl	Orange County Health Care Agency
Salamati; Armin	Orange County Health Care Agency
Sayyedi, Maryam	MECCA
Sharifaei, Joya	Community Member
Smith, Courtney	GREEN Foundation
St. Clair, Shelby	Orange County Health Care Agency
Tabesh, Nikoo	Orange County Health Care Agency
Thornton, April	Orange County Health Care Agency

Tran, Duan	Cal State Fullerton and member of BHAB
Wang, Jon	unknown
Welty, Iliana	MECCA
Whetsell, Brittany	Orange County Health Care Agency
Williams, Cyntralia	Orange County Health Care Agency
Wright, Ernesta	GREEN Foundation
Yang, Emily	OCAPICA

Development of BHEC Work groups

An unstated goal of the reformulated BHEC is to improve penetration rates and increase the use of mental health services by the unserved and underserved communities through connecting and partnering with different communities in Orange County. This intentional outreach is intended to increase the community's awareness of HCA services, and to create an increased level of trust in mental health treatment. BHEC has created work groups to address specific needs of Orange County residents. A summary of each of these work groups will be discussed below.

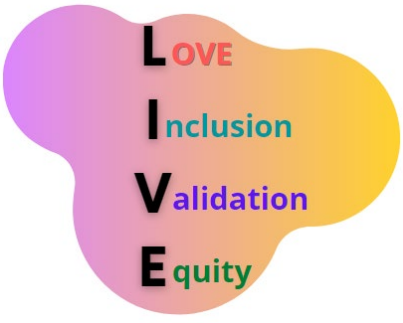
LGBTIQ+ Work Group

This work group is made up of individuals who have lived experienced and/or as allies are motivated to establish rights and equity for our LGBTIQ+ community. The group seeks to find ways to deepen outreach and connections to the OC's LGBTIQ+ community.

The work group's goals include:

- Increase Behavioral Health Service utilizations within the unserved and underserved communities.
- Partner w/ OC community collaborative partners.
- Find ways in bridging and enhancing relationships.
- Increase disseminations of information to/from the County.
- Gathering feedback from community members.
- Creating trust within the County and community.
- Share knowledge amongst participants.
- Learn from each other's strengths.

The group has created their own mission statement, which is as follows:



"Our mission is cultivating a welcoming and safe environment where our LGBTQ+ community members can thrive. To that end, our vision is to collaboratively promote equity, destigmatize biases, and provide safe spaces for LGBTQ+/OC residents and community. Additionally, we increase inclusion, empowerment, and affirming cultural competence services for the County of Orange residents through collaboration with all community partners, addressing our LGBTQ+ community's diverse needs with dignity and respect, eliminating stigma associated with mental health, and breaking barriers to live proudly."

The LGBTIQ+ group is comprised of 15 members from various county programs and community partners including:

- The Orange County LGBTQ+ Center
- Orange County Asian Pacific Islander Community Alliance (OCAPICA)
- DiDi Hirsch
- Asian Pacific AIDS Intervention Team (APAIT)
- Orange County Acceptance through Compassionate Care Empowerment and Positive Transformation (OC ACCEPT)
- HCA Program of Assertive Community Treatment (PACT)
- HCA Outreach and Engagement
- HCA Substance Use Disorder Santa Ana clinic
- HCA Community Counseling and Supportive Services
- HCA Prevention & Intervention Division

The work group has been facilitating training sessions on the special needs of LGBTIQ+ youth and teens to several different organizations including the Orange County Department of Education. Our community partners are also using their contact lists to make the community more aware of their services, which creates a synergistic effect for all stakeholders.

Community Relations and Education Work Group

Originally conceived In May 2020 as a new Cultural Competence Committee sub-committee named the Community Relations and Education (CORE) Sub-Committee, its work started in July 2020. The CORE Sub-Committee met several times in the summer and fall of 2020 and developed a document to define the governing structure of CCC. The work on this document continued by the CORE Sub-Committee and was finalized in late 2020.

Now called the Community Relations & Education Work Group, it's purpose it to enhance the BHEC's relations with the community including increasing participation in the BHEC as well as educating the public on the BHEC, the Cultural Competence Plan, and the BHEC's expanded scope of responsibilities including advancing policy change recommendations to the Behavioral Health Director that improve equity and advance antiracism in BHS. The Work Group also identifies opportunities to align and coordinate with similar efforts in other County agencies.

The immediate goals include:

1. Increased awareness of the group within the community
2. Increased participation
3. Coordination with other BHEC Work Groups to avoid duplication of effort.

The Work Group's goals are:

- More clearly define who we will target with communications activities.
- Conduct a community relations survey of past participants.
- Discuss/communicate changes that have taken place.
- Personally invite others to join and rejoin us.
- Further engage the community to increase awareness. This will lead to increased participation.

The work group is currently making progress in more clearly defining which groups to target with communications. The development of a survey of past community relations participants has begun. Discussions on how to best communicate changes within the group have been discussed and updated communications are pending. Members of the Work Group have personally reached out to invite others to join or to rejoin the Work Group.

Spirituality Work Group

The Spirituality Work Group consists of HCA employees and community members with a lived experience of mental illness and substance use as well as clergy from different religious traditions. The group has recently written and approved its own mission statement, which is as follows:

- To connect and collaborate with spiritual and/or faith-based communities on accessing equitable behavioral health resources and services.
- To promote spiritual and/or religious practices that enrich resilience, recovery and overall wellness.

The group is working on an outreach project to gather clergy and laity from different traditions to join together for an evening to discuss mental health. Given the recent suicide of son of Pastor Rick Warren of Saddleback Church, there is already a heightened awareness of suicide and mental health in Orange County; and this evening, which will be a "townhall," format, will seek to understand how the Health Care Agency can reach out to different churches, mosques, synagogues and other faith groups, to provide mental health services, break down cultural stigma around mental health treatment, and generate goodwill in the community.

HCA is already partnering with Roman Catholic Diocese of Orange to provide free training in Mental Health First Aid for Catholic laity, as the Diocese implements its own initiative to build a mental health ministry in as many of the 56 parishes in Orange County as possible.

Outreach and Engagement to Black/African Americans Work Group

The goal of this work group is to reach out to the Black/African American community within Orange County to help increase trust in County services, especially health care, reduce racism by building relationships, and encouraging greater use of County health services among Black/African American residents of Orange County. This group recognizes that there is a general lack of trust among the Black population due to past implicit bias and racism from County agencies, e.g., Social Services Agency, HCA and others, that has created anger and fear. A significant concern for the Health Care Agency is our difficulty in matching Black/African American clients/participants with clinicians of similar cultural background. HCA employs few Black clinicians, and this is an issue that is being addressed currently.

A goal of this work group is to reach out to African American churches, schools, and other establishments important to the community, to provide information about our services and to build linkages of mutual support and cooperation. Consideration is also being given to provide HCA literature at various food distribution events and other events for the unserved and the underserved. The work group will follow a two-track model, both looking inward to develop the resources of our own Black/African American clinicians and looking outward to develop further links in the community, by first creating a contact list or prospective partners.

Populations who speak in one of OC's six threshold languages or have limited English proficiency (LEP) and/or Other Communication Needs Work Group

The purpose of this work group is to provide culturally and linguistically appropriate service to all threshold language populations in Orange County. The work group has defined the following goals:

- Develop knowledge of the needs of each threshold population.
- Provide high quality translation and interpretation services.
- Connect with populations who speak in one of the threshold languages and community groups to make them aware of the services available to them.

Currently, the work group is reaching out to different County programs and community groups who can help us in our decision-making while being mindful that all populations who speak in one of OC's threshold languages are being represented.

The group has been meeting regularly and currently have several members from various County and community groups. Further, this work group generally is discussing high-priority language translations, including ASL, in BHS promotional materials.

Deaf and Hard of Hearing Work Group (Pending)

Members of the BHEC are currently working toward forming a group for the deaf and hard of hearing community. The group will consist of current BHS employees and community members including OCDEAF a large agency in Orange County. Currently two of our clinicians are partnering with OCDEAF to provide services to the deaf and hard of hearing. These clinicians provide clinical and consultation services. The immediate goal is to build the workgroup and then generate interest in university and graduate students to pursue a career in behavioral health.

MHSA Community Planning Process

In FY 2020-2021, the MHSA Community Planning Process for the coming FY 2021-2022 involved the engagement of Orange County mental health stakeholders through Virtual Community Engagement. Due to COVID-19, HCA modified its approaches and used electronic surveys and web-based meetings since in-person events were not permitted. In order to collect input from diverse groups of Orange County mental health stakeholders, HCA partnered with various Community Based Organizations (CBOs) and conducted 21 separate Community Engagement Meetings, holding focus groups with consumers and family members to learn what strategies and solutions they believed to be most effective and responsive to their community's unique needs on three strategic priorities identified in the MHSA Three-Year Plan from the prior year: 1) extend the scope and reach of mental health awareness campaigns, community training and education; 2) strengthen the County of Orange's (County) suicide prevention efforts by expanding the programs making up our crisis services continuum; and 3) improve access to needed behavioral health services.

Below are the CBOs that partnered with HCA as well as a chart that indicates the diversity of the priority populations that were outreached to and engaged.

CEM (n=21 meetings)	# Registered (n=480)	Children	TAY	Adults	Older Adults	Additional Population Characteristics
Arabic/Muslim Community	8			X	X	
Parents/Families (in Spanish)	8	X	X			Latino/Hispanic
BHS Consumers	31			X	X	Persons In Recovery w/ SUD
HCA Peers	12			X	X	
Cambodian Community	16			X	X	Asian/Pacific Islander
Chinese Community	6			X	X	Asian/Pacific Islander
Filipino Community	5			X	X	Asian/Pacific Islander
Family Resource Centers of OC	61	X	X			Latino/Hispanic
Korean Community	8			X	X	Asian/Pacific Islander
LatinX Transwomen	28					LGBTIQ, Latino/Hispanic
LGBTQ Community (in English)	6		X	X		LGBTIQ
LGBTQ Community (in Spanish)	4		X	X		LGBTIQ, Latino/Hispanic
LGBTQ Community (in Vietnamese/English)	6		X	X		LGBTIQ, Asian/Pacific Islander
Older Adults (two meetings)	26 / 31				X	
Parent Partners	11	X	X			
Permanent Supportive Housing Residents	9		X	X		Persons in Recovery, *(Homeless Individuals)*
Persons In Recovery	41			X		Persons in Recovery w/ SUD
Veterans / Military-Connected Families	30	X	X	X	X	Veterans
Vietnamese Community	107		X	X	X	Asian/Pacific Islander
Wellness Center Members	30			X		

HCA's collaboration with CBOs that are trusted by the community allowed HCA to engage more meaningfully with diverse groups of clients/consumers and family members. In terms of languages represented, these Community Engagement Meetings were conducted in English, Spanish, Vietnamese, Korean, Mandarin, Tagalog and Khmer, in addition to interpretation services for Farsi-speaking individuals. Four hundred and eighty-four individuals registered and 327 attended Virtual Community Engagement Meetings. HCA expanded outreach beyond the diverse groups represented by the Cultural Competence Committee and will continue work with the committee to identify and engage other under-represented groups, to ensure diverse participation in MHSA community planning process.

Recommendations and suggestions provided by clients, family members and community members during the Community Engagement Meetings were synthesized, and two areas of focus were identified for initial discussion with County and County-contracted providers, representatives from CBOs and service provider agencies as well as mental health advocates: 1) how to better improve technology skills and access, and 2) how to more accurately articulate mental health terms and language to better reach and connect with individuals from unserved and underserved communities. Meetings with providers and advocates were intended to better understand to what extent their organization may have tried different approaches identified by Community Engagement Meetings participants, sharing of lessons learned and assessing their interest in and capacity to potentially implement different recommendations generated in the Community Engagement Meetings.

Looking ahead to FY 2021-22 and beyond, the HCA and MHSA Coordination Office will continue to gauge trends in well-being, stress and coping among Orange County residents; monitor the MHSA fiscal outlook; and continue to adjust and adapt as needed to ensure needed services and supports are not disrupted. Moreover, we remain committed to partnering with the Cultural Competence Committee, consumers, family members, service providers and community organizations as, together, we strive to anticipate future needs, close existing gaps, address persisting disparities and support the health and well-being of Orange County's residents.

Summary

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

- BHEC created a forum for bringing the County and community-based organizations and contract providers and members of the community at large together to learn best practices in order to have services that are culturally and linguistically appropriate to the needs of the populations that we serve. Several of the above referenced programs, informed and influenced by the public private partnership, have succeeded in raising awareness among members
- The committee assisted the BHS programs to decentralize and standardize the language services.
- BHEC expanded its membership to include several peer support specialists and individuals with lived experience. The committee also started partnership with other government entities starting with the OC Department of Education.
- BHEC developed its Governing Structure document.
- BHEC deepened its relationship with the communities we serve especially the unserved and underserved communities. BHEC formed five Work Groups in partnership with members of the community as mentioned above.

CRITERION 5: TRAINING ACTIVITIES

Developing a culturally and linguistically aware workforce is essential to providing effective services. Cultural Awareness requires that direct service providers learn a set of values, understand varied cultural experiences, and establish skills to utilize when providing specialty mental health services to clients. Training curriculum should be targeted toward providing direct service providers with skills focused on cultural sensitivity and an understanding of how the consumer, their mental illness and/or substance use, their experience with the behavioral health system, and the stigma of mental illness and/or substance use, has impacted their access to services.

As the Health Care Agency moves toward more thorough training in aligning our operation with CLAS standards, we believe that consumers will more greatly benefit. As we consider integrating further aspects of cultural awareness and sensitivity into our services, research from SAMHSA demonstrates that this will further increase the efficacy of our services. In this section we will describe the cultural awareness trainings that were provided during FY 2019-20.

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

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

Additionally, it is required that cultural considerations are embedded into all trainings providing Continuing Education (CE/CME) units, as described in the training description, objectives, listed references, and training contents. Trainers are expected to incorporate cultural references in all training topics, bulletin notices and learning objectives relative to the topic. Trainings focused on skill building and education are conducted to address cultural sensitivity and humiliation, as well as reduce stigma and discrimination within the behavioral health system. This is done in order to prepare, develop, and maintain a culturally responsive, bicultural/bilingual workforce that also includes consumers and family members with valuable, lived experience.

