COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY

LIVE WELL SAN DIEGO

COUNTY OF SAN DIEGO BEHAVIORAL HEALTH SERVICES

CULTURAL COMPETENCE PLAN

2016

The County of San Diego has long had a commitment to cultural competence. Sharing a border with Mexico, San Diego has one of the highest rates of immigration of all of California's counties. The 2010 Brookings Institution report says that more than 22% of San Diego's population was born in another country and 42% of children have one or more foreign born parents.[1] In addition to ongoing immigration from Mexico, Central America, and South America, the 2014 Office of Refugee Resettlement report shows that that recent immigrants/refugees have included people from the following five countries of origin (in order of the proportion of total arrivals): Iraq, Iran, Somalia, Burma, and Afghanistan.[2]

The need to provide physical and mental health services to persons from many diverse cultures has been acknowledged throughout all parts of the County's Health and Human Services Agency, whether it be through Public Health, Behavioral Health, Aging and Independence Services, County Medical Services, etc. for persons receiving Medi-Cal and low income residents. The Health and Human Services Agency for San Diego has begun a ten-year effort called "Building Better Health Program" to align County services to promote both physical and mental health in collaboration with community partners and businesses. The goals are to build a better system, support healthy choices, and pursue policy changes for a healthy environment. This service has evolved into a greater, long-term *Live Well San Diego* vision to improve the health, safety and quality of life of all County residents.

The County of San Diego provides mental health services to over 60,000 children, youth, transition age youth, adults, and older adults each year. The services are largely contracted out, with few County programs. The County of San Diego Behavioral Health Services (SDCBHS) and its contractors provide services through approximately 200 programs, 350 school-based mental health sites, and over 700 Fee-for-Service practitioners under contract to the SDCBHS's Administrative Services Organization, Optum.

SDCBHS (composed of Mental Health Services and Alcohol and Drug Services) incorporated the recognition and value of racial, ethnic, and cultural diversity within its system, and included these values in its first Cultural Competence Plan in 1997. SDCBHS sees the creation of a truly culturally competent system as a developmental process. Some of the needed steps require additional resources, whether it be funding for culturally specific programs or the growing of bi-lingual staff at all levels, and some require a shift and increase in administrative focus. The groundwork has been laid through the creation of policies and procedures as well as the requirements for contractors, and BHS has been building upon this framework ever since.

To determine whether all population groups in the County were getting access to needed mental health services, the SDCBHS develops a triennial *Progress Towards Reducing Disparities in Mental Health Services* report to measure its service provision by age, gender, and racial/ethnic groups and to understand where SDCBHS can focus on to address disparities.

[1] "The State of Metropolitan America", Brookings Institution as cited by Katie Orr, KPBS, May 10, 2010. Note: *Progress Toward Addressing Disparities* Report is available in the Appendix 1.
[2] US Department of Health & Human Services, Office of Refugee Settlement, Fiscal Year 2014 Refugee Arrivals. Retrieved from: http://www.acf.hhs.gov/programs/orr/resource/refugee-arrival-data.

The data analysis began in FY 2001-2002. Through MHSA funding, adult and children's mental health services have been expanded to start to reduce the disparities noted in these reports. But there is always area for growth.

The Cultural Competence Plan is a report about where the SDCBHS is now and where we plan to go. It includes information on the eight criteria set by the State as indicators of cultural competence:

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

SDCBHS METHODOLOGY IN EVALUATING ITS SYSTEM

To understand the needs of the whole County mental health population for MHSA planning, the SDCBHS and its USCD Research Centers analyze service disparities on a triennial basis in a report titled *Progress Towards Reducing Disparities in Mental Health Services*. The most recent report covers four time points spanning across 11 years (Fiscal Years 2001-02, 2006-7, 2009-10, and 2012-13). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which we have used to supplement the State required information.

Although the SDCBHS functions as a unified system, the focus of the services for Adults/Older Adults and Children/Youth/Families differs slightly, as is age appropriate. The Adult and Older (A/OA) system focuses on psycho-social recovery and the Children, Youth and Families (CYF) system focuses on family centered treatment and resiliency. For the purposes of this report, much of the information on programs, initiatives, and future activities is divided into sections based on the population served.

ACKNOWLEDGEMENTS

Heath and Human Services Agency
Nick Macchione, Chief Administrative Officer and Agency Director

Behavioral Health Services
Alfredo Aguirre, Director

Quality Improvement Unit
Tabatha Lang, Chief

Cultural Competence Resource Team (CCRT)
Chair: Piedad Garcia

Tabatha Lang
Liz Miles
Terry Maxson
Leon Altamirano
Laura Andrews
Patrice Baker
Bevelynn Bravo
Juan Camarena
Cindi Cassady
Lauren Chin
Carrie Christie
Minola Clark Manson
Dasha Dahdouh
Amanda Forester
Dawn Griffin
Rick Heller
Celeste Hunter
Charity White-Voth
Dixie Galapon
Wendy Maramba
Tondra Lolin
Shun Miller
Joe Reimann
Nancy Rodriguez
Elisa Barnett
Bindu Khurana
Tamara Stark
Rosa Ana Lozada
John Sturm
Cecily Thornton-Stearns
Kathy Tomasic
Gary Ulmer-Goodrich
Karen Ventimiglia
Mercedes Webber
Michelle Ly
Kat Semel

UC San Diego – Health Services Research Center (HSRC)
Child and Adolescent Services Research Center (CASRC)

For any questions, please contact: BHSQIPOG@sdcounty.ca.gov

INTRODUCTION

Cultural Competence Plan Introduction 1

CRITERION 1 – Commitment to Cultural Competence

I. County Mental Health System Commitment To Cultural Competence..... 6
II. County Recognition, Value, and Inclusion Of Racial, Ethnic, Cultural and Linguistic Diversity Within The System..... 11
III. Each County Has A Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible For Cultural Competence 22
IV. Identify Budget Resources Targeted For Culturally Competent Activities..... 24

CRITERION 2 – Updated Assessment Of Service Needs

I. General Population..... 28
II. Medi-Cal Population Service Needs (Use Current CAEQRO Data If Available) 29
III. 200% Of Poverty (Minus Medi-Cal) Population And Service Needs..... 31
IV. MHSA Community Services And Supports (CSS) Population Assessment And Service Needs . 34
V. Prevention And Early Intervention (PEI) Plan: The Process Used To Identify The PEI Priority Populations 45

CRITERION 3 – Strategies And Efforts For Reducing Racial, Ethnic, Cultural, And Linguistic Mental Health Disparities

I. Identified Unserved/Underserved Target Populations (With Disparities)..... 48
II. Identified Disparities (Within The Target Populations) 50
III. Identified Strategies/Objectives/Actions/Timelines..... 53
IV. Additional Strategies/Objectives/Actions/Timelines And Lessons Learned 58
V. Planning And Monitoring Of Identified Strategies/Objectives/ Actions/ Timelines To Reduce Mental Health Disparities..... 61

CRITERION 4 – Client/Family Member/Community Committee: Integration Of The Committee Within The County Mental Health System

I. The County Has A Cultural Competence Committee, Or Other Group That Addresses Cultural Issues And Has Participation From Cultural Groups, That Is Reflective Of The Community 64
II. The Cultural Competence Committee, Or Other Group With Responsibility For Cultural Competence, Is Integrated Within The County Mental Health System 67

CRITERION 5 – Culturally Competent Training Activities

I. The County System Shall Require All Staff And Stakeholders To Receive Annual Cultural Competence Training 74
II. Annual Cultural Competence Trainings 80
III. Relevance And Effectiveness Of All Cultural Competence Trainings 85
IV. Counties Must Have A Process For The Incorporation Of Client Culture Training Throughout The Mental Health System..... 89

CRITERION 6 – County's Commitment To Growing A Multicultural Workforce: Hiring And Retaining Culturally And Linguistically Competent Staff

I. Recruitment, Hiring, And Retention Of A Multicultural Workforce From, Or Experienced With, The Identified Unserved And Underserved Populations 92

CRITERION 7 – Language Capacity

I. Increase Bilingual Workforce Capacity 99
II. Provide Services To Persons Who Have Limited English Proficiency (LEP) By Using Interpreter Services 107
III. Provide Bilingual Staff And/Or Interpreters For The Threshold Languages At All Points Of Contact 113
IV. Provide Services To All LEP Clients Not Meeting The Threshold Language Criteria Who Encounter The Mental Health System At All Points Of Contact 121
V. Required Translated Documents, Forms, Signage, And Client Informing Materials 122

CRITERION 8 – Adaptation Of Services

I. Client Driven/Operated Recovery And Wellness Programs 124
II. Responsiveness Of Mental Health Services 130
III. Quality Of Care: Contract Providers 140
IV. Quality Assurance 143

APPENDICES

This document is available separately and can be found in the Technical Resource Library at www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html *(Section 4).*

Appendix 1 1
Appendix 2 65
Appendix 3 66
Appendix 4 67
Appendix 5 75
Appendix 6 143
Appendix 7 161
Appendix 8 235
Appendix 9 238
Appendix 10 241
Appendix 11 270
Appendix 12 286
Appendix 13 290
Appendix 14 292
Appendix 15 296
Appendix 16 306
Appendix 17 316
Appendix 18 331
Appendix 19 335
Appendix 20 344
Appendix 21 355
Appendix 22 358

COMMITMENT TO CULTURAL COMPETENCE

I. The County of San Diego Behavioral Health Services' commitment to cultural competence

The County shall include the following in the CCP:

A. Policies, procedures, or practices that reflect steps taken to dully incorporate the recognition and value of racial, ethnic, and cultural diversity within SDCBHS.

SDCBHS has the following policies, procedures, and practices in place that recognize and value cultural diversity:

The County of San Diego Department of Human Resources Policies

County of San Diego Department of Human Resources (DHR) has policies in place that reflect recognition of racial, ethnic, and cultural diversity in areas of training and recruitment. These include:

- 1002 – Training and Development Program – "It is the policy of the Department of Human Resources to assist all departments and employees in the design, implementation and evaluation of professional and organizational development strategies through consultation, coaching, education and training." One such training opportunity that addresses cultural competency is Embracing Diversity and Encouraging Respect, which the County strongly encourages each employee to take.
- 109 – Equal Employment Opportunity – "It is County policy to provide the conditions which promote equal employment opportunity for all persons regardless of race, color, ancestry, national origin, religion, sex, marital status, age, sexual orientation, political affiliation or disability."
- 902 – Employee Organizations – "It is County policy to maintain positive and productive relationships with all employee organizations; to foster activities, which are collaborative, cooperative and non-adversarial; and to assure that all County practices are free from discrimination based on employee organization membership or participation by County employees."

SDCBHS Policies and Procedures

SDCBHS has had a number of policies and procedures in place for more than 10 years to ensure culturally appropriate services are available. These include:

- 01-01-203 – Culturally and Linguistically Competent Services: Assuring Access and Availability. The purpose of this policy is to assure improvements in the access and availability of culturally and linguistically competent services in County Behavioral Health Services. SDCBHS makes ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of San Diego residents.
- 01-01-201 – Cultural Competence Resource Team. The purpose of this policy is to establish a Behavioral Health Services Cultural Competence Resource Team (CCRT) to advise the BHS Executive Team of Adult/Older Adult (AOA) and Children, Youth, and Family (CYF) BHS Systems of Care (SOC) on issues of cultural competency. The policy promotes mental health, wellness and recovery, eliminates the debilitating effects of

psychiatric and alcohol and other drug conditions in a culturally centered manner, and promotes cultural competence.

- 01-02-202 – Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services. The purpose of this policy is to ensure that all individuals requesting services at Mental Health Plan (MHP) programs providing Specialty Mental Health Services have been evaluated for needing culturally/linguistically specialized services and linked with services or referred appropriately.
- 01-02-203 – Interpreter Services: Access and Authorization. The purpose of this policy is to establish a process to provide free interpreter service for mental health clients with Limited English Proficiency (LEP). This includes provider service authorization and the requirements for processing interpreter services payments.
- 01-04-210 – Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services. The purpose of this policy is to ensure that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner, to their special needs to assist them to access Specialty Mental Health Services.
- 01-06-207 – Grievances, Appeals, Expedited Appeals and State Fair Hearings: Monitoring the Beneficiary and Client Problem Resolution Process. The purpose of this policy is to establish procedures for the monitoring of the Mental Health Plan (MHP) Beneficiary and Client Problem Resolution Process; to ensure that client rights are maintained to their fullest extent; and to ensure the MHP compliance with federal, state and contract regulations.

SDCBHS Principles Which Support Cultural Competence

The County of San Diego has two systems of care: the Adult and Older Adult System of Care and Children, Youth and Families System of Care. The systems work together to create the Behavioral Health System. Additionally, the Community Services and Support (CSS) component of the Mental Health Services Act (MHSA) and the Comprehensive Continuous System of Care for co-occurring mental health and substance use have guiding principles addressing cultural competence which further embed this value in SDCBHS.

Adult and Older Adult System of Care (AOA SOC) Principles

The AOA SOC is based on Biopsychosocial and Rehabilitation (BPSR) principles that have proven to be effective in reducing psychiatric hospitalization and assisting behavioral health clients in becoming more productive community members. Biopsychosocial rehabilitation and recovery services are comprehensive, culturally competent, and age appropriate and tailored to individual client's needs and choices within their cultural context. The AOA SOC Guiding Principles are in the Appendix 2.

Children, Youth and Families System of Care (CYF SOC) Guiding Principles

The mission of CYF is to advance a rich array of services delivered through an integrated, community-based, behavioral health system of care that enables children and adolescents to achieve positive outcomes.

The CYF SOC Council's Vision is that San Diego children and youth are healthy, safe, and successful in school and their transition into adulthood, while being law abiding, and living in a home and community that support strong family connections. Currently, there are eight Guiding Principles of the CYF SOC, one of which is that services are culturally, linguistically, and developmentally appropriate. The principles focus on four sector collaboration, integrated care, youth guided and family driven, individualized, strength based, community based, outcome driven and culturally competent. In addition, the CYF SOC is incorporating Trauma Informed System to the guiding principles. The CYF SOC Guiding Principles are in the Appendix 3.

Clinical Director's Office (CDO)
The Clinical Director's Office provides quality management across the entire behavioral health system, in addition to developing and monitoring various workforce and integrated care programs. CDO also oversees hospital services, as well as long-term care coordination.

Prevention and Planning Unit (PPU)
The Prevention and Planning Unit is the outward face in the community for BHS and provides oversight, coordination, and leadership around prevention and early intervention activities and initiatives, including the integration of Live Well San Diego. BHS has integrated community outreach; Mental Health Services Act coordination; suicide prevention and stigma reduction planning; primary, secondary and environmental prevention activities for Alcohol and Other Drugs and Mental Health contracts and initiatives; and all strategic planning, advisory board coordination, legislation tracking and media activities under the Prevention and Planning Unit.

Community Services and Supports (CSS) Vision Statement and Guiding Principles
In addition to the Systems of Care described above, SDCBHS has implemented MHSA CSS programs and services. This includes:

- Full implementation of an approach to services through which each client and her/his family, as appropriate, participates in the development of an individualized plan of services determined by the individual's goals, strengths, needs, race, culture, concerns and motivations.
- Development and expansion of practices, policies, approaches, processes and treatments which are sensitive and responsive to clients' cultures.
- The Guiding Principles of CSS include cultural competency items such as:
  Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the race and ethnic diversity within counties and to eliminate disparities in accessibility and availability of behavioral health services.
- Implementation of more culturally and linguistically competent assessments and services that are responsive to a client's and family's culture, race, ethnicity, age, gender, sexual orientation, and religious/spiritual beliefs.

Comprehensive Continuous Integrated System of Care (CCISC): Co-Occurring Disorders
The CCISC initiative utilizes eight practice principles that directly impact the way services are planned and provided for the special cultural population of dually diagnosed (living with mental health and substance use disorders) individuals in SDCBHS. CCISC Training is available to County and contract behavioral health staff to help ensure programs become "dually diagnosed capable or enhanced" and work collaboratively across systems to improve services. In addition,

SDCBHS, with support from the Behavioral Health Services Advisory Board, adopted the CCISC model for designing system changes to improve outcomes for persons living with co-occurring disorders, within the context of existing resources, via a Consensus Document.

Trauma Informed Systems Integration

The San Diego County Health and Human Services Agency (HHSA) is dedicated to being a Trauma Informed System. Being trauma informed is a component of cultural competency, an approach to engage all people we serve, all staff and those we encounter whilst conducting business.

Trauma Informed Systems recognize and hold a universal awareness of trauma and/or complex stress as seen through social ecological and cultural lenses. Trauma often results in individualistic coping strategies that may contribute to multiple strengths and challenges over their lifespan. To this end, the Agency seeks to:

1. Ensure systems and services are outcome driven, culturally competent, recovery focused, client-partner directed, and trauma informed.
2. Support activities designed to support wellness and complete health, reduce stigma and raise awareness surrounding behavioral/medical health and wellness.
3. HHSA adopted a policy that on an annual basis, each region and division within the Agency will conduct a scan, develop and implement an action plan addressing trauma informed systems integration across policies, language, environments, and client partner inclusion in decision making.

SDCBHS Organizational Provider Operations Handbook (OPOH): Cultural Competence

SDCBHS maintains the OPOH, which is an addendum to all provider contracts. The handbook is updated at a minimum annually and serves as a way for the SDCBHS to keep its contractors up to date on new or changing requirements for the provision of services. The OPOH contains a "Cultural Competency" section which includes Culturally and Linguistically Appropriate Services (CLAS) Standards that have replaced the Culturally Competent Clinical Practice Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards, originally developed by the Health and Human Services Office of Minority Health, are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The Standards are as follows:

Principal Standard:

- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

- Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
- Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

- Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

- Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
- Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
- Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
- Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
- Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
- Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
- Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

The complete Cultural Competence section of the OPOH is included in the Appendix 4.

Uniform Clinical Records Manual

The Uniform Clinical Records Manual includes a Behavioral Health Assessment which requires information on the client's ethnicity, language, culture specific symptomatology/explanations for behavior, support systems, alternative health practices, cultural issues, and any family history of immigration and acculturation issues.

Next Steps Toward Increasing the Emphasis on Cultural Competence

As of December 2013, each legal entity, that includes both mental health and AOD providers, are required to have a Cultural Competence Plan that demonstrates the policies and practices of culturally competent services for both mental health and alcohol and drug services.

The County shall have the following available on site during the compliance review:

B. Copies of the following documents to ensure the commitment to cultural and linguistic competence services are reflected throughout the entire system:

1. *Mission Statement;*
2. *Statement of Philosophy;*
3. *Strategic Plans;*
4. *Policy and Procedures Manual;*
5. *Human Resource Training and Recruitment Policies;*
6. *Contract Requirements*
7. *Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence)*

SDCBHS shall have items 1-7 available on-site during the compliance review.

COMMITMENT TO CULTURAL COMPETENCE

II. County recognition, value, and inclusion of racial, ethnic, cultural and linguistic diversity within the system

The CCPR shall be completed by the County Behavioral Health Services Division. The County will hold contractors accountable for reporting the information to be inserted into the CCPR.

The County shall include the following in the CCPR:

A. A description, not to exceed two pages, of practices and activities that demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with mental health disparities; including, recognition and value of racial, ethnic, cultural, and linguistic diversity within the system. That may include the solicitation of diverse input to local behavioral health planning processes and services development.

The SDCBHS has traditionally solicited stakeholder input on behavioral health programming through a variety of committees, councils, workgroups, and other groups, ranging from client representatives participating in the SDCBHS Administration Core Planning Group to large stakeholder meetings. When MHSA funding became available, an even more extensive effort was made to include participants from identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities. Recognizing and valuing the diversity of County residents, a range of vehicles was used to ensure a wide scope of opportunities to provide input and ideas on needed improvements to behavioral health services. Community forums, regional meetings, focus groups, surveys, and the formation of age-focused ongoing Advisory Councils contributed to decisions to create programs which operationalize community outreach and engagement and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities. Those efforts from the Prevention and Planning Unit (PPU), as well as the Clinical Directors Office, are encompassed under the programs targeted to both children and adults.

Programs Focused on Serving Children, Youth and Families:
The following programs serve as examples of services offered to children and adolescents which demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities:

- **UPAC Multi-Cultural Counseling Center (MCC)** provides intensive cultural and language specific outpatient behavioral health services and case management for Seriously Emotionally Disturbed (SED) children and families utilizing a comprehensive approach that is community based, client and family driven, trauma informed, and culturally competent. The focus of this program is to provide services to underserved Asian Pacific Islander (API) and Latino SED clients with emphasis on API clients.
- **Community Research Foundation (CRF)** – Crossroads program provides outpatient behavioral health services to children, youth, and their families in the underserved rural 1000 mile square "backcountry" of East San Diego County. Services are provided where they are most convenient and appropriate for the families, which include schools, homes, church, community meeting centers, or even under the oak trees in an outdoor setting
- The **Community Circle Central** program at Logan Heights Family Counseling Center primarily serves Spanish-speaking Latino clients age 5 to 18 and their families. Mental health services are provided in 10 different schools, in the home, and in the community.
- **CRF – Nueva Vista Family Services (NVFS)** is a Full Service Partnership program which provides a range of behavioral health services to children and youth ages 5-21 years old. NVFS is dual diagnosis enhanced program and culturally sensitive to the community in which it serves, with over 75% of staff being bilingual (Spanish) and bicultural (Latino).
- **Episcopal Community Services (ECS) – Para Las Familias** program provides a wide range of behavioral health services to children, ages 0 to 5 and their families in the South Bay region. Services are made available to high-risk children, including behavioral health assessments and family therapy. The program's mission is to empower parents with increased knowledge and skill to meet the social-emotional and developmental needs of their children, as well as where and how to secure educational, health and other supportive services. To meet the population needs, 100% of the clinical staff is Latino/Hispanic cultural competent.
- **Palomar Family Counseling Services Prevention and Early Intervention School Based Component** provides social-emotional mental health evidence-based prevention and early intervention services for elementary school age children at public schools in Escondido, Oceanside, and Valley Center school districts. The program targets underserved and living in high-risk communities with high ratios of Latino and socio-economically disadvantaged families, many of whom are unemployed or under-employed, illiterate or with limited education, and homeless. Many families are single parent households, monolingual, with Spanish being their primary language. The Services include three components: Positive behavioral support (PBS) implemented through Building Effective Schools Together (BEST) model, Incredible Years Parent, Teacher and Child Training services, and screening with at-risk children.
- **Harmonium Family/Youth Partner Full Services Partnership** program serves eligible children, youth and their families that mostly reside in the southeast County communities. Due to obesity, diabetes and hypertension concerns, particularly in African American and Hispanic youth, the integration of medical treatment and mental health treatment is

always part of the treatment spectrum. The primary focus is to provide support services to help clients achieve their mental health treatment goals.

- **Peer-to-Peer Text and Chat Support and Referral Services for Youth** – Peer-to-Peer program provides bilingual (English and Spanish) non-crisis peer support using Live Chat and Text messaging to youth that is confidential, anonymous and mental health stigma free.
- **The Urban Youth Center of the Indian Health Council** serves at-risk and high-risk Urban American Indian and Alaska Native children and youth ages 10-24 and their families providing screening and assessment and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for local tribal youth.
- **McAlister Institute for Education and Treatment (MITE) – New Hope Alcohol and Drug Treatment and Recovery** provides services to pregnant and parenting adolescent females, primarily of Latina descent, who are using or have used alcohol and drugs. This Perinatal Teen Recovery Center offers treatment and recovery services for hard-to-reach Latino teen girls.
- **The Juvenile Forensic Services' (JFS) Stabilization, Treatment, Assessment and Transition (STAT)** team provides clinical services and crisis intervention to youth and their families in the Juvenile Justice System.
- **The Juvenile Forensic Assistance for Stabilization & Treatment (JFAST)** is a juvenile mental health court which began in July 2010, focused on diverting emotionally disturbed youth out of the Probation system, while setting up intensive mental health treatment and family support in the communities, thereby improving probation outcome, public safety, and reducing recidivism.
- **New Alternatives, Inc.** provides therapeutic services to adolescents who live on-site at a residential treatment center. The Day Rehabilitation program offers a variety of treatment modalities to the clients to meet their needs effectively, help stabilize their behaviors, and obtain lasting changes in various aspects of their life.

Programs Focused on Serving Adults and Older Adults:

The following programs that focus on adult and older adult clients demonstrate community outreach, engagement, and involvement efforts with identified racial, ethnic, cultural, and linguistic communities with behavioral health disparities:

- **Project In-Reach** provides services primarily to at risk African American and Latino citizens who are incarcerated adults or Transition Age Youth (TAY) at designated detention facilities and will be released in San Diego County. Services include in-reach, engagement; education; peer support; follow-up after release from detention facilities and linkages to services that improve participant's quality of life; diminish risk of recidivism; and diminish impact of untreated health, mental health and/or substance abuse issues.
- The **Breaking Down Barriers (BDB) Prevention and Early Intervention (PEI)** program uses a Cultural Broker outreach model to create effective collaborations with various agencies, community groups, participant and family member organizations, and other stakeholders to reduce mental health stigma and increase access to behavioral health services by unserved and underserved culturally-diverse communities. The program provides prevention and early intervention services through the efforts of Cultural Brokers who are individuals known in the local community who provide outreach and engagement support. Some of the services/programs include, but are not

limited to: mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), Lesbian/Gay/Bisexual/Transgender/Questioning/ Intersex (LGBTQI), African, and African American communities; the implementation and evaluation of strategies to reduce mental health stigma; and effective collaborations with other agencies, community groups, participants, and family member organizations. BDB is one of many programs implemented as a result of the MHSA.

- **The Fotonovela Project** published and distributed a bilingual Fotonovela that reached out to the Latino community as part of a "stigma busting" effort on mental health issues, including information on how and where to access mental health services. In June 2013, San Diego County won the Silver Anvil Award of Excellence for the Fotonovela.
- **Clubhouses** provide services that assist members in reducing social isolation, as well as increasing their social rehabilitation skills and independent functioning, and improving education and employment. The Friendship Clubhouse targets unserved Transitional Age Youth (TAY) and adult African-American and Latino clients. The Eastwind Clubhouse provides culturally competent services to Asian/Pacific Islanders in their preferred language. Casa del Sol has a special focus on the adult, older adult and TAY Latino populations. The Oasis Clubhouse provides support groups, independent living skills, job skills development, peer mentoring, and crisis intervention for TAY. The Deaf and Hard of Hearing Member-Operated Recovery and Skill Development Center Program provide social skill development, rehabilitative, recovery, and vocational supports and peer support and advocacy to the target population in Communication Accessible language.
- **Bio-Psychosocial Rehabilitation (BPSR)** Wellness Recovery Centers (WRC) provide outpatient mental health rehabilitation and recovery services, co-occurring substance use treatment, case management, and vocational services for clients living with serious mental illness ages 18 and over, including those who may have a co-occurring substance use disorder. The Southeast Mental Health Center, Maria Sardiñas BPSR WRC and South Bay Guidance WRC provide services to the underserved Latinos in the County's Central and South Regions. The UPAC BPSR WRC exclusively serves Asian/Pacific Islanders in their preferred language. The Chaldean-Middle Eastern Social Services Behavioral Health Program serves the County's East Region Middle Eastern refugees.
- **Outpatient Services for Deaf and Hard of Hearing**, a program of Deaf Community Services, provides specialized, culturally, linguistically and developmentally appropriate outpatient BPSR services for Medi-Cal and unfunded deaf and hard of hearing persons of all ages with serious mental illness, as well as those who may also have co-occurring substance use disorder. Providers are fluent in American Sign Language (ASL) and are members of the deaf community. As of July 1, 2010, services have been expanded to provide alcohol and drug counseling with the addition of an experienced and certified Alcohol and Drug counselor who is ASL-fluent.
- In 2013 two **Behavioral Health Services (BHS) and Faith Based Community Dialogue Planning Groups** were established to facilitate conversations in the Central and North Inland regions with particular emphasis in the African American and Latino communities. A Community Dialogue Breakfast was held in each of the regions and a compendium of recommendations was compiled. One key outcome was the formation of BHS Faith-Based Councils to provide input and recommendations to the BHS administrative team on community needs and solutions. Both Councils submitted ideas for faith-based programs which resulted in innovation funding set aside for faith-based

programs. BHS has been moving forward with the procurement process, beginning with an Industry Day occurring on January 22, 2015. The resulting program will include development of collaboration and partnerships, including outreach and engagement to faith-based congregations; community education utilizing Faith Based Champions; crisis in-home response to individual/family crisis situations such as suicides, homicides, domestic violence on a 24/7 on-call system, and a wellness and health ministry that focuses on adults diagnosed with a serious mental illness receiving mental health services while in jail.

- **Courage to Call** is a veteran-staffed 24/7 Helpline that provides free confidential information, self-screening tools and appropriate resources, guidance, and referrals to individuals who have served in the military and their families. The program also provides training to improve cultural awareness and understanding for community organizations and providers serving those with a military or military family background.
- **Survivors of Torture, International (SOTI)** provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength based, client and family driven, and culturally competent.

B. A narrative description, not to exceed two pages, addressing the county's current relationship with, engagement with, and involvement of, racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services.

The SDCBHS seeks to enhance client and family engagement and involvement of ethnically and linguistically diverse clients at all levels of the behavioral health planning process. The following describes these engagement and involvement efforts.

Behavioral Health Engagement and Involvement Efforts Focused on Services for Children, Youth and Families:

- **The CYF Behavioral Health System of Care Council (The Council)** was established to provide community oversight on the integrity of services and advancements of all aspects of the system of care. The Council is a strong four sectors partnership between youth/families, public agencies, private organizations and education. The Council embraces the following principles:
  - Integrated: Among the four sector partners services are comprehensive and accessible, coordinate behavioral and physical health care, provide seamless transition of care and utilize natural community supports.
  - Youth guided, family driven: Youth and families actively participate in service delivery, planning, and program and policy development.
  - Individualized: Services are flexible and designed to meet and build upon the unique needs, strengths and potential of each youth and family.
  - Strength-based: Individualized plans and services identify and utilize youth/family strengths to facilitate health and wellness.

- Community-based: Sector partners offer an array of services in each region and strengthen family and youth connections to neighborhood and local community resources.
- Outcome driven: Service delivery systems continuously improve services by measuring and evaluating outcomes and use results to modify practices.
- Culturally Competent: Service providers honor the diversity of cultures, address the complexities within and between cultures, and provide accessible and relevant services.

The Council meets monthly and has member representation from the Behavioral Health Board, Juvenile Probation and Juvenile Court, HHSA Region, Special Education Local Plan Areas (SELPA), First 5 Commission, San Diego Non Profits (SANDAN), Wraparound Constituency, Family and Youth Roundtable, Regular Education-Pupil Personnel Services, Alcohol and Drug Contractors Association, Youth-Representing Residential and Juvenile Justice, Behavioral Health Services, Child Welfare Services, School Board, Mental Health Contractors Association, Fee-for-Service and Healthcare Providers, San Diego Regional Center for Developmentally Disabled, Family Receiving Services, and a recent addition of Public Health.

- **The Children's System of Care Academy** provides seven CSOC specific trainings, including annual conference that increases the skills of the entire range of participants in order to provide better services to families and youth.
- **The Family/Youth Liaison (FYL)** program has the primary duty of coordinating and advancing family youth professional partnerships in the CYF BHS. The FYL Director works closely with CYF BHS administrative staff to ensure that family and youth voice and values are incorporated into service development and implementation plans.

Behavioral Health Engagement and Involvement Efforts Focused on Services for Adults:

- In order to provide feedback and recommendations to the Behavioral Health Services Director on the design and implementation of the AOA SOC, the following stakeholder process is in place: the **AOA System of Care Council, the Older Adult System of Care Council, the Behavioral Health Services Housing Council, and the Transition Age Youth (TAY) Workgroup**. These groups, as well, have a voice in making recommendations for policy development. Members are appointed from constituencies including: community organizations, Behavioral Health Board, Community College District, TAY, primary health care, advocacy, National Alliance for Mental Illness (NAMI), Mental Health Contractors Association, Employment Services, Probation, Sheriff, Police Departments, fee-for-service mental health practitioners, Cultural Competence Resource Team (CCRT), Co-Occurring Disorders/CADRE, Mental Health Coalition, Hospital Partners, Underserved Communities, long-term care, service providers for adults and older adults, veterans services, Case Management, and clients and family members. Diverse consumer and family cultural representation is also sought.
- **Program Advisory Groups (PAGs**), composed of at least 51% clients living with mental health issues and/or family members, are a required program component for Outpatient Programs. PAGs, which are ideally facilitated by peers/family members, provide feedback and ideas to mental health programs about improving recovery services. PAG meetings have a format, agenda, and record attendance and minutes. Through

Recovery Innovations and Family Youth Roundtable, PAGs have established implementation guidelines across the Adult Mental Health System of Care in an effort to standardize this important vehicle for soliciting feedback to improve programs.

- With the **Alcohol and Drug Advisory Board (ADAB)** and the Mental Health Board (MHB) merged into a combined Behavioral Health Advisory Board, it can efficiently address both the unique and common needs of both these communities, as well as meet the needs of clients who are diagnosed with co-occurring disorders. The Behavioral Health Advisory Board advises the Board of Supervisors, the Chief Administrative Officer, the Director, Health and Human Services Agency, and the Director of Behavioral Health Services regarding prevention, treatment and recovery services. The Boards have shared commonalities, but also differ in composition and structure. The Behavioral Health Advisory Board is thought to be a more efficient and streamlined advisory board, which would meet the State mandate of Welfare and Institutions Code 5604 and also mirror the delivery of services offered by BHS. In addition, the BHAB is a key communication and oversight link between the client and family community and the local behavioral health service system.

- **The SDCBHS Quality Review Council** involves a culturally diverse and representative group of members, including community behavioral health organizations, clients and family members, service providers, client-run service providers, and educational organizations. The members participate in the review of ongoing program monitoring, program and client outcomes and system problems to help ensure that clients continue to receive high-quality, effective services in a trauma-informed and recovery-oriented system.

- The SDCBHS, through its CYF SOC, has been working with the **Save Our Children Project** to address disproportionality and disparities in serving youth and families in southeast San Diego, especially the African American youth. The SDCBHS has joined efforts with the faith-based community and other stakeholders to help increase access and break down the stigma of individuals and families experiencing mental health conditions. This project includes collaboration with Probation and Child Welfare Services.

- Through **NAMI San Diego**, the Family-to-Family program reaches out to families that support relatives living with mental illness. This 12-week program provides an understanding about mental illnesses, as well as a wide array of coping skills. The program is offered in Spanish, Vietnamese, and Arabic. NAMI also provides a 10-week Peer-to-Peer education program that engages people living with mental illnesses and provides them information on the illnesses, treatment, preventing the relapse, and living well. It is offered in English and Spanish.

Community-Based Organizations:

SDCBHS has developed activities that involve community-based organizations. Funded by PEI, Community Health Promotion Specialists and Aging Specialists bring mental health awareness to the general public and to those populations not normally seen within the County Behavioral Health System and who may be at risk for developing a mental illness. Promotion and Aging Specialists have incorporated “Good Mental Health Is Ageless” training in presentations to

provide to community groups, including the older adult population and Hispanic older adult population. Staff attends Health Fairs throughout the county to distribute information and talk about mental health to community members. Staff also coordinates special events, such as the discussion of the San Diego County Report Card on Children and Families, including mental health and substance use data, and the "Es Dificil Ser Mujer" workshop.

C. A narrative, not to exceed two pages, discussing how the County is working on skills, development and strengthening of community organizations involved in providing essential services.

County Participation in State Initiative for Ethnically and Culturally Focused Community Based Organizations Providing Services to Children and Adults:

The Center for Multicultural Development (CMD) at the California Institute for Behavioral Health Solutions (CIBHS) and the Department of Health Care Services (DHCS) formed a collaborative with the objectives of: 1) fostering successful partnerships between counties and ethnic and culturally focused CBOs in the implementation of MHSA activities; and 2) providing strategies, training, and tools for developing organizational capacity of ethnic and culturally focused CBOs. In 2010, the County of San Diego identified two agencies, Chaldean Middle Eastern Social Services (CMSS) and Survivors of Torture, International (SOTI) to participate in trainings.

- **CMSS's Behavioral Health Program** is a community-based, comprehensive outpatient program that addresses the mental health needs of our Chaldean and Middle-Eastern communities in San Diego County with a host of services for individuals, couples, families, and refugees.
- **SOTI** provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength based, client and family driven, and culturally competent.
- As part of the County-wide effort to support health, safety and well-being of the region's residents through *Live Well San Diego*, the County of San Diego has been working to integrate a trauma-informed model in the philosophy, approach, and methods in order to become a fully trauma-informed organization and to more effectively engage all people served, all staff, and others whom the County conducts business with. The goal is to improve how the County responds to the needs of those whose lives have been impacted by trauma and or complex stress, and ensure stronger coordination of care to promote wellness. The SDCBHS has been leading the efforts to assist the Health and Human Services Agency (HHSA) in moving toward an integrated trauma informed system. With the assistance of a consultant, the SDCBHS has conducted an assessment of the trauma-informed competencies, and is leveraging the recommendations to begin the County-wide implementation and change. The system change will help build a better overall system, which includes a service delivery system, facilitates positive health choices by staff and clients; aids in the pursuit of policies and environmental changes that support health and safety; and helps continue to enhance the County culture from within.
- In July of 2014, the SDCBHS Quality Improvement Unit worked with CCRT to revise and enhance the Cultural Competence Handbook to infuse CLAS standards and trauma-informed principles.
- **Cultural Competency Academy (CCA)** is available for San Diego County and County-contracted Behavioral Health providers at three levels of service with separate year-long

intensive cultural competency training tracks with 57-64 hours of curriculum tailored to enhance their specific job responsibilities. CCA participants also work as a team to apply their knowledge and skill with a practicum to create lasting change in their agency/program.

- **Pathways to Well-Being** is a joint initiative between BHS CYF and Child Welfare Services (CWS) in partnership with the family/youth voice. The purpose of Pathways to Well-Being is to enhance the delivery of children's services through a collaborative team of mental health providers, CWS social workers, parent and youth partners, the child receiving services, and their family/caregivers. This approach enables strengths-based, culturally relevant, and trauma-informed services for foster youth.

Other County Efforts to Strengthen Community Based Organizations:
Primary Care and Mental Health Services Integration programs include efforts with multiple primary care health centers to develop collaboration, capacity, and infrastructure to transition clinically stable mental health clients to primary care for treatment of co-occurring disorders. Eleven community health centers are participating to enhance capacity and infrastructure and facilitate the transition of clinically stable mental health clients to the primary care centers.

- **Rural Health Initiative** developed extensive behavioral health prevention, education and intervention services within the context of several rural family practice clinics.

National Alliance on Mental Illness (NAMI San Diego) has helped address the county's current relationship with, engagement with, and involvement of racial, ethnic, cultural, and linguistically diverse clients, family members, advisory committees, local mental health boards and commissions, and community organizations in the mental health system's planning process for services, through the provision of the following culturally competent activities:

- **Elder Multicultural Access and Support Services** provides outreach to Latino Older Adults in the South, Central, and North Inland regions of the County with the goal of providing mental health prevention and early intervention services.
- **Family-to-Family** is a 12-week education program for families (offered in Spanish, Vietnamese, and Arabic), which provides exhaustive information about mental illnesses, on understanding and supporting the relative living with the illness, as well as a wide array of coping skills.
- **Peer-to-Peer** provides a 10-week education program (for English and Spanish) for people living with mental illnesses.
- **NAMI Support Groups,** which are offered in English and Spanish, are open to family members and to all that need the assistance.

County of San Diego is implementing the Faith-Based Task Orders focusing primarily on the African American and Latino communities in the Central and North Inland regions of San Diego County. These Task Orders are designed to develop meaningful collaborations and partnerships, increase outreach and engagement within the faith-based communities, increase education and training about BHS, identify what services are available for individuals with serious mental illness (SMI) and serious emotional disturbance (SED), and where and how to access mental health and alcohol and drug services and other resources. Contracts began in February 2016.

Housing for Mental Health Clients:
The Corporation for Supportive Housing (CSH) is a contracted housing technical consultant to Behavioral Health Services. CSH provides trainings and educational forums for housing developers and supportive service providers to foster an understanding of the cultural dimensions of housing people with mental health conditions. CSH's Fair Housing Training for Developers, for example, stresses not only the legal aspects of fair housing law requirements, but also the understanding of the various needs of this population. CSH continues to be the conduit working between the housing developers and service providers to resolve complex issues regarding tenancy and the related supportive services.

HHSA's Building Better Health Program:
In 2010, after two years of collaborative planning sessions among County staff and community stakeholders, the County of San Diego Board of Supervisors adopted a comprehensive, long-term initiative on health called Building Better Health: Health Strategy Agenda. The decision was sparked by the realization that San Diego County, like much of the nation, was facing a tidal wave of chronic disease and rising healthcare costs. Four major themes are identified that combined can affect the health of residents:

- Building a Better System
- Supporting Healthy Choices
- Pursuing Policy Changes for a Healthy Environment
- Improving the Culture From Within

The original Building Better Health: Health Strategy Agenda has since evolved into a greater, long-term Live Well San Diego initiative to improve the health, safety and quality of life of all County residents.

The theme of improving the culture from within focuses on increasing employee knowledge about health, promoting employee wellness, and implementing internal policies and practices that support employee health. Healthy County employees play a vital role in a healthier San Diego community.

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

In the design and development of services for culturally diverse groups, the lessons learned include the following:

- Building and developing relationships is a continuous and constant process to engage stakeholders through addressing common issues and concerns in a meaningful way.
- Meetings need to include key community leaders and representatives who can act as culture brokers and mediators. The meetings should be conducted in their own community.

- When engaging the community, we need to consider adjunct and complementary interventions that are common to the cultural and diverse groups that make up the community, and utilize trauma informed approaches.
- Outreach and engagement strategies for ethnically and culturally diverse communities take time. The process and investment of resources may require developing and accommodating to non-traditional ways to build relationships and think creatively while leveraging the countywide effort to integrate trauma-informed systems.

E. Identify county technical assistance needs.

The County will welcome technical assistance in the following area: the adaptation of evidence supported and/or promising practices for culturally diverse groups to improve understanding, engagement, access to care, and retention. For example, in San Diego, information on how to adapt evidence supported/best practices for Latinos, Asian/Pacific Islanders, Middle Easterners and Africans would be helpful.

COMMITMENT TO CULTURAL COMPETENCE

III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence.

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

The County shall include the following in the CCPR:

A. Evidence that the County Mental Health System has a designated CC/ESM who is responsible for cultural competence and who promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial, ethnic, cultural, and linguistic populations.

Dr. Piedad Garcia is the Ethnic Services Manager who is responsible for cultural competence and who promotes the development of trauma-informed and social-ecological mental health services that appropriately meet the diverse needs of the county's racial, ethnic, cultural and linguistic populations.

B. Written description of the cultural competence responsibilities of the designated CC/ESM.

The Ethnic Services Manager (ESM) is the Deputy Director for Behavioral Health Services. Dr. Garcia advises and directs planning, recommends policy, compliance and evaluation components of the county system of care. In her role as ESM, she makes recommendations to the BHS Director to assure access and quality services for linguistically, ethnically, and culturally diverse groups. The ESM is the current Chair of the Cultural Competence Resource Team.

In her capacity as the Deputy Director for Behavioral Health Services, she oversees a very large system of care that serves over 41,000 clients in an array of outpatient, inpatient, crisis residential, rehabilitation, and recovery services across San Diego County. Her support staff monitors, oversees, and ensures the provision of integrated behavioral health services and co-occurring disorder services that are culturally relevant and appropriate. Dr. Garcia takes lead responsibility for the development and implementation of cultural competence planning within the SDCBHS. She provides direction and oversight in the AOA SOC for diversity-related contracted and directly operated services. She also oversees and participates in the monitoring of organizational providers to verify that the delivery of services is in accordance with local and State mandates as they affect underserved populations.

As an Executive Team member of the BHS Management and Leadership team, the ESM makes program and procedure policy recommendations to the Behavioral Health Services Director and the Quality Improvement Unit. She also maintains close collaborative relationships with consumer and family organizations. An active advocate, she consults and has a supportive relationship with local planning boards, advisory groups and task forces, the State, and other behavioral health advocates. Dr. Garcia has also been selected to participate in the California Latino Mental Health Reducing Disparities Project, Latino Concilio, which develops the Latino Health Care Disparities Strategic Plan for the California Department of Health Care Services (DHCS).

COMMITMENT TO CULTURAL COMPETENCE

IV. Identify budget resources targeted for culturally competent activities.

The County shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.

EXAMPLES: BUDGET RESOURCES TARGETED FOR CULTURALLY COMPETENT ACTIVITIES

Chaldean Services	486,000
Survivors of Torture, Int.	390,352
MH Services for Deaf, Hard of Hearing	674,331
Client Operated Peer Support Services	748,400
Client and Family Liaison Services	522,355
Mental Health Systems, Center Star FSP	3,455,677
Union of Pan Asian Communities	1,706,777
Union of Pan Asian Communities, Elder Multicultural Access and Support (EMASS)	569,153
Maria Sardinas Outpatient	2,693,975
Indian Health Council, Southern Indian Health, Sycuan, and SD American Indian Health Center	1,965,000
Pathways Community Services for TAY	4,379,170
McAlister Institute for Treatment and Education (MITE) – New Hope	422,000
Breaking Barriers, MHS, Inc.	687,800
Reaching Out-Older Adults	540,380

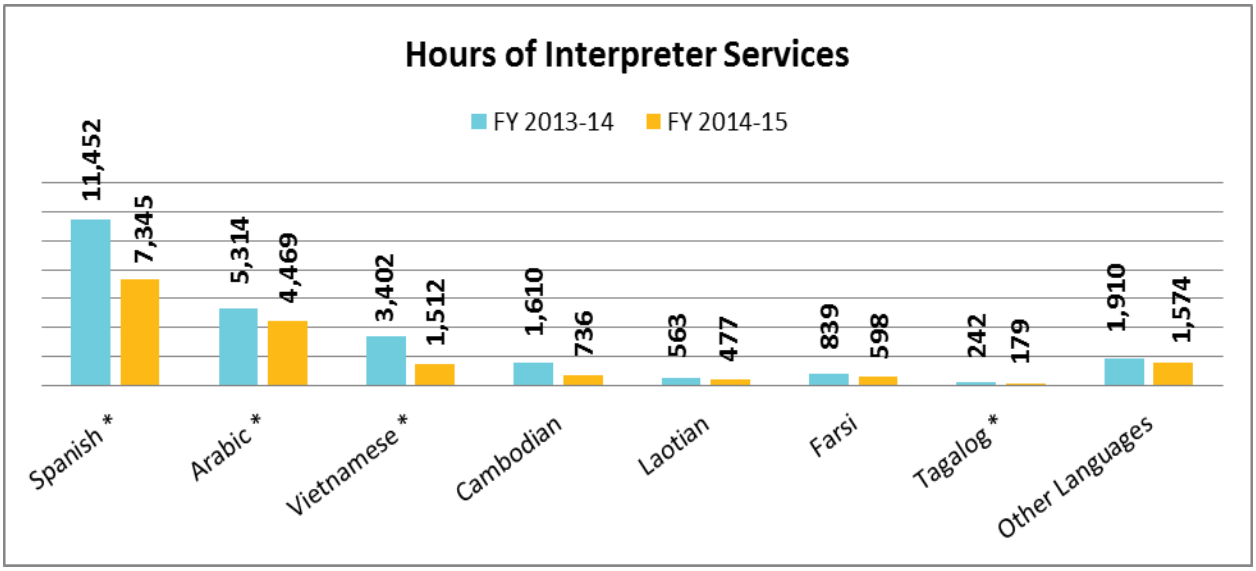
In addition to its ongoing programming, the SDCBHS has 133 contracts with programs through MHSA CSS funding and 58 contracts with programs through PEI to help address disparities and provide more culturally competent activities for persons with mental health problems. In addition, five new MHSA Innovations programs have started July 2015, and two programs are scheduled to begin July 2016.

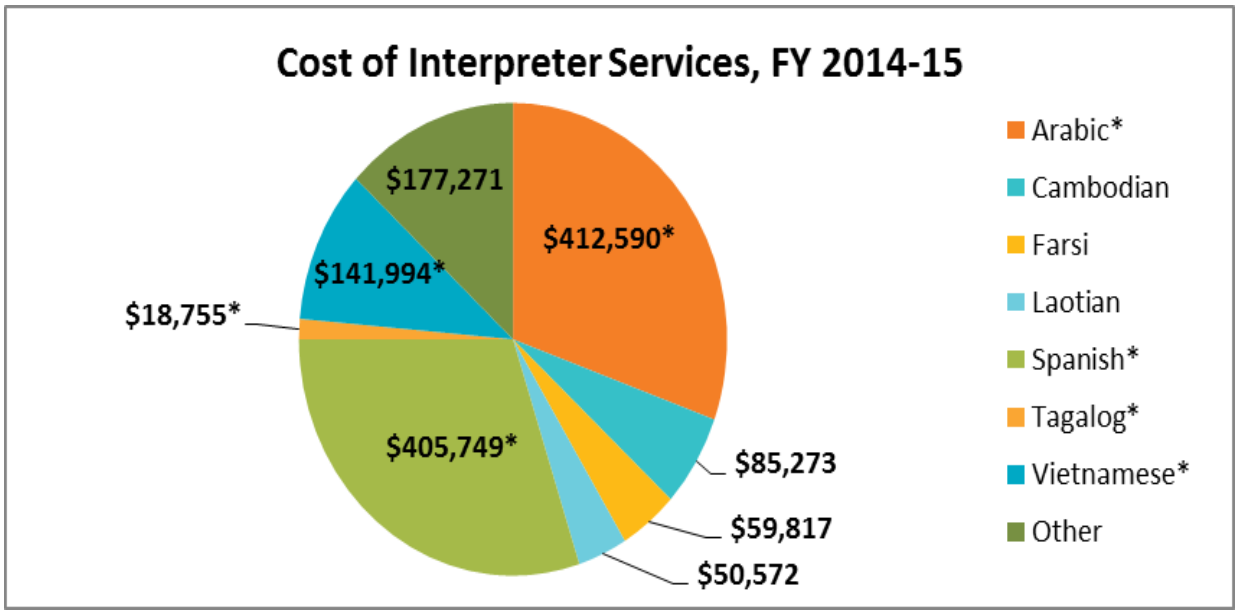
B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

1. *Interpreter and translation services;*
2. *Reduction of racial, ethnic, cultural and linguistic mental health disparities; school-based services and the Hispanic youth;*
3. *Outreach to racial and ethnic county-identified target populations;*
4. *Culturally appropriate mental health services; and*
5. *If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.*

1. Interpreter and translation services

The awareness of interpreter services, the demand for these services, and the consequent funding allocation for interpreter services has continued to increase, as shown below:





It should be noted that interpreter services are also available through the SDCBHS 24/7 Access and Crisis Line, Jewish Family Service Patient Advocacy, Interpreters Unlimited, Deaf Community Services, Accent on Languages, and more.

2. Reduction of racial, ethnic, cultural and linguistic mental health disparities

To widen the access to children's services to increase access and reduce ethnic disparities, the SDCBHS began its drive to bring services to the community through the school-based program. It was believed that minority groups would be more likely to be engaged because non-threatening treatment sites were established in local schools, and parents could participate without having to find transportation. The EPSDT and MHSA CSS funding allowed the County to expand the program from seven schools in 1999 to more than 350 schools throughout the County.

The penetration rate among Hispanic youth clients rose from 2.8 percent in FY 2001-02 to 5.8 percent in FY 2012-13; it is expected that programs funded through MHSA will continue to result in an increasing penetration rate.

Among the cultural disparities the County addressed, age targeted services were started through MHSA to reach out to underserved and unserved populations of Transition Age Youth (TAY) and older adults. A full-service partnership (FSP) program focuses on TAY and provides housing, treatment services, and a dedicated clubhouse with more age-appropriate services.

The SDCBHS is addressing the service disparities for the homeless population. Several Assertive Community Treatment (ACT) programs help the homeless and those being released from jail get an appropriate level of care in the community, so that they can avoid costly inpatient and jail services.

3. Outreach to racial and ethnic County-identified target populations

Many of BHS programs outreach to racial and ethnic specific populations. For example, the two following PEI programs target specific ethnic groups. The Elder Multicultural Access and Support Services (EMASS) PEI program is a peer-based outreach and engagement program targeted to Hispanic, African refugee, African American, and Asian Pacific Islander older adults to support prevention of mental illness and increase access to care. Breaking Down Barriers is another program that provides mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), Lesbian/Gay/Bisexual/Transgender/Questioning/ Intersex (LGBTQI), African, and African American communities.

4. Culturally appropriate mental health services

All County and Contracted outpatient programs are required to be moving along a continuum toward providing trauma-informed, social-ecological, and culturally appropriate services. Such services currently include having staff with language capabilities matching the community needs to the maximum degree possible, creating a welcoming atmosphere, authentically partnering with our clients to develop meaningful relationships, and providing free access to interpreter services. All providers have cultural competence plans in place, are moving toward proficiency testing of bilingual staff, and employing a self-examination test of their own agency cultural competence. All contracts have also been updated to include the implementation of CLAS Standards, as well as ensuring staff have received at least four hours of Cultural Competency Training each year. In 2014, SDCBHS updated the Cultural Competence Handbook. The

handbook contains tools that will assist Behavioral Health providers in making improvements throughout the system of care.

Still other programs are targeted toward specific ethnic, age, or cultural groups. In FY 14-15, the SDCBHS spent approximately $100,000,000 of the total budget on outpatient programs located on this continuum of providing culturally appropriate behavioral health services.

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

County clinical staff who speak any of the threshold languages (Spanish, Vietnamese, Tagalog, and Arabic) receive an additional hourly stipend. The SDCBHS strongly encourages its providers to consider a similar system to help in the attraction and retention of bilingual staff. At the current time, the SDCBHS is beginning to integrate trauma-informed systems, which includes developing authentic relationships with spiritual providers representing the diversity in our communities.

SDCBHS provides stipends with first priority for bilingual/bicultural licensed students through the following programs: San Diego State University – LEAD, San Ysidro Health Center, and Alliant International University.

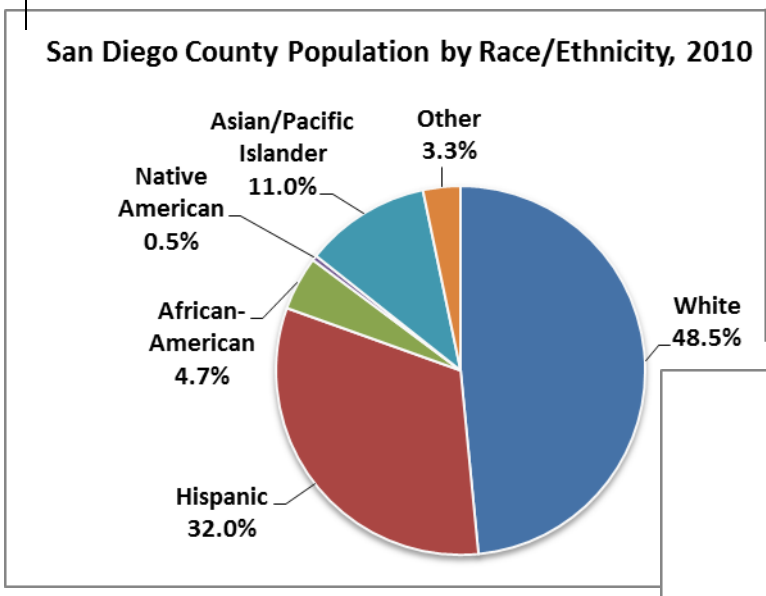
UPDATED ASSESSMENT OF SERVICE NEEDS

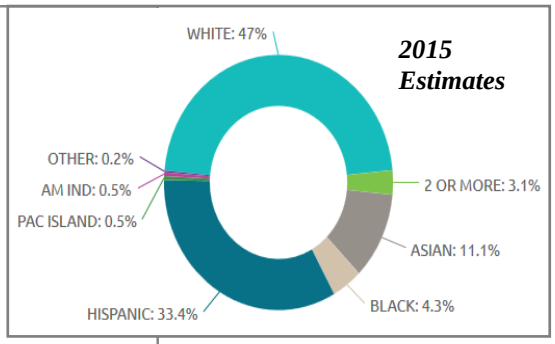
I. General Population

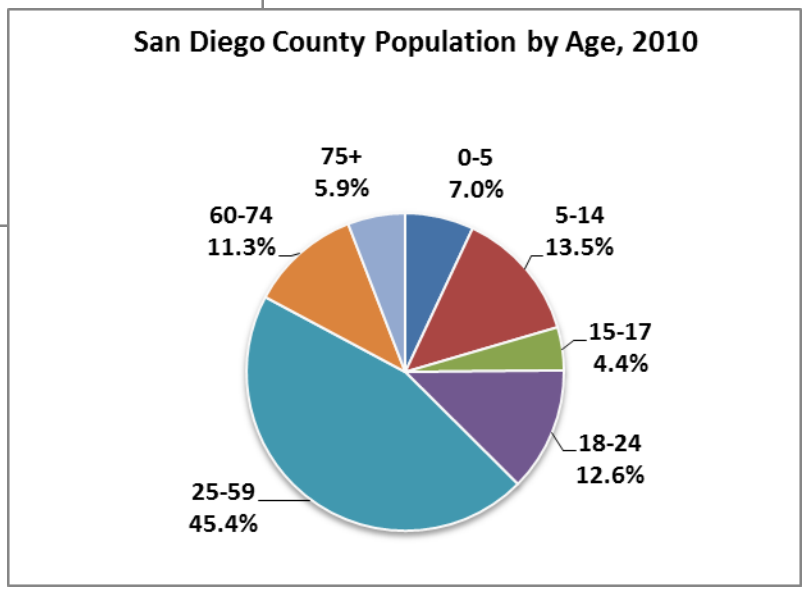
The County shall include the following in the CCPR:

A. Summarize the county's general population by race, ethnicity, age, and gender. The summary may be a narrative or as a display of data (other social/cultural groups may be addressed as data is available and collected locally).

San Diego County Population in 2010: 3,095,313					
Age Group		**Race/Ethnicity**		**Gender**	
0-5	203,423	*White*	1,500,047	*Male*	1,553,679
5-14	392,745	*Hispanic*	991,348	*Female*	1,541,634
15-17	128,000	*African-American*	146,600		
18-24	367,845	*Native American*	14,098	**Median Age**	
25-59	1,322,259	*Asian/Pacific Islander*	341,562	*Male*	33.3
60-74	329,865	*Other*	101,658	*Female*	36.1
75+	170,871				







Data Source: SANDAG Demographic and Socio-Economic Estimates, 2010 Census, San Diego

UPDATED ASSESSMENT OF SERVICE NEEDS

II. Medi-Cal population service needs (Use current CAEQRO data if available.)

The County shall include the following in the CCPR:

A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).

B. Provide an analysis of disparities as identified in the above summary.

Note: *Objectives for these defined disparities will be identified in Criterion 3, Section III.*

San Diego MHP Medi-Cal Enrollees and Beneficiaries Served in CY14 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	116,405	11,175
Hispanic	276,487	11,415
African-American	40,597	3,629
Asian/Pacific Islander	59,093	2,110
Native American	2,354	232
Other	104,608	6,151
Total	599,543	34,712

**The total is not a direct sum of the averages above it. The averages are calculated separately.*

The table above shows the racial/ethnic breakdown of Medi-Cal enrollees and beneficiaries served in San Diego County in Calendar Year 2014.

Data Source: EQRO Report 2016.

Medi-Cal Data for San Diego County Mental Health Plan, 2014			
	Average # of Eligible per Month	**# of Beneficiaries Served per Year**	**Penetration Rate**
TOTAL	599,543	34,712	5.79%
AGE GROUP			
0-5	109,210	2,075	1.90%
6-17	202,327	13,633	6.74%
18-59	205,100	16,173	7.89%
60+	82,908	2,831	3.41%

GENDER			
Female	333,012	16,199	4.86%
Male	266,532	15,853	5.95%
RACE/ETHNICITY			
White	116,405	11,175	9.60%
Hispanic	276,487	11,415	4.13%
African-American	40,597	3,639	8,94%
Asian/Pacific Islander	59,093	2,110	3.57%
Native American	2,354	232	9.86%
Other	104,608	6,151	5.88%

Data Source: Table figures above obtained from EQRO Report 2016.

Figure D-9. San Diego Number of Beneficiaries Served CY12 - Race/Ethnicity by Service Type

	African-American	Asian/Pacific Islander	Hispanic	Native American	Other	White
All	3,909	1,809	10,702	229	3,977	11,216
Inpatient Services	441	139	691	35	369	1,154
Residential Services	136	24	90	6	129	423
Crisis Stabilization	220	39	278	12	181	449
Day Treatment	301	37	489	18	61	379
Case Management	1,141	381	2,892	72	959	3,148
Mental Health Serv.	2,983	1,417	9,106	179	3,044	8,438
Medication Support	2,175	1,015	3,989	125	2,392	6,492
Crisis Intervention	207	49	482	17	165	625
TBS	91	18	334	7	50	191

Data Source: Figure D-9 obtained from EQRO Report 2014.

UPDATED ASSESSMENT OF SERVICE NEEDS

III. 200% of Poverty (minus Medi-Cal) population and service needs

The County shall include the following in the CCPR:

A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally.)

B. Provide an analysis of disparities as identified in the above summary.

Note: *Objectives will be identified in Criterion 3, Section III.*

Every three years, the SDCBHS develops a report titled "Progress Towards Reducing Disparities in Mental Health Services." The purpose of the report is to provide progress towards the reduction of disparities across racial/ethnic and age groups. The most recent report was published in 2014 for the FY 2012-13, and notes the disparities that exist in San Diego County and how they compare to FYs 2001-02, 2006-07, and 2009-10. The report is included in Appendix 1.

The table below shows the breakdown of uninsured individuals or individuals on Medi-Cal under 200% FPL compared to actual CYF and A/OA BHS clients in FY 2012-13.

	San Diego County Uninsured or Medi-Cal under 200% FPL, 2013		BHS Clients		San Diego County Uninsured or Medi-Cal under 200% FPL for 2013		BHS Clients	
	CYF Population				A/OA Population			
	Number	%	Number	%	Number	%	Number	%
White	31,855	13%	3,805	23%	75,783	22%	19,619	53%
Hispanic	177,589	71%	10,346	62%	211,751	60%	9,294	25%
African American	22,007	9%	2,044	12%	26,911	8%	5,348	15%
Asian/Pacific Islander	14,179	6%	437	3%	30,668	9%	2,147	6%
Native American	5,109	2%	91	1%	6,954	2%	276	1%
Total Clients	250,739	100%	16,723	100%	352,068	100%	36,684	100%

County of San Diego Behavioral Health Combined Population and Service Needs.

In planning for services, the County of San Diego Behavioral Health Services has found it more useful and reflective of the County's population to consider the combined needs of the Medi-Cal and Indigent populations. The Disparities Report is specifically developed to highlight the disparities that exist in our system and assist the SDCBHS in developing strategies to address specific service, access, and retention needs. The full report provides more definitive information by age, race/ethnicity, language, service utilization, and diagnosis to build on the

State information. The full report can be located at http://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/2014-15%20Updates/HSRC_2014%20Disparities%20Report_FINAL_8.26.2014.pdf.

The Disparities Report identified the following disparities in San Diego County's Behavioral Health Services:

Latino Adults may be underserved and not as easily engaged.

- 31% of Hispanic adult clients identified Spanish as their preferred language
- Only 19% of adult clients served were Hispanic, while the County population was 30%
- 13% of adults had only one visit to an outpatient program
- 45% of adults had fewer than eight visits
- Clients were less likely to use Forensic services than the overall Mental Health population

Latino Children may be underserved and not as easily engaged.

- Had among the lowest penetration rates in FY 2006-07, although it had increased since FY 2001-02. The proportion of Latino children in the County population continues to increase, going from 2.8% in FY 2001-02 to 5.8% in FY 2012-13.
- Almost 30% identified Spanish as their preferred language
- Approximately half the children receiving MH services identify themselves as Hispanic
- 30% had fewer than five visits to outpatient services; of that group 12% had only one visit

African American Adults may be underserved and/or not as easily linked with less acute levels of care.

- Were more likely to use only inpatient/emergency services (18%) and only jail services (27%) and less likely to use outpatient services than other racial/ethnic groups
- Had a high rate of diagnosis with Schizophrenia or Schizoaffective disorder
- 45% of the clients are female and 53% male

African American Children may be underserved and/or not as easily linked with less acute levels of care.

- Were more likely to use juvenile forensics services without using any other type of less restrictive services than other racial/ethnic groups
- Were more likely to use Day Treatment Services – a comparatively intensive treatment modality
- 13% had only one visit to outpatient services

Asian/Pacific Islander Adults were underserved.