Annual Cultural Competence Trainings

Cultural Competence trainings are comprised of several categories: those related to behavioral health best practices; those requiring on-going recertification (e.g., 5150 and 5585 designation); 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 and stakeholders on a variety of topics. Table 5.1 below is a chart that provides information on the cultural development trainings provided during FY 2019-20. 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 2019-20[1]

	Total Trainings	Number of Attendees	Combined Hours	Combined CEs Given
5150 LPS Initial Certification[1]	3	89	19.45	15
5585 Initial Certification Training	2	59	13	9
Addressing Challenging Client Situations with Cultural Humility	1	48	3.15	3
Be Loved & Accepted: Incorporating Affirmative Therapy and Spiritual Practices for LGBTOQ Clients	1	67	3.15	3
Beat the Holiday Blues	1	17	1.5	0
Building Resilience in Trauma-Informed Professionals	1	84	6.5	6
Crisis Intervention Training (CIT) - I[2]	8	257	64	0
CIT - II[2]	5	68	40	0
CIT - III[2]	2	36	16	0
CIT - Dispatch[2]	4	111	32	0
Cultural Awareness Training (Online)	1	884	1	1
Effecting Change through the Use of Motivational Interviewing: Interactive Training for Skill Development	4	142	19.3	18
Elements of Effective and Ineffective Clinical Supervision	1	110	6.5	6
EMDR Therapy with Children and Adolescents	1	26	3.1	3
Integrative Treatment of Complex Trauma - Adolescent Version (Part 1)	1	104	6.5	6
Integrative Treatment of Complex Trauma - Adolescent Version (Part 2)	1	89	6.5	6
Law and Ethics: Cultural Considerations When Working with Immigrants Families	1	105	6.5	6
Mental Health First Aid (MHFA; Adult) [2]	11	212	72	0
MHFA (Public Safety)[2]	2	40	16	0
MHFA (Spanish) [2]	1	21	8	0
MHFA (Youth)[2]	11	227	83.5	0
Moral Reconation Therapy (MRT)	1	10	7	26
Motivational Interviewing	1	45	6.5	6
Non-Violent Crisis Intervention Training - Full Day[3]	3	88	19.6	18
Non-Violent Crisis Intervention Training - Half Day[3]	6	113	18.75	18
Recovery - The Promise of Hope	1	42	3.1	3
Seeking Safety: Substance Use and Trauma-Informed Care	2	31	13	12
Spirituality Training (The Ultimate Recovery for Individuals with Severe Mental Illness)	1	57	3.15	3
Trauma and Eating Disorders	1	107	6.5	6

5.1 (Continued) Name of Cultural Development Trainings, FY 2019-20[1]

	Total Trainings	Number of Attendees	Combined Hours	Combined CEs Given
Veteran's Conference - Serving Those Who Served: Moving Beyond	1	183	7.5	5
Working Effectively in Behavioral Health Settings with Sign Language Interpreters	1	8	1	0
Working with Sign Language Interpreters	1	7	1	0
Grand Total	**82**	**3,487**	**514.75**	**179**

[1] *5150 - 4 trainings conducted, but only 3 reported in our database*

[2] *No CEUs were given for CIT or MHFA*

[3] *NVCI inclusive of Adults and Children*

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 (30.5%) or Community-Based (23.3%) Direct Service Providers. Personally speaking, the majority of participants identified as Community Members (28.8%), Family Members (16.0%), and/or Parents (14.1%). Roughly 17% of participants also identified as something other than what was listed in Table 5.3.

5.2 Cultural Development Training Attendance by Participants' Professional Role, FY 2019-20

Attendance by function*	Total Number	Percentage
County Administrator/Manager	166	7.1%
County Direct Service Provider	715	30.5%
County Support Staff	300	12.8%
Community-Based Administrator/Manager	200	8.5%
Community-Based Direct Service Provider	545	23.3%
Community-Based Support Staff	416	17.8%
Total	***2,342***	***100.0%***

**Some attendees reported multiple professional roles*

5.3 Cultural Development Training Attendance by Participants' Personal Role, FY 2019-20

Attendance by function*	Total Number	Percentage
Consumers	273	9.3%
Parents	414	14.1%
Family Members	469	16.0%
Community Member	847	28.8%
Caregiver	187	6.4%
Teacher	69	2.4%
Student	252	8.6%
Youth	25	0.9%
Other	405	13.8%
Total	***2,941***	***100.0%***

**Some attendees reported multiple personal roles*

Relevance and Effectiveness of All Cultural Competence Trainings

The HCA Cultural Competence training for health care professionals focuses on skills and knowledge that value diversity, understand and respond to cultural differences, and increase awareness of providers' and care organizations' cultural norms. Trainings can provide facts about patient cultures or include more complex interventions such as intercultural communication skills training, exploration of potential barriers to care, and institution of policies that are sensitive to the needs of patients from culturally and linguistically diverse (CALD) backgrounds (Govere 2016*, Cochrane-Horvat 2014*).

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

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

Data Collection and Methodology

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

Over the last three years, steps have been taken in order to improve data quality and tracking. At the start of July 2019, a new evaluation form and data tracking system were developed in order to consolidate data tracking and collection. Questions on the revised BHTS/MDP evaluation forms focus on knowledge gained as a result of the training, usefulness of course materials, effectiveness of training presenter and curriculum, as well as overall satisfaction with the training. Updated information regarding participant demographics are also collected in order to satisfy both local and state data collection requirements.

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

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

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

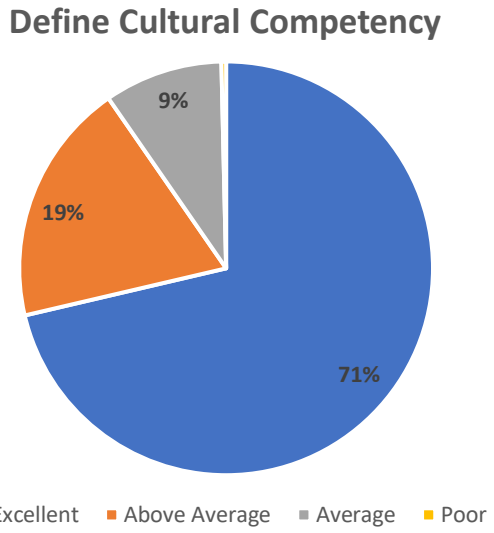
- Training Title, Date, Time, Location
- Board Accreditation Information
- Number of CE/CME Credits Provided
- Culturally Competent Trainings
- Trauma-Informed Care Trainings
- Drug Medi-Cal Trainings
- Mental Health Service Act (MHSA) Categories
- Training Sponsor
- Registration and Attendance Counts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

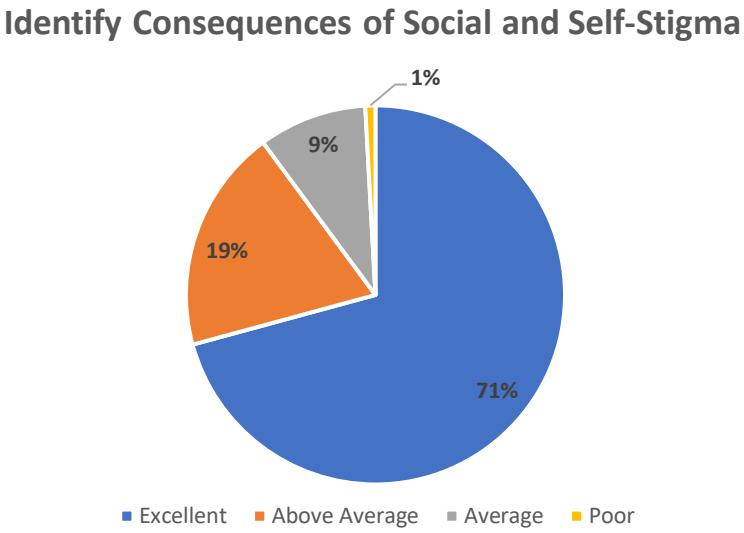
With the development of this new data tracking system, BHTS/MDP routinely reviews data to determine what trainings have been offered and areas where more trainings are needed.

Additionally, in March 2020 and until the end of FY 2019-20, all in-person trainings were canceled, and the department had to shift to online/virtual methods for facilitating trainings. This shift was made in response to the COVID-19 global pandemic. Once a system was in place to conduct trainings on virtual platforms, evaluation form data also needed to be collected electronically. After each training, BHTS/MDP began collecting all training evaluation form data online using Qualtrics.

Analysis of Annual Cultural Competence Training

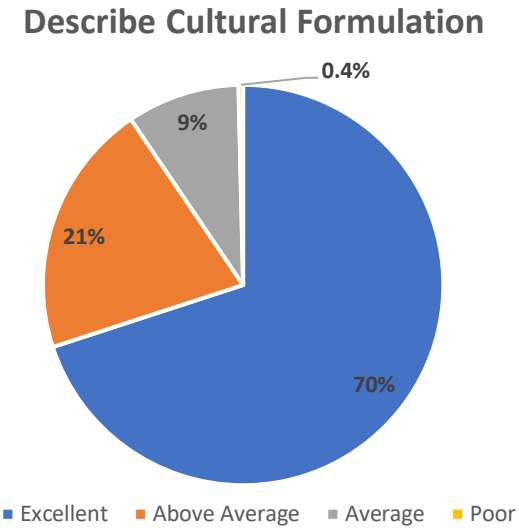
The annual Cultural Competence training is provided to both County- and Contract-operated staff. In November 2018, a revised Cultural Competence training was launched and focused on culture, cultural humility, stigma and self-stigma, unconscious bias, micro-aggression, racism, and cultural formulation (see Appendix IV). 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 2019-20 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 (19% above average and 71% excellent).





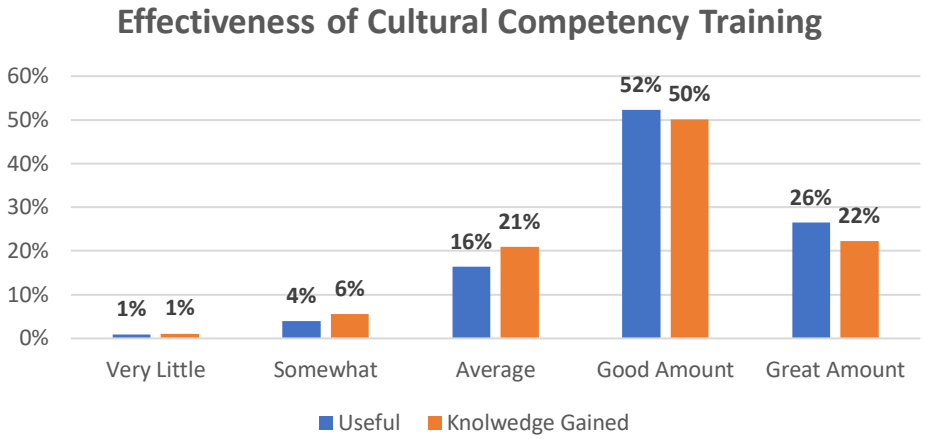
Similarly, roughly 90% of participants felt the training provided an above average (19%) or excellent (71%) description of how to identify the consequences of social and self-stigma. The focus of this objective was to understand how these concepts related to public health and its influence of the unconscious thoughts on judgement, stereotyping, and racism in our community.

Finally, nine out of every ten participants felt they could describe cultural formulation as a result of the training (21% above average and 70% 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 (52% and 26%, respectively) and learned new information (50% and 22%, respectively).

In terms of overall program quality and satisfaction, the majority of participants felt the quality of the training was excellent (67%) or above average (21%). Similarly, the presenter was perceived as able to effectively communicate knowledge of the subject matter (67% excellent and 20% above average). Ninety percent (90%) of participants indicated they were satisfied with the training, similarly nine out of every ten participants would recommend this training to someone they know (94%) or found this training to be user friendly (98%).



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

Descriptions of some cultural development trainings offered during FY 2019-20 are included in Appendix IV. These trainings were developed to provide County, Contract, and Community members with the skills necessary to interact with varied client experiences (e.g., racial, ethnic, cultural, and linguistic experiences).

Summary

Once again, Behavioral Health Services engaged in an active year of training, despite the on-going COVID-19 pandemic. Within two months, Behavioral Health Training Services (BHTS), the training department of BHS, successfully transitioned from in-person trainings at our Behavioral Health Training Center, to providing all trainings virtually with Zoom or WebEx. BHTS continued to prioritize cultural competence as a significant component of every training. The

subject matter experts who provided the trainings for BHS staff and contract providers continued to be strongly encouraged to include material in the training that explored the cultural considerations related to the subject of their trainings and to include this as one of the learning objectives of their training. BHS requires that all trainings be vetted by its Ethnic Services Manager who reviews the training for cultural sensitivity, principles of cultural competence, and to ensure that the training provided an inclusive, multi-cultural focus. Almost every training provided by BHS featured a strong cultural component, especially aiding our clinical staff to understand, support, and intervene in culturally appropriate ways with participants.

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

As we move forward with our goals for this year, staff training in specific CLAS standards will become a direct focus of the agency. These trainings will be offered directly to staff in different settings and will be accomplished through several different mediums. Further, we plan to consider how to more strongly integrate SAMHSA's research on building resilience within cultures through building strong kinship bonds, respect for elders, spiritual and religious traditions and other factors.

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

BHS remains strongly committed to recruiting, retaining, and promoting a multi-cultural, highly skilled workforce. The following section provides information about recruitment and retention efforts of our behavioral health professionals that are in line with the Recovery-focused philosophy. At present, BHS is coping with a vacancy rate of approximately 30%. 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.

Like many other public mental health agencies throughout the state and nation, HCA has seen a significant increase in service requests. Suicide attempts and fatal drug overdoses, especially among youth and young adults have increased. All these factors combined have caused a significant negative impact on staff, including employee retention, secondary traumatization, and poor morale in some programs. In order to gather data and ameliorate some of these factors, the Trauma Informed Care Work Group created a series of Supervisor Focus Groups after hearing reports that front-line supervisors were particularly impacted by these events. At present, the facilitators are gathering data and will be working with a research analyst to create a summary of the information. These findings will then be presented to the BHS management team for consideration. More information on these findings will be reported next year.

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 in order to increase penetration rates and further create linkages to the community to increase trust and build confidence in our services. This section documents the assessment, needs, specific competencies, and current strategies used by BHS to engage and strengthen our workforce.

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

Recruitment

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

Human Resources uses social media to advertise new positions and recruitments such as the sample below.