- 41% identified an Asian language as their preferred language

- 54% of clients were female and 46% male
- Had moderate to low access rates compared to most other racial/ethnic groups; the rates have gone up slightly over time

Asian/Pacific Islander Children were underserved.

- Had low access rates compared to other racial/ethnic groups, and the rates have gone down slightly over time.
- Had the lowest engagement rate and were most likely to discontinue services after one visit
- 16% had only one visit
- However, 89% identified English as their preferred language, 3% identified Vietnamese, and 7% assorted other languages

Native American Adults were underserved.

- Had among the second lowest access rates, although the rate has increased slightly over time
- 96% identified English as their preferred language
- 56% of the clients were female and 44% male

Native American Children were underserved and not as easily linked with less acute levels of care

- Had the lowest access rate among racial/ethnic groups, and there was a slight decline over time
- Were most likely to use inpatient only services

<u>Other Factors Affecting Children's Usage of Mental Health Services</u>

- 20% of children receiving mental health services were also involved with Child Welfare Services, and 36% were receiving Special Education services.
- 24% of children 12-17 used juvenile forensic services only.
- 18% of all CMHS clients were also open to the Probation System.
- Transitional Age Youth had the lowest access rates among age groups and their access to services declined slightly over time.
    - 31% had three or fewer visits to outpatient services.
    - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to use outpatient services.

The Gap Analysis and Disparities Report provided the foundation for determining service priorities for the CSS Plan, the WET Plan, and the PEI Plan.

UPDATED ASSESSMENT OF SERVICE NEEDS

IV. MHSA Community Services and Supports (CSS) population assessment and service needs.

The County shall include the following in the CCPR:

A. *From the County's approved CSS plan, extract a copy of the population assessment. If updates have been made to this assessment, please include the updates. Summarize population and client utilization data by race, ethnicity, language, age and gender (other social/cultural groups may be addressed as data is available and collected locally*).

From Original CSS Plan:
Section II, Part II: Analyzing Mental Health Needs in the Community

A detailed gap analysis was prepared to fully understand the scope of mental health needs among all four target population age groups. The Gap Analysis, which included estimates of unserved, underserved and inappropriately served individuals, was provided to, reviewed, and discussed by the MHSA Workgroups.

Unserved Populations in San Diego County

The formula used to determine the number of unserved individuals in San Diego County was based on the estimated prevalence of mental health needs among those in poverty, for all age groups, across each ethnic classification, contrasted to the numbers served in the current service system.

In addition, as suggested in the CSS Requirements, the number of individuals who received inpatient or emergency services (stated in DMH requirements as crisis only) and no other mental health services were included in the estimate of the unserved. Another factor considered was the estimated numbers of homeless. These data were provided by the San Diego Task Force on the Homeless.

As can be seen in the figures below, significant ethnic/racial disparities exist among numbers of persons expected to need services, compared to those receiving services in today's system. In addition to the notable disparities demonstrated in the data, these findings were re-affirmed through the community input provided by family members, providers and other interested community stakeholders.

Estimates for Unserved Populations in San Diego County

1. 15,821 Children and Youth (0-17)
   - Of these, the primary racial/ethnic groups who are unserved are Latinos (8,805) and Asian Pacific Islanders (1,447).
   - In addition to the ethnic/racial disparities, as many as 1,896 uninsured children may need mental health services and are currently unserved.

2. 8,900 Transition Age Youth (TAY) (between18 and 25)
   - In San Diego County, the unserved TAY are identified as between ages 18 and 25 years of age because there is no apparent service gap for 16 and 17 year olds.
   - Of this unserved group, the primary ethnic/racial disparity groups are Latinos (2,506) and Asian Pacific Islanders (312).
   - In addition, 1,127 youth utilized only crisis or emergency services, indicating needs for higher levels of services.

3. 16,007 Adults (25-59)
   - The majority of the unserved adults come from two primary ethnic/racial disparity groups: Latinos (9,422) and Asian Pacific (1,970).
   - 4,615 adults utilized only emergency or inpatient mental health services, indicating a need for community-based intensive services in order to prevent these occurrences.
   - Native Americans were much more likely to be in this category than expected, based on their prevalence in the general population.
   - In addition, there are an estimated 11,000 adults without insurance who may need mental services and who are currently unserved. We received significant community input about the need to expand culturally competent services for these groups.
   - As a result of community input, SDMHS will track service use by Transitional Age Adults, ages 50-59 years, to better understand mental health needs among this population.

4. 4,613 Older Adults (60+)
   - 578 older adults received only emergency or inpatient services, but were not connected to other services.
   - Prevalence estimates will be evaluated on an ongoing basis because the MHSA Older Adult Workgroup felt the prevalence estimates were too low, as stigma and isolation contribute to more underreporting and lack of recognition of mental illness among older adults.

Chart A. Service Utilization by Race/Ethnicity

The following tables provide estimates that guided the development of the CSS programs of the total number of persons needing MHSA-level mental health services who already are receiving

services, including those fully served or underserved/inappropriately served, by age group, race ethnicity, and gender.

Transition Age Youth 18-24	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	5	0	746	574	5409	100%	130,559	100%	337,506	100%
RACE/ETHNICITY										
African American	2	0	102	52	626	11.6%	8,935	7%	20,623	6%
Asian Pacific Islander	0	0	35	26	259	4.8%	12,660	10%	35,965	11%
Latino	1	0	209	129	1,579	29.2%	53,620	41%	122,665	36%
Native American	0	0	9	3	32	.6%	1,611	1%	2,147	1%
White	1	0	349	239	2,567	47.5%	48,699	37%	143,093	42%
Other (and UK)*	1	0	42	125	346	6.4%	5,034	4%	13,013	4%

** Other includes other, unknown and 2 or more races*
*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages18+*
**** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines*

Adults 25-59	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	261	184	4004	3949	30,776	100%	347,997	100%	1,917,017	100%
RACE/ETHNICITY										
African American	46	39	583	558	3,656	11.9%	19,618	6%	78,404	4%
Asian Pacific Islander	10	11	174	190	1,626	5.3%	26,296	8%	164,799	9%
Latino	30	25	748	793	5,993	19.5%	127,502	37%	390,659	20%
Native American	0	3	22	33	189	0.6%	1,432	0%	7,896	0%
White	166	103	2300	2211	16,549	53.8%	87,216	25%	803,549	42%
Other*	9	3	177	164	2,763	9.0%	85,531	25%	471,710	25%

Older Adults 60+	Fully Served***		Underserved or Inappropriately Served		Total Served		County Poverty Population**		County Population	
	MALE	FEMALE	MALE	FEMALE	Number	%	Number	%	Number	%
TOTAL	14	15	175	373	577	100%	96,530	100%	434,147	100%
RACE/ETHNICITY										
African American	2	2	17	40	186	6.7%	4,676	5%	14,248	3%
Asian Pacific Islander	0	0	7	16	197	7.1%	9,482	10%	40,446	9%
Latino	0	2	29	74	420	15.1%	21,908	23%	56,392	13%
Native American	0	0	1	0	7	0.3%	414	0%	1,856	0%
White	12	10	107	226	1,571	56.6%	58,922	61%	314,353	72%
Other*	1	1	14	17	393	14.2%	1,530	2%	6,852	2%

** Other includes other, unknown and 2 or more races*

*** County poverty population is based on prevalence data and the percentages are estimated based on percentages for Ages 18+*

**** Fully served are those receiving Wraparound or AB2034 services according to DMH guidelines.*

B. Provide an analysis of disparities as identified in the above summary.

Analysis of Ethnic Disparities in Fully Served, Underserved or Inappropriately Served Populations in San Diego County

The populations continue to have disparities in mental health services in San Diego County. The disparities and variations in penetration rates and retention rates continue to be addressed through training, staffing, evidence-based practices, program evaluation, etc. Specific programs have been developed through MHSA to increase services to these populations based on the original gap analysis.

Latinos
The data on the disparities point to a clear need to increase access to care for Latino children, TAY, adults, and older adults who live in poverty. Latino females, as compared to males, are underrepresented in both children and TAY age groups. There is no gender gap among adult Latinos. According to the data, Older Adult Latino males are underrepresented. Latino children who are fully served in the Children's System of Care/Wraparound Services program represent approximately 27% of all fully served. Latino fully served adults and older adults in the REACH program represent only 12% of all fully served population of the REACH program.

Asian/Pacific Islanders
The Asian/Pacific Islander population is under-represented in the public mental health system, comprising 8% of the target population and only 5% of current mental health clients. This need is complex and poses a challenge to the mental health system because the grouping of Asian/Pacific Islanders is composed of many linguistically and ethnically diverse groups. This umbrella group includes Amerasian, Cambodian, Chinese, Filipino, Hawaiian Native, Hmong, Japanese, Korean, Laotian, Pacific Islander, and Vietnamese. The Asian/Pacific Islander population also represents over 30 languages and dialects.

African Americans
The African American general population is expected to stay relatively constant at 5-6%, yet they are over represented in acute inpatient care, in the juvenile forensic system, and in adult jail mental health services. They are also more likely to receive a diagnosis of schizophrenia and are more likely to be male.

Native Americans
While there may not be a substantial difference between Native Americans served and the county's Native American population, San Diego County is home to 17 reservations, composed of numerous tribal groups. The gap analysis noted that Native American children compose one percent of the children's mental health system, yet have varying rates of contact with other systems:

- They represent 1.6% of the mental health clients concurrently receiving Child Welfare Services;
- 3.2% are concurrently receiving services in Alcohol & Drug Services; and

- 0.2% of the children concurrently open to Juvenile Forensic Services.

Other populations that San Diego County has targeted since the original gap analysis was conducted for MHSA planning include Veterans, LGBTIQ, and individuals in jail.

Veterans

In order to measure disparities in mental health services among veterans in San Diego County, the number of A/OA veterans have been monitored. When compared to FY 2010-11, the overall veteran admissions in FY 2014-15 have increased by 19.5% (4,377 vs. 5,232). Compared to previous fiscal years, the largest number of A/OA veteran admissions were in FY 2013-14. The proportion of veteran admissions to the Emergency Psychiatric Unit (EPU), San Diego County Psychiatric Hospital (SDCPH), and Full Service Partnership (FSP) programs in FY 2014-15 has been increasing over the last six fiscal years, and has increased by 2.0% since FY 2013-14.

Number of Veteran Admissions in A/OA System of Care

Fiscal Year	Grand Total	Veteran Admissions to EPU/SDCPH/FSP	*Percentage of Veteran Admissions to FSP/EPU/SDCPH*
FY 2010-11	4,377	941	*21.5%*
FY 2011-12	4,806	1,034	*21.5%*
FY 2012-13	5,276	1,262	*23.9%*
FY 2013-14	5,341	1,294	*24.2%*
FY 2014-15	5,232	1,372	*26.2%*

In an effort to ensure that veterans are competently served, BHS has been assessing trends of FSP involvement. When compared to FY 2013-14, the overall number of admissions to FSP programs among A/OA veterans has decreased by 42.9% in FY 2014-15 (52 vs. 91).

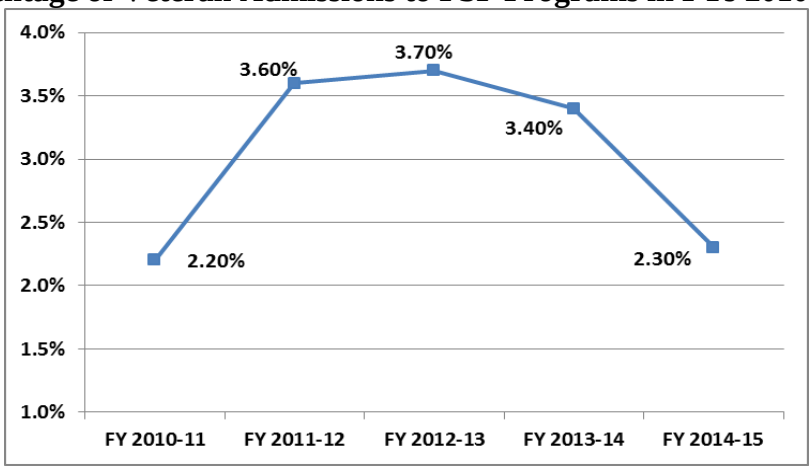
Veteran Admissions to FSP Programs

Fiscal Year	FSP Program Admissions	Veteran FSP Admissions	*Percentage of Veteran Admissions to FSP*
FY 2010-11	2,325	52	*2.2%*
FY 2011-12	2,276	81	*3.6%*
FY 2012-13	2,499	93	*3.7%*
FY 2013-14	2,706	91	*3.4%*
FY 2014-15	2,266	52	*2.3%*

Total/Percentage Breakdown of Veteran Admissions by Facility Type

In order to show the trend of veterans in FSP programs through the previous fiscal years, the total percentage of A/OA veterans in FSP programs in FY 2010-14 is shown below. Compared to previous fiscal years, FY 2012-13 has shown to be the most successful with a 3.7% of FSP veterans served.

Percentage of Veteran Admissions to FSP Programs in FYs 2010-2015



LGBTIQ

To ensure that LGBTIQ are appropriately served, BHS has been monitoring client sexual orientation among all population groups. Many clinicians feel uncomfortable reporting sexual orientation; however, with various trainings and outreach efforts, clinicians are now more comfortable reporting client sexual orientation. In FY 2014-15, the sexual orientation variable was answered for 73% of clients, compared to 66% of clients in FY 2013-14. The majority of clinicians deferred the sexual orientation response, especially among clients' ages 0-11 years. The proportion of clients for whom sexual orientation was deferred declined steadily as client age increased. In addition, among responses that were not missing or deferred, clients were most frequently identified as "heterosexual."

Grand Total of Client Sexual Orientation in CYF in FY 2013-14

FY 2013-14 (Percentage of clients within each age group)

Sexual Orientation	Age (years)				
	0-5	6-11	12-15	16-17	18+
Bisexual	0%	0%	2%	2%	3%
Deferred	74%	49%	23%	10%	7%
Gay Male	0%	0%	0%	0%	1%
Heterosexual	3%	14%	39%	47%	51%
Intersex	0%	0%	0%	0%	0%
Lesbian	0%	0%	0%	1%	1%
Other	0%	0%	0%	0%	0%
Questioning	0%	0%	1%	1%	1%
Transgender	0%	0%	0%	0%	0%
Decline to State	0%	0%	1%	1%	1%
MISSING	22%	36%	34%	37%	34%
TOTAL	100%	100%	100%	100%	100%

Grand Total of Client Sexual Orientation in CYF in FY 2014-15

FY 2014-15 (Percentage of clients within each age group)

Sexual Orientation	Age (years)				
	0-5	6-11	12-15	16-17	18+
Bisexual	0%	0%	2%	4%	4%
Deferred	80%	50%	17%	7%	5%
Gay Male	0%	0%	0%	1%	1%
Heterosexual	3%	19%	49%	56%	64%
Intersex	0%	0%	0%	0%	0%
Lesbian	0%	0%	0%	1%	2%
Other	0%	0%	1%	0%	1%
Questioning	0%	0%	1%	1%	1%
Transgender	0%	0%	0%	0%	1%
Decline to State	0%	1%	1%	1%	1%
MISSING	17%	30%	28%	30%	21%
TOTAL	100%	100%	100%	100%	100%

To fully understand the scope of mental health needs among LGBTIQ, client sexual orientation have been monitored in the A/OA system as well. In FY 2014-15, the sexual orientation variable was answered for 41% of clients compared to 40% in FY 2013-14. The majority of clinicians deferred the sexual orientation response, especially among clients' ages 18-24 years. The proportion of clients for whom sexual orientation was deferred declined steadily as client age increased. In addition, among responses that were not missing or deferred, clients were most frequently identified as "heterosexual."

Grand Total of Client Sexual Orientation in A/OA in FY 2013-14

FY 2013-14 (Percentages within age groups)

Sexual Orientation	Age (years)			
	<18-24	25-59	60+	TOTAL
Bisexual	1%	1%	0%	1%
Deferred	3%	1%	1%	1%
Gay Male	0%	1%	0%	1%
Heterosexual	19%	26%	27%	25%
Intersex	0%	0%	0%	0%
Lesbian	0%	1%	0%	0%
Other	0%	0%	0%	0%
Questioning	0%	0%	0%	0%
Transgender	0%	0%	0%	0%
Decline to State	0%	1%	1%	1%
Missing	75%	70%	71%	71%
TOTAL	100%	100%	100%	100%

Grand Total of Client Sexual Orientation in A/OA in FY 2014-15

FY 2014-15 (Percentages Within Age Groups)

Sexual Orientation	Age (years) <18-24	25-59	60+	TOTAL
Bisexual	3%	1%	<1%	1%
Deferred	2%	1%	1%	1%
Gay Male	<1%	1%	<1%	1%
Heterosexual	32%	37%	36%	36%
Intersex	<1%	<1%	<1%	<1%
Lesbian	1%	1%	<1%	1%
Other	1%	<1%	<1%	<1%
Questioning	1%	<1%	<1%	<1%
Transgender	<1%	<1%	<1%	<1%
Decline to State	<1%	1%	1%	1%
Missing	60%	58%	62%	59%
TOTAL	100%	100%	100%	100%

Jail Population

Over the past two years, San Diego County has implemented programs and conducted analysis on disparities in mental health services among the jail population. Overall, 9,354 adults ages 18 and older received mental health services in jail which constitutes 19% of the total number of adults (49,043) who received mental health services. For children and youth, 1,843 children ages 0-17 received mental health services in Juvenile Forensic Services (JFS) which constitutes 9% of the total number of children and youth (19,801) who received mental health services. Men made up 77% of the jail population and 51% of the total mental health adult population, compared to women who made up 23% of the jail population and 48% of the total adult mental health population. Among the ages 0-17, men made up 75% of the JFS population and 56% of the total child and youth mental health population. Women made up 25% of the jail population and 44% of the total child and youth mental health population.

As shown below, there is a high percentage of African Americans in San Diego County jails than the overall BHS clients served. African American adult clients made up 20% of the population receiving jail services, compared to 12% of the adult BHS population. Similarly, African American child and youth clients made up 18% of the population receiving JFS services, compared to 9% of the child and youth BHS population. All other races were more proportional to their percentages in the overall mental health population.

Jail Services/Juvenile Forensic Services Report for FY 2014-15
Demographics of JFS/Jail Population Compared to Overall BHS Population

	Age 0-17				Age 18+			
	FY 2013-14		FY 2014-15		FY 2013-14		FY 2014-15	
Total Clients Receiving Jail/ JFS Services:	2,195	11%	1,843	9%	10,643	22%	9,354	19%
Total Clients Receiving All MH Services:	20,117		19,801		48,481		49,043	

Age	Age 0-17 FY 2013-14 JFS Population	Age 0-17 FY 2013-14 All BHS Population	Age 0-17 FY 2014-15 JFS Population	Age 0-17 FY 2014-15 All BHS Population	Age	Age 18+ FY 2013-14 Jail Population	Age 18+ FY 2013-14 All BHS Population	Age 18+ FY 2014-15 Jail Population	Age 18+ FY 2014-15 All BHS Population
Age 0-5	0	10.39%	0	11.00%	Age 18-25	20.18%	17.94%	18.77%	17.29%
Age 6-11	0.25%	34.50%	0.10%	34.85%	Age 26-59	75.61%	69.80%	76.55%	69.68%
Age 12-15	26.27%	32.82%	26.27%	32.54%	Age 60+	4.22%	12.26%	4.68%	13.03%
Age 16-17	55.74%	22.29%	56.79%	21.61%					
Age 18+	17.74%	0	16.85%	0					
Gender									
Female	24%	43%	25%	44%	Female	18%	47%	23%	48%
Male	76%	57%	75%	56%	Male	82%	52%	77%	51%
Unknown	0%	0%	0%	0%	Unknown	0%	0%	0%	0%
Race/Ethnicity									
African American	17%	10%	18%	9%	African American	20%	12%	20%	12%
Asian/Pacific Islander	2%	3%	2%	3%	Asian/Pacific Islander	3%	5%	3%	5%
Hispanic	59%	56%	58%	55%	Hispanic	24%	24%	24%	23%
Native American	1%	1%	1%	1%	Native American	1%	1%	1%	1%
White	18%	21%	17%	20%	White	48%	44%	47%	42%
Other	3%	10%	3%	13%	Other	4%	13%	4%	17%

In FY 2014-15, the most common diagnosis among the JFS population was Oppositional/Conduct Disorders (33%), compared to the overall BHS population of clients ages 0-17 where the most prevalent diagnosis was Stressor and Adjustment Disorders (25%), followed by Depressive Disorders (20%). Conversely, the most common diagnosis among the jail population was Schizophrenia and Other Psychotic Disorders (23%), compared to the overall BHS population of clients ages 18 and older where the most prevalent diagnosis was Depressive Disorders (32%).

Homeless Population

In 2015, the annual Point-In-Time-Count (PITC) identified 8,742 homeless individuals living on the streets or in shelters throughout San Diego County. The total number of homeless individuals represents an increase of 2.8% over the PITC conducted in 2014. The County of San Diego is working to better coordinate services to help end homelessness. On September 29, the San Diego County Board of Supervisors approved to add 10 million dollars in one-time MHSA funding to leverage the development of permanent supportive housing for homeless persons with serious mental illness who are enrolled in Full Service partnerships/Assertive Community Treatment (FSP/ACT) programs. The MHSA funding is in addition to 33 million dollars the County has leveraged to create 249 supportive housing units for homeless. The new

funds will enhance the County's efforts to increase housing stock in the County of San Diego and help create approximately 69 new permanent supportive housing units.

In 2015, BHS released the 100 Homeless Person Request for Proposal (RFP) that will provide mental health and addiction services and subsidies from the SDHC for up to 100 clients who will have access to an array of housing options. A second RFP was released to provide home finding services to adults who are enrolled in designated BHS contracted and county outpatient mental health clinics, have a desire to upgrade current housing, have housing instability, and who may be homeless or at-risk of homelessness.

Additionally, Supervisor Cox announced the approval of the recommendation to launch "Project One for All" which will support the seriously mentally ill homeless population. The program will be implemented in the City of San Diego and the unincorporated areas of the County. "Project One for All" added 200 service slots to the following FSP/ACT programs: IMPACT (50), Center Star (50), North Star (50), and Catalyst (50) in the middle of FY 2015-16. Additional outreach and engagement slots were added to two other programs: Friend-to-Friend and Neighborhood House Association.

Unique Clients Served	All Homeless		All A/OA Clients	
	4,444		43,780	
Age	Age			
Age <18-25	491	(11%)	7,483	(17%)
Age 26-59	3,609	(81%)	30,826	(70%)
Age 60+	344	(8%)	5,471	(12%)
Gender	Gender			
Female	1,393	(31%)	20,305	(46%)
Male	3,049	(69%)	23,306	(53%)
Other / Unknown	2	(0%)	169	(0%)
Race / Ethnicity	Race / Ethnicity			
White	2,453	(55%)	19,090	(44%)
Hispanic	820	(18%)	9,672	(22%)
African American	867	(20%)	5,392	(12%)
Asian / Pacific Islander	118	(3%)	2,232	(5%)
Native American	49	(1%)	314	(1%)
Other	77	(2%)	1,968	(4%)
Unknown	60	(1%)	5,112	(12%)

Preferred Language	Preferred Language			
English	4,216	(95%)	34,059	(78%)
Spanish	134	(3%)	2,500	(6%)
Tagalog	7	(0%)	135	(0%)
Vietnamese	11	(0%)	438	(1%)
Other Asian	8	(0%)	320	(1%)
Arabic	6	(0%)	863	(2%)
Middle Eastern	3	(0%)	157	(0%)
Other / Unknown	59	(1%)	5,308	(12%)

In FY 2014-15, the largest proportion of clients identified as homeless were White (55%), followed by nearly a quarter of African American clients (20%). The majority of the homeless clients served in FY 2014-15 were between the ages of 26 and 59 and male.

UPDATED ASSESSMENT OF SERVICE NEEDS

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations.

The County shall include the following in the CCPR:

A. Which PEI priority population(s) did the County identify in their PEI plan? The County could choose from the following six PEI priority populations:

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

All six of the priority populations were identified in San Diego County's PEI Plan. Twenty PEI Project Work Plans were submitted, each one identified at least one of the Priority Populations, and most addressed at least two or three. San Diego County identified 10 priority populations based on community member input; most of these are contained within the broader six listed above. These are as follows: Older Adult Issues; Community and Domestic Violence; School Age; Early Childhood Services; Veterans and their Families; Native American Communities; Rural Community Issues; Co-occurring Disorders; First Break of Psychosis/Transition Age Youth; Primary and Secondary Prevention through outreach, education and media campaigns.

B. Describe the process and rationale used by the County in selecting their PEI priority population(s) (e.g., assessment tools or method utilized).

The County of San Diego utilized community input from the CSS Planning process, data from the Gap Analysis, and ongoing community input through our sustained Stakeholder-led Councils (Children's System of Care Council, Adult System of Care Council, Older Adult System of Care Council, Housing Council, and Mental Health Board). From this community-based input, San Diego County developed eight focus areas: Native American Communities, Veterans and their Families, Co-Occurring Disorders, School Age and Early Childhood, Community and Domestic Violence, First Break of Psychosis, Rural Community Issues (East County, North Inland, Mountain Regions), and Older Adult Issues. A September 2007 "Kickoff Forum," co-facilitated by the Director of Behavioral Health Services and the Mental Health Services Deputy Director, introduced these eight PEI areas of focus and the PEI planning process to the larger community.

The MHSA Planning Team and MHS staff then organized eight community-based forums throughout the county for the purpose of soliciting stakeholder input within each of the focus areas. These community forums, each of which was facilitated by a lead member from the PEI Planning Team or staff support team, took place from November 2007 through March 2008.

During the same time the "Kickoff Forum" and the community forums were taking place, Dr. Hanger, ADD in charge of the MHSA Plan, and members of the PEI Planning Team attended numerous existing community-based stakeholder meetings as part of the outreach campaign to present and outline the PEI planning process, guidelines and timeline and engage community members in the planning process. Between July 2007 and April 2008 the MHSA Planning Team members and support staff participated in over 60 stakeholder meetings across six regions within San Diego County covering a variety of cultural and ethnic communities and age-ranges.

These stakeholder meetings included our ongoing Mental Health Councils, the constituency of which includes consumers, family/caregivers, providers, community experts, public agencies (City and County), education representatives, as well as open membership from local stakeholders. These Councils are chaired by members of the stakeholder community – not by Mental Health staff. Additional ongoing community meetings included community commissions (e.g., Children Youth and Family Commission, Domestic Violence Commission), which are similarly comprised of consumers, professionals, providers (public and private), interested community members, and designees from political offices.

Finally, 30 focus groups were convened specifically to obtain further stakeholder input from the immigrant, African Refugee, African American, Asian/Pacific Islander and LGBTQ communities, as well as other unserved and underserved populations. To ensure stakeholder input was also received from those with serious mental illness and serious emotional disturbances, focus groups were also facilitated in client clubhouses and an adult day health center. Separate from these public meetings, community and stakeholder input was solicited and received in a variety of formats including phone messages, website submissions (the County maintains an ongoing website, www.sandiego.networkofcare.org, which includes a section dedicated to disseminating information related to our MHSA planning process), e-mail and mail (PEI Community Input Forms, memos, letters, and full proposals). The information received was compiled for public review in a more "consumable" PEI Community Input Summary document.

All summary documents incorporating community input were posted on the County of San Diego's Behavioral Health Network of Care website for public information and review. In addition, these summary documents were sent to all members in our continually expanding e-mail distribution list of consumers, professionals, agencies, and other interested parties. All community/stakeholder input received to date, as well as summary documents prepared by the PEI Planning Staff, were also presented in an open, public session of our April 2008 Mental Health Board. The Mental Health Board serves as the initial cross-threading work group, as they are a non-conflict body of existing consumers and other stakeholders. Given the "contracting" nature of our County's mental health services, the issue of "conflict" had been previously resolved during the CSS planning process by our County's requiring the absence of fiscal conflict as a condition of cross-threading membership.

Following additional community input received during the public comment period, the April 2008 Mental Health Board provided a ranking of key community needs and priority populations. These rankings were taken up further by 10 workgroups consisting of a County Mental Health Chief, Regional Program Coordinator, or Assistant Deputy Director as lead, pertinent inter-Agency

County staff, non-conflict community experts, and non-conflict consumers and stakeholders. (During the stakeholder input process, community members had recommended separating School Age and Early Childhood Services into two separate focus tracts for further detailed planning.

Additionally, in the majority of the forum and focus groups, input was received recommending that the County address universal ("primary") prevention needs of suicide risk and stigma and discrimination, as well as targeted ("secondary") prevention for focus populations, within a separate work group. These workgroups scrutinized community input, relative data, and Mental Health Board rankings, as well as holding intensive meetings to develop PEI plans.

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

I. Identified unserved/underserved target populations (with disparities):

The County shall include the following in the CCPR:

- *Medi-Cal*
- *Community Services and Supports (CSS) population: Full Service Partnership (FSP) population*
- *Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce*
- *Prevention and Early Intervention (PEI) priority populations: These populations are County identified from the six PEI priority populations*

A. List identified target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations)

Progress Towards Reducing Disparities

Efforts to decrease barriers to behavioral healthcare among racial/ethnic minorities and clients in different age groups have been a focus for the SDCBHS for many years. The process is complicated by the fact that the demographic breakdown of those eligible for services in the SDCBHS differs markedly from the demographic makeup of the county as a whole. For example, although persons of Hispanic origin make up 30% of the adults in the population of San Diego County, this segment accounts for 60% of the target (eligible client) population.

RACE/ETHNICITY	Estimates of San Diego County Population (age 0-17)*	Target Population Children and Youth**	Actual Clients CYF BHS (FY 2012-13)
White (non Hispanic)	35%	13%	23%
Hispanic	49%	71%	62%
African American	6%	9%	12%
Asian/Pacific Islander	10%	6%	3%
Native American	<1%	2%	1%

RACE/ETHNICITY	Estimates of San Diego County Population (age 18+)*	Target Population A/OA**	Actual Clients A/OA BHS (FY 2012-13)
White (non Hispanic)	53%	22%	53%
Hispanic	30%	60%	25%
African American	5%	8%	15%
Asian/Pacific Islander	12%	9%	6%
Native American	<1%	2%	1%

*Source: 2011-2012 California Heath Interview Survey data.

**Estimates of target population (eligible clients) were derived from California Health Interview Survey (CHIS) estimates applied against 2013 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% FPL that could potentially have a SMI.

NOTE: Percentages may not add up to 100% due to rounding.

Therefore, efforts to increase service utilization often need to focus on specific groups disproportionately to their presence in the overall county population. In order to evaluate the

disparities that exit in San Diego County and to report on the progress towards the reduction of disparities across racial/ethnic groups and age groups, the SDCBHS develops a triennial *Progress Towards Reducing Disparities in Mental Health Services* report. The latest report covers four time points spanning across 11 years (Fiscal Years 2001-02, 2006-07, 2009-10, and 2012-13).

The SDCBHS uses this report to assess the disparities and to prioritize focus on target populations based on the data on the overall service utilization, types of services used, engagement and retention, client diagnosis, and racial/ethnic distribution rates.

Furthermore, the Statements of Work for CSS, WET and PEI contracts include specific language on priority populations and target areas that are continuously monitored by the SDCBHS.

The PEI Target Populations selected by San Diego County include all of the following on the State list:

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

Through the County PEI Planning Process, the following target populations were also identified:

- Children ages 0-5
- Adults, older adults, transition age youth
- Children 0-17, families and clients in target regions with the highest risk of child abuse and neglect
- Clients of all ages with co-occurring disorders
- Senior population ages 60 and over
- LGBTIQ
- Veterans, active duty military, reservists, National Guard, and family members
- Asian and Pacific Islander adults
- Latino population
- African American population
- Native Americans and Alaska Natives
- Refugees and asylees

A1. From the above identified PEI priority population(s) with disparities, describe the process and rationale the County used to identify and target the population(s) (with disparities)

The detailed history on the planning process and rationale in identifying target populations can be found in Criterion 2 of the Cultural Competence Plan.

The County of San Diego continuously receives stakeholder input for community program planning and the focus areas. The feedback is often received through the monthly Behavioral Health Board, System of Care stakeholder-led councils, and workgroup meetings. The stakeholder-led councils provide a forum for council representatives and the public to stay informed and involved. Council members, in turn, share the information with their constituents and other groups involved in behavioral health services and issues. Membership includes consumers and family members, as well as other key stakeholders in the community such as providers, Probation, First 5, health plans, program managers, representatives of consumer and family organizations, advocacy groups, law enforcements, education representatives, and County partners.

In addition to ongoing communication with stakeholders, the SDCBHS conducted a dynamic Community Program Planning process to obtain stakeholder input. Thirteen regional forums were held in October and November 2015, and were attended by 884 community stakeholders. The stakeholders included service providers, family members, advocacy and education groups, faith based organizations, and public safety partners. Translations services were also made available. During each forum, stakeholders received an overview of BHS and were given the opportunity to rank priorities for Mental Health Prevention, Community-Based Mental Health Treatment, Acute and Long Term Care, and Workforce Development. Each forum gave the attendees an opportunity to participate in three separate discussions. Input received guided the development of the FY 2016-17 Annual Update, including FY 2015-16 mid-year enhancements. Throughout the year, BHS stakeholder-led councils provided a forum for council representatives and the public to stay informed of MHSA programs.

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

II. Identified disparities (within target populations):

The County shall include the following in the CCPR:

A. List disparities from the above identified populations with disparities (within Medi-Cal, CSS, WET, and PEI priority/target populations).

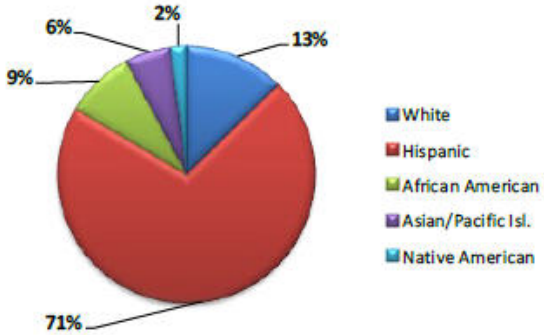
Client Disparities

As mentioned earlier, the SDCBHS uses the triennial *Progress Towards Reducing Disparities in Mental Health Services* report as a guide on the current disparities that exist in the County and progress towards the reduction of the disparities over the years.

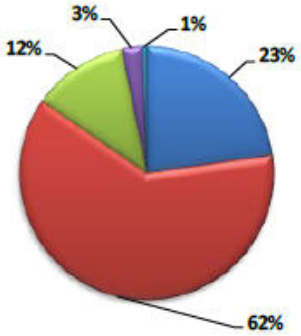
A comparison of the San Diego County target population to those who received behavioral health services demonstrated that the most notable disparities continue among Hispanic adults, as mentioned in Section I of this Criterion. Additionally, although Hispanic, Asian/Pacific Islander, and Native American individuals were less likely to utilize services than expected given the number of potential clients, their service utilization rates have varied across the four time periods examined. The most noticeable increases in service utilization from FY 2001-02 to FY 2012-13 were seen for Hispanic and African American clients for all services.

	FY 2012-13			
	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2013		CYF BHS Clients	
Race/Ethnicity**	Number	%	Number	%
White	31,855	13%	3,805	23%
Hispanic	177,589	71%	10,346	62%
African American	22,007	9%	2,044	12%
Asian/Pacific Isl.	14,179	6%	437	3%
Native American	5,109	2%	91	1%
Total Clients	250,739	100%	16,723	100%

Eligible Clients: Estimates of San Diego County Uninsured or Medi-Cal under 200% FP for 2013

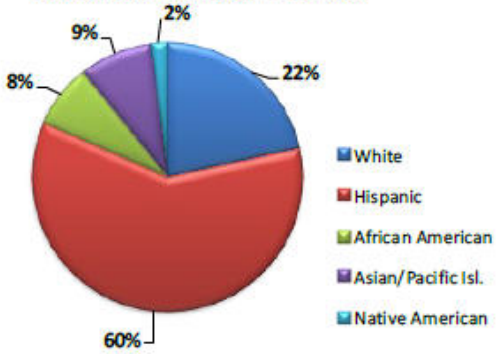


Actual Clients: CYF BHS Clients FY 2012-13

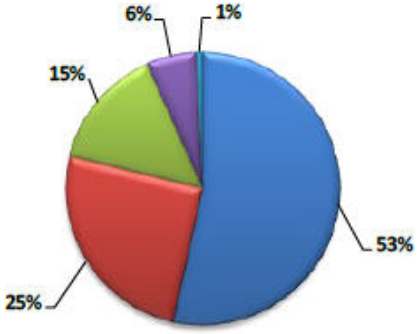


	FY 2012-13			
	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2013		A/OA BHS Clients	
Race/Ethnicity**	Number	%	Number	%
White	75,783	22%	19,619	53%
Hispanic	211,751	60%	9,294	25%
African American	26,911	8%	5,348	15%
Asian/Pacific Isl.	30,668	9%	2,147	6%
Native American	6,954	2%	276	1%
Total Clients	352,068	100%	36,684	100%

Eligible Clients: Estimates of San Diego County Uninsured or Medi-Cal under 200% FPL for 2013



Actual Clients: A/OA BHS Clients FY 2012-13



- **Children and Youth ages 0-5**:
  - Had the lowest service utilization rates among age groups given the rarity of diagnosable mental health problems in this age category. However, service utilization rates increased slightly over time as a result of the implementation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Mental Health Services Act-funded PEI programs.
  - Had the lowest retention rates among age groups, indicating they were more likely to receive only one visit. In addition to treatment programs, there are also assessment only programs for this age group, which may explain why many youth ages 0-5 have only one visit.

- **Transition Age Youth ages 18-24:**
  - Had the lowest Outpatient service utilization rates among adult and older adult age groups. However, their service utilization to services increased from FY 2006-07 to FY 2012-13 as specific services for TAY clients were put into place.
  - Had the lowest long term engagement rates among adult and older adult age groups.
  - Were more likely to use Inpatient/Emergency services or only Jail services, and were less likely to use Outpatient services than the other A/OA BHS age groups.
- **Older Adults:**
  - Had lower service utilization/penetration rates compared to clients ages 25-59. However, rates markedly increased in FY 2009-10 and were maintained through FY 2012-13.
  - Were the most likely age group to utilize Outpatient services, and least likely to utilize only Jail services than either of the other adult age groups.
- **African American Children and Youth:**
  - Had the largest proportions of clients diagnosed with Oppositional/Conduct Disorders or ADHD of all racial/ethnic groups.
  - Were the highest users of JFS of all the racial/ethnic groups.
- **African American Adults and Older Adults:**
  - Were more likely to have had only Jail services than the other racial/ethnic groups.
  - Had the highest rate of being diagnosed with Schizophrenia or Schizoaffective Disorder.

The complete report is available in Appendix 1.

Staffing Disparities – noted in the 2013 WET Needs Assessment

- The skilled workforce positions across the behavioral health system have been difficult to recruit for and retain due to non-competitive salaries and benefits that remain below community standards. The second biggest concern among management is lack of adequate training to expand the skill level of the workforce.
- The direct service provider staff has been difficult to fill due to applicants lacking bilingual language skills and necessary experience.
- Hospitals and clinics are struggling from the overall shortage of nurses available in the county. San Diego County is designated as a Registered Nurse Shortage Area with an estimated RN workforce of 29,000, with one nurse per every 50 individuals.

- Several areas within San Diego County are designated as Mental Health Professional Shortage Areas, according to Office of Statewide Health Planning and Development (OSHPD).
- Out of 137 vacant positions at the time of the survey, 23 positions have been vacant for longer than three months, especially direct service provider positions. Out of all vacant positions, 83 were for a direct service provider.
- Intense competition exists in the community for bilingual professionals and bilingual clinical positions.
- Hispanic and African American workforce is underrepresented in the mental health system, compared to the San Diego client population; however, the proportion of both racial/ethnic groups has slightly increased in the workforce.
- While the overall number of full-time equivalent (FTE) staff that are required to be filled by an individual with lived experience as a consumer or family member has increased by 202% (from 54.2 FTE in 2008 to 163.80 FTE in 2013), more effort is needed to increase the number of positions offered and training opportunities to bridge the transition from peer support to management.
- The number of direct services employees in the workforce who are proficient in Tagalog dropped by 32.67% from 2008 to 2013, the number proficient in Cambodian dropped by 37.50%, the number proficient in Russian dropped by 22.22%, and the number proficient in Laotian remained constant at 1%. There is a need for Language Proficiency of staff in the following languages: Spanish, Tagalog, Vietnamese, Arabic, Russian, Cambodian, American Sign Language, Lao, Somali, and Swahili.

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

III. Identified strategies/objectives/actions/timelines

The County shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.

The SDCBHS adopted the following strategies as the basis of planning for services and program expansion as each phase of the MHSA was rolled out:

CSS Plan Strategies/Actions/Objectives/Timelines
The CSS Plan identified the following Strategies/Objectives for the Provision of Culturally and Linguistically Competent Services to Address Disparities in Access to Care:

Based on the evident disparities in access to care for the ethnically diverse groups noted and listed in the previous question, SDCBHS committed to continuing expansion of its capacity to provide culturally competent services in the MHSA-funded programs described in the CSS Plan. The initial plan included the following specific strategies and interventions to address access-to-care disparities countywide:

- Conduct outreach to engage and increase access to care for Latinos and Asian/Pacific Islanders, African Americans, and Native Americans in the mental health system.
- Increase penetration and rates of client retention for underserved and unserved clients in age groups and racial/ethnic groups and for females.
- Provide linguistically and culturally appropriate services in settings that are more acceptable to ethnically diverse individuals and have less stigma associated with them, such as primary care clinics and school-based programs.
- Provide culturally competent mental health services in all MHSA programs by educating and training providers on evidence-based and promising clinical practices, interventions and skill sets, including coordination and integration of mental health and primary care, clinical practice guidelines, screening/assessment protocols, chronic disease management and cultural competence.
- Include training on working with interpreters, the deaf and hard of hearing, victims of trauma, and gender and sexual orientations in cultural competence training.
- Require enhancement of the bilingual and bicultural capacity in all programs by recruiting, hiring, retaining and retraining culturally competent staff.
- Address disparities in services for females in all age groups by requiring MHSA programs to ensure females are assessed for mental illness.
- Increase access to services for all ethnic/racial groups and females by implementing the MHSA program to provide more mental services in community clinics.
- Establish relationships with tribal communities for as many of the 17 Native American tribes as possible who have reservations in San Diego County.
- Implement a Breaking the Barriers program, designed to evaluate how to address stigma and increase access for selected underserved communities.

WET Plan Strategies/Actions/Objectives/Timelines

The intent of the Workforce Education and Training (WET) component is to remedy the shortage of qualified individuals within the public mental health workforce that provides services to address severe mental illnesses. WET strategies include recruitment of high school and community college students for mental health occupations, development of curriculum to increase knowledge and skills of the existing workforce, promotion of the meaningful employment of consumers and their family members in the mental health system, and financial incentives that promote cultural and linguistic diversity in the public mental health workforce. The initial strategies identified in the Work Plan included:

- Addressing shortages in bilingual staff – Spanish, Vietnamese, Arabic, Tagalog, Russian, Cambodian, ASL, Lao, Somali, and Swahili.
- Implementing trainings/educational opportunities to build staff to fill unique qualifications for hard to fill jobs and for clinical supervision.
- Creating incentives to encourage nurses, child psychiatrists, and others to enter public mental health employment and take hard-to-fill positions.
- Increasing the numbers of Latino and African American staff.
- Creating positions and a career ladder for mental health consumers and/or family members.

PEI Strategies/Actions/Objectives/Timelines

The initial PEI Work Plan identified the following strategies towards reducing disparities:

- Provide education and outreach campaigns to reduce stigma and discrimination and to aid in suicide prevention for all age groups, race/ethnicities, persons with co-occurring substance abuse disorders, and caregivers.
- Assist in maintaining a safe home and a community safety net for children and in reducing the effects of trauma exposure (including gang experience).
- Promote healthy, effective parenting styles, connecting children with necessary health and other related service, to prevent re-traumatization of children and families already exposed to domestic and/or community violence.
- Increase Native American community involvement and education through services designed and delivered by Native American community members.
- Strengthen the skills of parents, staff, and educators to promote the development, growth, health, and social competence of young children and help reduce their behavioral/emotional problems.
- Reduce the potential negative outcomes associated with mental health issues in the early stages of mental illness.
- Increase access to care for older adults from minority populations.
- Educate caregivers and primary care service providers in effort to increase awareness and understanding of the older adult concerns, and create a wellness focus.
- Support caregivers of clients with Alzheimer's, to reduce incidence of caregiver mental health problems.
- Provide outreach and outreach services to the Veterans community to improve their knowledge of, and access to, mental health services.
- Provide prevention services for clients in rural community clinics to help them address behavioral health issues, addiction, and severe mental illness at an early stage.
- Support persons being treated for substance abuse in dealing with mental health issues through providing integrated services.

B. List the strategies/actions/timelines identified for each targeted area as noted in Criterion 2 in the following sections:

II. Medi-Cal population → combined for San Diego
III. 200% Poverty combined for SDCMHS →

The SDCBHS has historically conducted its planning for the combined populations of Medi-Cal and 200% Poverty, as explained in Criterion 1. Prior to receiving MHSA funding, the SDCBHS had already adopted a number of strategies to increase access to care and reduce disparities for ethnic, racial, and cultural groups. Changes in services over the years have occurred in both the CYF and the A/OA Systems of Care.

In light of a rapidly expanding County population and in response to the national effort to advance health equity, improve quality, and help eliminate health care disparities, the SDCBHS has replaced Culturally Competent Clinical Practice Standards with the Culturally and Linguistically Appropriate Services (CLAS) Standards. The requirement to adhere to CLAS

Standards is part of each contractor's Statement of Work. The CLAS Standards are also available in the Organization Provider Operations Handbook—a part of all service provider contracts. Additionally, the SDCBHS has been requiring its County and contracted agencies to complete regularly scheduled self-assessments to evaluate cultural and linguistic competence of the programs' services and staff in effort to enhance the quality of services provided to the County population. More information on the surveys can be found in Criterion 5 of the Cultural Competence Plan.

The CLAS Standards and the survey protocols are part of the newly enhanced Cultural Competence Handbook available in the Appendix 5. The Handbook is a tool to help guide the providers in making improvements in the delivery of culturally and linguistically appropriate services throughout the system of care. The Handbook also encourages providers to assess local community needs; develop, implement and sustain a Cultural Competence Plan; and to develop a process to assess staff cultural competence.

Additionally, the SDCBHS has supported the County in the implementation of the Affordable Care Act (ACA). The County administration has been working hand in hand with five Medi-Cal approved health plans (Care 1st, Community Health Group, Health Net, Kaiser Permanente, and Molina Healthcare), to develop communication around the ACA and Cal MediConnect, and access to services under coverage expansion and to continuously address barriers to client care. The SDCBHS, the health plans, and other community partners meet on a monthly basis. As the result of a recent Medi-Cal Managed Care Geographic Expansion process, two additional Medi-Cal Managed Care Health Plans will be entering San Diego County. The timeline for beneficiary enrollment activities has not yet been identified. The County will continue to work closely with all Health Plans.

The report on disparities outlined earlier has served as a guide for planning the effective use of MHSA CSS, PEI and WET funding.

Additionally, over the course of FY 2013-14, the leads for the CCRT California Reducing Disparities Project (CRDP) Work Groups volunteered to address the recommendations put forth by the CCRT Chair (who also serves as the designated Cultural Competence/Ethnic Services Manager) per their request to move forward and enhance the BHS System of Care as it addresses equity and disparities in the prevention and early intervention arena, access to care and in the treatment delivery system for diverse communities of San Diego County. The document is available in Appendix 6.

The elimination of the health disparities is always a priority for the County, and the SDCBHS continuously and systematically evaluates disparities on a regular basis, and collaborates internally and externally to develop and implement strategies to eliminate health disparities.

IV. *MHSA/CSS population -- Objectives/Actions/Timelines*

The majority of MHSA programs and strategies are implemented through the CSS component, and approximately 78% of the total MHSA funding is allocated to these services. These programs ensure that individualized services are provided to children and adults who have a severe emotional/mental illness. There are currently 26 CSS programs that offer integrated, recovery-oriented mental health treatment, case management and linkage to essential services, housing and vocational support, and self-help. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 7.

V. PEI priority populations (s) selected by the County, from the six PEI priority populations—Objectives/Actions/Timelines

PEI programs are designed to prevent mental illness from becoming severe and disabling. Seventeen percent of the total MHSA funding is allocated to the PEI component. Programs utilize strategies to reduce negative outcomes that may result from untreated mental illness, such as: suicides, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes. There are currently 43 PEI programs that provide services to hard-to-reach populations in an effort to reduce stigma associated with mental illness, make people aware of mental health resources in their communities, and connect underserved and unserved populations with resources at an early stage of their mental illness. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 7.

VI. WET Plan—Objectives/Actions/Timelines

The intent of the WET component is to remedy the shortage of qualified individuals within the public mental health workforce which provides services to address severe mental illnesses. WET strategies include recruitment of high school students for mental health occupations, development of curriculum to train and retain staff, promotion of the meaningful employment of consumers and their families in the mental health system, stipend programs, and promote the inclusion of cultural competency in training and education programs. There are currently nine (9) WET programs that address disparities in the workforce to ensure that the County can more effectively provide services for ethnic/racial and cultural populations. These programs focus on expanding the workforce and making skills development training available to existing staff. The complete chart that details each program, listing its goal, target population, services offered, and start date can be found in Appendix 7.

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

IV. Additional strategies/objectives/actions/timelines and lessons learned:

The County shall include the following in the CCPR:

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

The SDCBHS is continuously involved in strategy development and implementation in an effort to remediate disparities in access and treatment. Examples include:

- Chaldean Middle Eastern Social Services focus on members of the Middle Eastern community who have not traditionally accessed mental health services due to cultural or language barriers. The goal of the program is to decrease stigma around mental health issues through the provision of culturally competent services that increase wellbeing and symptom management. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals for Middle Eastern population and the manifestations of mental disorders in this population. The program collaborates with mental health providers, CWS, Chaldean Catholic Church in El Cajon, Survivors of Torture & Trauma, law enforcement, and Middle Eastern private practice providers of physical and mental health services. In Fiscal Year 2014-15, Chaldean Middle Eastern Social Services provided assertive outreach and engagement, mental health counseling, intake and screening, and case management to 207 unduplicated clients.
- Courage to Call is a veteran-staffed 24/7 Helpline that provides free confidential information, self-screening tools and appropriate resources, guidance, and referrals to individuals who have served in the military and their families. The program also provides training to improve cultural awareness and understanding for community organizations and providers serving those with a military or military family background.
- CWS and SDCBHS made operational the Core Practice Model (CPM) Guide with the creation of Pathways to Well-Being. Pathways to Well-Being seeks to positively impact all CWS children/youth by providing mental health screening, mental health assessment as warranted, and thoughtful and timely linkage to mental health and supportive services for our most impacted children and youth.
- Project Enable/In-Reach is an outreach and engagement program for incarcerated individuals ages 18 and over who have or are at risk of substance use and/or psychological disorders as they prepare to exit the detention facility. One of the goals of this program is to provide services primarily to at-risk African American and Latino adults incarcerated in San Diego County. The program is focused on preventing the onset of mental illness and providing early intervention to help decrease severity. Services include: in-reach and engagement; education; peer support; and follow up after release from detention facilities and linkages to services that improve participant's quality of life, diminish risk of recidivism, and diminish impact of untreated health, mental health and/or substance abuse issues.

- In 2013, two SDCBHS and Faith-Based Community Dialogue Planning Groups were established to facilitate conversations in the Central and North Inland regions with particular emphasis in the African American and Latino communities. A Community Dialogue Breakfast was held in each of the regions and a compendium of recommendations was compiled. One key outcome was the formation of SDCBHS Faith-Based Councils to provide input and recommendations to the SDCBHS administrative team on community needs and solutions. Both Councils submitted ideas for faith-based programs which resulted in innovation funding set aside for faith-based programs. SDCBHS has been moving forward with the procurement process, beginning with an Industry Day that took place January 2015. The resulting program will include development of collaboration and partnerships including outreach and engagement to faith-based congregations, community education utilizing Faith-Based Champions, crisis in-home response to individual/family crisis situations such as suicides, homicides, domestic violence on a 24/7 on-call system and a wellness and health ministry that focuses on adults diagnosed with a serious mental illness receiving mental health services while in jail.
- Union of Pan Asian Communities (UPAC) Multi-Cultural Counseling (MCC) program provides cultural/language specific outpatient mental health services to the target population of underserved Asian Pacific Islander and Latino children and families.
- The Urban Youth Center of the Indian Health Council serves at-risk and high-risk Urban American Indian and Alaska Native children and youth ages 10-24 and their families providing screening and assessment and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for local tribal youth.
- The KidSTART program was developed as a response to the need of integrated services for foster children ages 0-5. This program was developed in collaboration with the First 5 Commission and Child Welfare Services. KidSTART provides a focused, comprehensive system to identify, assess and treat children with developmental delays, behavioral and/or mental health issues at the earliest age possible, when that treatment can be most effective and cost-efficient. The core principles of KidSTART service delivery are: developmental knowledge, relationship/attachment focus, family support, links to existing children's services, responsiveness to community, and culture and outcomes.
- Elder Multicultural Access and Support Services (EMASS) program provides outreach, education, advocacy, peer counseling support and transportation services to older adult Hispanics, African refugees, African-Americans and Filipinos by Promotoras, a Latin American approach that uses community peer workers and community health workers.
- Survivors of Torture, International (SOTI) provides outpatient mental health services to adult and older adult victims of trauma and torture who are severely mentally ill and to children who suffer from a severe emotional disturbance. SOTI utilizes a comprehensive and integrated approach to provide bio-psychosocial rehabilitation services in the community which are recovery and strength-based, client and family driven, and culturally competent.

A1. Share what has been working well and lessons learned through the process of the County's development of strategies, objectives, actions, and timelines that work to reduce disparities in the County's identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

MHSA funding has enhanced the SDCBHS' efforts to increase the selection of services provided in San Diego County, thus ensuring care for greater numbers of County residents. MHSA has also done much to promote prevention and early intervention for mental wellness, as well as addiction-free lifestyles. Integrating behavioral health and primary care has been an essential element of the service transformation. The intent was to improve health care delivery and health outcomes and reduce disparities in access to and engagement in services. Services that have been implemented include, but aren't limited to, behavioral health consultation and telepsychiatry in rural community health centers, treatment of depression within the primary care setting, and supported transition of individuals with stable yet serious mental illness from specialty mental health to primary care. Integration services have also included provider education, training and psychiatric consultation to help providers meet the unique needs and challenges of individuals who often have mental health or substance abuse, as well as physical health issues.

Prior to the implementation of MHSA, there were no culturally specific prevention services for Native Americans; however, SDCBHS has developed "Dreamweaver Consortium," consisting of four Indian Health Clinics serving 18 reservations in San Diego County to provide preventive mental health and alcohol and drug services.

PEI programs like Positive Parenting Program (Triple P), Breaking Down Barriers, Courage to Call, Bridge to Recovery, Kickstart, Older-Adult programs and school-based interventions have not only made a difference in the lives of San Diego families and communities, but have played an integral role in reducing health disparities in our county, as well.

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

V. Planning and monitoring of identified strategies/objectives/actions/timelines to reduce mental health disparities.

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

The County shall include the following in the CCPR:

A. List the strategies/objectives/actions/timelines provided in Sections III and IV above, and provide the status of the County's implementation efforts (i.e., timelines, milestones, etc.).

All programs are currently active and can be noted in the MHSA program summaries for CSS, PEI, WET, and Innovations (Appendix 7).

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

Note: *County shall be ready in 2011 to capture and establish current baseline data to be used for ongoing quality improvement and qualitative analysis of the County's efforts to reduce identified disparities. Baseline data information and updates of the County's ongoing progression in the reduction of mental health disparities will be required in 2011 and in subsequent CCPR Annual Updates.*

Additionally, in subsequent CCPR Annual Updates, counties will share what has been working well and lessons learned, through the process of the County's planning and monitoring of identified strategies, objectives, actions, and timelines to reduce mental health disparities.

Between 2008 and 2010 the SDCBHS undertook an initial review of the tools and reports it was using to monitor program and client outcomes. The goal was to be better able to measure the success of efforts to increase access to services for the underserved and unserved populations, as well as to build the recovery orientation of its mental health system. The following tools continue to be used today:

- As mentioned earlier, the SDCBHS develops a triennial *Progress Towards Reducing Disparities in Mental Health Services* report. The latest report covers four time points spanning across 11 years (Fiscal Years 2001-02, 2006-07, 2009-10, and 2012-13), and is used as a guide on the current disparities that exist in the County and progress towards the reduction of the disparities over the years. The full report is available in Appendix 1. The SDCBHS will continue updating the report on a regular basis.

- The SDCBHS has contracts with the University of California San Diego (UCSD) Health Services Research Center (HSRC), and Child and Adolescent Services Research Center (CASRC) to track client and system outcome measures, evaluate programs, and provide service utilization data. The reports developed by the Research Centers assist the

SDCBHS in making the relevant decisions in regards to the reduction of health disparities.

- The QI Unit, in conjunction with its UCSD Research Centers, develops annual systemwide and program-level databooks that contain information on the age, gender, diagnosis, and race/ethnicity, preferred language, living arrangement, substance use, insurance status, and history of trauma among clients served, as well as the services provided. The reports have been enhanced over the years to include focus on diverse cultural groups being served. The reports are distributed to the Executive team and the Contract Monitors who use the results to track the populations served and the services received, and use the information to have discussions with individual program managers on a regular basis.

- The SDCBHS continues to monitor CYF and A/OA client satisfaction with services through the use of semiannual State-developed survey tools (Youth Services Survey for CYF clients and Mental Health Statistics Improvement Program for A/OA clients). Survey tools are provided in multiple threshold languages, and the County feels that the survey is an important way to hear the client voice on the program level. Many of the County's providers have a requirement in their contracts to participate in this survey. Additionally, the SDCBHS includes a supplemental questionnaire on a regular basis that focuses on such areas like Peer and Family Support Specialists, substance use, foster care, physical health, trauma-informed systems, and spirituality.

- The behavioral health entities are required to have a Cultural Competence Plan in place, and individual programs are encouraged to enhance the Plan to better match the clients they serve and their communities' needs.

- The QI Unit uses the annual and biennial surveys to evaluate the programs' progress in becoming culturally and linguistically competent. More information on the surveys is available in the Criterion 5.

- The QI Unit recently underwent a rigorous review and enhancement of the access times log (which now includes race/ethnicity and preferred language) in an effort to better assess the timeliness of access to care across San Diego County. The SDCBHS continuously leverages the report to track disparities in access.

- Additionally, the SDCBHS:
    - Reviews Quarterly Status Reports (QSRs) and Monthly Status Reports (MSRs) from providers as a tool for data and outcomes.
    - Hosts monthly meetings with regional program managers to ensure that all programs receive timely System of Care updates.
    - Monitors access times to services on a regular basis.
    - Conducts program site visits annually or more often, if necessary.
    - Continuously reviews the Cultural Competence Staffing report on a regular basis.
    - Reviews the Cultural Competence Training report on a regular basis.
    - Updates contractual Statements of Work on a regular basis and as necessary.

C. Identify county technical assistance needs.

The SDCBHS would like technical assistance with a recommendation of evidence-informed strategies that are used by other counties and nationwide to help reduce health disparities and improve access to care.

Client/Family Member/Community Committee: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

I. The county has a Cultural Competence Committee, or other group that addresses cultural issues and has participation from cultural groups, that is reflective of the community.

The County shall include the following in the CCPR:

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

Policy #BHS-01-01-201 (Cultural Competence Resource Team, see Appendix 8) establishes the BHS Cultural Competence Resource Team (CCRT) to advise the Deputy Directors of Adult/Older Adult and Children, Youth and Families Systems of Care on issues of cultural competency.

The CCRT is an advisory board operating at the behest of the Behavioral Health Director. The Committee consists of a Chairperson (also the Ethnic Services Coordinator) twenty (20) voting members, and two (2) Subcommittees. The Executive Committee consists of the Subcommittee Chairpersons and the CCRT Chair. The CCRT meets monthly for one and a half hours on the first Friday of the month.

Membership is chosen in such a way as to be as representative as possible of the Behavioral Health community. The recruitment procedure is as follows:

1. CRITERIA FOR SELECTION

   A. Candidates will be recruited from San Diego, a rich, culturally-diverse community, which is not limited to, but will include:
      i. County Regions
      ii. County Contractors
      iii. Community Hospitals
      iv. Optum Programs
      v. Community Services Programs
      vi. Consumer/Community Organization (adult & youth)

   B. Candidates will have demonstrated a sincere interest in cultural diversity (résumé, if applicable) and an expressed interest in promoting the Cultural Competence Resource Team's agenda (written letter, with paragraph on why candidate desired to become a member).

      The CCRT shall consist of no more than 20 active, voting members and an unspecified number of Inactive Honorary members. Active members are appointed by the Behavioral Health Director (BHD). Inactive membership and Honorary members can be designated by the CCRT Chairperson and the BHD.

C. Candidates can become active members in one of three ways:
   i. Direct appointment by the BHD;
   ii. Active participation on a Subcommittee task force project, followed by a recommendation by Subcommittee Chairperson; or
   iii. Recommendation by CCRT Chairperson.

2. ACTIVE MEMBERSHIP

Active membership shall be reserved for those members who are committed to:

A. Thorough review of the Cultural Competence Plan for County Behavioral Health and a commitment to read all materials pertinent to CCRT.
B. Attend CCRT monthly meeting (notify CCRT of any absences)
C. Accept assignments to one or more of the three subcommittees and assume role in the subcommittee's task force projects.
D. Willingness to take advantage of every opportunity to actively promote and support the goals of the CCRT.

3. INACTIVE MEMBERSHIP

Inactive membership shall be reserved for those persons who have served as an active member for two or more years and for personal or professional reasons are unable to attend the CCRT meetings on a regular basis.

Inactive members agree to act as a consultant, as well as to promote and support the goals of the CCRT in the workplace and the community. Membership can be activated by written request to the Chair.

4. HONORARY MEMBERSHIP

Honorary membership shall be reserved for those persons in the community who have outstanding achievement in the Cultural Competence arena, and who support and promote the goals of the CCRT.

All levels of membership entitle the holder to receive CCRT minutes and newsletters.

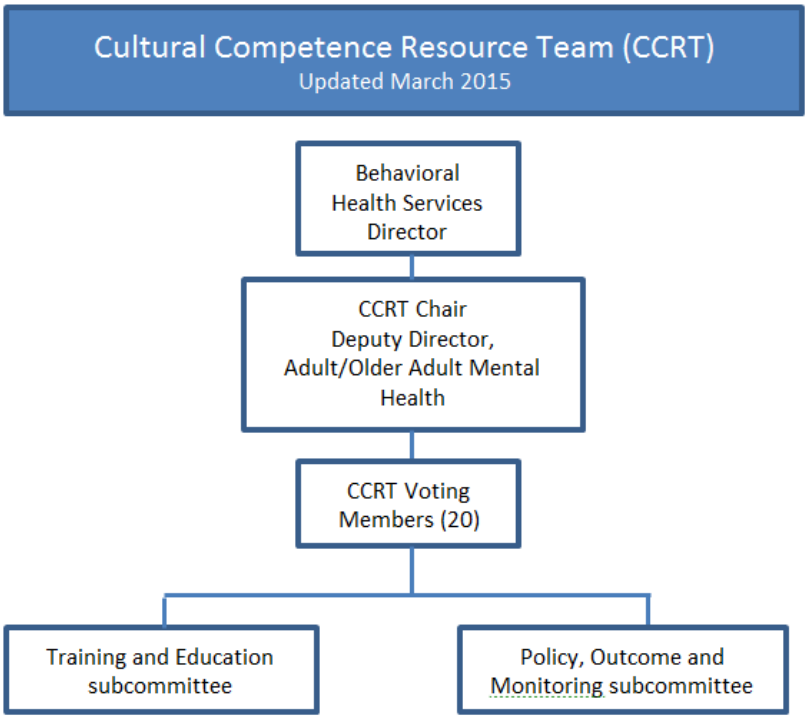
Inactive and Honorary members have an open invitation to attend all CCRT meetings, at their convenience.

B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including County management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary.

Policy #BHS-01-01-201 assures that members of the CCRT are reflective of the community, including County management level and line staff, clients and family members from ethnic,

racial, and cultural groups, providers, community partners, contractors, and other members, as necessary. The policy states that members of the resource team shall be appointed by the Deputy Directors of BHS and that appointees be from various organizational units and disciplines within BHS, as well as member-at-large appointees from the community including consumers and family representatives. Representation from key groups such as, County Behavioral Health Quality Improvement, the Clinical Staff Association, the Mental Health Contractors Association, and the Behavioral Health Board will be requested to be appointees.