Assessment of County Workforce

During the initial 2012 workforce needs assessment, an electronic survey was disseminated to better understand the cultural and linguistic characteristics that made up Orange County's behavioral health workforce. This follow-up assessment, conducted in August 2021, was a collaborative effort between the County's Behavioral Health Training Services (BHTS) department and its Human Resources Division. The summary statistics provided below primarily include County employees and do not represent the total number of County contracted agencies or individual County contractors.

Results from BHS were compiled together to obtain results across various job classifications, racial and ethnic backgrounds, and primary languages. This assessment included an evaluation of currently filled and vacant positions by job titles, number of positions designated for consumers and family members and occupied by consumers or family members, and the capability of staff (based on bilingual pay status) in providing services in a threshold language (Spanish, Vietnamese, Farsi, Korean, Mandarin Chinese, and Arabic). The survey assessed the County's needs in different areas, which included: needs in different occupational categories, needs across positions, and needs concerning language proficiency.

Needs by Occupational Category

Across County-operated BHS programs, there is a need to fill vacant positions among PHMS employees who provide direct and non-direct services in order to meet the needs of the current clientele (Table 6.1). Based on the most recent needs assessment, roughly 81% of the needed positions are currently filled. Comparing the number of filled to vacant positions, the greatest need was among Psychiatrists (Child and Adolescents, Geriatric), Psychiatric Mental Health Clinical Nurse Specialist and Licensed Clinical Social Worker.

6.1 Number of PMHS Employees and Vacancies, August 2021[1]

	Total Number
Total Number of Current PMHS Employees	1,233
Total Number of PMHS Vacancies	231
Total Number of Current PMHS Direct Service Filled Positions	631.5
Total Number of Current PMHS Direct Service Vacancies	154

[1]The total number of current PMHS direct service filled positions does not include Executive and Management staff (see table 6.2, *n* = 37). The numbers presented in this table are reflective of only staff who provide direct services to the community.

6.2 Currently Filled and Vacant BHS Positions, August 2021[1]

	Number of Positions Filled	*Number of Vacancies*	*Total Number of Positions*
Psychiatrist - General	0	2	2
Psychiatrist - Child and Adolescent	11	5	16
Psychiatric Mental Health Nurse Practitioner	15	3	18
Mental Health Worker	41	9	50
Psychiatrist - Geriatric	22	5	27
Licensed Behavioral Health Clinician	359	94	453
Licensed Clinical Psychologist	52	6	58
Executive and Management Staff	37	6	43
Mental Health Specialist	113	22	135
Psychiatric Mental Health Clinical Nurse Specialist	12	6	18
Total	***662***	***158***	***820***

[1] Position classifications not currently used in Orange County include Case Manager, Behavioral Health Clinician I/II, Licensed Professional Clinical Counselor, Licensed Psychiatric Technician, Occupational Therapist, Physician Assistant, Substance Abuse/AOD/SUD Counselor

Positions Designated for Consumers or Family Members

There is a need in Orange County to fill vacancies in our peer specialist workforce, also known as Mental Health Workers, who provide services. While there are vacancies to be filled, Orange County employs peer specialists to provide services to those who can be difficult to reach. Employing peers helps the agency align treatment goals the principles of recovery, recovery resulting in greater orientation that benefits the agency and the individuals who are served. The agency can provide individuals with greater quality of care and support to successfully meet recovery goals with peers providing a great deal of "on the ground" assistance in linking clients to resources and other services, advocacy, and social support.

Peers enhance the level of treatment provided by other professionals, leading to less inpatient and crisis services, greater engagement in treatment, decreased symptoms, increased development of coping skills and life satisfaction, and diversification of the mental health workforce. This could lead to major cost-savings for the County's mental health system in the future. Additionally, the presence of peers can help create a recovery environment, altering negative attitudes and reducing stigma while instilling hope and helping those around them to start "believing in recovery." While there are several benefits to having peer specialists as part of the mental health workforce, Orange County has experienced some difficulty establishing peers in services. The lack of a job classification with opportunities for

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

6.3 Number of Peer Specialists Providing Services, August 2021

	Total Number
Number Employed	41
Number of Vacancies	9
Total Peer Positions Available	50

Language Proficiency

There are six threshold languages in Orange County. They include Spanish, Vietnamese, Farsi, Korean, Mandarin Chinese, and Arabic. As of August 2021, all employees in Orange County's BHS system spoke English. Of the 478 BHS staff who spoke a language other than English, 62.8% of the workforce were able to provide services in Spanish, 9.4% in Vietnamese, 2.3% in Korean, 2.5% in Farsi, and 0.8% in Arabic (see Table 6.4). However, there is a need for more staff who speak Mandarin Chinese, which is a recently added threshold language in Orange County. Additionally, to better understand the staff who could provide bilingual services to those in the community, an analysis of job classification by language was conducted (see Table 6.5). Staff most likely to indicate they could provide bilingual services included Behavioral Health Clinicians, Mental Health Specialists, Office Specialists, Mental Health Workers, and Service Chiefs.

6.4 Languages Spoken by BHS Staff, August 2021

	Frequency	Percent
Spanish	300	62.8%
Vietnamese	45	9.4%
Korean	11	2.3%
Farsi	12	2.5%
Arabic	4	0.8%
Other Languages	8	1.7%
Missing Language Identification	98	20.5%
Total	***478***	100.0%

*Other included Cambodian, Cantonese, Mandarin, and Tagalog

6.5 Number of Bilingual Staff, by Position, August 2021

	Spanish	Vietnamese	Korean	Farsi	Arabic	Other	Missing	Total
Behavioral Health Clinician I-II	133	18	9	5	4	0	20	189
Mental Health Specialist	40	8	0	0	0	2	13	63
Office Specialist	44	2	0	1	0	0	18	65
Mental Health Worker I-III	23	1	0	0	0	0	1	25
Service Chief I-II	12	5	0	1	0	1	5	24
Office Technician	8	1	0	0	0	0	9	18
Office Assistant	1	1	0	0	0	0	4	6
Information Processing Technician	5	0	0	0	0	0	2	7
Deputy Public Guardian II	3	1	0	0	0	0	0	4
Office Supervisor C-D	4	0	0	0	0	0	3	7
Staff Specialist	3	0	0	0	0	0	3	6
Clinical Psychologist I-II	7	2	0	2	0	0	7	18
Community Worker II	3	0	0	0	0	0	0	3
Sr. Deputy Public Guardian	2	0	0	0	0	0	0	2
Comprehensive Care Nurse II	1	0	1	0	0	1	1	4
HCA Program Supervisor I-II	1	0	0	2	0	0	0	3
Staff Assistant	4	2	0	0	0	0	1	7
Behavioral Health Nurse	0	0	0	0	0	0	1	1
Psychiatrist	1	2	0	1	0	1	3	8
Community Health Assistant II	0	0	0	0	0	1	0	1
Research Analyst III-IV	1	0	0	0	0	0	1	2
Data Entry Technician	0	1	0	0	0	0	1	2
Estate Administration Specialist II	0	0	0	0	0	0	0	0
Secretary III	1	0	0	0	0	0	0	1
Supervising Deputy Public Guardian	1	0	0	0	0	0	0	1
Health Program Specialist	0	0	1	0	0	1	0	2
Information Processing Specialist	0	0	0	0	0	1	1	2
Sr. Comprehensive Care Nurse	0	0	0	0	0	0	1	1
Sr. Office Supervisor C-D	0	0	0	0	0	0	1	1
Supervising Comprehensive Care Nurse	0	1	0	0	0	0	0	1

6.5 (Continued) Number of Bilingual Staff, by Position, August 2021

	Spanish	Vietnamese	Korean	Farsi	Arabic	Other	Missing	Total
Nursing Assistance	0	0	0	0	0	1	0	1
Contract Employee	0	0	0	0	0	1	2	3
Total	***293***	***48***	***12***	***8***	***3***	***13***	***98***	***478***

Client Driven/Operated Recovery and Wellness Programs

Peer Mentor programs and use of Peer Specialists throughout system

There is growing attention and respect in the behavioral health field for the unique and valuable skills of people with lived experience (i.e., peers) in the workplace. Peer support services have been shown to improve social functioning, quality of life, engagement, and retention in treatment, as well as to reduce health care costs, psychiatric hospitalizations, and incarcerations in the people they serve. Peer specialists utilize skills they have acquired through lived experience and training to support individuals in their recovery, with the goal of instilling a sense of hope and empowerment. Peer specialists serve as role models, mentors, and advocates of recovery and well-being for the people they serve. They are strategically placed in service areas throughout our BHS system of care including PACT programs, Recovery Outpatient, Recovery Supports, Crisis Services Unit, Veterans programs, Supported Employment programs, Re-Entry programs, SUD services, Older Adult services, and Children and Youth Services. There are currently about 250 peers comprising our peer workforce across the behavioral health system and this number continues to grow.

The "Peer Support and Wellness Center" is a peer run center that provide services to walk-in adults, 18 years of age and older, who have been diagnosed with a serious mental illness, may also have a co-occurring substance use disorder, and have demonstrated progress in their recovery. There are three locations, in central, west and south regions of Orange County. Activities are designed to encourage and empower members to seek interests and passions outside of the adult system of care and offer a pathway for full integration back into the community. Assistance is also offered with employment readiness, job searching and educational opportunities. All three locations provide a warm, welcoming and accepting environment, and serve all members who meet program criteria regardless of their personal history, race, ethnicity, gender identity or sexual orientation. Multi-cultural events such as Hispanic Heritage Day, Black History Month and Multi-Cultural Day are very popular with members and are frequently held to educate and inform members about other cultures and the customs and traditions they enjoy, including dance, music and food. These Peer Support and Wellness Centers also offer a variety of groups such as Diversity Plus and the LGBTIQ group that are specifically designed for the widely diverse membership.

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

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

- **Track 1** is designed for peers to work with clients who have been referred from the clinics, recovery centers and some FSPs to work on short term goals that are part of the larger overall treatment plan. It's a 60-day program, following a 2-week engagement period, where peers assist clients

with getting ID, learning how to utilize public transportation, helping them to attend wellness centers, access community resources, budgeting and other things like that which can be accomplished within the two-month timeframe.

- **Track 2**, utilizes peer navigators stationed at the CSU and works to engage clients being discharged and linking them to Open Access and ultimately to a permanent clinical home. The navigator informs the client about peer mentoring services and if the client is willing, they are linked to a peer mentor who will help them get linked to services after discharge. This could take up to two months as clients are kept until they have had their first physician's appointment in the clinic. Clients are offered free yellow cab transportation as they are being discharged from the CSU, to get them to their home for the night or wherever they may be staying if homeless.

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

Peer specialists are also utilized as a member of multidisciplinary treatment teams in outpatient behavioral health setting, including PACT and FSP programs. Working alongside clinical/medical providers, peer specialists play a crucial role in connecting with clients and assisting them to achieve their treatment goals. Consumer and family member peer specialists provide peer support in adult and older adult system of care while parent and youth partners are employed in the children and youth system of care. Peer specialists also play a crucial role in the treatment team providing outpatient services for the LGBTIQ population, as well as veterans and military-connected family members, where support from a trusted peer of similar background is key to engaging clients for effective treatment. Additionally, specialized peer support from forensic peer specialists is available for re-entry clients and more recently, peer support became available to those receiving SUD services.
Other notable programs utilizing peer specialists include a peer-run 24-7 Orange County Warmline, supported employment program, family support services, socialization program for older adults, and few crisis programs such as crisis residential, in-home crisis stabilization, among others.

The core values of the peer support draw upon cultural strengths and provide services and assistance in a manner that is trusted by, and aligns with, the community's ethnic and culturally diverse populations. Cultural competence is an essential part of the program development, recruitment and hiring of staff, with the emphasis that this unique workforce with lived experience reflect the diversity of the community being served. In addition, peer specialists encourage participants and other staff working with the participants to use recovery language, as well as help model recovery and instill hope that recovery is possible. They normalize and destigmatize seeking and receiving mental health treatment and by sharing their own lived experiences. Peers also demonstrate empathy, caring and concern to bolster participants' self-esteem and confidence. As a result, a unique bond between the peer and the participant can be developed, which gives the participant space to open up about their reluctance or challenges with medication, services, a doctor, etc.

Summary

The recruitment of highly skilled staff has become even more of a challenge for BHS, especially in COVID-19 era. The agency continues to have the most difficulty in recruiting psychiatrists, and psychiatric nurse practitioners. These medical specialists are in short supply nation-wide, and BHS continues to seek qualified applicants regularly. New strategies to increase recruitment are regularly considered.

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

BHS continues to recruit trainees and interns to provide services to our population. The agency has previously established linkages with local universities such as California State University, Fullerton, the University of California, Irvine and other schools which continue to provide opportunities for students to work in the public mental health sector. Staff are currently attending hiring fairs at these universities with the recruitment of multi-cultural staff being the highest priority.

The agency is implementing a standardized Clinical Supervision program due to the promulgation of AB93, which passed into law in 2019. A component of this program will be to increase linkages with universities and provide oversight for all student training by working closely with universities to monitor that training. This year, the agency wrote and received a grant through OSHPD to pay interns a stipend for their work in the agency. By offering a stipend, the agency hopes to attract a more diverse, robust, and high-quality workforce, and then retain those that fit within the agency ethos and culture.

Overall, the need to recruit and retain new employees, especially those who are multi-cultural and multi-lingual, has risen to significant levels. New hiring and retention practices are currently being discussed at the management level. The data from the Supervisor Focus Groups will be presented to the BHS management team by the end of 2021. Further information on the results will be reported next year.

CRITERION 7: LANGUAGE CAPACITY

Offer Language Assistance to Individuals who have Limited English Proficiency (LEP) and/or Other Communication Needs, at No Cost to Them, to Facilitate Timely Access to All Health Care and Services

Language assistance is offered to Orange County beneficiaries of Health Care Agency Services using a myriad of resources, both County- and Contract-operated. The Tables 7.1 through 7.6 examine the interpretation and translation services utilized during FY 2019-20. 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 Western Interpreting Network (WIN).

Starting in November of 2017, Language Line began providing telephonic interpretation services to several behavioral health programs across Orange County. In FY 2019-20, this program facilitated 2,812 calls, which accumulated to roughly 841.9 hours of telephonic interpretations (see Table 7.1). Additionally, most telephonic interpretation services provided during FY 2019-20 were in Spanish, followed by Vietnamese, Korean, Mandarin Chinese, and Arabic (see Table 7.2). In FY 2019-20, out of the 2,812 total calls, roughly 95% were made in one of those languages.