C. Organizational chart



D. Committee membership roster listing member affiliation, if any.

The list below consists of voting members, alternates, and County administrative support.

Member	Organization
Altamirano, Leon	Southern Indian Health Council
Andrews, Laura	Mental Health America
Baker, Patrice	Harmonious Solutions
Barnett, Elisa	Cultural Competence Academy
Burnett, Jennifer	The Knowledge Center
Cassady, Cindi	Deaf Community Services
Clark Manson, Minola	BHETA
Camarena, Juan	SDSU

Galapon, Dixie	Family Health Centers of San Diego
Garcia, Piedad	BHS – A/OA SOC
Heller, Rick	HSRC
Hunter, Celeste	CASRC
Lang, Tabatha	BHS
Lozada, Rosa Ana	Harmonium
Maramba, Wendy	BHS – CYF SOC
Miles, Liz	BHS – QI
Miller, Shun	Courage to Call
Newman, Stan	HHSA – The Knowledge Center
Peifer, Fahimeh	MHS, Inc.
Rodriguez, Nancy	County Case Management
Stark, Tamara	Exodus Recovery
Thornton-Stearns, Cecily	BHS – A/OA SOC
Voth-White, Charity	BHS – A/OA SOC
Webber, Mercedes	Recovery Innovations

Client/Family Member/Community Committee: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM

II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The County shall include the following in the CCPR:

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

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence at the County.

Policy #BHS-01-01-201 (Cultural Competence Resource Team) and Policy #01-01-203 (Culturally and Linguistically Competent Services: Assuring Availability) demonstrates that the CCRT is integrated within the County Behavioral Health System through the following charges and activities: see Appendix 9.

The charge of the CCRT is to serve as the "eyes, ears and conscience" of the County of San Diego's Behavioral Health Services system regarding the development of cultural competence in the delivery of behavioral health services to culturally diverse populations and system-wide adherence to the local Cultural Competency Plan. The CCRT is a formal mechanism for providing to both organizational and contracted individual providers input and feedback on cultural competence (#BHS-01-01-201). Members provide such input collectively and conversely bring the message of the CCRT to the community organizations, committees, councils and advisory boards to which they belong.
To provide a context for CCRT members of proposed changes or issues facing the SDCBHS, a practice has been implemented of briefing the CCRT at the beginning of most meetings about the economic and regulatory realities at the State and their expected influence on the County.

The CCRT meets monthly and includes discussion with respect to cultural competence issues at the County, such as: Adult and Older Adult Services; Children's Services; Education and

Training; Policy and Program Development; Health Care Disparities; California Mental Health Planning; etc.

In recent years, the following procedures and practices have been implemented to enhance the CCRT activities including:

- Presenting an annual services review through presentation of data from the QI Work Plan Evaluation Report, which includes staff linguistic and cultural proficiency, participation in cultural competency trainings, consumer satisfaction survey results, etc.
- An annual retreat has afforded CCRT members the opportunity to learn, in greater depth, about new initiatives that the SDCBHS is considering and to hear reports on the successes or failure of initiatives undertaken, and system and client outcomes. The CCRT then charts its course for the next year and also has the opportunity to make recommendations on impending service changes with an emphasis on cultural competence and improving services for cultural and linguistic minorities. The CCRT also uses the retreat as a time to review its current ethnic/racial and cultural composition and considers changes to reflect the changing demographics and needs of San Diego.

The CCRT also contributed to the development of practices which are increasing the emphasis on culturally competent programming being a priority.

- The Team participated in the planning, formulation and review of the Disparities Report, "Progress Toward Reducing Disparities FY 2012-2013," which dealt with changes in cultural disparities in the behavioral health system over a five-year period. Information from a variety of reports was consolidated to concisely present a picture of services by age group and ethnicity/race. This report is updated every three years.
- The CCRT played a vital role in providing input, reviewing, and approving the new Cultural Competence Handbook 2014. This extensive tool thoroughly demonstrated SDCBHS' commitment to cultural competence and provides a framework for providers to also adhere to required cultural competency requirements. See Appendix 5.
- The CCRT and its Education Subcommittee recognized the need for and assisted in the development and adoption of the CC-PAS tool, clinical and non-clinical, for providers to use for organizational cultural competence self-evaluation.
- The CCRT formed five groups to review each target population targeted by the State for the CRDP. Each group reviewed the comprehensive recommendations of the CRDP for their target population and then presented recommendations to the chair of programs that would enhance the quality of services and reduce disparities for their target group. The CCRT provided recommendations to the Behavioral Health Assessment form of the Electronic Health Record on Sexual Orientation/Gender Identity.
- The CCRT participated in the FY 2014-2015 External Quality Improvement Review (EQR) by attending the Cultural Competence related sessions, providing information on CCRT local activities, and responding to questions related to the CCRT.
- The CCRT recommended including "translation/interpreter services" language in the October 2015 Community Forum fliers, resulting in a large participation of the Deaf and Hard of Hearing community.

2. Provides reports to Quality Assurance/Quality Improvement Program in the County;

SDCBHS, with the guidance of the CCRT, will ensure ongoing progress toward meeting service availability based on the cultural and linguistic needs of the population of San Diego County requiring behavioral health services.

There is a close linkage between the CCRT and the Quality Improvement Unit of the SDCBHS. The Director of the Quality Improvement is a lead member of the CCRT, and other QI Performance Improvement Team staff also participate on the Committee to be sure that the two-way exchange of information is maintained.

In the monthly meetings of the CCRT there is a regular agenda item on Quality Improvement during which time topics are discussed such as: Cultural Competency Evaluation Tools for the System Programs and Staff; San Diego County Behavioral Health Services Annual Databook; Client Assessments and Reports; Quality Review Audits; Electronic Medical Records System Training (Anasazi); Culturally Competent Program Annual Self-Evaluation (CC-PAS); etc.

CCRT members have informally provided reports back from various Councils, meetings and conferences attended which increases the CCRT's and QI's understanding of the community. CCRT members will have time to share handouts from other meetings and to relay community concerns and needs.

3. Participates in overall planning and implementation of services at the County;

The CCRT participates in overall planning and implementation of services at the County through analysis of demographic information to determine or identify gaps in service provision and assurance that cultural and linguistic needs are considered in strategic plans, human resource training and recruitment, and contracting requirements. (Policy #01-02-203)

Overall planning and implementation of services in San Diego County continues to be regularly discussed at CCRT meetings, covering target areas such as:

- Access to Care – the need to continue with multiple efforts to engage culturally and ethnically diverse individuals who are unserved or underserved
- Evidence-Based Practices – the need to continue to measure success of EBP put into place on integrated physical health and mental health services and dual diagnosis services in areas of diverse populations
- Workforce Development – the need to evaluate expansion of cultural competence education to include establishing community liaisons or culture brokers to enhance its outreach to diverse underserved populations
- Evaluation and Outcomes – the need to identify a set of standards or elements that would encompass defining criteria that would go beyond what is being currently required, possibly using EBPs as interventions with specific outcomes

- Quality of Care – the need to identify and evaluate a set of specific quality of care standards that would inform the administration on how well we are meeting the needs of ethnically diverse clients in our system.

The CCRT has also participated in ongoing input and review of the development and implementation of all phases of the MHSA Plans, as MHSA is a standing item on the agenda. The CCRT also continues to maintain its interest in reports on the outcomes of services implemented to benefit ethnic/racial/ and cultural minorities. The CCRT has provided feedback on suggested uses of Enhancement funding for the CSS Plan. The Ethnic Services Coordinator continues to carry CCRT's concerns to SDCBHS Executive Core meetings. CCRT input, additionally, was carried into mulitple phases of the BHSA process, through member participation on the Children's, Adults, the TAY Taskforce, Older Adult and Housing Councils, and stakeholder and work groups. Since the last CCP in 2010, the largest effort, by far, that has been made to address the State's CRDP initiative. The CCRT, through its members and through its Ethnic Services Coordinator participated in the review of the State's recommendations for the five target populations and proceeded to make recommendation of which programs would align with the local culture and community needs.

4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;

San Diego County's commitment to cultural competence in policies and practices is documented in the CCRT meeting minutes which have been included in the Appendix 10.

The CCRT transmits recommendations to the executive level by providing recommendations to the Ethnic Services Coordinator and the Director of QI, who can directly relay recommendations from the CCRT to the Behavioral Health Director.

The CCRT works with QI on performance outcomes and standards for assessing the behavioral health system's cultural competence in servicing culturally diverse populations and recommending data collection strategies. The CCRT is able to recommend corrective action when the system's performance does not meet expected standards of cultural competence. (Policy # BHS-01-01-201)

After reviewing reports and recognizing the limited progress that the County has made in increasing the availability of services to cultural and ethnic minorities in our system of care, the CCRT will take a more pro-active stance on ensuring that concerns and recommendations to SDCBHS administration are addressed, including the following:

- Inviting the Behavioral Health Director to attend meetings twice yearly or as needed to advise him of questions, problems seen, and proposals, centering on cultural competency.
- Ask the SDCBHS administration for a report on whether programs are successfully serving their target populations.
- Ask the SDCBHS administration what its goals are for reaching racial/ethnic and cultural minorities through behavioral health programs and recommend that a goal of a specific percentage improvement be established.

- Establish a process for Executive level review of CCRT recommendations (contained in meeting minutes), with the CCRT to track follow-up.

5. Participates in and reviews County MHSA planning process.

The CCRT participated in the development of the MHSA planning process. Presentations were made directly to the CCRT by the MHSA staff. The CCRT has contributed to and reviewed the ongoing County MHSA planning process through participation in stakeholder groups, the Children, Adult, and Older Adult Councils. Additionally, the views of the CCRT are also reflected by the Ethnic Services Coordinator, ADDs and QI in all Executive planning committees.

6. Participates in and reviews County MHSA stakeholder process;

- The CCRT, as discussed above has participated in the SDCBHS MHSA stakeholder input process both as a group and as individual members. The CCRT members serve on a variety of different stakeholder groups including the Children's Adult, and Older Adult Councils, the TAY Workgroup, the Housing Council, the Family/Youth Roundtable, etc.
- On the Committee level, the CCRT Education & Training Committee provided input to the Behavioral Health Training and Education Committee on education and training needs for cultural and linguistic minorities.

7. Participates in and reviews County MHSA plans for all MHSA components;

For evidence of CCRT participation in and review of County MHSA programs, community feedback, and the annual updates for MHSA components, see the attached CCRT meeting minutes located in the Appendix 10. MHSA is a standing item on the agenda and there is always a MHSA representative in attendance at the monthly meetings.

8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and

Peer and family representatives participate in review of client developed programs. Members of two leading client/client family operated agencies—Recovery Innovations of CA and the Family Youth Roundtable serve on the CCRT, bringing their unique expertise to all discussions. Additional representation from UPAC, Southern Indian Health Council, Mental Health America, Deaf Community Services, HSRC and CASRC, Optum, BHETA, The Knowledge Center, Harmonium, Courage to Call, MHS Inc, and Exodus Recovery assist with the review of the client developed programs.

9. Participate in revised CCPR (2010) development.

The purpose and structure of the CCRT supports the local Cultural Competence Plan as mandated by the State Department of Mental Health, as can be seen in Policy # BHS-01-01-201, included in the Appendix 8.

The CCRT has been participating in the revision of the CCPR (2015), devoting time in each meeting time since October 2014 to give input, feedback, and final review of portions of the CCPR, as they became ready. The Education and Training Committee, additionally, focused its meetings on working on the development of a training plan, in conjunction with the Behavioral Health Training and Education Committee.

B. Provide evidence that the Cultural Competence Committee participates in the above review process.

As discussed and documented above in Sections 1-8, San Diego County's CCRT participates in the review process for County MHSA planning process.

- County MHSA stakeholder process
- County MHSA annual updates for all MHSA components
- Client developed programs (wellness, recovery, and peer support programs)

This is evidenced in the attached meeting minutes see Appendix 10.

C. Annual Report of the Cultural Competence Committee's activities including:

i. Detailed discussion of the goals and objectives of the committee;
ii. Were the goals and objectives met?
iii. if yes, explain why the county considers them successful
iv. if no, what are the next steps?
v. Reviews and recommendations to County programs and services;
vi. Goals of cultural competence plans;
vii. Human Resources report;
viii. County organizational assessment;
ix. Training plans; and
x. Other County activities, as necessary

i. CCRT meets on a monthly basis and makes it a priority to discuss goals and objectives of the committee and the sub-committees. The attached meeting minutes detail the discussion, decisions made, and the priorities and goals of the committee.

ii. CCRT continues to set new goals and objectives as they relate to enhancing the services to be culturally and linguistically appropriate, and trauma informed. CCRT met a large number of goals that were discussed at the beginning of the year, some of which included, but weren't limited to: working with the consultant on trauma-informed systems to move in the direction of integrating all SDCBHS programs into trauma-

informed systems; assisting the QI team in finalizing the Cultural Competence Handbook; assisting the MHSA team in developing a year-end update on MHSA-funded programs; developing recommendation in response to the California Reducing Disparities Project (CRDP) report; and working with the Executive members of the CYF and A/OA Systems of Care to understand the Culturally and Linguistically Appropriate Services (CLAS) Standards that have been incorporated into the contracts along with other new language.

iii. The SDCBHS considers the goals successful because throughout the year the sub-committees and leads from various internal teams updated CCRT at monthly meetings and continuously worked to obtain input from the committee members in order to meet the goals. Other criteria in this Cultural Competence Plan further detail the activities, initiatives, and goals that were achieved as the result of the effort at CCRT.

iv. N/A

v. Over the course of FY 2013-14, the leads for the CCRT CRDP Work Groups volunteered to address the recommendations put forth by the CCRT Chair per their request to move forward and enhance the BHS System of Care as it addresses equity and disparities in the prevention and early intervention arena, access to care and in the treatment delivery system for diverse communities of San Diego County. The recommendations are available in Appendix 6.

vi. As of December 2013, Cultural Competence Plans are required for all legal entities. To support the entities in their efforts to update or develop the respective Cultural Competence Plans, CCRT assisted the QI Unit in enhancing a Cultural Competence Handbook as a tool to guide the providers.

vii. A representative from the QI Unit presented the results from the 2013 SDCBHS workforce assessment, specifically highlighting the diversity among the racial/ethnic groups, language proficiency among staff, and utilization of interpreter services across the system.

viii. The SDCBHS recently developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report that covered four time points spanning across 11 years ((Fiscal Years 2001-02, 2006-07, 2009-10, and 2012-13). CCRT used this report to assess the disparities and to prioritize focus on target populations based on the data on the overall service utilization, types of services used, engagement and retention, client diagnosis, and racial/ethnic distribution rates. Representatives from the Research Centers presented key findings from the report at one of the CCRT meetings. Additionally, CCRT leveraged the 2013 workforce assessment to assist the committee with developing specific strategies that focus on developing a culturally competent workforce.

ix. The Behavioral Health Services Training and Education Committee (BHSTEC) meets quarterly and develops training topics that include recommendations from the Behavioral Health Education and Training Academy (BHETA) and suggestions from other members in attendance. The Committee's focus areas for FY 2015-16 included such topics like: cultural competency, integrating faith-based communities, and working with hard-to-engage populations.

x. For other activities discussed at CCRT, please see the meeting minutes in Appendix 10.

CULTURALLY COMPETENT TRAINING ACTIVITIES

I. The County system shall require all staff and stakeholders to receive annual cultural competence training.

The County shall include the following in the CCPR:

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

1. The projected number of staff who need the required competence training. This number shall be unduplicated.

Approximately 2,500 unduplicated mental health staff are required to complete a minimum of four (4) hours of cultural competence training annually. The staff includes: County and contracted unlicensed direct service staff; licensed mental health staff; psychiatrists; nurses; volunteers; managers; and support staff. This is mandated for each SDCBHS contract.

2. Steps the County will take to provide cultural competence training to 100% of their staff over a three-year period.

SDCBHS has shown growth in reaching the target of 100% of staff trained in cultural competence by requiring County and contracted staff, including support staff working with clients, to receive four hours of cultural competence training each year. This requirement is contained in the Organizational Provider Operations Handbook (OPOH), which is a part of each contract. The SDCBHS has contracted out the vast majority of its services, ranging from hospitalization to outpatient services for all age groups, in which County and contracted providers are responsible for obtaining and providing the required four hours of cultural competence trainings for their staff. County program monitors and the QI Unit track completion of the required four hours of training on a regular basis (see page 81 for the complete report).

To ensure continued compliance, a four-prong approach to expanded training has been implemented, which takes into consideration the changing economic and environmental climates.

First Prong: County and Contractor Self-Provided Trainings

Trainings are provided for County employees at no cost and for a small number of contracted providers' staff on a fee basis through County Health and Human Services Agency's training unit, The Knowledge Center (TKC).

Cultural Competence Trainings Offered by The Knowledge Center:

FY 2013-14	FY 2014-15
Encouraging Healthy Nutrition in a Culturally Competent Way Beyond the Gender Binary Disability Etiquette African American Populations African American Populations – Journey to Good Health LGBT Services for Older Adults	Middle East and East African Populations Helping Native American Families Develop Positive Life Stories Filipino Americans and Mental Health Working Effectively with Healthcare Interpreters Role of Spirituality in Healthcare Setting the Triadic Stage for Success: Working Effectively with Healthcare Interpreters
FY 2015-16 LGBTIQ Population Filipino American Population Disability Etiquette Deaf and Hard of Hearing Culture	

Several of San Diego County's larger contractors, including Community Research Foundation (CRF), New Alternatives, and Mental Health Systems, Inc. (MHS) offer their own cultural competency training to their individual programs to meet the four-hour requirement. Their courses are also offered to agency staff and to the public on a fee basis. CRF offers both live trainings and online courses for their staff. Course examples include, "A Culture-Centered Approach to Recovery" and "Valuing Diversity in the Workplace." An additional example of training is the MHS training titled "Cultural Competency 101 – Awareness and Understanding." This class is a four-hour introduction to concepts and theories of culture. Participants are presented with demographics and information which demonstrate MHS's commitment to cultural sensitivity, raising cultural awareness and interactive opportunities for participants to become aware of their own cultural values, beliefs, and assumptions. This content is presented to include organizational and individual elements of cultural competence and activities which facilitate integration and application.

Second Prong: SDCBHS Contracted Trainings through BHETA

The SDCBHS contracts with the Behavioral Health Education and Training Academy (BHETA) at San Diego State University to offer free clinical, administrative, and cultural competency trainings to County and contracted BHS staff. BHETA offers instructor-led classroom trainings, as well as, e-learning courses. The three-hour e-learning course titled, "Cultural Competency," provides an introduction to cultural competency and resiliency in behavioral health, an overview of culture, introduces a method of self-assessment, as well as, including the use of cultural assessment in treatment. In FY 2013-14, over 600 individuals completed this e-learning course. In November 2014, the Behavioral Health Education & Training Academy (BHETA) hosted an hour-long webinar on CLAS to all County-contracted agencies that was conducted by SDCBHS in collaboration with the Union of Pan Asian Communities (UPAC), a County-contracted agency. The webinar met one hour of the required four hours in cultural competence training that each County-operated and County-contracted employee must meet annually. More specifically, the trainers: addressed each of the 15 components; discussed the applicability of the standards to the organizational policies and procedures, operations, and client care; and shared strategies for

implementing the standards in the organization. Additional information on specific trainings provided by BHETA is included in Appendix 11.

Third Prong: SDCBHS Cultural Competence Academy Intensive Training
As part of the SDCBHS Workforce Education and Training (WET) Plan, a Cultural Competence Academy for San Diego County Behavioral Health Services has been implemented to provide a more intensive training initiative to further the objectives identified by the Cultural Competency Resource Team (CCRT). Through the contract with BHETA, the County has established a Cultural Competency Academy (CCA) that provides integrated training on cultural responsiveness to improve the cultural awareness, knowledge, and skills of staff providing services in the San Diego County's Behavioral Health Services. CCA uses trauma-informed, innovative and evidence-based training methods to ensure trainees can implement changes in practice and the system of care to better meet the needs of San Diego's increasingly diverse population.

CCA is available for San Diego County and County-contracted behavioral health providers at every level of service. Support staff, managers, and direct service providers are enrolled in separate year-long intensive cultural competency training tracks with a curriculum tailored to address their specific job responsibilities. CCA participants also work as a team to apply their knowledge and skill with a practicum to create effective change back at their agency/program. Further resources are available at a lending library for participants to check out books, videos, and journal articles to enhance their knowledge throughout the year.

To date, a total of 262 individuals have attended CCA since FY 2011-12, and 112 graduates have completed the year-long training and practicum. Many additional participants, who didn't complete the entire training, have the opportunity to graduate by completing their practicum or upon making up a class when it is offered again in the next cohort. In FY 2014-15, the CCA offered three tracks (for program managers, customer service staff, and direct service providers) for the African American training series and three tracks for the Native American training series. The CCA worked closely with the Native American community in San Diego County to develop the curriculum and reach out to the trainers. Participants received in-depth knowledge and skills-based training that included history and statistics, self-assessment, outreach and engagement, and client assessment. Appendix 12 provides additional information about the trainings provided by CCA to date.

Fourth Prong: WET Workforce Building Activities
The goal of the WET Plan has been to build an education and training structure that supports growing and maintaining a public mental health workforce consistent with the Mental Health Services Act (MHSA) and WET fundamental concepts. Another goal is to ensure culturally and linguistically competent workforce, including clients and family members, capable of offering client- and family-driven wellness, recovery, and resilience-oriented services within an integrated service experience. To achieve these goals, the following programs have been implemented:

Specialized Training Modules: This action was designed to increase the number and diversity of trainings offered to San Diego County's public mental health workforce. The training modules outlined support the core competencies for the public mental health workforce: the philosophy

of client and family-driven services that promote wellness, resilience, and recovery-oriented services that lead to evidenced-based, value-driven outcomes. Cultural diversity must be incorporated into staffing, environment, and service delivery models. Additionally, in the WET Needs Assessment, providers associate life stages as another area related to cultural sensitivity training, since each age group presents unique challenges and issues that require special knowledge, skills and competencies. In accordance with this consideration, training has been aligned with targeted population groups to include Early Childhood, Youth, Transition Age Youth, Adult, and Older Adults, as well as, culturally, linguistically, and ethnically diverse communities where appropriate.

Public Mental Health Academy: This action uses multiple strategies to reduce barriers to employment and to create opportunities for individuals, including consumer and family members, to become part of San Diego County's public mental health workforce. The Academy is intended to be a collaborative, community-based educational academy. It focuses on two distinct, but related, pathway tracks that lead to certification, skill development, and employment in the public mental health workforce.

1) Public Mental Health Credential/Certificate Pathway for potential future and incumbent mental health employees in a variety of direct services occupations, both licensed and unlicensed direct positions. The Public Mental Health Worker Certificate of Achievement is a 19-unit program that prepares individuals for entry level positions in the public mental health system, and serves as a springboard for those who wish to pursue further study in the field. In addition, the certificate program has been instrumental in enhancing the knowledge and skills of some entry-level personnel already working in the field.

2) Consumer Family Pathways programs have been implemented to assist consumers and family members become members of the public mental health workforce. These programs include: Peer to Peer Recovery Education; Peer Specialist Training; and Peer Advocacy Training. A local university partners with the organizations that provide these trainings and has facilitated the translation of six existing certificate programs into academic credits. This partnership also provides mentoring and other support to assist individuals in achieving their educational and employment goals.

Both pathways have been designed to create a pipeline of professionals who have the skills to deliver services based on the principles of recovery, wellness, and consumer and family involvement.

School-Based Pathways/Academy: High-school-based Mental Health Worker Career track: In order to promote mental health careers to young students, a partnership with a public charter school has been developed that focuses on preparation for health careers. The specialized mental health career track serves 50 high school students per year in a two-year certificate program. Furthermore, the curriculum and specialized activities are provided school wide, with an emphasis on increasing awareness about mental health issues and reducing stigma. The program creates linkages to public mental health careers through a specific curriculum, as well as, integration with core academic subjects. The initiative provides exposure to careers in the variety of public mental health occupational areas through internships, career speakers, and job shadowing opportunities. The student population that is served by this program is ethnically diverse, with current enrollment of 50% Hispanic, 28% African American, 12% Other

race/ethnicity, and 10% Caucasian. In addition, 52% of participants have a primary language other than English, and 64% are fluent in a language other than English.

Nursing Partnership for Public Mental Health Professions: The SDCBHS has partnered with a local School of Nursing to expand capacity for developing additional public mental health professionals in nursing occupations. In particular, curriculum and teaching modalities for Psychiatric Nurse Practitioners have been developed and implemented. This program serves individuals who have trained as Family Nurse Practitioners and wish to specialize in psychiatric care, as well as, those who are newly entering the field of Advanced Practice Nursing.

Community Psychiatry Fellowship/Child Psychiatry Fellowship: Through the partnership with a local School of Medicine/Department of Psychiatry, the County's WET efforts include training programs for general community psychiatry residents and fellows, and for child and adolescent psychiatry residents and fellows. The program fosters the development of leaders in Community Psychiatry, and provides medical students and psychiatry residents with instruction on the principles of Community Psychiatry and exposure to the unique challenges and opportunities within this context. Community Psychiatry fellows work within County and contracted provider sites to gain clinical, administrative, managerial, leadership, and policy exposure. Community Psychiatry work in diverse program settings, including UPAC BPSR which allows fellows to have exposure to non-mainstream clinical populations.

LCSW/MFT Residency/Intern: Several programs focused on increasing the presence of licensed individuals in the County have been implemented through partnership with existing training programs. As a result, these programs have incorporated MHSA philosophies and values of recovery, resilience, and wellness within their curricula. Of particular note is the Linguistically and Ethnically Diverse (LEAD) Project that is focused on increasing the presence of ethnically and linguistically diverse licensed MFT's in the County. This program provides supervision, along with licensure exam preparation courses for ethnically and linguistically diverse MFT interns in exchange for a commitment to practice in the County's public mental health workforce. The contract ended August 2015. A total of 15 participants have completed the program. Each of these participants is bilingual and bicultural, with a wide range of races/ethnicities and languages represented, including the following:

- Mexican-American female fluent in Spanish
- Italian-American fluent in Spanish
- Latina fluent in Spanish
- Asian-American male fluent in Vietnamese and English
- Hispanic female fluent in both Spanish and English
- Pacific Islander female fluent in Chamorro and English
- Asian female fluent in Spanish and English and able to speak Chinese (more specifically Cantonese)
- Asian female fluent in Chinese (more specifically Mandarin) and English
- Hispanic female fluent in both Spanish and English.
- Iranian male fluent in Farsi and English
- Mexican-American female fluent in Spanish and English

- Cuban female fluent in English and Spanish
- Hispanic female fluent in English and speaks conversational Spanish
- Mexican male fluent in Spanish and English
- German male fluent in German, Spanish and English

Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff: The focus of this action is to offer stipends to recruit and retain qualified mental health workers in return for a commitment to employment in the County's public mental health system. Multiple financial incentive programs have been implemented. Many are incorporated into programs described above, including the Public Mental Health Academy and the LEAD program. Additional financial incentives programs are in place within the following:

- MFT Consortium (A partnership of all MFT training programs in the County)
- Advanced Standing Program MSW program (a one-year MSW for those who possess a BSW)
- Masters of Rehabilitation Counseling, Psychiatric Rehabilitation Specialization

3. How cultural competence has been embedded into all trainings.

All trainings provided through the SDCBHS are required to have a cultural competence component. These trainings are conducted by BHETA, QI Unit, HHSA, The Knowledge Center, and contracted training organizations. Policies have been developed and implemented to ensure that all trainings for mental health services are consistent with mental health philosophy and principles. Training standards that have been developed have a cultural competency component embedded, as appropriate.

Guidelines for BHETA (the largest provider of trainings for the SDCBHS) are provided below:

Guidelines for BHETA Topics

Behavioral Health Services Training and Education Committee (BHSTEC), the hub for training planning in the Behavioral Health Services system, drives the training topics that BHETA implements each fiscal year. BHSTEC's role is to provide direction to BHETA to address education and training needs across the entire behavioral health system:

- To ensure that education and training consistently meet the objectives of the system at the program and direct service levels.
- To consider workforce development training needs.
- To analyze and evaluate current trainings and redundancies.

The Guidelines for BHETA Trainers are included in Appendix 13.

CULTURALLY COMPETENT TRAINING ACTIVITIES

II. The Annual cultural competence trainings

The County shall include the following in the CCPR:

A. Please report on the cultural competence training for staff. Please list training, staff, and stakeholder attendance by function (if available, include if they are clients and/or family members).

1. *Administration/Management;*
2. *Direct Services, Counties;*
3. *Direct Services, Contractors;*
4. *Support Services;*
5. *Community Members/General Public;*
6. *Community Event;*
7. *Interpreters; and*
8. *Mental Health Board and Commissions; and*
9. *Community-based Organizations/Agency Board of Directors.*

Contractors are required to report on trainings attended by staff on their Quarterly Status Reports (QSRs). The County compiles summary statistics on the training attendance by extracting these data from over 200 QSRs for each of 12 months. These data are aggregated across the system and are available for FY 2014-15 on page 84 of this report. The topic of individual trainings is created by each provider since providers are responsible for their individual cultural competence trainings. Some trainings may be provided by a legal entity and are reported separately by individual attending programs. The SDCBHS collects the following information: the topic or description of the training (as self-reported); course length; attendance by function; total attendees/provider/training; the course date; and the program reporting. It should be noted that in smaller programs the program manager may function both as an administrator and a direct service provider, which creates potential for duplication. Due to the time consumption and labor involved with the data collection process, the names of presenters have not been captured, nor have we been able to categorize trainings by the topic types requested in item B.

B. Annual cultural competence trainings topics shall include, but not be limited to the following:

1. *Cultural Formulation;*
2. *Multicultural Knowledge;*
3. *Cultural Sensitivity;*
4. *Cultural Awareness; and*
5. *Social/Cultural Diversity (Diverse Groups, LGBTQ, SES, Elderly, Disabilities, etc.);*
6. *Mental Health Interpreter Training;*
7. *Training staff in the use of mental health interpreters;*
8. *Training in the use of interpreters in the Mental Health Setting.*

Behavioral Health Education and Training Academy

In FYs 2014-15 and 2015-16, BHETA provided instructor-led and e-learning training opportunities that covered the following topics: Training/e-Learning	Number of Attendees/Trainees
Social Determinants of Health/Mental Health	24
Introduction to Geriatric Health (Series)	29
CCA: Introduction to Latino Populations	258
Cultural Competency	511
Effectively Working with LGBTIQ Youth	35
Introduction to African American Populations	21
Introduction to Geriatric Mental Health	81
Introduction to LGBTIQ Population	269
Introduction to Trauma-Informed Care	187

Cultural Competence Academy

Since inception, the CCA has successfully completed three cohorts. Thus far, 262 staff have attended the CCA. Of these participants, 112 have graduated having and completed the year-long training and practicum. The Native American and African American tracks are still in progress, and 35 individuals are still attending.

The Knowledge Center

The Knowledge Center offered the following cultural competency classes over a span of three fiscal years:

Title	Hours	CEUs	Enrolled	Completed
FY 2011-12				
Helping Native American Families Develop Positive Life Stories	4	4	41	38
A Tale of Two Mommies: LGB Families	4	4	29	26
Filipinos and Mental Health	4	4	24	22
From Bellbottoms to Blackberries: Multiple Generations	2.5	2.5	75	72
Understanding Cultural Patterns to Improve Outcomes	4	4	27	25
African-American Populations	4	4	20	18
Disability Etiquette	4	4	21	21
Building Cultural Competence to Encourage Healthy Nutrition	7	6	19	18
Understanding Deafness and Deaf Culture	4	4	27	25

Working Effectively with Interpreters	4	4	18	13
FY 2012-13				
Multiple Generations in the Workplace	4	4	25	24
LGB Families: A Tale of Two Mommies	4	4	14	12
Gangs and Hate Groups: Trends, Issues, Strategies	7	6	31	28
Managing Multiple Generations	4	4	42	41
I Can Hear You: Deaf Culture and ASL	4	4	28	25
Cultural World Views on Causation of Illness and Medicine	4	4	22	20
Beyond the Gender Binary: Serving the Transgender Population	4	4	19	17
Disability Etiquette	7	7	16	14
Cultural Competence in Mental Health	4	4	23	19
Culture Competence to Serve the Latino Community	4	4	19	15
Southeast Asian Communities	4	4	26	23
African-American Population: A Journey to Good Health	8	8	25	22
FY 2013-14				
African-American Population: A Journey to Good Health	8	8	22	19
Encouraging Healthy Nutrition in a Culturally Competent Way	9	8	29	29
Cultural Awareness for Suicide Prevention	4.15	4	32	23
LGBT Services for Older Adults	4	4	*Not available*	16
Disability Etiquette	4	4	25	22
African-American Populations	4	4	34	28
FY 2014-15				
Sexual Orientation Assessment	4	4	34	27

The Role of Spirituality in Healthcare	8	8	37	35
Middle Eastern and African Cultures	4	4	45	38
Helping Native American Families	4	4	13	11
Principles of Disability Etiquette	4	4	44	40
Engaging Multiple Generations in the Workplace (offered twice, 4 hours each)	8	8	24	22
FY 2015-16				
Cross-Cultural Encounters	6	6	46	42
Principles of Disability Etiquette	4	4	24	21
Cultural Competency Overview	4	4	12	12
Disability Awareness and Professionalism: An Interactional Perspective	4	4	31	30
Understanding Deafness & Deaf Culture	4	4	41	36
Filipino Americans and Mental Health Training	4	4	*Not available*	*Not available*
Sexual Orientation and Gender Assessment	4	4	*Not available*	*Not available*

MHS Staff Cultural Competence Training, Fiscal Year 2014-15

		Total FTE	Total Unduplicated Individuals	# Completed CC Training	% Completed CC Training
2014-15	Unlicensed Mental Health Direct Services Staff	1,030.19	1,202	1,062.00	88.39%
	Licensed Mental Health Direct Services Staff	841.94	962	887.00	92.19%
	Other Health Care Staff	172.47	206	164.50	79.95%
	Managerial/Supervisory Staff	181.28	239	189.88	79.33%
	Support Staff	241.39	306	212.24	69.35%
Total		**2,467.27**	**2,915**	**2,515.62**	**86.31%**

		CYF MHS Programs				A/OA MHS Programs			
	MHS	Total FTE	Total Unduplicated Individuals	# Completed Training	% Completed Training	Total FTE	Total Unduplicated Individuals	# Completed Training	% Completed Training
2014-15	Unlicensed Mental Health Direct Services Staff	68.73	113	80	70.80%	947.46	1,075	975	90.74%
	Licensed Mental Health Direct Services Staff	93.78	127	99	77.95%	748.16	835	788	94.36%
	Other Health Care Staff	6.67	10	7	70.00%	165.80	196	158	80.46%
	Managerial/Supervisory Staff	16.25	30	13	43.33%	160.03	204	174	85.09%
	Support Staff	23.57	45	17	37.78%	216.82	260	194	74.69%
Total	**2,915**	**209.00**	**325**	**216**	**66.46%**	**2,238.27**	**2,570**	**2,289**	**89.06%**

CULTURALLY COMPETENT TRAINING ACTIVITIES

III. Relevance and effectiveness of all cultural competence trainings.

The County shall include the following in the CCPR:

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

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

Rationale: "The Institute of Medicine (IOM) report, *Unequal Treatment*[1], recommended that all healthcare professionals should receive training in cross-cultural communication—or cultural competence—as one of multiple strategies for addressing racial/ethnic disparities in healthcare. This recommendation emerged from robust evidence highlighting the fact of healthcare providers failing to acknowledge, understand, and manage socio-cultural variations in the health beliefs and behaviors of their patients that may impede effective communication, affect trust, and lead to patient dissatisfaction, non-adherence, and poor health outcomes, particularly among minority populations. Similarly, another IOM report, *Crossing the Quality Chasm*[2], noted that patient-centered care—particularly its attributes of being respectful of patients' values, beliefs, and behaviors—is an essential pillar of quality." (Excerpt retrieved from: http://journals.lww.com/academicmedicine/Fulltext/2010/04000/Commentary__Linking_Cultural_Competence_Training.14.aspx.

Formulating a training curriculum has been a developmental process for the SDCBHS. It is understood that Cultural Competence trainings improve the attitudes, knowledge, and skills of providers. Culturally competent interventions that are embedded in best practices or promising practices, such as IMPACT and Salud, also improve patients' ratings of care. Through the Disparities Report, discussed previously, the SDCBHS has been able to pinpoint some of the inequalities which need to be addressed. This report has been brought to the planning groups in the CCRT, and efforts have been made to start addressing the disparities. BHETA, the CCRT Education and Training Committee, and BHS Training and Education Committee have been working together to create coursework curricula to address disparities as outlined in the Cultural Competence Training Plan.

Need: In FY 2013-14, approximately 62% of the SDCBHS population was ethnically diverse, compared to 54% of the SDCBHS workforce. The profiles of the provider staff and the SDCBHS client profiles are dissimilar, as can be seen from the following chart reproduced from the WET Needs Assessment conducted in 2008 and subsequently in 2013. The need for staff to receive cultural competence training is apparent in order to have clinicians/direct service staff to work as effectively as possible with their clients. The chart is a comparison of the workforce and the clients served from 2008, prior to the implementation of MHSA WET, and a recent assessment conducted in 2013.

Race/Ethnicity	2008 Workforce	2008 Mental Health Clients	2008: Comparison	2013 Workforce	FY 2012-13 Mental Health Clients	2013: Comparison
White	56%	44%	Over +12%	41%	39%	Over +2%
Hispanic	20%	29%	Under -9%	25%	33%	Under -8%
Black	10%	13%	Under -3%	11%	12%	Under -1%
API	10%	5%	Over +5%	10%	4%	Over +6%
Native American	0.3%	0.7%	Under -0.4%	0.9%	0.6%	Over +0.3%
Multi-Race or Other	3%	8%	Under -5%	1%	4%	Under -3%
Unknown / Not Reported	N/A	N/A	N/A	11%	6%	Over +5%

"Over" = ethnicity in the workforce is overrepresented / "Under" = ethnicity in the workforce is underrepresented
Green indicates a positive change from 2008 to 2013 / the ethnicity is more represented in the 2013 workforce

2. Results of pre/post tests (counties are encouraged to have a pre/post test for all trainings);

SDCBHS contractors are encouraged to have pre/post tests for their trainings. The HHSA Knowledge Center (TKC) and BHETA utilize pre/post-tests routinely for cultural competency courses. CRF, MHS, and New Alternatives provide their own cultural competency trainings for their staff.

3. Summary report of evaluations; and

Since almost 1,000 trainings (both web- and classroom-based) took place throughout this large County and were provided by a variety of providers, there has not been a summary report of evaluations created. However, all trainings conducted through BHETA and TKC have surveys to allow for participant feedback. BHETA also evaluates the transfer of learning as part of the evaluation process.

*NOTE: BHETA, along with other training departments of service provider agencies, has the capability to provide summary of trainings they offer.

*NOTE: HHSA Knowledge Center retains the evaluation data on all cultural competency classes, which are reviewed to influence the selection of future instructors and topics. These data are utilized for the annual report that is submitted to the State.

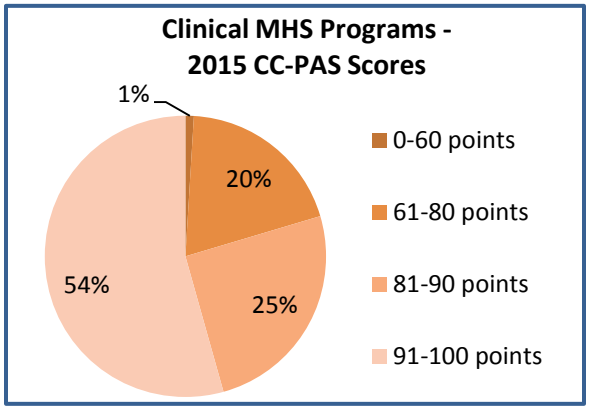
4. Provide a narrative of current efforts that the County is taking to monitor advancing staff skills/post skills learned in trainings.

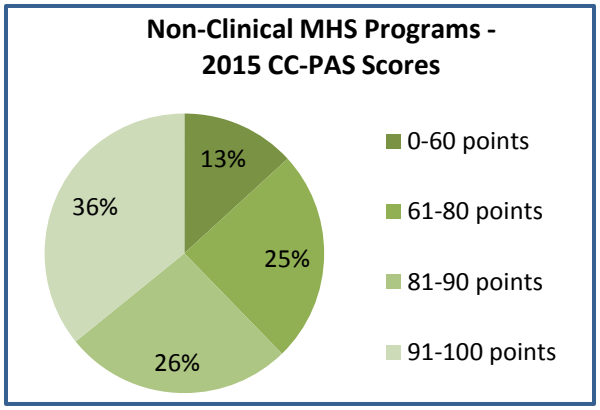
The County is working with providers to rate their own agency's cultural competence through the Cultural Competence Program Annual Self-Evaluation (CC-PAS). It is expected that improvement will be seen as staff advances in their cultural competence skills. Staff competence

can also be measured by a biennial administration of the California Brief Multicultural Competence Scale (CBMCS), which is a tool recommended for usage by providers in the Organizational Provider Operational Handbook in which, over time, staff scores should show incremental improvement. The CC-PAS is completed by the program managers, and the CBMCS is completed by all staff.

2015 CC-PAS Report

In April 2015, the SDCBHS QI Unit requested that each contracted Mental Health Services (MHS) and Alcohol and Drug Services (ADS) Program Manager complete the survey. The survey is broken out into two separate surveys—clinical and non-clinical—based on the populations served by the programs. A total of 103 clinical MHS programs and 53 non-clnical MHS programs completed the survey. The survey contains 20 cultural competence standards and a correspoding question on whether the program requests technical assistance for each of the standards. The program managers were asked to identify whether they have met, partially met, or not met each standard. The responses are assigned a score (5 points for Met Standard, 3 points for Partially Met Standard, and 1 point for Standard Not Met) and summed up for each program. The highest possible survey score was 100, meaning each of the 20 standards was met. Below is the breakdown of the systemwide scores:



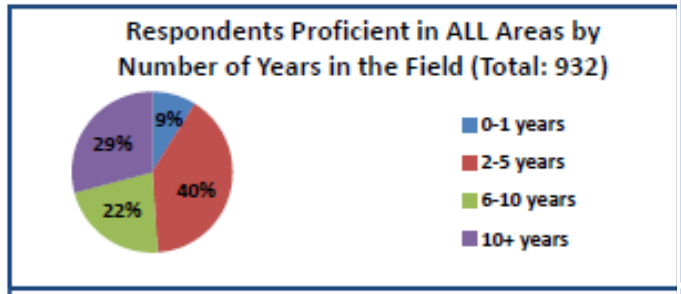


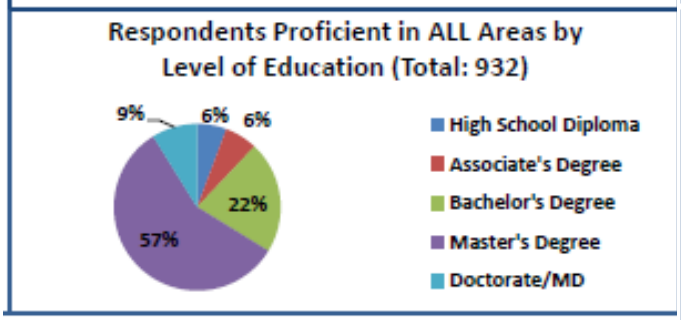
Additionally, program managers were asked to identify any standards for which their program would require technical assistance. The table below summarizes the responses:

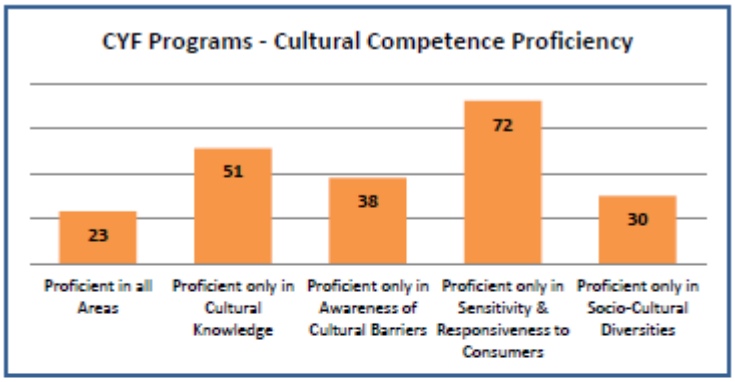
Technical Assistance Requests, 2015 CC-PAS Results				
	1-5 standards	6-10 standards	11-15 standards	16+ standards
Non-clinical MHS Programs *(N=53)*	14 26.4%	2 3.8%	2 3.8%	2 3.8%
Clinical MHS Programs *(N=103)*	24 23.3%	3 2.9%	-- 0%	--0%

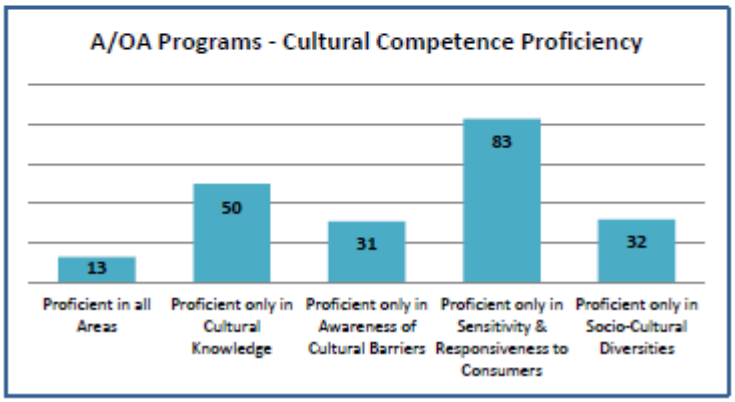
2013 CBMCS Report

The CBMCS tool is a 21-item scale that measures individual, self-reported multicultural competency and training needs of behavioral health staff in the following four areas: cultural knowledge; awareness of cultural barriers; sensitivity and responsiveness to consumers; and socio-cultural diversities. The charts below summarize the results from the most recent report in areas of staff proficiency.









Both reports are available in the Appendices 14 and 15.

5. *County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.*

The SDCBHS leverages the CC-PAS, the CBMCS, the Culturally and Linguistically Appropriate Services (CLAS) Standards, and entity-specific Cultural Competence Plans to measure change in the levels of cultural competency on provider and staff-levels. To measure the effectiveness of cultural competence training over time, the Disparities Report is conducted every three years, anticipating positive changes in retention and penetration rates. The contractors are required to have a Cultural Competence Plan in place, the program managers are required to complete the CC-PAS annually, and to all program staff are required to complete the CBMCS biennially. These requirements are outlined in each program's contract.

CULTURALLY COMPETENT TRAINING ACTIVITIES

IV. Counties must have a process for the incorporation of Client Culture Training throughout the mental health system.

The county shall include the following in the CCPR:

A. Evidence of an annual training on Client Culture that includes a client's personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:

- *Cultural-specific expressions of distress (e.g., nervous);*
- *Explanatory models and treatment pathways (e.g., indigenous healers);*
- *Relationship between client and mental health provider from a cultural perspective;*
- *Trauma;*
- *Economic impact;*
- *Housing;*
- *Diagnosis/labeling;*
- *Medication;*
- *Hospitalization;*
- *Societal/familial/personal;*
- *Discrimination/stigma;*
- *Effects on culturally and linguistically incompetent services;*
- *Involuntary treatment;*
- *Wellness;*
- *Recovery; and*
- *Culture of being a mental health client, including the experience of having a mental illness and of the mental health system.*

The SDCBHS contracts with BHETA, which, in turn, has a contract with a client-run organization Recovery Innovations to provide trainings on adult client culture. The following excerpt on the trainings has been provided by Recovery Innovations:

This one-day training provides participants with an understanding of client culture. The training provides an overview of recovery and resilience. Resiliency and culture differences are highlighted for participants through personal stories told by multicultural consumers. The trainer discusses recovery culture through presentation and video. Family members and consumers share their experiences in the mental health system for greater understanding of the consumer perspective. A panel discussion further enhances understanding and awareness.

Learning objectives:

- Describe the benefits of creating an environment supportive of recovery.
- Discuss recovery within a multicultural consumer base.
- Describe the consumer/family experience of the mental health system.
- Delineate the reasons to include family members in treatment planning.

Five one-day trainings were given to approximately 85 mental health providers in FY 2014-15.

"Consumer Client Culture Training" provides seven hours of continuing education credits for MFTs/LCSWs as required by the California Board of Behavioral Sciences and is also qualified

for County Cultural Competency Requirements. It has been presented several times each year and components can be changed, as needed.

The National Alliance on Mental Illness (NAMI) contract has the following objectives:

- A minimum of 90 clients will participate in peer education training to encourage client awareness of mental illness, coping skills, resources available, and mutual support possibilities (10 two-hour classes).
- A minimum of 10 people will complete the peer education "Train the Trainer" course.
- Family education materials are available in English, Spanish, Vietnamese, and Arabic. Peer education materials are available in English and Spanish.

The Family Youth Roundtable contract also provides a quarterly Principles to Family/Youth Professional Partnership course to a minimum of 30 administrative and/or direct service staff for an annual minimum of 120 participants. The goal of this training is to introduce and educate administrative and direct service staff on the value of incorporating family/youth partners at different program levels.

Furthermore, The Consumer Family Pathways Program includes: Provider Education Training conducted by consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and family members trained as Family-to-Family Education Program teachers who have been certified through the NAMI Provider Education Training. These series of trainings focus on current providers in the public mental health system. A penetrating, subjective view of family and consumer experiences with serious mental illness, this training helps providers realize the hardships that families and consumers face and appreciate the courage and persistence it takes to live with and recover from mental illness. The training focuses on family culture, client culture, and provider culture, and will also play an important role in educating contract agencies and County-operated programs on the benefits of hiring and advancing consumers.

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

1. Family focused treatment;

An example of family-focused treatment is the one-and-a-half-hour training that is offered by Family and Youth Roundtable titled "Families Stand Together."

2. Navigating multiple agency services; and

The SDCBHS contracts with Family and Youth Roundtable to provide the Employment Training Academy whose goal is to provide training that enhances contractors' skills in hiring families and youth as part of their workforce. Contained within the Academy is an element called "Pathways for Partnership" for family and youth audiences which includes information on navigating multiple agency services.

The 40-hour training covers navigating multiple agency services. Pathways for Partnership guides family members and youth who have had involvement with public systems, from being a recipient of services to opening opportunities to become a "partnership broker." This training teaches family members and youth to utilize their experience "as a recipient of services from a public child-family serving system" to assist other family members, youth and providers to better understand the cultural differences, system mandates, and roles within a Children's System of Care for Family and Youth partners. In addition, this training provides an in-depth review of roles for family/youth involvement, as well as prepares recipients to serve family and youth receiving services, to identify resources, linkages and support systems that assist in recipients meeting treatment goals. Furthermore, this training supports a cohesive foundation of the roles and responsibilities of Family & Youth Partners, thus providing the community with consistency in training and an organized service-delivery support for the advancement of Family-Youth-Professional Partnership.

3. Resiliency

Training on resiliency is embedded throughout many of the offered trainings. One example is the web-based BHETA Cultural Competence course, a three-hour class providing an introduction to cultural competence, discussed earlier in the Plan.

County's Commitment to Growing A Multi-Cultural Workforce: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

I. **Recruitment, hiring, and retention of a multicultural workforce from, or experienced with, the identified unserved and underserved populations.**

The County shall include the following in the CCPR:

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

The initial assessment of the County of San Diego's mental health workforce was conducted in 2008, and the findings were submitted as part of the Exhibit 3: Workforce Needs Assessment. Results of a follow-up assessment conducted in 2013 are summarized below. The assessment results can also be found on the SDCBHS' Technical Resource Library page at: http://www.sandiegocounty.gov/content/sdc/hhsa/programs/bhs/technical_resource_library.html.

Shortages by Occupational Category

Approximately 82% of the County of San Diego's mental health workforce is contracted staff employed by community-based organizations (CBO) or network providers. The County itself employs approximately 18% of the total workforce. From 2008 to 2013, the workforce of the County-operated programs fell 3%. In FY 2014-15, SDCBHS had a total of 786.25 FTE.

Current workforce distribution figures indicate that the highest percentage of positions are in Licensed Mental Health Direct (35.8%), followed by Unlicensed Direct (24.3%), and Support Staff (22.9%). A comparison with the initial assessment shows an increase in the proportion of the non-psychiatric health care workforce (such as physicians, nurses, medical assistants, etc.) from 80.1 authorized full time equivalent staff (FTEs) in 2008 and 170.3 authorized FTEs in 2013.

Total Mental Health Workforce by Category

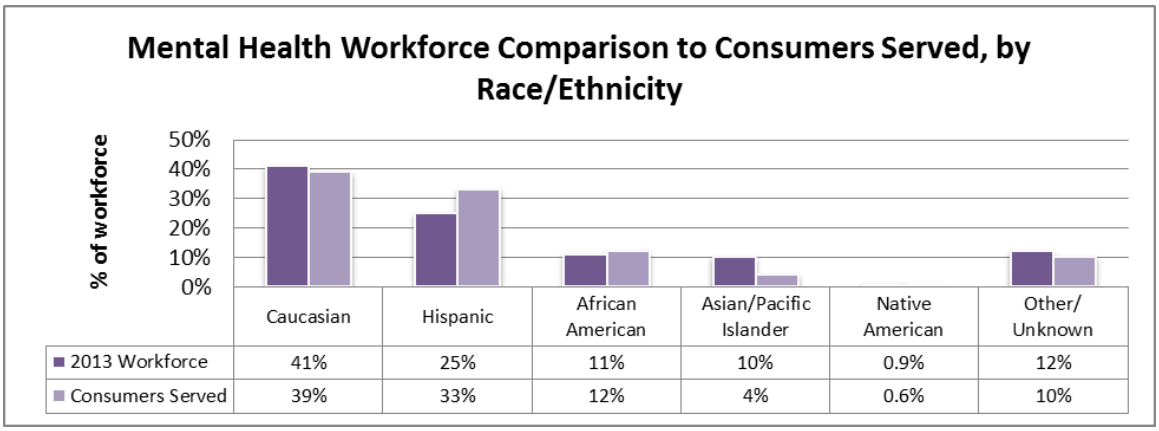
FTEs Authorized	2008		2013	
Unlicensed Direct Service	366.4	21.7%	622.0	24.3%
Licensed Direct Service	658.7	39.0%	913.6	35.8%
Other Healthcare	80.1	4.7%	170.3	6.7%
Managerial/Supervisory	226.1	13.4%	263.8	10.3%
Support	356.9	21.1%	585.6	22.9%
Total	**1,688.2**		**2,555.3**	

Compared to the 2008 workforce assessment, a larger proportion of authorized FTEs were filled in 2013 (96.87% vs. 83.74% in 2008). In addition, it was estimated that approximately 100 unlicensed positions and 50 licensed positions would become available. The recent assessment indicates that licensed direct service positions increased by 254.9 FTEs and unlicensed positions increased by 255.6 FTEs.

Comparability of Workforce, by Race/Ethnicity, to Target Population Receiving Public Mental Health Services

Both San Diego County's public mental health workforce and its target population receiving public mental health services are diverse. Examining the workforce by diversity, the current public mental health workforce in San Diego County is 40.5% Caucasian, 25.3% Latino/Hispanic, 10.6% African American, 9% Asian/Pacific Islander, and 1% Native American. Similarly, the client diversity is as follows: 39.4% Caucasian, 33% Latino/Hispanic, 12.4% African American, 4.4% Asian/Pacific Islander, and 1% Native American.

In comparison with 2008, the current public mental health workforce is generally more ethnically and culturally diverse; however, some cultural and ethnic groups remain under-represented. For example, 33% of the mental health population is Hispanic/Latino while only 25% of the total workforce is. Further among specific workforce categories, the percentages of licensed direct service providers and managerial/supervisory staff are even lower: 22.3% and 11.7%, respectively.



	Caucasian	Hispanic	African American	Asian/Pacific Islander	Native American	Other/ Unknown
2013 Workforce	41%	25%	11%	10%	0.9%	12%
Consumers Served	39%	33%	12%	4%	0.6%	10%

Positions Designated for Individuals with Consumer and/or Family Member Experience

Consumers and family members offer a wealth of life experiences, cultural competencies compassion, understanding of the mental health system, and related resources. They assist in linking consumers to services, provide useful information on navigating the mental healthcare system, and give much-needed encouragement and moral support to their peers.

Over the past several years, the number of specifically designated consumer/family positions in the public mental health workforce has tripled, from 54.2 FTEs in 2008, to 163.8 FTEs in 2013.

Position with Lived Experience	2008 # of FTEs	2013 # of FTEs	% Change
Peer Support Specialists	21.7	30.7	41%
Family Support Specialists	30.5	56.6	86%
Managerial/Supervisory	2.0	15.7	685%
Total Staff with Lived Experience	54.2	163.8	202%

Language Proficiency

The threshold languages for San Diego County are: (1) Spanish, (2) Vietnamese, (3) Tagalog, and (4) Arabic. In addition to these threshold languages, multiple other linguistic needs were previously identified, including, Chaldean, Hmong, Cambodian, Laotian, Somali and Swahili. Unfortunately, the diversity in language proficiency among the public mental health workforce has not significantly improved in recent years.

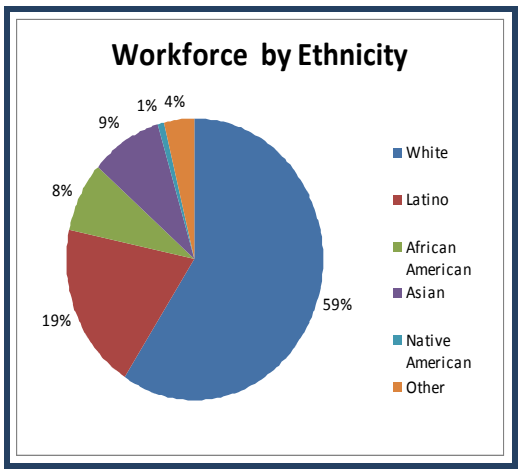
Language Spoken by Staff	Level of Staff	2008 # of FTEs	2013 # of FTEs	% change
Spanish*	Direct Service Staff	465	474	1.94%
	Others	198	183	-7.58%
Tagalog*	Direct Service Staff	77	52	-32.47%
	Others	39	13	-66.67%
Vietnamese*	Direct Service Staff	14	18	28.57%
	Others	7	3	-57.14%
Arabic*	Direct Service Staff	14	14	0.00%
	Others	2	6	200.00%
Russian	Direct Service Staff	9	7	-22.22%
	Others	1	2	100.00%
Cambodian	Direct Service Staff	8	5	-37.50%
	Others	3	5	66.67%
Sign	Direct Service Staff	18	13.5	-25.00%
	Others	11	7.5	-31.82%

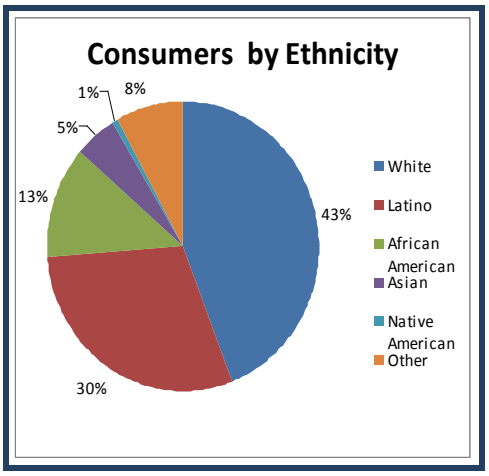
**Indicates a threshold language*

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.

Disparities by Race/Ethnicity

The Workforce Education and Training (WET) Plan contains a comparison of SDCBHS staffing with the races/ethnicities of its client population. Provided below is a detailed breakdown of that comparison from the 2008 WET Needs Assessment.





The WET Plan also notes that Unlicensed Direct Staff and Support Staff are the closest in proportions to the diversity of those being served, while licensed, management/supervisory, and other healthcare position classifications are significantly less representative of the diversity of those being served. This indicates a shortage of therapists, psychologists, and psychiatrists with bi-lingual skills that are needed by the mental health population.

The table below indicates how the workforce and the diversity of the clients have shifted after the implementation of WET.

Race/Ethnicity	2008 Workforce	2008 Mental Health Clients	2008 Comparison	2013 Workforce	FY 2012-13 Mental Health Clients	2013 Comparison
White	56%	44%	Over +12%	41%	39%	Over +2%
Hispanic	20%	29%	Under -9%	25%	33%	Under -8%
Black	10%	13%	Under -3%	11%	12%	Under -1%
API	10%	5%	Over +5%	10%	4%	Over +6%
Native American	0.3%	0.7%	Under -0.4%	0.9%	0.6%	Over +0.3%
Multi-Race or Other	3%	8%	Under -5%	1%	4%	Under -3%
Unknown / Not Reported	N/A	N/A	N/A	11%	6%	Over +5%

"Over" = ethnicity in the workforce is overrepresented / "Under" = ethnicity in the workforce is underrepresented
Green indicates a positive change from 2008 to 2013 / the ethnicity is more represented in the 2013 workforce

C. If applicable, the County shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the County during the review of their WET Plan submission to the State.

The County of San Diego did not receive cultural consultant technical assistance recommendations.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out County WET planning and implementation efforts.

Target Reached:

Obtained a broad spectrum of stakeholder input on education and training needs

The target was built upon Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) planning processes which included over 950 adult and older adult client surveys in threshold languages (English, Spanish, Vietnamese, and Tagalog) and 700 family member surveys, 60 stakeholder meetings, and ongoing input from age-based Care Councils.

- Aggregated information on workforce gaps from stakeholder groups.

Target Reached:
Developed a workforce needs assessment

- Contracted with San Diego State University Research Foundation Academy for Professional Excellence to lead effort and provide expert advice.
- Phase 1: Collected baseline information from a broad range of stakeholder and community members involved with the public mental health system. The efforts included 25 semi-structured focus groups, and members of hard-to-reach communities were especially sought out for participation. Over 50 Key Informant Interviews were conducted with individuals who had in-depth experience with targeted key populations. Additional focused surveys were administered to a target group of 290 clients/family members, program managers, and direct mental health service providers. Finally, existing County data was aggregated.
- Phase 2: Completed data analysis comparing the ethnic and age composition of the San Diego population, the SDCBHS mental health population, and the workforce. Compiled baseline information about educational institutions in San Diego with programs geared toward mental health occupations from high schools to post-doctorate degrees. Conducted an in-depth training assessment survey of 721 SDCBHS staff regarding specific training needs. Also conducted additional Key Informant Interviews with community partners with workforce development expertise.

Target Reached:
Developed WET Needs Plan

- Community and stakeholder input on WET Needs Assessment gathered through System of Care Councils, and contractor and County staff meetings.
- WET Work Group, which included subject matter experts from Key Informants, MHS staff, and stakeholder representatives.
- A Cross Threading Group, composed of stakeholders from all groups, but who would not financially benefit from any contracts, reviewed the recommendations and set priorities for funding. The recommendations were brought to three planning presentations around the County open to the mental health community and the public.

Target Reached:
Mental Health Board Approval and Submission to the State

- Final input from community meetings was incorporated into the WET Plan.
- The WET Plan was submitted to the Mental Health Board and approved in April, 2009.

Target Reached:
Program Procurement and Implementation

- Currently, the target populations reached include the current public mental health workforce through the behavioral health training component under Training and Technical Assistance. San Diego State University Foundation, Academy of Professional Excellence is the County's current contractor through BHETA to provide behavioral health training to current providers. Training topics are numerous, but always include cultural competency components, including a Cultural Competency Academy implemented in 2012. Additional targeted populations include consumers and family members.
- The SDCBHS implemented the Consumer/Family Academy with Early Implementation Activities funding under Training and Technical Assistance. Currently, the Consumer

Family Pathway has been incorporated into the Public Mental Health Pathways. The County contracts with Youth Family Roundtable, NAMI, and Recovery Innovations to provide targeted training and support to consumers and family members.

- During the program development process, each WET program was required to address the following components in their Statements of Work:

Target Population

1.1. **The contractor shall create culturally and linguistically appropriate, targeted approaches to ethnically and linguistically diverse populations based on community and public mental health workforce need. Potential populations may include, but are not limited to:**

1.1.1. Latino population.
1.1.2. Asian/Pacific Islander population.
1.1.3. Lesbian, gay, bisexual, and transgender (LGBT) population.
1.1.4. Individuals in or recently out of the foster care system.
1.1.5. Other populations as defined by County staff, community and public mental health workforce need.