7.1 Total Number of Telephonic Interpretation Services Provided by Month, FY 2019-20

Month	Number of Calls	Minutes on Call	Facilitated Hours
July-19	215	3,717	62.0
August-19	205	4,081	68.0
September-19	-	-	0.0
October-19	249	4,003	66.7
November-19	247	4,385	73.1
December-19	235	4,516	75.3
January-20	242	4,711	78.5
February-20	271	5,038	84.0
March-20	285	5,577	93.0
April-20	286	4,465	74.4
May-20	317	5,484	91.4
June-20	260	4,539	75.7
Total	***2,812***	***50,516***	***841.9***

Source: Language Line Telephone Interpretation Report, FY 19-20

7.2 Top Five Telephonic Interpretation Requests, FY 2019-20

	Number of Calls	Minutes on Call	Facilitated Hours
Spanish	1,794	31,774	529.6
Vietnamese	351	5,949	99.2
Korean	223	4,306	71.8
Mandarin Chinese	182	3,481	58.0
Arabic	123	1,960	32.7
Total	***2,673***	***47,470***	***791.2***

Source: Language Line Telephone Interpretation Report, FY 19-20

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

7.3 Health Care Agency Programs to Request Telephonic Interpretation Services, FY 2019-20

Program Name	Number of Calls	Minutes on Call	Facilitated Hours
MHSA-Community Supportive Services-Children	737	16,071	267.9
MHSA-Community Supportive Services-Adults	495	7,113	118.6
Children and Youth Services	495	8,290	138.2
HIV/Sexually Trans Diseases	193	3751	62.5
Adult Mental Health Services-Outpatient/Crisis	177	4,254	70.9
Tuberculosis/Refugee Preventative Health Services	170	3208	53.5
Correctional Mental Health	127	1,859	31.0
California Children Services	108	1608	26.8
MHSA-Prevention and Early Intervention	83	1,243	20.7
Correctional Medical Services	69	753	12.6
Epidemiology and Asses	43	414	6.9
Alcohol and Drug Use Services	38	880	14.7
Public Health Nursing	34	501	8.4
Maternal and Child Health	12	162	2.7
Office of Compliance	8	56	0.9
Public Guardian	5	101	1.7
Maternal and Child Health-Community	4	30	0.5
Juvenile Health Services	2	85	1.4
MHSA - Workforce Education and Training	1	6	0.1
Unknown Program	10	48	0.8
Total	***2,811***	***50,433***	***841***

Source: Language Line Telephone Interpretation Report, FY 19-20

Staff from the Multi-Cultural Development Program also provided in-person interpretation services (see Table 7.4). In-person interpretation services were provided primarily in Vietnamese, Spanish, and Mandarin Chinese. In FY 2019-20, there were 32 requests for in-house ASL interpretation services, which totaled to 89.5 hours.

7.4 Hours Billed for In-Person Interpretation by Threshold Language, FY 2019-20

	Number of Interpretations	Facilitated Hours
ASL*	32	89.5
Vietnamese	18	52.0
Spanish	15	34.0
Mandarin Chinese	7	14.0
Arabic	3	12.75
Total	***75***	***202.3***

**Data was pulled from the two sources in the WET Interpretation Log and Language Line Services Invoices (e.g., General, ASL)*

Source: WET Interpretations Log Database, FY 19-20 and Language Line Services Invoices FY 19-20

In 2019-20, several ASL interpretation services were also provided by WIN. A total of 32 ASL interpretation services were conducted at various departments and programs throughout Orange County, which totaled to 65 hours of service (see Table 7.5). In some cases, two interpreters were requested by a program to provide services. In this case, the total number of interpreter hours facilitated was 89.5 hours.

7.5 Contracted ASL Interpretation Services through WIN: Total Number of Hours by Program, FY 2019-20

	Total Number of Services	Hours	Interpreter Hours**
1:1 Supervision Sessions	4	7.5	7.5
Behavioral Health Training Services	9	12.5	17.5
Behavioral Health Training Services Open House	1	1	1
Cultural Competency Committee Meetings	5	7	11.5
Crisis Intervention Trainings	5	10	10
Case Management Services	1	7.5	15
Deaf Cultural Competence	1	2	2
EQRO Administrators	1	1.5	3
Multicultural Development Program Data Planning	1	1.5	1.5
Mental Health in Black Communities	1	1	1
Non-Violent Crisis Intervention Training	1	3.5	7
Preparing Substance Use Treatment	1	2.5	5
Suicide Awareness	1	7.5	7.5
Total	***32***	***65***	***89.5***

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

Source: WIN Annual Report, FY 19-20

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 BHS. During FY 2019-20, document translation requests were primarily made for Chinese, Spanish, Arabic, and Vietnamese. This accounted for 71% of the total number of document translation requests.

7.6 Document Translation Request by Threshold Language, FY 2019-20

	Total Number	Percent
Chinese*	59	20%
Spanish	54	18%
Arabic	50	17%
Vietnamese	49	16%
Farsi	44	15%
Korean	44	15%
Armenian	1	0.3%
Lao	1	0.3%
Total	***302***	100%

** Includes Simplified or Traditional Chinese*

***All Canceled or No Reply Requests were removed from this analysis*

Source: WET Interpretations Log Database, FY 19-20

Interpretation Services for Persons who have Limited English Proficiency (LEP)

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

- **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.
- **Suicide Prevention Hotline** (1-877-727-4747; 1-877-7CRISIS) is available in our threshold languages.
- **NAMI Warmline** (1-877-910-9276; 1-877- 910-WARM) allows individuals to talk with a trained peer who is under the supervision of a licensed professional. The Warmline also employs peers who speak our threshold and emerging languages.

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

- For **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.

Form Name	Form Number	Click Icon to View Form
1) Contact Information - Language Services @ MDP	Information Sheet	
2) Telephonic Interpretation - Request Service	Information Sheet	
3) Onsite Interpretation - Instructions	Information Sheet	
4) Onsite Interpretation - Request Service - Blank Form	Information Sheet	
5) Onsite Interpretation - Request Service - Sample Completed Form	Information Sheet	
6) ASL Interpretation - Instructions	Information Sheet	
7) ASL Interpretation - Request Service	Information Sheet	
8) Document Translation - Instructions	Information Sheet	
9) Document Translation - Request Service Form	Information Sheet	

Additional considerations for using Language Line services include:

- All BHS 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.
- Language posters are in each of the BHS 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.

Use of Bilingual Staff or Interpretation Services for People with LEP

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

Summary

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

CRITERION 8: ADAPTATION OF SERVICES

Adaptation of services to the needs of the community is the hallmark of a flexible organization. Concurrently, adaptation of internal systems to the needs of the workforce is equally important. Agencies that can lead internal change flexibly, efficiently, and compassionately, show themselves to be more responsive to community stakeholders, and create more efficacious outcomes. Managing change within an organization is not a quick or easy process. HCA has been challenged with the integration of our Peer Workforce in the past years, but slowly, the increased use of peers and youth or parent partners, as well as acceptance of them as part of the treatment teams is increasing.

Change, when managed well, builds resilience within an organization. Yet rapid change, or change strategies that are not communicated well, can be destabilizing and traumatizing. So, it becomes important to strike a balance between the pace of adaptation and communication of the factors necessitating that change. COVID-19 was a catastrophically rapid change, and the agency found itself having to respond daily to changes in policy, guidance and state mandates. These changes and adaptations have left the staff, especially front-line managers exhausted and burned out. Our Trauma-Informed Care Focus Groups focusing on front-line managers are a hopeful step in gathering data to create initiatives for positive change and giving staff a voice to make their needs known. Below, we present other areas of adaptation that are intended to make our services both more efficacious and more compassionate, both toward the community and our own staff.

Responsiveness of Mental Health Services

Peer Workforce Development Initiative

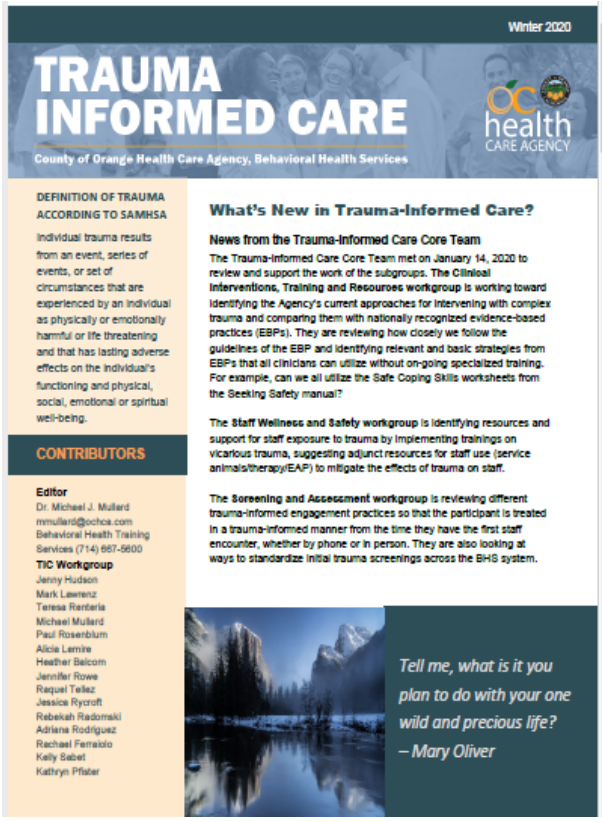
The Peer Workforce Development Initiative began in 2018 as an ongoing Behavioral Health Services' movement towards greater recovery and resiliency orientation and to promote meaningful integration of peer specialists into the behavioral health workforce. Behavioral Health Services identified three key focus areas under the Peer Workforce Development Initiative: 1) Develop an Organizational Understanding of the Peer Role; 2) Strengthen the Peer Workforce through Retention, Supervision, and Career Ladder; 3) Create a Wellness Culture and Reduce Stigma.

Action plans were developed under each focus area with dedicated workgroups comprising of peer specialists, clinicians, service chiefs, administrators representing all service areas within Behavioral Health Services. To date, the workgroups have established a Workplace Wellness Advocate program, conducted a study and produced a report on agency's understanding of the peer role, initiated a classification and compensation study, developed a Peer Supervisor Practice Guidelines, adopted and disseminated tools and resources for supervisors of peers and created a peer orientation program for newly hired peers.

As Orange County looks to implement California Peer Certification AB803 bill, Behavioral Health Services hopes to also align the Peer Workforce Development efforts with the standards and requirements for certified peer specialists. For example, training requirements for not only peer specialists, but also for supervisors of peers will be adhered to. Practice Guidelines and Code of Ethics for Peer Specialists will be adopted per State certification requirements. The peer workforce's impact and contributions to the overall mental health services provided will continue to increase.

Trauma-Informed Care Initiative

In May of 2018, the first members of the Trauma-Informed Learning Collaborative for BHS met to discuss the goals and priorities for the initiative. This formed the Trauma-Informed Care Core Implementation Team (TIC-CIT) consisting of representatives from each BHS service area. Based on the results of the first Wellness-Oriented Trauma-Informed Care Organizational Self-Assessment (WOTIC OSA) completed by over 400 BHS staff in June 2018, the team decided to focus on *Domain 3: Wellness and Trauma, Educated and Responsive Workforce*. The team collaborated with the existing Peer Workforce Development Initiative in developing a Workplace Wellness Advocate (WWA) program and supported several trauma-focused trainings hosted by the Behavioral Health Training Services department throughout the year. The team also prioritized the need to develop current practice guidelines for all BHS staff based on SAMHSA's standardized definition from Tip 57.



Winter 2020

TRAUMA INFORMED CARE

County of Orange Health Care Agency, Behavioral Health Services

DEFINITION OF TRAUMA ACCORDING TO SAMHSA

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

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What's New in Trauma-Informed Care?

News from the Trauma-Informed Care Core Team

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

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

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

Tell me, what is it you plan to do with your one wild and precious life?
– Mary Oliver

With support from management, the Core Implementation Team identified 3 focus areas for continuing the work towards being a trauma-informed system. Working groups were established with CIT staff as the leads to continue the work and system change. In response to improving communication about our transformation to a more Trauma-Informed care system, we created a Trauma-Informed Newsletter (see below for a sample and in Appendix). The newsletter seeks to provide updated information about the TIC Workgroup activities, the implementation progress, and successes. It is hoped that the newsletter will be a fun and informative way to highlight the importance of trauma-informed services as well as provide a better understanding of the benefits for further integration of this model into all programs. We plan to release several versions of the newsletter in 2022.

Cultural/Linguistic Options Available to Clients

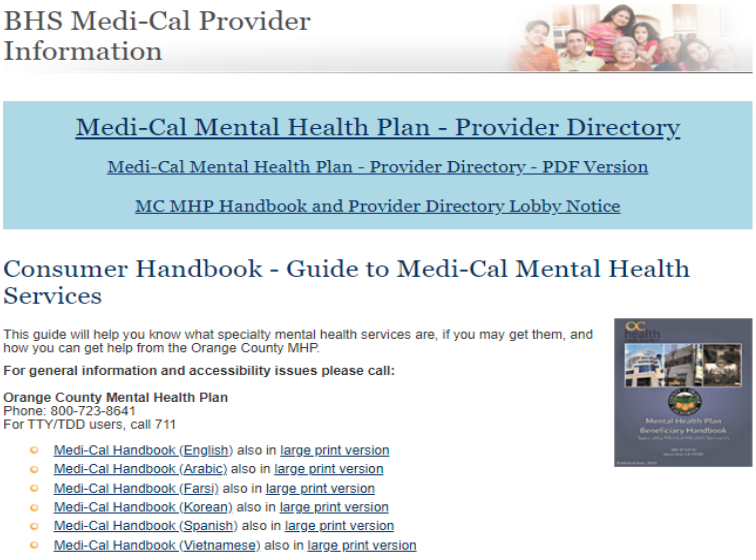
The information below outlines Orange County's commitment to providing culturally and linguistically appropriate behavioral health services. The Medi-Cal Provider Directory, for example, is listed on the website and is available electronically and in hard copy to beneficiaries.

- Behavioral Health Services Mission Statement:

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

- BHS Statement of Philosophy: Partnering with our clients and the community, we value:
  - Excellence in all we do
  - Integrity in how we do it
  - Service with respect and dignity

- HCA/BHS Goals: HCA's goals for BHS describe how we will achieve our vision and our mission – the value created, or the desired improvement in a condition that is of direct consequence to our clients and the public. Employees' individual performance measures are, in turn, based on HCA's goals and strategic directions.
- Encourage excellence by ensuring a healthy work environment that values employees.



- Support the workforce through the effective use of technological and other resources.
- The commitment to ensure our behavioral health services are culturally and linguistically appropriate to the needs of the populations we serve is also documented in several Behavioral Health Services written policies and procedures shown in Criterion 1.

Quality of Care: Contract Providers

Behavioral Health Services (BHS) Contracts

Orange County's commitment to ensure that services are culturally competent is also documented in provisions that have been incorporated into Behavioral Health Services provider contracts. Below is standard language in all BHS contracts under Compliance Sections:

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

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

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

Below are some samples of contracts from BHS service areas:

- The contract for Mental Health Services Act (MHSA) Community Services and Supports (CSS) -funded Wellness Center provides that the contractor shall provide a program that is "culturally

and linguistically appropriate." The contract also states that, "The philosophy of the Wellness Center shall draw upon cultural strengths and utilize service delivery and assistance in a manner that is trusted by, and familiar to, many of Orange County's ethnically and culturally diverse populations. Cultural competence shall be a continuous focus in the develop0/28ment of the programming, recruitment, and hiring of staff that speak the same language and have the same cultural background of the members that are to be served. This inclusion of Orange County's multiple cultures is assisting in maximizing access to services offered at the Wellness Center. The Orange County Health Care Agency (HCA) has provided training for all staff on cultural and linguistic issues."

- The contract for Transitional Age Youth (TAY) Crisis Residential Services includes the requirement that, "CONTRACTOR shall include bilingual/bicultural services to meet the needs of persons speaking in threshold languages as determined by COUNTY. Whenever possible, bilingual/bicultural therapists should be retained. Any clinical vacancies occurring at a time when bilingual and bicultural composition of the clinical staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless ADMINISTRATOR consents, in writing, to the filling of those positions with non-bilingual staff."
- For the Prevention and Early Intervention (P&I) contracts, language capability is a condition of employment and a specific program need to meet program goals. Specific contract language is used such as, "Contractor shall make e v e r y reasonable effort to accommodate participants' developmental, cultural and linguistic needs," which is needed to effectively serve the target populations, i.e., the unserved and underserved. In the staffing section of P&I contracts, additional language is used, such as, "Contractor shall make its best effort to include bilingual/bicultural services to meet the diverse needs of the community threshold languages as determined by County. Whenever possible, bilingual/bicultural staff should be retained. Any staffing vacancies occurring at a time when bilingual and bicultural composition of the staffing does not meet the above requirement must be filled with bilingual and bicultural staff unless Administrator consents."

Quality Assurance

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

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

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

POW Cross-Cutting Indicators

<table>
<tr><td></td><td colspan="2">Primary Point of Entry into BHS System</td><td colspan="4">Spectrum of Treatment and Services Provided</td></tr>
<tr><td>Cross-Cutting Indicators</td><td>Crisis Assessment</td><td>Assessment, Referral, and Linkage</td><td colspan="2">Prevention</td><td>Early Intervention</td><td>Treatment & Recovery</td><td>Treatment - Acute Stabilization</td></tr>
<tr><td>Global Health</td><td></td><td></td><td colspan="2">PROMIS Global Health</td><td></td><td></td><td></td></tr>
<tr><td>Recovery</td><td></td><td></td><td colspan="2"></td><td></td><td>MORS</td><td></td></tr>
<tr><td>Self-Sufficiency/ Resilience</td><td></td><td></td><td colspan="2"></td><td></td><td>OC Self-Sufficiency/ Resilience Matrix</td><td></td></tr>
<tr><td>Mood/Affect - General</td><td rowspan="3">EHR Hospital Assessment</td><td rowspan="2">Modified SBIRT/ SAMHST</td><td colspan="4" rowspan="3">YOQ/OQ/SOQ</td><td rowspan="3">AUDIT-C/DAST/Assist CRAFFT/SACS</td></tr>
<tr><td>Substance Abuse</td></tr>
<tr><td>Social Support/ Functioning</td><td rowspan="6">Risk/Needs Screen</td></tr>
<tr><td>Suicidal Ideation</td><td rowspan="5">Risk/Needs Screen</td><td colspan="4"></td></tr>
<tr><td>Trauma Exposure*</td><td colspan="2"></td><td>Risk/Needs Screen</td><td></td></tr>
<tr><td>Hospitalizations</td><td colspan="2"></td><td colspan="2">Episodes, # days</td></tr>
<tr><td>Incarcerations</td><td colspan="2"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Homelessness</td><td colspan="2"></td><td>Episodes, # days</td><td></td></tr>
<tr><td>Employment /Education</td><td></td><td></td><td colspan="2"></td><td>Employment/Education</td><td></td></tr>
<tr><td>Violence/ Aggression</td><td rowspan="3">EHR Hospital Assessment</td><td rowspan="2">Risk/Needs Screen</td><td colspan="4"></td></tr>
<tr><td>Psychosis</td><td colspan="4"></td></tr>
<tr><td>Medical Illness/ Conditions</td><td></td><td colspan="4"></td></tr>
<tr><td>Referrals</td><td colspan="4">Referrals</td><td>Referrals</td><td>Referrals</td></tr>
<tr><td>Linkages</td><td colspan="4">Linkages</td><td>Linkages</td><td>Linkages</td></tr>
</table>

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

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

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

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

Grievance and Appeals Resolution Processes

In this section we describe our beneficiary problem resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve Grievance and Appeals.[5]

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

The beneficiary has several ways to file a grievance:

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

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

The grievance/appeal forms are in the County's threshold languages - Chinese, Korean, Vietnamese, English, Spanish, Farsi, Arabic and can be readily accessible at the county/county-contracted outpatient behavioral health program lobby and via County website - BHS Medi-Cal Provider Information | Orange County, California - Health Care Agency (ochealthinfo.com)

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, Inc. 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 https://www.mhsinc.org/patients-rights-advocacy-services-downloads/

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

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

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

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

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

The MCST program provides consultation and education to the programs daily and trains on a regular basis about the grievance requirement and process. The MCST also educates the individual beneficiaries who filed a

grievance/appeal about their rights and the grievance requirements and process. MCST also obtains feedback, suggestions and comments from California Department of Health Care Services (CDHCS) and other auditing entities. MCST is also receptive with obtaining feedback, suggestions and comments from behavioral health programs/facilities and beneficiaries to help improve the grievance/appeal system.

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

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

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

AQIS has a team of competent clinical staff under the Managed Care Support Team (MCST) who have the cultural and linguistic capability of investigating grievance via English and Spanish. Within AQIS, MCST 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.

Summary

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

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

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

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

Final Summary

The year 2021 has been a remarkably eventful year. HCA continues to be challenged by the on-going COVID-19 pandemic and all its attendant stressors. Trying to maintain a resilient culture within the agency has been difficult, as evidenced by a staffing vacancy of approximately 19% within Behavioral Health Services. Living in a state of crisis for any length of time tends to narrow and shorten one's vision. The full impact of living in this state of crisis is perhaps only now being fully realized as we slowly move out of pandemic footing and look back at the lessons learned. Even through these challenges, it was critical for HCA to maintain a strengths-based culture in accordance with the philosophy of SAMHSA's Recovery Model. Use of Recovery Model principles assisted us in utilizing a Trauma-Informed approach to assess and respond to some of our own workforce issues in order to begin making changes.

One of the most impactful changes has been the reorganization of the Cultural Competence Committee into the Behavioral Health Equity Committee (BHEC), with the intention of bringing enhanced equitable community participation to this group. The BHEC, with its workgroups, strives to identify and recommend strategies that become incorporated into the Cultural Competence Plan. BHEC's Steering Committee formed the initial five workgroups with focus on the following topics: Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of OC's six threshold languages or have Limited English Proficiency (LEP) and or other communication needs; and LGBTIQ+.

Before we began to update the plan for 2021, the Cultural Competence Plan workgroup met with the BHS management to discuss setting attainable goals for the coming year. As explained in the Introduction section, the goals were chosen through considering where it would be possible to achieve the greatest impact. All the goals were formulated in consultation with our new Office of Population Health Equity as well as the Behavioral Health Equity Committee steering committee members.

Certainly, the hiring and retention of a multi-cultural and multi-lingual workforce, itself a CLAS standard, remains of highest priority. However, further training the clinical and office staff in CLAS standards, such as in communication and language assistance, is equally important. Through on-going training over the coming months and years, we plan to shift the culture in a meaningful way. Through a review of the agency's policies, procedures, and CLAS-related activities, we intend to identify and address any possible elements of racism or other explicit or implicit bias.

BHS hopes that this Cultural Competence Plan Update for 2021 has provided a review of our current philosophies, principles, and practices. BHS continues to actively work toward improving our training in multi-cultural practices including cultural humility, in order to better meet the needs of a diverse community and a diverse workforce. We are excited about helping the agency to implement our goals and look forward to reporting on progress next year.

APPENDIX I: POLICIES AND PROCEDURES GOVERNING CULTURAL COMPETENCE

Cultural Competency

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

	SIGNATURE	**DATE APPROVED**
Director of Operations Behavioral Health Services	_Signature on File_	__8/29/19____

SUBJECT: Cultural Competency

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

California Code of Regulations, Title IX, Chapter 11

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

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

PROCEDURES:

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

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

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

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

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

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

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

Meeting Consumer Language Needs

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

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

SUBJECT: Meeting Consumer Language Needs

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

Department of Mental Health Information Notice No. 02-03

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

Dymally-Alatorre Bilingual Services Act 1973

PROCEDURES:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Distribution of Translated Materials

Health Care Agency **Behavioral Health Services** **Policies and Procedures**	Section Name: Sub Section: Section Number: Policy Status:	Client's Rights Cultural Competency 02.01.03 ☐New ☒Revised	
	SIGNATURE	DATE APPROVED	
Director of Operations Behavioral Health Services	Signature on File	8/3/16	

SUBJECT: Distribution of Translated Materials

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

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

FORMS:

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

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

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

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

PROCEDURES:

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

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

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

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

MHP and DMC-ODS Provider Directory

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

	SIGNATURE	DATE APPROVED
Director of Operations Behavioral Health Services	Signature on File_	_11/6/19___

SUBJECT:	MHP and DMC-ODS Provider Directory

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

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

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

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

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

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

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.

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

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."

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.

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

Health Care Agency **Behavioral Health 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 Behavioral Health Services	Signature on File	11/6/19

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 Behavioral Health Services (BHS) 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 BHS.

POLICY:

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

SCOPE:

This policy apply to all functions of BHS 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 BHS County staff shall contact the BHS contracted interpreting agency (current agency information available at HCA Forms under BHS 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 BHS 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 BHS 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 BHS 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 BHS 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.

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

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

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

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

PURPOSE:

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

POLICY:

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

SCOPE:

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

REFERENCES:

BHS P&P 02.06.01 Advance Directives

BHS P&P 02.05.01 Notice of Privacy Practices

FORM:

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

PROCEDURE:

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

   A. Notice of Privacy Practices (NPP)

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

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

D. MHP Provider List

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

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

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

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

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

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

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

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

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

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

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

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

b) MHP Provider List

c) Notice of Privacy Practices (NPP)

d) Completed Receipt of the Notice of Privacy Practices

e) Car Seat Regulation

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

VII. Advance Directive:

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

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

VIII. Signatures:

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

Training Specifically Pertaining to Cultural Competency

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

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

SUBJECT:	Trainings Specifically Pertaining to Cultural Competency

PURPOSE:

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

POLICY:

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

SCOPE:

This applies to all BHS County and County Contracted programs.

REFERENCES:

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

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

California Welfare & Institutions Code Section 5600.2 (g)

California Welfare & Institutions Code Section 5600.9 (a)

National CLAS Standards, 2013

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.

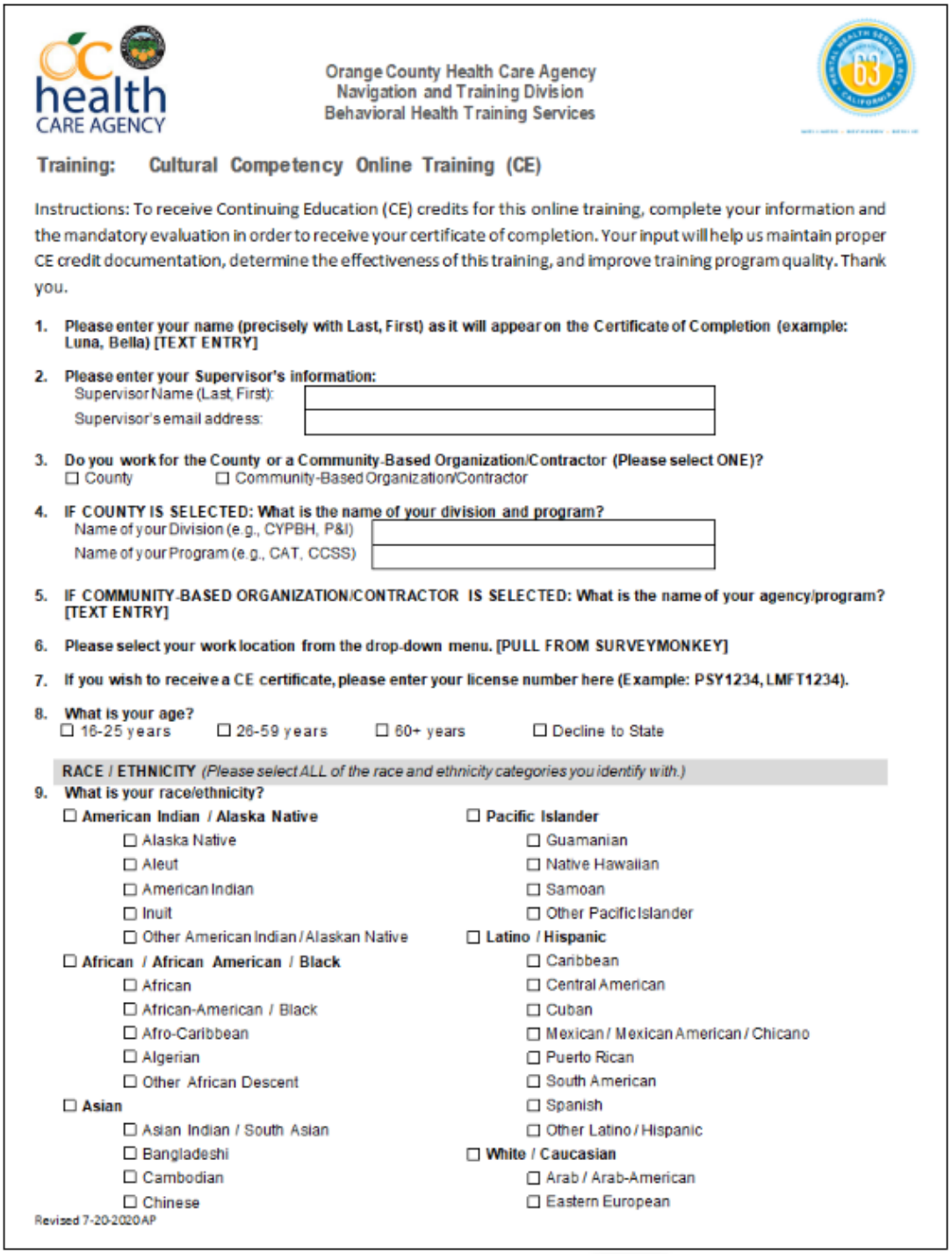
c) **Suggested work groups:** Community Relations and Education; Spirituality; Outreach and Engagement to Black/African Americans, populations who speak in one of the threshold languages or have Limited English Proficiency (LEP) and or other communication needs; Veterans and Military; LGBTIQ

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.