E. Share lessons learned on efforts in rolling out County WET planning and implementation efforts.

During the planning and implementation process, the County of San Diego has learned how valuable it is to expand beyond our traditional mental health partners. To ensure the success of the development and implementation of WET programs, outreach included local schools, universities, and workforce developers such as the San Diego Workforce Partnership and the Department of Rehabilitation. The SDCBHS worked closely with our community partners to ensure any prospective partners were aware of WET and their potential role along the educational/workforce pathway.

Our WET programs have successfully engaged culturally and ethnically diverse participants. Currently, programs are working to identify mechanisms to sustain efforts beyond the WET funds availability. Some programs have similar state level investments being made, such as stipends for those in training for licensed positions. Programs that have received WET support for curriculum development will be able to incorporate these curricula, such as the Psychiatric Nurse Practitioner program, the 19-unit Mental Health Work Certificate of Achievement for entry-level mental health positions, and the high school-level curriculum and mental health career pathway program. Other activities will require ongoing support from other MHSA funding sources if the County continues to benefit from the programs. These include those programs focused on: enhancing knowledge, skills, and cultural competence of the existing workforce, and those providing training to prepare consumers and family members for employment in the public mental health workforce.

F. Identify County technical assistance needs.

We would like technical assistance with information on the success of the programs in other counties, and the techniques/processes used to recruit, train, and maintain a culturally diverse and bilingual workforce. It would be helpful to learn of particular strategies that have been successful for specific ethnic populations such as Latino, Vietnamese, Filipino, Arabic, African refugees, etc. In particular, SDCBHS would be interested in strategies that have been successful in increasing the cultural and ethnic diversity of licensed clinical staff.

SDCBHS would also be interested in learning more strategies to sustain WET programs once funding ends.

LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The County shall include the following in the CCPR:

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

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

The SDCBHS had been seeking ways to develop the diversity of the systemwide workforce for a number of years, but the lack of available funding for incentives and training was a serious limitation. The inclusion of Workforce Education and Training funding in the MHSA has enabled the County to grow the bilingual staff capacity of its workforce. The WET Plan can be located at: http://sandiego.camhsa.org/files/MHSA-3-Year-Plan-FYs-2014-15-thru-2016-17-11-21-14-Final.pdf.

To specifically address building bilingual staff capacity, the following programs have been developed and implemented, with the progress to date in implementation discussed:

Action #3 (WET Plan p.35+): Public Mental Health Credential/Certificate Pathway
"This credential/certificate will be part of an accredited institution, such as a community college, and will assist individuals with educational qualifications for current and future employment opportunities. Recruitment…would focus on specific shortages in the public mental health direct service areas, as well as on the delivery of services to targeted population groups such as early childhood, youth, transition age youth, adult older adults, and linguistically and culturally diverse communities. Partnering with a community college has a decided advantage in that it will create options for the credential/certificate to be matriculated into AA and/or BA programs to assist those with lower levels of education to move…into a career pathway continuum. In addition, when coupled with practicum and mentorship opportunities and/or scholarships or stipends, the credential/certificate pathway could serve to encourage participation from culturally diverse populations, e.g., age, income, ethnicity and/or traditional healers."

Progress to Date: The program was selected through a competitive procurement process called Request for Proposal (RFP), and the successful bidders were San Diego Community College District and Alliant International University.

San Diego City College's Public Mental Health Academy is embedded within the Institute for Human Development. The Academy initiates a career pathway for a diverse population of students through a 19-unit Mental Health Work Certificate of Achievement. The certificate program serves as both workforce development for entry level positions in the mental health and human services field and as an academic stepping stone toward higher academic degrees in the field of mental health. The Academy has also established a pre-certificate preparation course for potential students who are non-native English speakers. The Public Mental Health Work Certificate of Achievement program started in October 2010. As of January 2016, a total of 331 individuals were enrolled in the program and 126 participants so far have graduated. Among

those enrolled in the program, 33 (10%) have a primary language other than English, and 86 (26%) are bilingual. Among those who have completed the program, 15 (12%) have a primary language other than English, and 36 (29%) are bilingual.

Alliant International University's Community Academy is a partnership between NAMI San Diego, Recovery Innovations Inc., the Family Youth Round Table, and the California School of Professional Psychology (CSPP) at Alliant International University. It provides training and employment assistance for individuals with lived experience of mental illness and/or family members, including support provided through pairings with academic and peer mentors. The Community Academy supports the partners' six existing certificates and has facilitated translation of these certificates into academic credit. In addition, the program links students, partnering agencies, and the community with community trainings and evidence-based literature that address stigma, recovery into practice, addresses barriers to accessing career pathway through stipends, support, and provides community training addressing stigma about mental illness and recovery. As of March 2016, 59 participants have completed the program and 12 are currently enrolled. Among those who have completed the program, 21 (36%) have a primary language other than English, and 26 (44%) are bilingual. Among the 12 individuals who are currently enrolled, 2 (17%) have a primary language other than English, and 3 (35%) are bilingual.

Action #4 (WET Plan, p.40+): School-Based Pathways/Academy
"In order to promote mental health careers to students, this action will create a partnership between the County of San Diego and San Diego County schools to implement a mental health component/track to existing established Health Care Pathways programs. The intended result is an increase in the number of high school students who choose to pursue mental health careers. The schools that will be targeted will include those whose enrollments include a high number of students who are linguistically, culturally, and economically diverse. This partnership with the schools affords San Diego County the opportunity to increase the diversity of the mental health workforce, while also reducing the stigma associated with mental illness. Exposure to occupations will include those indicated as priority areas, including both clinical and non-clinical direct positions, as well as a focus on occupations that serve particular areas of need, e.g., early childhood, transition age youth, adult, and older adult, as well as cultural and linguistic diversity.

Progress to Date: The Program was selected through the RFP process, and the successful bidder was Health Sciences High and Middle College (HSHMC). HSHMC is a public charter high school that provides students an opportunity to explore opportunities in healthcare through its college preparatory curriculum, specialized electives and four-year, work-based internship program. With WET funding, HSHMC has created a specialized mental health worker career track for juniors and seniors. Up to 50 students per year are able to participate in the two-year certificate program. Curriculum and specialized activities are offered school-wide to encourage all campus students to take steps toward ending the stigma associated with mental health challenges, to have greater awareness and know more about seeking services for their own needs, and to consider this area of development as part of their own career exploration.

As of August 2015, a total of 103 students have completed the mental health career Pathways program. Among those enrolled in the last contract year 2014-15, 26 (52%) have a primary language other than English, and 44 (88%) are bilingual. The contract ended August 2015.

Action #5 (WET Plan p. 42+) Nursing Partnership for Public Mental Health Professionals
"This program is targeted "to expand the capacity for developing additional public mental health professionals in nursing occupations that are most needed. Programming would be in coordination with existing nursing pathways at local institutions of higher education. The areas of nursing need are: Clinical Specialists, licensed Vocational Nurses, Registered Nurses, and Psychiatric Nurse Practitioners. Schools that will be targeted will include those whose enrollments include a high number of students that are linguistically, culturally, and economically diverse. Academic instruction will be coupled with practicum and mentorship opportunities with public mental health contractors or with the County of San Diego. The objectives include increasing the skill levels and educational attainment of diverse culturally and linguistically diverse/representative groups and increasing the number of culturally and linguistically diverse individuals working in public mental health occupations."

Progress to Date: The Program was RFP'd, and the successful bidder was California State University San Marcos School of Nursing. WET funding has supported the development of curriculum and teaching modalities for an integrated Psychiatric/Mental Health Clinical Nurse Specialist (CNS) and Nurse Practitioner (NP) program. This Advance Practice Nurse will receive a Master of Science in Nursing, be eligible for national certification, and may practice in inpatient, outpatient or community settings with prescriptive authority and skills in psychotherapy and other treatment modalities. As of August 2015, a total of 12 students completed the program, and eight students are currently in the program. Four students are Caucasian, one is African American, one is Asian, one is Pacific Islander, and one is Middle Eastern. All are fluent in English, one is bilingual in Tagalog and one is bilingual in Arabic. Students ranged in ages from 25 to 59 years, with two individuals being veterans. The contract ended August 2015.

Action #6 (WET Plan, p. 44) Community Psychiatry Fellowship
"*This program is directed toward remedying the shortage of psychiatrists through partnering with a medical school to fund a position(s) with the intent of increasing family medicine/psychiatry fellows with a community psychiatry specialization. The program may target culturally and economically diverse populations."*

Action #7 (WET Plan p. 46) Child Psychiatry Fellowship
"This program is directed toward remedying the shortage of child psychiatrists through partnering with a medical school to fund a position(s) with the intent of increasing family medicine/psychiatry fellows with a community child psychiatry specialization. The program may target culturally and linguistically diverse populations."

Progress to Date (actions 6 & 7 combined): The Community Psychiatry Fellowship program at UCSD began in fall of 2011. As of March 2016, five participants have completed the general community psychiatry fellowship, and three participants have completed the child community psychiatry fellowship. Additionally, three participants (2.5 FTEs) are currently enrolled in the general community psychiatry fellowship, and two are enrolled in the child community

psychiatry fellowship. Among these individuals, two are fluent in Spanish, one in Arabic, one in Russian, and one in Mandarin Chinese.

Action #8 (WET Plan, p. 48), LCSW/MFT Residency/Intern
"This program is directed at increasing the presence of licensed students in San Diego. The County of San Diego will explore developing a partnership with established LCSW and MFT training programs to fund residency/internship slot(s) to offer students compensation in exchange for a commitment to practice in San Diego County's public mental health workforce. The program objectives include having students be fluent in threshold and critically needed languages and be affiliated with under-served or unserved communities including Latino, African-American, Vietnamese, Cambodian, Hmong, Lao, and Samoan, and/or experiences or providing services to such communities."

Progress to Date: The Program was RFP'd and three bidders below were successful. The programs started in September 2010.

San Diego State University-LEAD (MFT) – The LEAD Project seeks to increase the presence of ethnically and linguistically diverse licensed clinicians in San Diego County by funding stipends for bilingual/bicultural MFT interns in exchange for a commitment to practice in San Diego County's public behavioral health workforce. In addition, this program also provides supervision hours and classes to prepare interns for licensure. As of August 2015, a total of 15 participants have completed the program. Each of these participants is bilingual and bicultural, with a wide range of races/ethnicities and languages represented, including the following:

- Mexican-American female fluent in Spanish
- Italian-American fluent in Spanish
- Latina fluent in Spanish
- Asian-American male fluent in Vietnamese and English
- Hispanic female fluent in both Spanish and English
- Pacific Islander female fluent in Chamorro and English
- Asian female fluent in Spanish and English and able to speak Chinese (more specifically Cantonese)
- Asian female fluent in Chinese (more specifically Mandarin) and English
- Hispanic female fluent in both Spanish and English.
- Iranian male fluent in Farsi and English
- Mexican-American female fluent in Spanish and English
- Cuban female fluent in English and Spanish
- Hispanic female fluent in English and speaks conversational Spanish
- Mexican male fluent in Spanish and English
- German male fluent in German, Spanish and English

The contract ended August 2015.

Alliant International University – Alliant International University, on behalf of San Diego MFT Educators' Consortium that represents all the MFT programs in San Diego County, is the host of the San Diego County MFT Residency/Internship Program. The

program provides three educational stipends each year in exchange for a commitment to work in the County's public behavioral health system for at least two years.

Action #9 (WET Plan p.40): Targeted Financial Incentives to Recruit and Retain Licensable and Culturally, Linguistically and/or Ethnically Diverse Public Mental Health Staff

"This program is designed to aid in the recruitment and retention of licensed eligible and culturally, linguistically and/or ethnically diverse public mental health staff to work in both the County and contracting community-based organizations (CBOs). The WET Needs Assessment also revealed a number of positions in licensed and unlicensed direct services were deemed hard to fill, including bilingual clinical positions. The objectives of this program include: increasing the ethnic diversity of licensed professionals, increasing the number of employees from underserved backgrounds, and increasing the number of employees with critical linguistic proficiencies.

Financial incentives will be awarded on a competitive basis. Criteria will include:

- *Fluency in threshold and critically needed languages, e.g., Spanish, Vietnamese, Tagalog, Arabic, Chaldean, Hmong, Cambodian, Laotian, Somali and Swahili.*
- *Culturally underserved, unserved or underrepresented community affiliation e.g., Latino, African-American, Vietnamese, Cambodian, Hmong, Lao and Samoan and/or experience providing services to such community members.*
- *Focus on specific regions or particular cultural/language diversity-focused positions (e.g., rural, non-English speaking, Native Americans, refugees/immigrant populations).*

Candidates will be selected from a pool of candidates who have submitted a complete application. In addition, the application process will include an interview that will, in part, be used to assess the candidate's capacity to complete any educational programming required by the designated position and/or their commitment to continuing employment in the public mental health field in San Diego County (i.e., a demonstrable, longstanding family or community ties in San Diego and/or an interest in working within the County for the foreseeable future).

Application pools will be opened and reviewed on a semi-annual basis. In years in which no funding is awarded, funding will "roll over" for allocation in future years. Opportunities will be explored to leverage financial incentives and assistance funding through coordination and/or integration with federal, state, regional, and educational financial incentive programs. Candidates may be eligible for the following financial incentives, depending on merit and/or need."

Recipients of the larger stipends, scholarships and/or loan assumptions will be contractually obligated to work for Mental Health Services or contracting CBLs after completing studies for a period of time equal to the period in which they received support, with a minimum commitment of two years. Those who do not meet their obligations will be required to reimburse the County for the full amount of assistance, plus interest.

2. Updates from Mental Health Services Act (MHSA), Community Service and Support (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.

WET PLAN--EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

Language, other than English		Number who are proficient	Additional number who need to be proficient	**TOTAL (2) + (3)**
(1)		(2)	(3)	(4)
1. Spanish	Direct Service Staff	375	245	620
	Others	179	0	179
2. Tagalog	Direct Service Staff	37	16	53
	Others	17	0	17
3. Vietnamese	Direct Service Staff	13	22	35
	Others	6	0	6
4. Arabic	Direct Service Staff	10	16	26
	Others	2	1	3
5. Russian	Direct Service Staff	9	4	13
	Others	1	0	1
6. Cambodian	Direct Service Staff	8	1	9
	Others	3	1	4
7. Sign	Direct Service Staff	13	2	15
	Others	11	2	13
8. Lao	Direct Service Staff	1	3	4
	Others	1	3	4
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
	Direct Service Staff	0	0	0
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	466	309	775
	Others	220	7	227

In addition to WET Plan activities to grow bilingual staff, all CSS programs contain a requirement for staff to be able to provide services in languages appropriate for their target populations, and have accordingly made efforts to hire bilingual staff to the maximum degree available. Several CSS Plans focus specifically on providing bilingual services to clients:

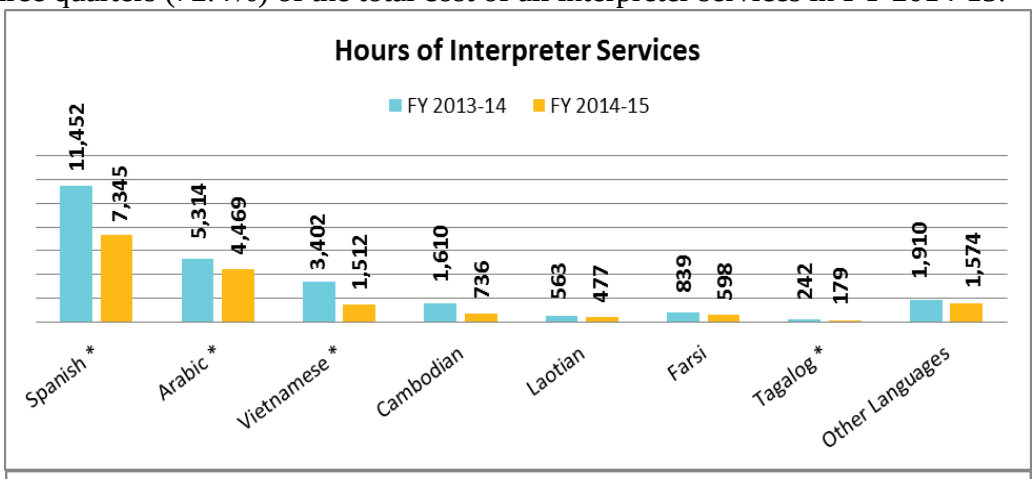
- **The Council of Community Clinics** focuses on primary health and mental health integration for Latinos in their communities through care provision in 11 community-based, primary-care clinics. Five of the clinics utilize Promotoras to engage Latinos with diabetes and depression through interventions provided in Spanish.

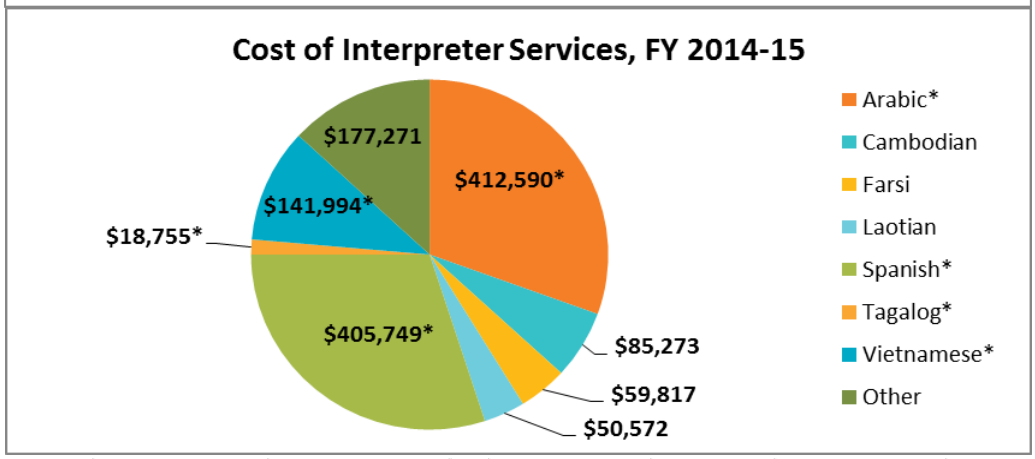
- **Chaldean Middle-Eastern Outpatient Services** provides services to the recently immigrated Middle Eastern community in San Diego who have previously been unable to access mental health programs due to cultural and language barriers. Services are provided by bilingual and bicultural Middle Eastern mental health service professionals. The Annual CSS Update Submission, as of FY 2014-15, stated that 207 clients were served.

- **Cultural Language Specific Outpatient Services for Children and Youth** include a Full Service Partnership (FSP) designed to address disparities and reduce stigma associated with mental health services and treatment for Latino and API populations. This program, with its cultural and language specific services, provides mental health services to seriously emotionally disturbed (SED) Latino and Asian/Pacific Islander (API) children and their families, utilizing a comprehensive approach that is community based, client and family focused, and culturally competent. Expanded services include case management, treatment plans that address obesity and diabetes, co-occurring services, and additional outreach and education to targeted populations in the Southeast area.

3. Total annual dedicated resources for interpreter services.

SDCBHS has provided services to persons with Limited English Proficiency through the usage of interpreter services. In FY 2014-15, there were 8,443 fewer hours of interpreter services provided to clients in San Diego County, compared to FY 2013-14 (16,889 vs. 25,332), and cost of interpreter services decreased by $122,806 from FY 2013-14 to FY 2014-15 ($1,474,826 vs. $1,352,020). The total cost of threshold language interpreter services was $979,087, which is nearly three quarters (72.4%) of the total cost of all interpreter services in FY 2014-15.





Number of Interpreter Services by Quarter, FY 2014-15		
	Children	Adults
Quarter 1	2,149	2,525
Quarter 2	1,954	2,371
Quarter 3	1,660	2,355
Quarter 4	1,585	2,483

Top 5 Most Requested Languages in FY 2014-15 Among Children and Adults			
Children		Adults	
*Spanish**	5,630	*Arabic**	3,931
*Arabic**	512	*Spanish**	1,791
*Vietnamese**	496	*Vietnamese**	1,073
Cambodian	156	*Cambodian*	707
Farsi	96	*Farsi*	520

LANGUAGE CAPACITY

II. Provide services to persons who have Limited English Proficiency (LEP) by using interpreter services.

The County shall include the following in the CCPR:

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

County Behavioral Health Services Cultural Competency Standards requires that provider programs develop staff's language competency for threshold languages. However, if program staff cannot meet the need for language assistance, then the program shall provide interpreter services. Policy MHS #01-02-203 Interpreter Services: Access and Authorization establishes a process to provide free interpreter service for mental health clients with Limited English Proficiency (LEP). Selected interpreter services include:

- Interpreters Unlimited (for language interpreting)
- Deaf Community Services (deaf and hearing impaired)
- Network Interpreting Service (back up when Deaf Community Services is not available).

Current Standards and Requirements

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

Culturally and Linguistically Appropriate Services (CLAS) Standards:

The Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competent across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 standards.

The standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Staff competence – SDCBHS and the Cultural Competence Resource Team (CCRT) have identified the following methods that providers will be encouraged to implement for evaluating staff competence in cultural competence: 1) use of the California Brief Multicultural Competence Scale (CBMCS) or other standardized measure; 2) conducting a survey amongst their clients to determine if the program's clinical and administrative services are perceived as culturally competent; 3) conducting a survey amongst their clients to determine if the program's

clinical and administrative services are perceived as linguistically competent. The CBMCS is available on line. Surveys can be developed independently; or if providers prefer samples of surveys, they are available in the recently updated Cultural Competence Handbook.

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

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

The SDCBHS contracts with its Administrative Services Organization (ASO), OptumHealth, to provide a 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD.

In FY 2014-15, the Access and Crisis Line (ACL) received 91,682 calls, with an average call volume ranging from 6,717 to 8,150 calls per month. Of those, approximately 3.8% were calls conducted in language other than English and 0.3% were Hearing Impaired calls. The ACL is staffed by a highly trained staff, 67% of whom have an independent license and 26% are license-eligible, registered interns. There are four ACL staff who are bilingual in English/Spanish. During the regular work day, there is at least one Spanish-speaking staff member available to immediately handle problems and inquiries from Spanish callers. To the maximum degree possible, the Optum management seeks out bilingual speakers with mental health knowledge to staff the ACL, finding themselves in competition with other County contractors for a comparatively small pool of persons both with mental health experience and bi-lingual in Vietnamese or Arabic. The ACL also contracts with the Language Line to provide immediate interpreter services as needed in threshold and non-threshold languages.

2. *Least preferable are language lines. Consider use of new technologies, such as video language conferencing. Use new technology capacity to grow language access.*

San Diego County explored utilizing the Health Care Interpreter Network (HCIN) which is a cooperative of California hospitals and healthcare providers sharing trained healthcare interpreters through an automated video/voice call center system to provide video language conferencing. Through this system, videoconferencing devices and all forms of telephones throughout a hospital/healthcare system connect within seconds to an interpreter on the HCIN system. When a language isn't available from an interpreter at an HCIN hospital, the call connects automatically to a contracted telephonic language provider. The languages currently offered are Spanish, Cantonese, Mandarin, Vietnamese, Lao, Mien, Cambodian, Hmong, Korean, Russian, Farsi, Armenian and Hindi. American Sign Language is also available on HCIN video stations.

HCIN is currently not being implemented for San Diego County because of the cost and because two of the four County's threshold languages (Tagalog and Arabic) are not available. Annual membership fees in HCIN are: $40,000 for public hospitals, $50,000 for populations with significant indigent/Medi-Cal service, $60,000 for other community hospitals. In addition,

installation costs are between $120,000 and $150,000 per site. Since State funding for services has been cut, the County's ability to add features has been drastically limited. However, San Diego County will continue seeking more affordable options for video interpreting services, which can be shared with several hundred provider sites over a large geographical area.

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

SDBMHS Policy #01-02-203 (Interpreter Services: Access and Authorization) sets forth the protocol for implementing language access through the County's 24-hour phone line that has statewide toll-free access (the Access and Crisis Line). Providers must inform clients of their right to receive help from an interpreter and document the response to the offer. Upon request of the client, providers must arrange for language assistance. Providers can get linked with the Language Line provided by the ASO, if they do not have an in-house link to other interpreter services. The process used at the Access and Crisis Line to link a caller with its Language Line is as follows:

1. Ask the caller to hold while you get an interpreter.
2. On the Avaya IP Agent Software, press Conference Hold to place the caller on hold.
3. Dial 1-888-724-7240. Press 1 for Spanish interpreters. Press 2 for all other languages.
4. Client ID 795254
   Organizational Name: Optum, Crisis Line
   People Soft Code: 41270 1540 1815
5. Advise the interpreter:
   "Interpreter, this is the San Diego County Access and Crisis Line. I have a monolingual (language) caller on the line. I would like you to interpret directly. I will speak directly to the client and will start with our standard greeting. If you are ready, I will add the caller."
6. Add the Limited English speaker to the line and use the standard greeting.
7. At the closing ask the caller: "Is there anything else I can assist you with today?" If no, state: "Please release the interpreter when you are ready."

4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

ACL staff go through four phases of training to learn how to maintain contact with a caller and establish rapport, provide support, intervention and referrals, and handle the documentation required. One-to-one coaching is provided to learn these skills and tasks. Trainees initially monitor calls and observe the process and then go on to progressively participate in the calls and eventually to handle calls independently while being monitored. The goal for mastery of the Language Line and TDD is to: 1) successfully determine that the caller required an interpreter; 2) connect the caller to the Language Line; 3) conference in the caller; 4) successfully complete the call. Trainees are required to have five successes before being allowed to handle such calls alone. However, at all times, clinical supervision is readily available should staff experience a problem.

Individual providers are expected to train their staff on connecting with the Access and Crisis Line to receive quick language assistance for a caller or drop-in visitor with limited English proficiency.

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right.

In the Quick Guide to Mental Health Services for Adult, Older Adults, and Children, distributed to all new consumers, there is a section that states:

"San Diego's Mental Health Plan Provides:

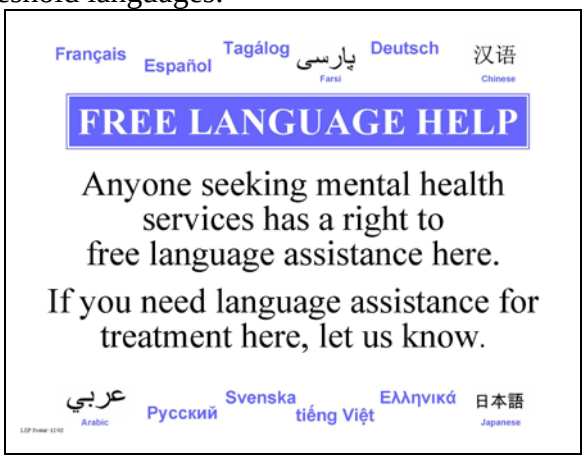
- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired"

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, and Arabic and is available at all organizational provider locations and through Behavioral Health Services Administration. See copies in the Appendix 16.

In addition, the County provides a Guide to Medi-Cal Mental Health Services in San Diego, a booklet about the mental health services that San Diego County offers and about the Medi-Cal Service Plan. The booklet is available in English, Spanish, Tagalog, Vietnamese, and Arabic. There is a section in the beginning of the booklet that states,

"If you feel you have a mental health problem, you may contact the San Diego Mental Health Plan Access and Crisis Line directly at (888) 724-7240. This is a toll-free number that is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language."

Additionally, all SDBMHS programs are required to have a copy of the sign below posted in their waiting rooms in threshold languages:



C. Evidence that the County/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

Appendix 17 has examples of client records and services provided by County contractors in Spanish, Arabic, and Vietnamese.

1. Share lessons learned around providing accommodations to persons who have LEP and have needed interpreter services or who use bilingual staff.

The following lessons learned were shared in discussions with stakeholders:

- More bilingual staff are needed on site. Higher salaries for bilingual staff are needed for higher retention.
- When using Interpreter Unlimited (the free service available through the SDCBHS), it would be easier to have a way of scheduling electronically, rather than through phone calls and faxing.
- Therapists need to be patient – the process of recovery tends to be slower for non-English speaking client than with English-speaking clients. Similarly, there is an impact on the therapy process (i.e., with an interpreter, 60 minutes is spent with the client, but 30 minutes is spent for interpretation).
- It is helpful to have a pre- and post-session meeting with the interpreter.
- It would also be helpful to have a system in place to provide an evaluation of each interpreter service session.
- It's important to train clinicians how to utilize interpreters – and likewise train interpreters about mental health services.
- It's better to use a professional interpreter, rather than a family member to translate. Translators should be neutral and someone the client does not know personally.
- Clear instructions should be given to LEP clients so they know what to discuss with the clinician before a session.
- Families with LEP may not initially understand what psychotherapy is, so it needs to be explained to help them be more receptive to services.

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

SDBMHS had identified the following historical challenges and lessons learned for:

- Dedicating adequate funds to provide needed level of interpreter services at a time when there are many conflicting priorities.
- Staff needs to reflect the target population, but the scarcity of qualified personnel has limited access to language appropriate services.
- Staff retention is influenced by lack of resources to compensate at market rate for bilingual staff.

- Direct service programs need continuing monitoring to ensure that they are not overly relying on interpreter services, rather than directly hiring bilingual staff.

E. Identify County technical assistance needs.

- SDBMHS would find it helpful to have technical assistance on County programs which are successfully reaching out to clients with limited English proficiency. It would be useful to know strategies to engage clients, the amount of time it took for engagement to occur, and lessons their staffs learned in putting together a successful program.
- San Diego is among the counties with the highest immigrant influx each year and is interested in learning how other counties nimbly respond to the changing needs of new immigrant groups.

LANGUAGE CAPACITY

III. Provide bilingual staff and/or interpreters for the threshold languages at all points of contact.

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

The County shall include the following in the CCPR:

A. Evidence of availability of interpreter (e.g., poster/bulletins) and/or bilingual staff for the languages spoken by community.

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

SDCBHS has provided services to persons with Limited English Proficiency through the usage of interpreter services.

In FY 2014-15, there were 8,443 fewer hours of interpreter services provided to clients in San Diego County, compared to FY 2013-14 (16,889 vs. 25,332), and cost of interpreter services decreased by $122,806 from FY 2013-14 to FY 2014-15 ($1,474,826 vs. $1,352,020). The total cost of threshold language interpreter services was $979,087, which is nearly three quarters (72.4%) of the total cost of all interpreter services in FY 2014-15.

Similar to the previous year, in FY 2014-15, clients were more likely to utilize Spanish translation services (43.5%), followed by Arabic (26.5%), and Vietnamese (8.9%). Adults and children were least likely to utilize Tagalog (0.1%) and Farsi (3.5%) translation services.

Client use of interpreter services is documented in the monthly invoices which the SDCBHS receives from Interpreters Unlimited. Client use of interpreter services is also documented in each client's clinical record.

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

The 24-hour Access and Crisis Line has Spanish coverage (the County's second most used language) during regular day operating hours. See a sample of their weekly schedule below:

Weekly Schedule — July 25-31

SUNDAY 25			MONDAY 26			TUESDAY 27			WEDNESDAY 28			THURSDAY 29			FRIDAY 30			SATURDAY 31		
Overnight			*Overnight*			*Overnight*			*Overnight*			*Overnight*			*Overnight*			*Overnight*		
ED	9PM	7:30A	LARRY	9PM	7:30A	LARRY	9PM	7:30A	LARRY	9PM	7:30A	ED	9PM	7:30A	ED	9PM	7:30A	ED	9PM	7:30A
RONDA	9PM	7:30A	RONDA	9PM	7:30A	RONDA	9PM	7:30A				LARRY	9PM	7:30A						
						GIANG	9PM	7:30A	GIANG	9PM	7:30A	GIANG	9PM	7:30A	GIANG	9PM	7:30A	RONDA	9PM	7:30A
ANGELA	9PM	7:30A	ANGELA	9PM	7:30A										ANGELA	9PM	7:30A	ANGELA	9PM	7:30A
Day			*Day*			*Day*			*Day*			*Day*			*Day*			*Day*		
HILDA	7AM	3:30P	KIM	7AM	1:00P	KIM	7AM	3:30P	KIM	7AM	3:30P	KIM	7AM	3:30P	KIM	7AM	3:30P	HILDA	7AM	3:30P
MARY D	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MAGGIE	7AM	3:30P	MARY D	7AM	3:30P
CHRIS	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	RAY	7AM	3:30P	MARY C	7AM	3:30P
			HEIDI	7AM	3:30P	HEIDI	PTO		HEIDI	7AM	3:30P	HEIDI	7AM	3:30P	HEIDI	7AM	3:30P			
			RACHEL	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P	JOANNE	8AM	4:30P			
			ALICIA	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P	MARY C	8AM	4:30P			
			HILDA	9AM	5:30P	ALICIA	9AM	5:30P	ALICIA	PTO		ALICIA	PTO		ALICIA	PTO				
															CINDY	9AM	5:30P			
						HILDA	9AM	5:30P	JACQUI	9AM	5:30P	IC	9AM	5:30P						
			CHRIS	7:30A	4:00P	CHRIS	PTO		CHRIS	PTO		CHRIS	PTO		CHRIS	7:30A	4:00P			
Evening			*Evening*			*Evening*			*Evening*			*Evening*			*Evening*			*Evening*		
PAT	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	VERONICA	1PM	9:30P	PAT	1PM	9:30P
RACHEL	PTO		CINDY	1PM	9:30P	CINDY	1PM	9:30P	CINDY	1PM	9:30P	CINDY	1PM	9:30P	MARY M	1PM	9:30P	JOANNE	1PM	9:30P
JACQUI	3PM	11:30P	GIGI	3PM	11:30P										GIGI	3PM	11:30P	JACQUI	3PM	11:30P
ALICIA	1PM	9:30P	MARY M	3PM	11:30P	RACHEL	3PM	11:30P	RACHEL	3PM	11:30P	RACHEL	1PM	9:30P						
JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P	JIM	3PM	11:30P						
SUNDAY 25			MONDAY 26			TUESDAY 27			WEDNESDAY 28			THURSDAY 29			FRIDAY 30			SATURDAY 31		

Color Legend

	=	Spanish Speaker
	=	"Non-Threshold" language (Ex: Polish, German, Russian, Hebrew)

=

In view of the shortage, and in some cases scarcity, of clinicians and other direct service staff who are bilingual in threshold languages, especially Vietnamese and Arabic, the SDCBHS does not currently require providers to submit evidence of in-house staff linguistic proficiency during regular day operating hours. However, an overall picture of staff language proficiency has been included in Criterion 6. The majority of services are conducted during business hours, so it is possible to use the report as a gross indicator of bi-lingual availability.