APPENDIX III: SAMPLES OF TRAINING EVALUATION FORMS

Cultural Competence 3.0 Online CE Training Survey



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

Training: Cultural Competency Online Training (CE)

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

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

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

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

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

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

6. **Please select your work location from the drop-down menu. [PULL FROM SURVEYMONKEY]**

7. **If you wish to receive a CE certificate, please enter your license number here (Example: PSY1234, LMFT1234).**

8. **What is your age?**
   ☐ 16-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

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

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

☐ **American Indian / Alaska Native**
- ☐ Alaska Native
- ☐ Aleut
- ☐ American Indian
- ☐ Inuit
- ☐ Other American Indian / Alaskan Native

☐ **African / African American / Black**
- ☐ African
- ☐ African-American / Black
- ☐ Afro-Caribbean
- ☐ Algerian
- ☐ Other African Descent

☐ **Asian**
- ☐ Asian Indian / South Asian
- ☐ Bangladeshi
- ☐ Cambodian
- ☐ Chinese

☐ **Pacific Islander**
- ☐ Guamanian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Pacific Islander

☐ **Latino / Hispanic**
- ☐ Caribbean
- ☐ Central American
- ☐ Cuban
- ☐ Mexican / Mexican American / Chicano
- ☐ Puerto Rican
- ☐ South American
- ☐ Spanish
- ☐ Other Latino / Hispanic

☐ **White / Caucasian**
- ☐ Arab / Arab-American
- ☐ Eastern European

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☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Mien
☐ Pakistani
☐ Sri Lankan
☐ Thai
☐ Vietnamese
☐ Other Asian

☐ European
☐ Iranian / Persian
☐ Iraqi
☐ Lebanese
☐ Palestinian
☐ Middle Eastern - Other
☐ Other White / Caucasian
☐ **Decline to State**
☐ **Other (please specify)** _____

LANGUAGE – PRIMARY / PREFERRED

10. What is your English ability?

☐ Fluent ☐ Limited ☐ None ☐ Decline to State

11. What is your primary language?

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

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

12. What is your sex assigned at birth?

☐ Male ☐ Female ☐ Intersex ☐ Decline to State

13. What is your current gender identity?

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State
☐ Questioning or unsure of gender identity ☐ Another gender identity _____

14. What is your sexual orientation?

☐ Gay ☐ Lesbian ☐ Heterosexual or Straight ☐ Bisexual ☐ Queer
☐ Questioning or unsure of sexual orientation ☐ Another sexual orientation ☐ Decline to State

DISABILITY *(Please select ALL that apply.)*

15. Do you have any disabilities? A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

☐ No, I don't have any of these disabilities
☐ Difficulty seeing
☐ Difficulty hearing or having speech understood
☐ Other communication disability
☐ Physical / mobility disability
☐ Chronic health condition
☐ Learning disability
☐ Dementia
☐ Developmental Disability
☐ Other mental / cognitive (e.g., traumatic brain injury) _____
☐ Other disability _____
☐ Decline to state
☐ Participant unable to answer

MILITARY STATUS

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16. What is your military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

17. Has one of your family members served in the military? If yes, what is their military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

18. What is your organizational role? (Please select only one box)

	Admin/Manager	Direct Service Provider	Support Staff
County	☐	☐	☐
Community-based Organization/Contractor	☐	☐	☐

19. Of the roles listed below, which ones do you best identify with? (Please check all that apply)

☐ Consumer ☐ Parent ☐ Family Member ☐ Community Member / General Public ☐ Caregiver
☐ Teacher ☐ Student ☐ Youth ☐ Other (please specify) _____

20. What is your current professional status? (Please select only one box)

☐ MD ☐ RN ☐ Psychologist ☐ LCSW ☐ LMFT ☐ LPCC ☐ CADC/CATC/RAS
☐ Unlicensed Staff ☐ Intern ☐ Peer Support Worker ☐ Faith-based Partner ☐ Not a service provider

21. Based on your experience(s) today, how useful were each of the training components in meeting the following educational objectives listed on the training announcement?

	Very Poor	Below Average	Average	Above Average	Excellent	N/A
Define cultural competency as it relates to culture, competence, race and ethnicity.	☐	☐	☐	☐	☐	☐
Identify how the consequences of social and self-stigma influences one's unconscious thoughts, judgements, and stereotypes.	☐	☐	☐	☐	☐	☐
Describe cultural formulation interviewing practices that integrate culturally responsive approaches into service attitudes and interactions with clients to reduce the effects of stereotyping.	☐	☐	☐	☐	☐	☐

22. Please select your rating for:

	Poor	Fair	Good	Very Good	Excellent
The presenter(s) ability to communicate knowledge of the subject.	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐

23. How much did you learn as a result of this CE program?

☐ Very Little ☐ Little ☐ Some ☐ A Good Bit ☐ A Great Deal

24. How useful was the content of this CE program for your practice or other professional development?

☐ Not useful ☐ A Little Useful ☐ Somewhat Useful ☐ A Good Deal Useful ☐ Extremely Useful

25. What is most useful and/or helpful to you with this training?

☐ Contents are useful for my work ☐ Online option was more convenient ☐ CE credit offer
☐ Other (please specify) _____

26. Was this online training user friendly?

☐ Yes ☐ No

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27. **Based on my experience(s) with this training:**

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
I would recommend this training to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during my most recent activity with this training.	☐	☐	☐	☐	☐
Overall, I am satisfied with this training and the services I received here.	☐	☐	☐	☐	☐

28. **Please provide any comment(s) about your experience and/or suggestions for future trainings.**

_____

_____

_____

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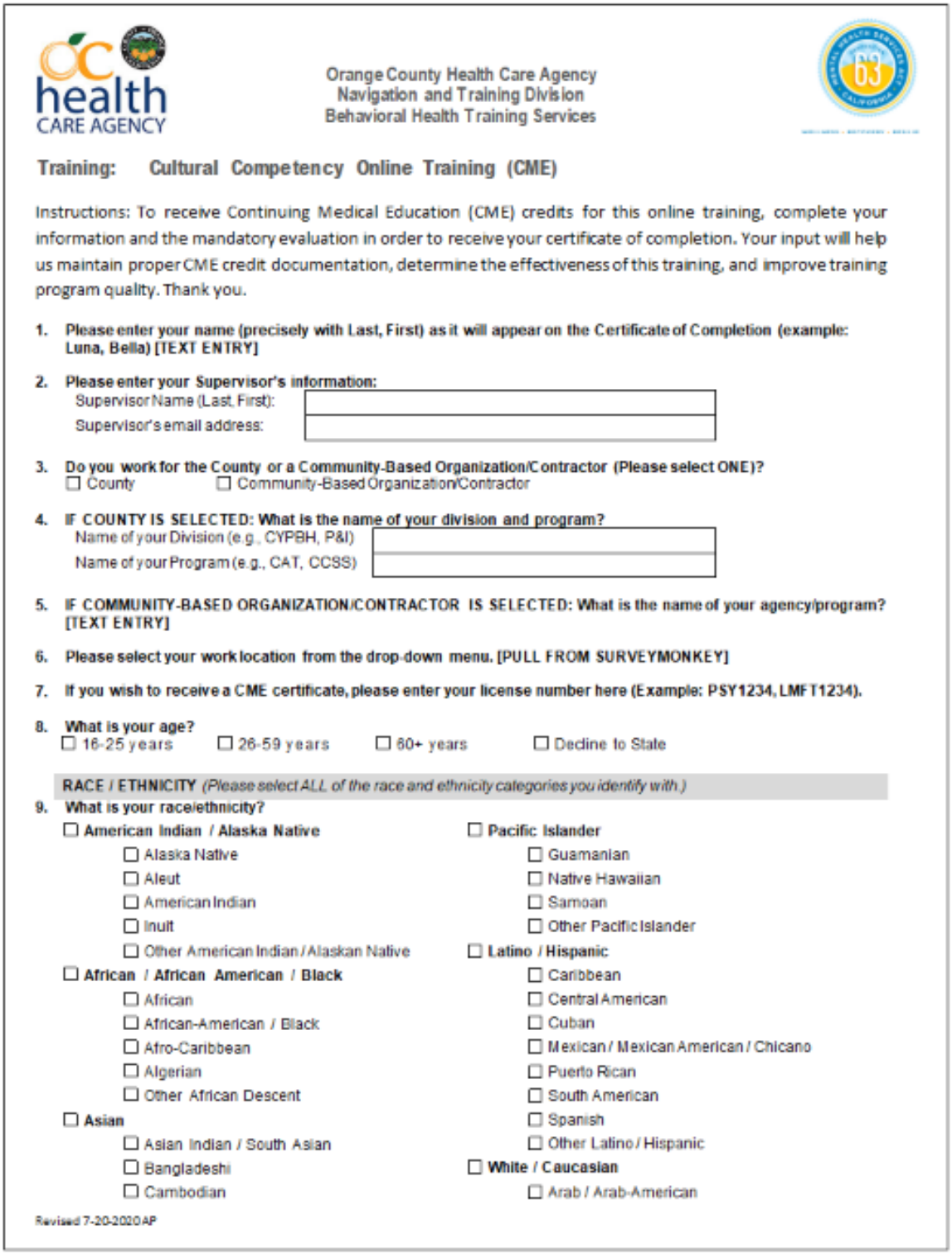
Cultural Competence 3.0 Online CME Training Survey



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

Training: Cultural Competency Online Training (CME)

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

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

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

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

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

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

6. **Please select your work location from the drop-down menu. [PULL FROM SURVEYMONKEY]**

7. **If you wish to receive a CME certificate, please enter your license number here (Example: PSY1234, LMFT1234).**

8. **What is your age?**
   ☐ 16-25 years ☐ 26-59 years ☐ 60+ years ☐ Decline to State

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

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

- ☐ **American Indian / Alaska Native**
  - ☐ Alaska Native
  - ☐ Aleut
  - ☐ American Indian
  - ☐ Inuit
  - ☐ Other American Indian / Alaskan Native
- ☐ **African / African American / Black**
  - ☐ African
  - ☐ African-American / Black
  - ☐ Afro-Caribbean
  - ☐ Algerian
  - ☐ Other African Descent
- ☐ **Asian**
  - ☐ Asian Indian / South Asian
  - ☐ Bangladeshi
  - ☐ Cambodian
- ☐ **Pacific Islander**
  - ☐ Guamanian
  - ☐ Native Hawaiian
  - ☐ Samoan
  - ☐ Other Pacific Islander
- ☐ **Latino / Hispanic**
  - ☐ Caribbean
  - ☐ Central American
  - ☐ Cuban
  - ☐ Mexican / Mexican American / Chicano
  - ☐ Puerto Rican
  - ☐ South American
  - ☐ Spanish
  - ☐ Other Latino / Hispanic
- ☐ **White / Caucasian**
  - ☐ Arab / Arab-American

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☐ Chinese
☐ Filipino
☐ Hmong
☐ Japanese
☐ Korean
☐ Laotian
☐ Mien
☐ Pakistani
☐ Sri Lankan
☐ Thai
☐ Vietnamese
☐ Other Asian

☐ Eastern European
☐ European
☐ Iranian / Persian
☐ Iraqi
☐ Lebanese
☐ Palestinian
☐ Middle Eastern - Other
☐ Other White / Caucasian
☐ **Decline to State**
☐ **Other (please specify)** _____

LANGUAGE – PRIMARY / PREFERRED

10. What is your English ability?

☐ Fluent ☐ Limited ☐ None ☐ Decline to State

11. What is your primary language?

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

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

12. What is your sex assigned at birth?

☐ Male ☐ Female ☐ Intersex ☐ Decline to State

13. What is your current gender identity?

☐ Male ☐ Female ☐ Transgender ☐ Genderqueer / Non-Binary ☐ Decline to State
☐ Questioning or unsure of gender identity ☐ Another gender identity _____

14. What is your sexual orientation?

☐ Gay ☐ Lesbian ☐ Heterosexual or Straight ☐ Bisexual ☐ Queer
☐ Questioning or unsure of sexual orientation ☐ Another sexual orientation ☐ Decline to State

DISABILITY *(Please select ALL that apply.)*

15. Do you have any disabilities? A disability is defined as a physical or mental impairment or medical condition lasting at least six months that substantially limits a major life activity, which is not the result of a severe mental illness.

☐ No, I don't have any of these disabilities
☐ Difficulty seeing
☐ Difficulty hearing or having speech understood
☐ Other communication disability
☐ Physical / mobility disability
☐ Chronic health condition
☐ Learning disability
☐ Dementia
☐ Developmental Disability
☐ Other mental / cognitive (e.g., traumatic brain injury) _____
☐ Other disability _____
☐ Decline to state
☐ Participant unable to answer

MILITARY STATUS

16. What is your military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired

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☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

17. Has one of your family members served in the military? If yes, what is their military status?

☐ Under age 18 ☐ Currently Active (includes Reserves and Guard) ☐ Retired
☐ None / Never served ☐ Served (includes Reserves and Guard) ☐ Decline to state

18. What is your organizational role? (Please select only one box)

	Admin/Manager	Direct Service Provider	Support Staff
County	☐	☐	☐
Community-based Organization/Contractor	☐	☐	☐

19. Of the roles listed below, which ones do you best identify with? (Please check all that apply)

☐ Consumer ☐ Parent ☐ Family Member ☐ Community Member / General Public ☐ Caregiver
☐ Teacher ☐ Student ☐ Youth ☐ Other (please specify) _____

20. What is your current professional status? (Please select only one box)

☐ MD ☐ RN ☐ Psychologist ☐ LCSW ☐ LMFT ☐ LPCC ☐ CADC/CATC/RAS
☐ Unlicensed Staff ☐ Intern ☐ Peer Support Worker ☐ Faith-based Partner ☐ Not a service provider

21. Based on your experience(s) today, how useful were each of the training components in meeting the following educational objectives listed on the training announcement?

	Very Poor	Below Average	Average	Above Average	Excellent	N/A
Define cultural competency as it relates to culture, competence, race and ethnicity.	☐	☐	☐	☐	☐	☐
Identify how the consequences of social and self-stigma influences one's unconscious thoughts, judgements, and stereotypes.	☐	☐	☐	☐	☐	☐
Describe cultural formulation interviewing practices that integrate culturally responsive approaches into service attitudes and interactions with clients to reduce the effects of stereotyping.	☐	☐	☐	☐	☐	☐

22. Please select your rating for:

	Poor	Fair	Good	Very Good	Excellent
The presenter(s) ability to communicate knowledge of the subject.	☐	☐	☐	☐	☐
The overall quality of this training.	☐	☐	☐	☐	☐

23. How much did you learn as a result of this CME program?

☐ Very Little ☐ Little ☐ Some ☐ A Good Bit ☐ A Great Deal

24. How useful was the content of this CME program for your practice or other professional development?

☐ Not useful ☐ A Little Useful ☐ Somewhat Useful ☐ A Good Deal Useful ☐ Extremely Useful

25. What is most useful and/or helpful to you with this training?

☐ Contents are useful for my work ☐ Online option was more convenient ☐ CE credit offer
☐ Other (please specify) _____

26. Do you intend to make changes or apply what you have learned from this training?

☐ Yes ☐ Change already in place ☐ Not relevant to my work

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

_____

_____

28. **What barrier(s) do you expect to encounter in your attempts at change?**
☐ No barriers ☐ No self-discipline to change ☐ No time to apply/practice new changes
☐ Change is not possible in current condition/system

29. **How much commercial bias was presented by the speaker(s) or the training?**
☐ None ☐ Very Low ☐ Low ☐ Moderate ☐ High ☐ Very high

30. **Was this online training user friendly?**
☐ Yes ☐ No

31. **Based on my experience(s) with this program:**

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
I would recommend this program to someone I know.	☐	☐	☐	☐	☐
The staff treated me with courtesy and respect during my most recent activity with this program.	☐	☐	☐	☐	☐
Overall, I am satisfied with this program and the services I received here.	☐	☐	☐	☐	☐

32. **Please provide any comment(s) about your experience and/or suggestions for future trainings.**

_____

_____

_____

_____

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APPENDIX IV: TABLE OF CULTURALLY COMPETENT TRAININGS

Training Title	*Training Description*	*Presenter(s) Name*
5150 LPS Initial Certification	This training is intended to educate the county and contracted adult and older adult mental health service providers about the 5150 process and impart the skills necessary to conducting assessments for and initiating involuntary detention for a 72-hour psychiatric hold. The 5150 training will cover relevant laws, historical information, criteria to initiate a hold, timeline and patient rights. The clinicians' role in the 5150 process, risk assessment techniques, as well as the steps to initiate a hold will be discussed. In addition, an overview of 5585 designation will be included in the event that there is a minor involved. This training is also designed to provide the clinician with the knowledge to test and pass certification.	Various Trainers
5585 Initial Certification	The target population for this training is County and County-Contracted Children and Youth Behavioral Health Service providers requiring 5585 certification to perform their job duties, which includes conducting risk assessments of minors and initiating involuntary detention for a 72-hour psychiatric hold. An overview of the history, explanation of 5585 and associated LPS legislature will be discussed. This training is intended to educate the practitioner about the 5585 process and provide the skills necessary to initiate a 5585 hold and paper work completion. Additionally, an overview of 5150 designation will be included in the event that there is an adult involved. This training is also designed to provide the clinician with the knowledge to test and pass certification for designation.	Various Trainers
Addressing Challenging Client Situations with Cultural Humility	Substance use disorders are pervasive and chronic conditions that can impact the lives of any person regardless of ethnicity, race, culture, religious preference, sexuality, gender or any other individual or group factor. Learning how to approach each individual who asks us for help with humility and a willingness to accept those individual differences is crucial to provide effective treatment for successful outcomes. This training will help participants define cultural humility and begin to raise awareness of cultural factors that can have an impact on treatment retention and outcomes. Using the most current data	Grant Hovik, M.A.

	and incorporating real world clinical examples, the training will demonstrate the importance of incorporating cultural humility into practice.	
Be Loved & Accepted: Incorporating Affirmative Therapy and Spiritual Practices for LGBTOQ Clients	This three-hour workshop is designed for therapists and spiritual leaders who work with the LGBTIQ community. The presenters will go over relevant terminology, Cass's identity development model and components of affirmative therapy. A panel of spiritual leaders will share stories from their communities highlighting challenges faced by LGBTIQ members. Additionally, spiritual leaders will identify ways that faith-based communities can create safe spaces and be LGBTIQ affirming.	Luyen Pham, LMFT and Reverand Dayna Kinkade
Beat the Holiday Blues	In this training participants will have an opportunity to learn the significance of the impact of holiday blues and COVID-19 pandemic stress and anxiety upon the Deaf /Hard of Hearing individuals' well-being, gain understanding the 6 types of self-care for each dimension of wellness, and gain awareness of the importance of the individuals creating a goal and a few action steps during the holiday season. The goal is to provide the guideline on how to maintain effectively well-being during the COVID-19 pandemic and holiday season.	Belinda McCleese, LMFT
Building Resilience in Trauma-Informed Professionals	With the DSM-5 (APA, 2013) definition of "trauma" for the first time acknowledging that exposure to others' trauma can comprise a type of traumatic event, increasing attention has been paid to the need to help mental health professionals recognize and ameliorate the potential negative effects of exposure to others' trauma, termed secondary traumatic stress, vicarious trauma, or compassion fatigue. Based on the Resilience for Trauma-Informed Professionals (R-TIP; Kerig, 2018) curriculum, this workshop will introduce participants to evidence-informed techniques effective for mental health professionals and non-professionals alike, that are designed to foster preparedness, resilience, and adaptive coping in the face of secondary exposure to trauma, and will emphasize the practical application and dissemination of these skills in real-world contexts.	Patricia Kerig, Ph.D.
CIT I	The Basic course introduces law enforcement officers to types of mental illnesses and provides them a better understanding of crisis and how to give basic intervention and assistance.	Various Trainers

CIT II	The Intermediate course provides updates from Level 1 and teaches officers techniques to de-escalate mental health crisis in a controlled learning environment with the aid of an Interactive Video Training Simulator	Various Trainers
CIT III	The Advanced course is a comprehensive overview of CIT that implements all skills learned in Levels 1-3 in a controlled learning environment with the aid of Live Roleplaying Scenarios.	Various Trainers
CIT – Dispatch	CIT – Dispatcher training provides public-safety dispatchers with an overview of mental illness, tools to assess suicidal callers and crisis intervention techniques. Students are expected to involve in live role-playing scenarios in a controlled learning environment involving mental health issues that dispatchers will encounter. The training encompasses the intersection of crisis calls and mental health involvement, including: suicide, PTSD, depression, bipolar, dissociative identity disorder, excited delirium, developmental disabilities, Alzheimer's/dementia and substance use disorders.	Various Trainers
Cultural Competence Training (Online)	This training provides an overview of a culturally responsive approach to incorporate into service attitudes and interactions with clients. The concepts of culture, race, ethnicity and diversity as well as stigma and self-stigma are discussed. The training also demonstrates the influence of unconscious thought on our judgement as it relates to stereotyping and racism. Strategies are also provided to recognize diversity and embrace uniqueness of other cultures beyond the mainstream American culture.	Bijan Amirshahi, LMFT, LPCC
Effecting Change through the Use of Motivational Interviewing: Interactive Training for Skill Development	Motivational interviewing (MI), a treatment approach developed by William Miller, has been well established as an effective way to promote behavior change in individuals. Following a brief review of the fundamental MI principles and micro-skills, this experiential MI Skill Development training will focus on helping clients to engage in change talk, and then make commitments to make behavioral changes based on goals that they have identified. Ample time will be devoted to role-play practice to enable participants to gain skills necessary to elicit change-talk from clients with low levels of	Grant Hovik, M.A.; James Peck, Psy.D.

	readiness for change, thereby increasing levels of motivation and moving them toward action to address their substance use issues.	
Elements of Effective and Ineffective Clinical Supervision	In this six-hour course, participants will gain an in-depth look at the clinical supervision process and outcomes. In particular, the presentation will illustrate effective and ineffective elements of clinical supervision, as well as topics of interest such as secrets that supervisees and supervisors keep from one another. Also reviewed will be the topics of supervisor self-disclosure and supervisee evaluation.	Nicholas Ladany, Ph.D.
EMDR Therapy with Children & Adolescents	This training is designed to help clinicians who primarily work with children and adolescents adapt EMDR therapy to their population. Case examples will be used to illustrate how the standard EMDR protocol can be modified to engage children of various developmental stages in the process. In addition, strategies to address children or teenager's resistance, avoidance, and dissociative symptoms to facilitate EMDR reprocessing of traumatic memories will be presented along with case examples.	Keunho Keefe, Ph.D.
Integrative Treatment of Complex Trauma - Adolescent Version (Part 1)	This presentation will provide an overview of Integrative Treatment of Complex Trauma for Adolescents (ITCT-A). ITCT-A is an evidence-based treatment that was developed to assist clinicians in the evaluation and treatment of adolescents who have experienced multiple forms of psychological trauma, often in the context of negative living conditions such as poverty, deprivation and social discrimination.	John Briere, Ph.D.
Integrative Treatment of Complex Trauma - Adolescent Version (Part 2)	This presentation will provide an overview of Integrative Treatment of Complex Trauma for Adolescents (ITCT-A). ITCT-A is an evidence-based treatment that was developed to assist clinicians in the evaluation and treatment of adolescents who have experienced multiple forms of psychological trauma, often in the context of negative living conditions such as poverty, deprivation and social discrimination.	Cheryl Lanktree
Law & Ethics	This training will address multicultural child rearing practices in a framework that includes poverty and immigration. A culturally sensitive approach to assessment and intervention will be emphasized, including guidelines for working with families from diverse populations. In addition, this training will focus on the basic legal and ethical issues related to suicide, social media, and substance use. Participants will review current expert opinion, legal updates and standard of care related to (1) proper use of DSM-5 when diagnosing substance related disorders; (2)	Pamela Harmell, Ph.D.

	updates on relationship between social media and suicide; (3) American Academy of Pediatrics suicide assessment; (4) substance use disorders and the risk of suicide; (5) legal and ethical issues with informed consent and "safety agreements;" and (6) Non-suicidal self-injury (NSSI). Literature updates, along with relevant Codes of Ethics will be included in all areas of discussion.	
MHFA (Adult)	Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. This training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a person in crises and connect them with help.	Various Trainers
MHFA (Public Safety)	Mental Health First Aid for Public Safety teaches you how to identify, understand and respond to signs of mental illnesses and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. It focuses on the unique experiences and needs of public safety personnel and is a valuable resource that can make a difference in their lives, their coworkers' and families' lives, and the communities they serve. This training covers defusing crises, promoting mental health literacy, combatting stigma of mental illness, enabling early intervention through recognition of signs and symptoms and connecting people to care.	Various Trainers
MHFA (Spanish)	Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders. This training gives you the skills you need to reach out and provide initial support to someone who may be developing a mental health or substance use problem and help connect them to the appropriate care. This training covers common signs and symptoms of mental illness and substance use, as well as how to interact with a person in crises and connect them with help.	Patricia Morales and Ingrid Leyton
MHFA (Youth)	Youth Mental Health First Aid teaches you how to identify, understand and respond to signs of mental illness and substance use disorders in youth. This 6-	Various Trainers

	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.	
Moral Reconation Therapy (MRT)	In this four-day 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.	Kelly Coburn, LMFT and Matthew Kee, LMFT
Motivational Interviewing	Motivational interviewing (MI), a treatment approach developed by William Miller, has been well-established as an effective way to promote behavioral changes in individuals. Following a brief review of the fundamental MI principles and micro-skills, this experiential MI Skill Development training will focus on helping clients to engage in change-talk, and then make commitments to make behavioral changes based on goals that they have identified. Ample time will be devoted to role-play-practice to enable participants to gain skills necessary to elicit change-talk from clients with low levels of readiness for change, thereby increasing levels of motivation and moving them toward action to address their substance use issues	Andrew S. Kurtz, M.A., MFT
Non-Violence Crisis Intervention (NVCI; Adult and Youth; Full or Half day)	This six-hour training is designed for the staff who work directly with behavioral health consumers in an outpatient/recovery center setting. Early intervention and non-physical methods for preventing or managing disruptive behavior will be emphasized for the best possible "care, welfare, safety and security" of all those who are involved in a crisis situation.	Various Trainers
Non-Violence Crisis Intervention (NVCI; Re-Certification)	This three-hour training is a recertification/refresher course for all county staff who works directly with behavioral health consumers in an outpatient/recovery center setting. Clerical, medical, clinical staff and supervisors will be trained on crisis prevention that emphasizes early intervention and	Various Trainers

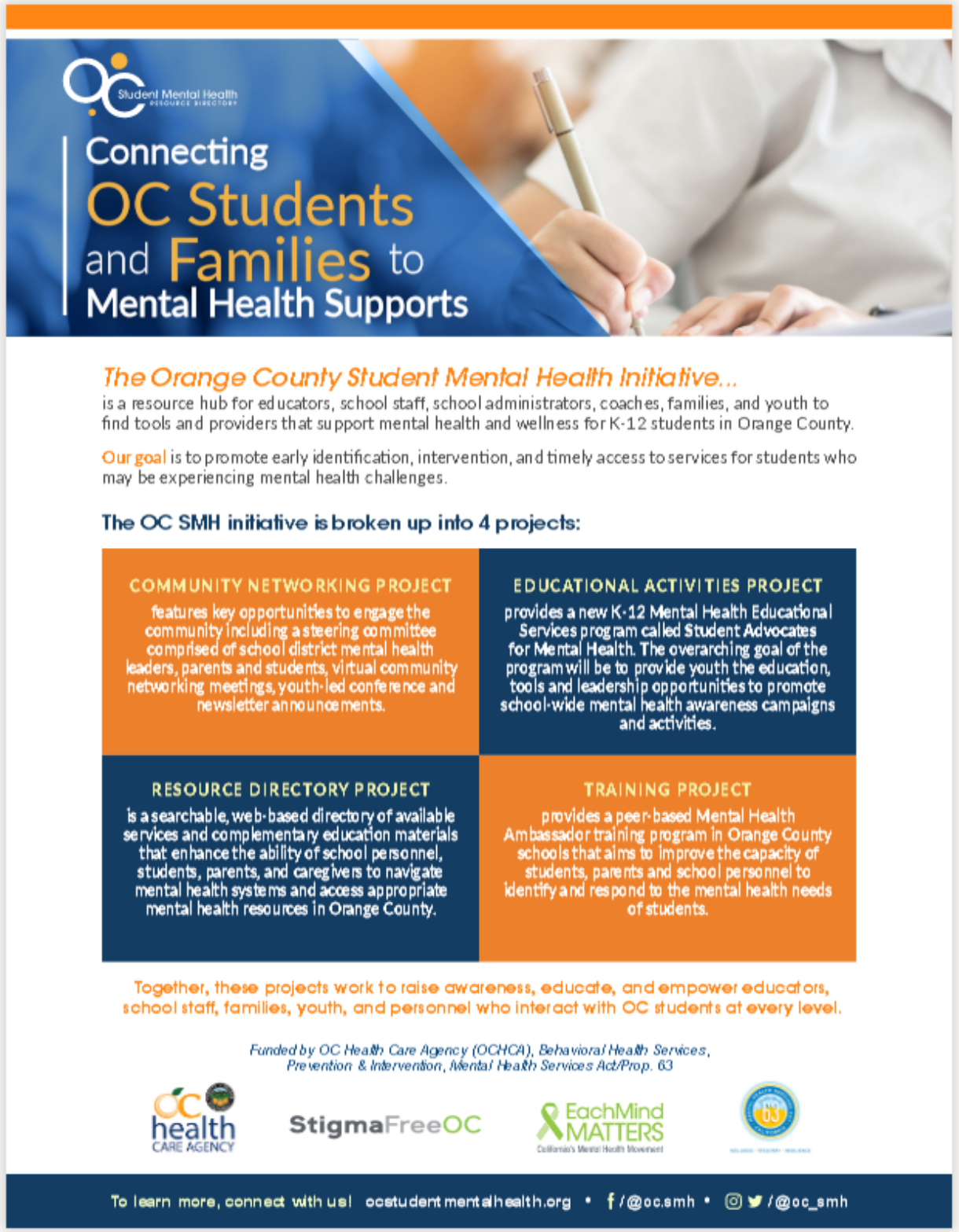
	nonphysical methods for preventing or managing disruptive behavior. The goal is to provide for the best possible "Care, Welfare, Safety, and Security" of all those who are involved in a crisis situation.	
Recovery: The Promise of Hope	This training will address issues related to the process of recovery from persistent and severe mental illnesses and/or substance use. The training will consist of two parts: In the first half, recovery and guiding principles of recovery will be defined, and the factors promoting and hindering recovery will be discussed in depth including video clip interviews with individuals in the process of recovery. In the second half, four of these same individuals will share their stories of recovery with the audience, followed by a question and answer session.	Keunho Keefe, Ph.D.
Seeking Safety	Seeking Safety is an evidence-based treatment for trauma and substance use which teaches present-focused coping skills to help clients attain safety in their lives. Basic information on trauma, posttraumatic stress disorder (PTSD) and co-occurring disorders will be provided. Key themes relevant for this population will be discussed, including dissociation, self-injury, reenactments, and stage-based models of treatment, emotional responses by staff, staff self-care, and diversity issues. Trauma-informed versus trauma-specific treatment will also be highlighted. This training is highly clinically-oriented and will offer the opportunity to role-play client scenarios. Real-world challenges will be emphasized, including power struggles, threatened harm to self and/or others, and reenactment of classic trauma roles. Assessment tools and resources will also be provided.	Summer Krause, LPC, CADCIII
Spirituality Training (The Ultimate Recovery for Individuals with Severe Mental Illness)	This three-hour workshop is designed for counselors and therapists who work with severe mental illness. The presenter will discuss the historical evolution of Spirituality & Mental Health in terms of barriers and causes of conflict. Direct relationship between mental health and spiritual health will be presented via research findings. The audience will also learn screening and treatment approaches in spiritually guided mental health care to assist people in their recovery journey.	Clayton Chau
Trauma and Eating Disorders	This training will explore the interface between complex trauma and its co-morbidity with the multiple types of eating disorders including anorexia/bulimia, binge eating and others. Topics will	Gabriel Grant, M.A.

	include understanding risk factors for eating disorders, the range of disordered eating including its symptoms, etiology, cross-cultural elements including prevalence in the African American, Latinx, and LGBTIQ communities. Special attention will be paid to the public health focus of treatment using safety as a framework. Use of the Central Trauma Roles Schema will be addressed.	
Veteran's Conference	The Community Behavioral Health Summit provides an opportunity to engage in active dialogue on how we can address the needs of our Veterans and their families and also seek collaborative support for those needs. We intend to accomplish this goal by discussing ways we work together in order to help our Veterans and their families build resiliency. Our end goal is to promote a seamless continuity of care for our Veterans and their families both in and out of the VA.	Various Trainers
Working Effectively in Behavioral Health Setting with Sign Language Interpreters	In this course participants will have an opportunity to learn the primary role of interpreter, gain understanding the possible negative impact of the use of family member as interpreter upon the therapeutic procedure and gain awareness of the importance of clinician briefing with interpreter before and after sessions. Additionally, the participants will learn the four different interpersonal dynamics between clinician, client and interpreter: and the impact of the use of interpreter upon family dynamics. The goal is to provide the guidelines on how to work effectively with sign language interpreters in the mental health setting.	Belinda McCleese, LMFT
Working with Sign Language Interpreters	In this course participants will have an opportunity to learn the significance of the impact of mental health issues upon the deaf and hard of hearing population, gain understanding the four different definitions of deafness, and gain exposure to the relationship with Americans with Disability Acts and providing qualified sign language interpreters. The goal is to provide the guidelines on how to work with sign language interpreters properly and to have effective communication with the target population.	Belinda McCleese, LMFT

APPENDIX V: PREVENTION AND EARLY INTERVENTION MARKETING MATERIALS

Start Well/Early Childhood Mental Health Consultation Services

K-12 School-Based Mental Health Services



The Orange County Student Mental Health Initiative...

is a resource hub for educators, school staff, school administrators, coaches, families, and youth to find tools and providers that support mental health and wellness for K-12 students in Orange County.

Our goal is to promote early identification, intervention, and timely access to services for students who may be experiencing mental health challenges.

The Resource Directory Project, one of four OC SMH initiative, serves as a one-stop-shop for student mental health resources in Orange County.

The Center for Applied Resource Solutions (CARS) is partnering with the Orange County Health Care Agency to develop a comprehensive school mental health Resource Directory.

The OC Resource Directory is a searchable, web-based directory of available services and complementary education materials that enhance the ability of school personnel, students, parents, and caregivers to navigate mental health systems and access appropriate mental health resources. By promoting education, awareness, and connection with providers, the Resource Directory will be vital to improving help-seeking and creating access points for school personnel, students, and families in need of mental health supports.

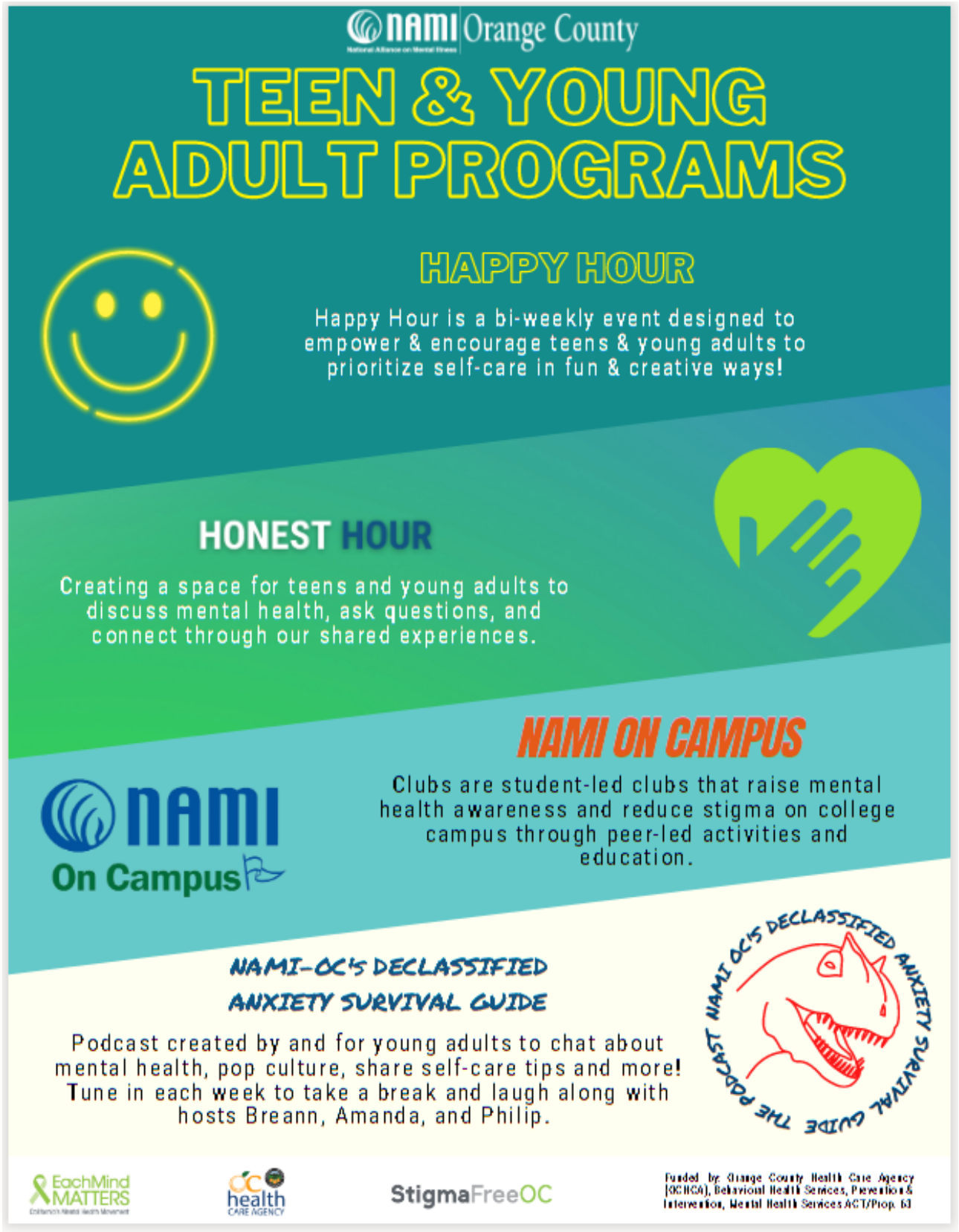
The Resource Directory Project is led by Miranda March from the Center for Applied Research Solutions (CARS).
For more information contact Miranda at OCresourcesinfo@cars-rp.org

Funded by OC Health Care Agency (OCHCA), Behavioral Health Services, Prevention & Intervention, Mental Health Services Act/Prop. 63

OC health CARE AGENCY StigmaFreeOC EachMind MATTERS California's Mental Health Movement

To learn more, connect with us! ocstudentmentalhealth.org • f /@oc.smh • /@oc_smh

TAY and Young Adult Mental health Services


NAMI Orange County
TEEN & YOUNG ADULT PROGRAMS
HAPPY HOUR
Happy Hour is a bi-weekly event designed to empower & encourage teens & young adults to prioritize self-care in fun & creative ways!
HONEST HOUR
Creating a space for teens and young adults to discuss mental health, ask questions, and connect through our shared experiences.
NAMI On Campus
NAMI ON CAMPUS
Clubs are student-led clubs that raise mental health awareness and reduce stigma on college campus through peer-led activities and education.
NAMI-OC'S DECLASSIFIED ANXIETY SURVIVAL GUIDE
Podcast created by and for young adults to chat about mental health, pop culture, share self-care tips and more! Tune in each week to take a break and laugh along with hosts Breann, Amanda, and Philip.
NAMI OC'S DECLASSIFIED ANXIETY SURVIVAL GUIDE THE PODCAST
EachMind MATTERS
OC health CARE AGENCY
StigmaFreeOC
Funded by Orange County Health Care Agency (OCHCA), Behavioral Health Services, Prevention & Intervention, Mental Health Services ACT/Prop. 63


OUR STORIES
MY STORY IS//YOUR STORY IS//OUR STORY
LAGUNA PLAYHOUSE
SING IT. DANCE IT. READ IT. WRITE IT. DRAW IT. SPEAK IT. TELL IT.
CREATE 3-MINUTE VIDEO ABOUT Y(OUR) STORY.
APPLY NOW.
LAGUNAPLAYHOUSE.COM/EDUCATION-OUTREACH/OUR-STORIES
YOUR STORY + YOUR PROCESS.
Through storytelling, improvisation, creative writing, movement, visual art and music - you develop skills to express who you are and what you stand for, using video/theatre creation as a tool for self-empowerment.
YOU WILL LEARN TO...
· Use your voice with confidence
· Structure your story for greatest impact
· Present in real life – interviews, podcast, YouTube, performance
WHAT STORY WILL YOU TELL?
FUNDED BY: OC HEALTH CARE AGENCY (OCHCA), BEHAVIORAL HEALTH SERVICES, PREVENTION & INTERVENTION, MENTAL HEALTH SERVICES ACT/PROP. 63
EDUCATION & COMMUNITY ENGAGEMENT
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OC health CARE AGENCY
StigmaFreeOC