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

SDBMHS has a contract in place with Interpreter's Unlimited to provide interpreter services. Their contract Statement of Work includes the following statements about ensuring interpreters are trained and monitored for language competence:

- "Contractor shall ensure all personnel assigned to provide language interpretive services meet all applicable licensing, applicable certification, training and/or professional criteria during all periods of services provision. Interpreters shall demonstrate proficiency in English and non-English languages, possess knowledge of specialized terms used in the mental health field, and have clear understanding of interpreting ethics and practice."
- "Contractor shall maintain files of language interpretation professional criteria of all assigned personnel, including contracted and subcontracted personnel. Contractor will maintain and make available personnel files of aforementioned professional criteria upon request of the County."

Evidence of Interpreter Services Training by the Language Line (used by the SDCBHS 24/7 Access and Crisis Line):

"Recruiting, Training & Quality Processes at Language Line Services" (LLS)

Language Line Services has implemented the highest standards for its interpreters in recruiting, training, and interpreter certification in the country. It has also specifically trained its interpreters on the Standards for Practice from the National Council on Interpreting in Health Care. The details of Language Line Services' recruiting assessment, training, and certification program are described below.

1. Interpreter Recruiting Process

To ensure and maintain premium language interpretation services, Language Line Services (LLS) deploys a comprehensive testing and evaluation process to retain the best interpreters. All interpreters are tested and accredited by Language Line Services' highly qualified and experienced raters to provide our customers with the most accurate and professional telephonic interpreting services in the industry.

Resumes are received from a wide variety of sources from all over the country. Language Line Services is represented at every major professional interpretation

conference in the country, including the annual conferences of National Association of Judiciary Interpreters and Translators (NAJIT), American Translators' Association (ATA), and other interpreters associations.

LLS closely monitors all interpreter training developments nationwide and keeps a database of schools, organizations, websites, and agencies for recruiting purposes. LLS recruiting department initiates and maintains relationships with those recruiting sources that have proven to be most productive. It also conducts extensive Internet research on language-related sites and frequently identifies candidates over the Internet. Furthermore, LLS gives presentations and workshops on the unique nature of telephonic interpreting at different interpretation training programs to attract the best candidates with related training background.

LLS also has an extensive referral program through its staff interpreters and advertises in major newspapers and publications targeted towards certain ethnic groups and language professionals.

Once candidates are identified, they are screened, tested and accredited through the following multi-step process:

1) Preliminary screening through an over-the-phone interview to verify skills indicated on the candidate's resume.
2) An oral proficiency test for both English and the target language. The proficiency test evaluates key areas, such as the speaker's comprehension ability, grammar, breadth of vocabulary, pronunciation and enunciation, and overall presentation. If proficiency is at the Advanced or Superior level, the candidate is scheduled for the next requisite test.
3) Interpreter Skills Assessment (ISA) is a Language Line Services proprietary test, developed with over 20 years' experience as the leader of the industry. The ISA is a rigorous, criterion-referenced integrative test designed to specifically evaluate a candidate's interpretation skills. It is bi-directional from English into a target language and from the target language into English. It is conducted in the consecutive mode, mirroring in content, as well as format, the interpretation scenarios LLS interpreters handle, including calls from the medical settings. The ISA is evaluated by both an objective scoring method and a subjective assessment, with an emphasis on the objective scores.

2. Interpreter Training and Certification:

A. Orientation Processes

Language Line Services has a two-week new hire orientation process for its interpreters. During the orientation, new hires undergo basic training, job shadowing

with senior interpreters, service observation and feedback, and Question-and-Answer Sessions. Specifically, the following will be covered:

- The basics of interpretation
- The roles of an interpreter and the Interpreter Code of Ethics. Confidentiality is emphasized and each interpreter is required to sign a Non-Disclosure Agreement, which is witnessed and kept on file; interpreters are also trained on HIPAA and GLB Act requirements on confidentiality.
- Methods and Procedures of call handling, Personnel Guide, and other administrative matters.
- Interpreting skills and customer service skills. In addition to training on fundamental interpreting skills, such as note taking and memory retention, the trainer also teaches new hires the required skills for providing exceptional customer service and the highest degree of professionalism.
- Review of industry standards; interpreters listen to scenarios of simulated typical interpretation calls. LLS has developed standards for each industry based on formal feedback gathered from customer surveys and Voice of the Customer programs, as well as from participation in professional organizations such as the American Translators Association, National Council on Interpreting in Health Care, and ASTM.

New hires also job shadow senior interpreters and discuss their learning with the Orientation Trainer. In addition to learning and practicing typical industry scenarios and terminology, new-hires are provided an internally developed, 575-page At-A-Glance Industry-Specific Glossaries as a job aid to assist them on calls.

The new-hire orientation also contains an evaluation component. Only those who meet the predetermined criteria, as demonstrated through role playing and other exercises, will be deemed qualified to take calls as active interpreters.

Every new hire is assigned to a Senior Language Specialist (SLS) who will then provide hands-on, one-on-one training. The SLSs are senior interpreters with extensive education and experience in the interpretation field. Each SLS works with a group of 15-30 interpreters. The SLS will not only share his or her skills and experience with the new hire, but will also observe the new hire during calls and provide immediate feedback and coaching. Usually feedback is given to new hires within the same day of the observation, no later than the next business day, to help new hires build up skills and confidence, identify improvement areas, and offer guidance.

B. Training, Continuing Education and Development for the Interpreters:

The Interpreter Training Department at LLS provides on-going training in the following areas: Finance, Insurance, Court, Medical, Technical Terminology, 911, Stress Reduction, and Customer Service Skills.

Many of the training curricula are developed in collaboration with external training/teaching experts and with input from customers. The Advanced Medical Training for healthcare interpreters was developed internally by medical professionals who are also interpreters for LLS, as well as interpreters with experience as trainers and healthcare interpreters; this training is used to supplement the more basic Medical Interpreter Training that LLS co-developed with the Cross Cultural Health Care Program, a leading medical interpreting training organization, located in Seattle, Washington (www.xculture.org).

All of LLS's training programs provide both training material and instructed training sessions. The training contents are pertinent to real call scenarios that the interpreters deal with on the job. During the training sessions, the interpreters actively participate in role playing and discuss terminology in their working languages. Training sessions are taught by the instructors who have been involved in the training development because of their expertise in the industry; they are also senior interpreters.

LLS also trains the interpreters on healthcare interpreting requirement based on the document of Standards of Practice issued by the National Council on Interpreting in Health Care.

C. Interpreter Certification:

Because of a lack of standard certifications at the national level, and in response to clients' needs and the demand for interpreters with proven competence in interpreting for specific industries, LLS has become a pioneer in the certification field. In the late 1990's, LLS developed its own internal certification program with the collaboration and validation of external experts. All certification tests have been validated by a psychometrician and external experts, including LLS clients from the industry. The tests have been designed to represent the breadth of calls that LLS interpreters encounter during their work, as well as the wealth of terminology that exists within each industry and the industry-specific protocols. Each test is an oral over-the-phone exam that is administered on a one-to-one basis, and in the consecutive mode. In addition to their work experience, test candidates are provided with test preparation materials prior to each testing round.

To be deemed Certified in any given industry, an interpreter must have met the following criteria:

- Passed the initial Interpreter Skills Assessment Test
- Undergone the New Hire Orientation
- Completed Industry-specific Training
- Passed the Industry-specific Certification Test
- Maintained satisfactory service observation ratings
- Received positive customer feedback based on data from the Voice of the Customer Program.

All six criteria are carefully reviewed once an interpreter has passed the Certification Test, and industry-specific certifications are issued only to those interpreters who have demonstrated a consistent quality of performance and level of expertise worthy of certification, as measured by the aforementioned standards.

This multifaceted model is based on the Company's belief that no single form of evaluation can provide a complete assessment of an interpreter's proficiency. Our model examines diverse domains to measure interpreter competency and utilizes both skills assessments and performance-based evaluation criteria for certification. The aforementioned six components include evaluations of interpreters' job performance through service observation and customer feedback, training participation, as well as skills assessment through testing. This makes Language Line Services' certification distinctly different from any other certification program. LLS has filed for a patent for this comprehensive certification program and the patent is pending.

Currently, LLS' Medical Certification Test, Language Proficiency Test, and Interpreter Skills Assessment, along with several LLS training programs, are all available to LLS customers through Language Line University.

3. Quality Monitoring

LLS has a department dedicated to managing our quality monitoring process, the Quality Assurance Department. A group of Senior Language Specialists (SLS) are trained to not only conduct quality monitoring, but also to provide constructive feedback. A Senior Language Specialist usually works with 15-30 interpreters and all SLSs are selected for their top-notch language and interpretation skills and are trained to provide in-language observation and feedback.

Additionally, the Interpreter Training Department works closely with the Quality Assurance Department in identifying training needs and developing training programs at a higher level. Many Senior Language Specialists are also trainers who can train the interpreters on their teams. Observation information is also frequently taken into consideration in interpreter communications, e.g., the monthly interpreter newsletter covers issues and challenges identified through monitoring, without using real client or interpreter names to maintain confidentiality.

Interpreters are evaluated according to their performance level, which is determined by both service observation data as well as customer feedback. Performance is reviewed and measured according to the identified needs of the individual interpreter. The interpreter manager will evaluate the performance of an interpreter at any time if there is a concern raised by either external or internal customers. A formal written appraisal is conducted once a year.

LANGUAGE CAPACITY

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health systems at all points of contact.

The County shall include the following in the CCPR:

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

Policy BHS #01-02-201 – Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services (Appendix 18) includes practices and procedures for referring and otherwise linking clients who do not meet the threshold language criteria (e.g., LEP clients) to culturally and linguistically appropriate services.

See also the SDBMHS Organizational Provider Operations Handbook section on Cultural Competence (Appendix 4) for procedures in place to serve, link and refer, as necessary, clients to culturally and linguistically appropriate services.

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

See answer above in Section IV. A.

C. Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 (see page 32) requirements:

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

Based on the Civil Rights Act of 1964 (42 U.S.C., Section 2000(d), 45 C.F.R., Part 80), when a need is determined, the County of San Diego Health and Human Services Agency (HHSA) – Behavioral Health Services (BHS), shall ensure that a process is in place for accommodating and referring clients to available culturally and/or linguistically appropriate services. That process is established through Policy BHS #01-02-201 (Appendix 18). The policy also requires that all providers provide language assistance to persons with Limited English Proficiency (LEP) to ensure them equal access to programs and services.

The policy states that all LEP persons speaking threshold or non-threshold languages shall be informed in a language they understand that they have a right to free oral interpretation assistance. It also states that:

- There is no expectation that family members provide interpreter services.
- A consumer/client may choose to use a family member or friend as an interpreter, after being informed of the availability of free interpreter services.
- Other than in extenuating circumstances, minors (under the age of 18) may not be used as interpreters even if the applicant/beneficiary requests to do so; although at the applicant's/beneficiary's request, the minor may be present in addition to the County-provided interpreter. Temporary extenuating circumstances may include using a minor child to determine the appropriate language needs of the adult so that an appropriate interpreter or bilingual staff person could be called or in order for the County to ask the client to wait while the County obtains the interpreter service.

LANGUAGE CAPACITY

V. Required translated documents, forms, signage, and client informing materials.

The County shall have the following available for review during the compliance visit:

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:

1. *Member service handbook or brochure;*
2. *General correspondence;*
3. *Beneficiary problem, resolution, grievance, and fair hearing materials;*
4. *Beneficiary satisfaction surveys;*
5. *Informed Consent for Medication form;*
6. *Confidentiality and Release of Information form;*
7. *Service orientation for clients;*
8. *Mental health education materials; and*
9. *Evidence of appropriately distributed and utilized translated materials.*

Samples of the materials listed in items 1-8 above are made available at the tri-annual DHCS compliance visit. The availability of materials at provider locations is monitored by the Quality Improvement Unit through Site Reviews and other reports.

B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients' preferred language.

The SDCBHS provides documented evidence in the clinical chart at each DHCS tri-annual compliance review. Please see the Appendix 17 for a sample of such case notes.

C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results (e.g., back translation and culturally appropriate field testing).

The County of San Diego used the mandated State satisfaction survey for all of its outpatient providers. Translations are made available when requested by programs.

Summary reports of results of the Youth and Adult Satisfaction Surveys and the MHSIP are in the Appendix 19 and 20.

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).

Currently the SDCBHS uses a translation service to provide needed translations and updates of translated documents. Materials received from the translation service are reviewed by SDCBHS clinicians for accuracy prior to distribution.

E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

The text difficulty of all documents is tested through the WORD grading system, and wording is modified to the maximum degree possible to keep materials at a sixth grade reading level.

ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs.

The County shall include the following in the CCPR:

A. List and describe the County's/Agency's client-driven/operated recovery and wellness programs.

SDCBHS has the following client driven recovery and wellness programs:

Recovery Innovations
Recovery Innovations offers a number of services that create opportunities to empower people and organizations to recover. Recovery education classes such as WRAP, WELL, and Medication for Success enable people to develop self-help skills. One-to-one Peer Support and recovery classes in the San Diego County Short Term Acute Residential Treatment (SART) crisis facilities provide people an introduction to recovery and community recovery links. Peer Employment Training and other recovery trainings for individuals and unique trainings for professional staff equip people and organizations with the tools to transform their operations to a recovery-based model. The Peer Liaison Services program assists people to advocate for their needs and rights by acting as a two-way conduit to gather and disseminate information between the Mental Health System of Care and people receiving services and their families.

Recovery Innovations Peer Employment Training Program
The Peer Employment Training (PET) program is a 75-hour training provided for people with lived experience of recovery from mental health or co-occurring mental health and substance abuse challenges to work in the service system as a Peer Support Specialist. The training focuses on ways to use personal experience and skills to inspire hope in the lives of other individuals receiving services. Prerequisites include: High School Diploma or GED, Completion of WRAP (Wellness Recovery Action Plan) and attending the PET orientation.

National Alliance on Mental Illness (NAMI) Programs
Trained NAMI volunteers bring peer and family-led programs to a wide variety of community settings, from churches to schools to NAMI Affiliates. With the unique understanding of people with lived experience, the following programs and support groups provide free education, skills training and support:

- **Family-to-Family** is a class for families, partners and friends of individuals with mental illness. The course is designed to facilitate a better understanding of mental illness, increase coping skills and empower participants to become advocates for their family members. This program was designated as an evidence-based program by SAMHSA. The course is also available in Spanish, De Familia a Familia de NAMI.
- **Peer-To-Peer** is a recovery education course open to anyone experiencing a mental health challenge. The course is designed to encourage growth, healing and recovery among participants. This program is also available in Spanish, De Persona a Persona de NAMI.

- **San Diego Helpline** is a telephone service for families, friends and those affected by serious mental illness. NAMI provides information about available classes and support groups, as well as assist with other mental health related resources.
- **Family and Adult Peer Support Line** provides specialized culturally and developmentally appropriate behavioral health service for adults, older adults, and their families who live in communities with a high concentration of ethnic minorities in order to promote their social and emotional wellness. This non-crisis, confidential, anonymous, stigma-free, toll-free, peer support line provides countywide telephone counseling services, support and referrals to adults and older adults, including those who may struggle with alcohol or drugs.
- **Next Steps** comprises of peer specialists and family support specialist folks, including folks who speak Spanish and API languages.
- **Friends in the Lobby** partners with Sharp Mesa Vista Hospital, UCSD Medical Center, Scripps Mercy Hospital, Bayview behavioral Health Campus, Alvarado Parkway Institute, Palomar Medical Center, Tri-City Hospital, Crestwood Behavioral Health, and the VA Medical Center La Jolla to provide outreach and engage individuals visiting their loved ones in local hospitals. The innovative program that began January 2016 is part of NAMI San Diego.

Family Youth Roundtable

The Family/Youth Liaison (FYL), a client/family operated organization, has the primary duty of coordinating and advancing family, youth, and professional partnership in CYF. The Family is defined as a caregiver of a child/youth who has or is currently receiving services from a public child/family-serving agency. Youth is defined as a person age 0 to 25 that has received or is currently receiving services from a public child/family-serving agency.

The Family and Youth Roundtable Executive Director also collaborates with CYFBHS administrative staff to ensure family and youth voices and values are incorporated into MHSA service development and implementation plans, as well as in the overall County of San Diego CYFBHS service delivery system.

The goal of the Roundtable contract is to advance and coordinate family/youth partnership in new and existing CYFBHS programs. Advancement shall be demonstrated by:

- Reinforced policies and procedures on family/youth professional partnership through participation in County of San Diego Contract Officer Representative (COR) Team reviews.
- Increased family/youth representation in policy, practice, evaluation, program development, and implementation planning.

Program Advisory Groups

Program Advisory Groups (PAGs) are composed of at least 51% mental health consumers and/or family members who are integrated in outpatient programs as a required program component that provides feedback and ideas to mental health programs about recovery services in the program. PAG meetings follow an agenda, attendance is recorded and minutes are taken. Guidelines for implementing PAGs across the Adult/Older Adult Mental Health System of Care have been instituted in an effort to standardize this important vehicle for soliciting feedback to improve programs.

Clubhouse Programs
The Adult/Older Adult System of Care currently supports the operation of 15 Clubhouse programs located throughout the different geographic regions of San Diego County. The Clubhouse programs provide social and vocational rehabilitation, as well as recovery and vocational services that assist members to increase their social rehabilitation skills, reduce social isolation, increase independent functioning, and increase and improve education and employment. Additional services include employment activities. Many different tools and techniques are employed to help clients learn living and interpersonal skills and to provide opportunities for advancement. In six of the Clubhouses, a Supplemental Security Income (SSI) Advocate is also available to provide assistance and support to non General Relief mental health consumers seeking to apply for and secure SSA/SSI benefits.

Warm Line, Mental Health Systems, Inc.
The "Warm Line" is an essential non-crisis peer telephone support service for persons recovering from mental illness who are living in the San Diego County community. The peer-run service assists callers by providing support, understanding, information, and referrals. The "Warm Line" is operated seven hours a day in the late afternoons/evenings each week by persons who are succeeding in managing their mental health symptoms and who are supporting others in their recovery efforts. The goals of the Warm Line program include promoting stability and reducing problematic situations that may lead to a crisis. Callers are provided information and referrals to appropriate community resources and non-crisis intervention services including offering coping techniques in order to assist callers to improve their self-care skills.

Older Adult Elder Multicultural Access and Support Services (EMASS) Program
The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County. EMASS is an age and culturally/linguistically appropriate, peer-based, outreach and engagement model to support prevention activities and increase access to care. It utilizes "Promotoras" or Community Health Workers (CHW) as liaisons between their communities and health, human service and, social organizations to bring information to their communities. The CHW and/or peer community liaison functions as an advocate, educator, mentor, outreach worker, role model, cultural broker, and translator.

Roadmap to Recovery
Roadmap-to-Recovery (R2R) groups provide a non-threatening and non-judgmental learning environment led by trained Peer Facilitators who discuss how clients can best interact and learn to advocate for themselves with their treatment team. Through discussion, the R2R groups aim to educate about self-management and treatment of their illnesses from the experiences of others. The R2R program utilizes collections of drawings made by clients to facilitate discussion that provides reassurance and support by the sharing of participants' own stories.

Next Steps Program
A project under development with NAMI San Diego, the Next Steps Program, provides comprehensive, peer-based care coordination, brief treatment, and health system navigation to adults with mental health and/or substance abuse issues who present at the San Diego County Psychiatric Hospital (SDCPH) and other participating sites throughout the County. The program

goal is to reduce problems associated with substance abuse, improve participants' mental and physical well-being, and reduce unnecessary use of psychiatric hospitalizations. Support, education, and advocacy will also be provided for families as a key part of the program in which five outreach teams consisting of one Alcohol and Other Drugs (AOD) counselor and one Peer or Family Support Specialist each, as well as other clinical and peer support staff, are integrated into the new model.

The Community Academy
The Community Academy program is funded by the County of San Diego, Mental Health Services through the Mental Health Services Act (MHSA) Workforce Education and Training. The program is offered entirely at no cost and provides training and support to individuals and their family members with lived experience with mental illness. In line with national recovery models, this program attaches value to the lived experience of individuals affected by mental illness and/or who gained experience assisting their family members. This program has the end goal of advancing these individuals along the pathway of the public mental health field. Students accepted into this program are linked with certificate training programs through partnering agencies – National Alliance on Mental Illness, Recovery Innovations of CA, and the Family and Youth Roundtable. Students receive a field placement, mentorship, and are offered an array of additional trainings to tailor the program to their specific area(s) of interests as they move along their pathway into the public mental health field. A one-year commitment is required. Stipend assistance is offered on a need basis to assist with barriers that students may face as they work to obtain their career and academic goals.

Courage to Call
Courage to Call is a peer-to-peer support program staffed by veteran peers providing countywide outreach and education to address the mental health conditions that are impacting Veterans, Active Duty Military, Reservists, National Guard and their families (VMRGF), and provide training to service providers of the VMRGF community. Mental Health Systems, Inc., provides the services in collaboration with 2-1-1 San Diego and Veterans Village of San Diego.

1. *Evidence the County has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.*

SDBHMS offers the following alternatives to accommodate individual preferences:

The Language Line provides interpreter services designed to help individuals understand a program/service delivery without altering, modifying, or changing the intent of a message. This free service is available to clients with limited English proficiency (LEP) in threshold and non-threshold languages, if it is needed for the delivery of specialty mental health services. American Sign Language (ASL) interpretation is also available.

The Warm Line service has two Spanish-speaking staff for some shifts and utilizes the Language Line for clients who request to speak with peers in their preferred language.

The newly established Adult Peer Support line has Spanish-speaking staff for Spanish-language callers, and plans the use of the Language Line for most non-English speakers. This program also is working collaboratively with providers to remotely utilize an Asian American peer for a more culturally attuned response to Asian/Pacific Islanders who use this service.

Program Advisory Groups in the South Region are conducted in English and Spanish to accommodate the high Spanish-speaking population.

Roadmap-to-Recovery (R2R) groups are facilitated in languages that reflect the population it serves. Clients can choose which R2R group they wish to attend.

Staff in SDCBHS programs/facilities reflects the diversity and closely matches the demographics within the community.
SDCBH programs are required per their contract to target diverse communities. One example is the Family Youth Roundtable contract Statement of Work that states "Contractor shall liaison with organizations targeting unserved and underserved communities. Those ethnic communities may include Asian/Pacific Islander, Hispanic, African or African American, Native American or Deaf."

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

The following programs are client-driven/client operated:

Friendship Clubhouse
The data analysis indicated that in the Central region, Adult and TAY African Americans and Latinos may be groups that are unserved. Friendship Clubhouse improves both access and services by providing culturally appropriate services for these unserved populations.

Eastwind Clubhouse
The Eastwind Clubhouse located in San Diego County's Central region provides culturally competent services to Asian/Pacific Islanders in three Asian languages: Vietnamese; Hmong and Cambodian.

Older Adult Elder Multicultural Access and Support Services (EMASS) Program
The EMASS program targets underserved seniors (ages 60 and over) in the Filipino, East African Refugee (Somali), Latino/Hispanic, and African American communities in the North, Central, and South regions of San Diego County.

Casa del Sol Clubhouse
This client-operated clubhouse program creates an environment that is welcoming to the culturally and ethnically diverse population of the region, with a special focus on Adult, Older

Adult, and TAY Latino population in that area. All program staff are bilingual Spanish, so monolingual Spanish-speaking members can be accommodated.

Roadmap-to-Recovery (R2R)
Where appropriate and facilitator availability permits, a minimum of one R2R group in each clinic is conducted in a threshold language (other than English) that serves the majority of clients in that clinic or HHSA region.

Warm Line Service
The Warm Line service has bilingual Spanish peer specialists for some shifts.

Family and Adult Peer Support Line
This program utilizes a bilingual Spanish family member staff. This program will also offer family support in selected Asian/Pacific Islander languages.

Deaf Community Services (DCS) Clubhouse
The DCS Clubhouse is a safe environment for Deaf, Hard-of-Hearing, Deaf-Blind, and late-deafened persons at risk for or living with behavioral health disorders to improve their quality of life and work towards achieving their personal goals. The Clubhouse is a learning environment where members explore their own interests and become confident learners through a variety of activities. The mission is to promote healthy living, reduce the risk for behavioral health issues, and help members of the deaf community to achieve their personal goals. This is done through a variety of activities including: peer support advocacy, self-help groups, social activities, vocational activities, educational activities, and workshops.

Breaking Down Barriers
The Breaking Down Barriers program provides prevention and early intervention services through the efforts of Cultural Brokers to:

- Provide mental health outreach, engagement and education to persons in the Latino, Native American (rural and urban), Lesbian/Gay/Bisexual/Transgender/Questioning, African, and African American communities;
- Implement and evaluate strategies to reduce mental health stigma; and
- Create effective collaborations with other agencies, community groups, participants, and family member organizations.

ADAPTATION OF SERVICES

II. Responsiveness of Mental Health Services

The County shall include the following in the CCPR:

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

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The County may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the County).

SDCBHS has been primarily occupied in the last decade with building up the spectrum of services available to foster recovery, while seeking to meet the age-specific and geographical needs of mental health consumers. A Provider Directory listing linguistic and specialty services are available to the public. This list is provided to clients upon request. The Provider Directory lists the cultural specialties of San Diego's organizational providers and is available on the Network of Care in multiple languages. Policy and Procedure MHS-01-02-203 (Interpreter Services: Access and Authorization) requires contractors and the County to meet the language preferences of clients to the maximum degree possible.

Because the penetration rate for Asians and Pacific Islanders has traditionally been low, SDCBHS has increased efforts to decrease this disparity. The Children, Youth, and Families System of Care has implemented the CARE outpatient program using MHSA funding which targets Asians and Pacific Islanders. WET initiatives have contributed to building a workforce that is bilingual and bicultural in order to meet the needs of San Diego's threshold populations and other ethnic groups. Additionally, SDCBHS has contracted for over 20 years with the Union of Pan Asian Communities to provide services to the Asian and Pacific Islander populations.

As mentioned in Criterion 3 of this report, SDCBHS has set up 26 programs through Community Services and Support funding to address gaps in services for underserved and unserved populations. Please see the CSS program listing, with target populations served in the Appendix 7.

SDCBHS has engaged in Faith-Based Community Dialogue Planning in the Central Region and the North Inland Region. Recommendations were compiled and made available in a Compendium of Proceedings and from these recommendations BHS and Faith-Based Councils were established. Language was also added to contracts to address outreach and engagement of Faith-Based congregations in these two identified regions to address access to care, wellness and education, and health equity. The Faith-Based Task Orders began February 2016.

The Access and Crisis Line can also connect clients who wish to see a Fee-For-Service (FFS) provider with a number of specific language capabilities; however, there continues to be a shortage of staff with capabilities in Asian and African languages.

As discussed previously, contractors are bound by the requirements in the Organizational Providers Operations Manual to provide clients with language appropriate services. The County has provided services to persons with Limited English Proficiency through the usage interpreter services. In FY 2014-15, there were 8,443 fewer hours of interpreter services provided to clients in San Diego County, compared to FY 2013-14 (16,889 vs. 25.332), and cost of interpreter services decreased by $122,806 from FY 2013-14 to FY 2014-15 ($1,474,826 vs. $1,352,020). Similar to the previous year, in FY 2014-15, clients were more likely to utilize Spanish translation services (43.5%), followed by Arabic (26.5%), and Vietnamese (8.9%). Adults and children were the least likely to utilize Tagalog (0.1%) and Farsi (3.5%) translation services.
While SDCBHS contractors have bilingual staff in programs, the significant expenditure for interpreter services is evidence to the need for SDCBHS to become more innovative and recruiting staff with bilingual capability.

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

In the Quick Guide to Mental Health Services for Adult, Older Adults, and Children there is a section that states:

"San Diego's Mental Health Plan Provides:

- A system to meet the needs of persons of diverse values, beliefs, orientations, races, and religions
- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired"

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, and Arabic and is available at all organizational provider locations and through Behavioral Health Services administration. A copy is provided in the Appendix 16. An audio version is also available via the SDCBHS Network of Care website.

In addition, the County provides a Guide to Medi-Cal Mental Health Services that is a booklet that includes information about the mental health services that San Diego County offers and how to get the services. The booklet is available in English, Spanish, Tagalog, Vietnamese, and Arabic. There is a section in the very beginning of the booklet that states,:

"If you feel you have a mental health problem, you may contact the San Diego County MHP Access and Crisis Line directly at (888) 724-7240. This is a toll-free telephone number that

is available 24 hours a day, seven days a week. Verbal and oral interpretation of your rights, benefits and treatments is available in your preferred language. You do not need to see your regular doctor first or get permission or a referral before you call.

Additionally, in the section "How Do I Get These Services?" the booklet refers to the Access and Crisis Line and states:

> "You can request a list of providers in the region where you live including their language and cultural specialties. There are County-contracted clinics and many individual outpatient therapists providing services in all of San Diego to meet many language and cultural needs. Free language assistance is available for mental health services. You have a right to mental health services in a language you understand. Free interpreting is available."

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

*(Counties may include **a.)** Evidence of community information and education plans or policies that enable Medi-Cal beneficiaries to access specialty mental health services, or **b.)** Evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs (e.g., number of community presentations and/or forums used to disseminate information about specialty mental health services, etc.)*

SDCBHS has the following policies, procedures and, practices in place for informing Medi-Cal beneficiaries of available services under consolidation of specialty mental health services:

In order to inform all Medi-Cal beneficiaries of available services under consideration of specialty mental health services, the County of San Diego Mental Health Services has in place Policy #MHS-01-04-210 (Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services) that ensures that all threshold language-speaking clients and clients needing information in alternate formats receive information in writing or in an appropriate manner to their special need to assist them to access Specialty Mental Health Services.

The SDCBHS widely distributes its "Quick Guide to Mental Health Services" in English and the four other threshold languages to inform clients of what mental health services are and how they can be accessed. Additionally, the County has made an effort to provide community information and education through a number of types of media. The Ethnic Services Coordinator provided a series of radio broadcast interviews in Spanish over the last few years.

As part of the process of setting priorities for the uses of MHSA funding, SDCBHS conducted extensive outreach activities to all cultural and linguistic groups through focus groups, community forums, regional meetings, over 60 stakeholders meetings, surveys, meetings with community commissions, client and family liaison agencies, etc., to try to ensure that the needs of all were heard and recorded.

Most recently, nine MHSA forums were held to gather community feedback (see attachment for Flyer). In addition, below are examples of evidence of outreach for informing under-served populations of the availability of cultural and linguistic services and programs from the Quarterly Status Reports (QSRs) that contracted programs submit to SDCBHS:

Children's Mental Health Services QSRs

Fred Finch Youth Center has been involved in various community outreach and collaborations with other agencies regarding trauma-exposed services. Staff is routinely involved in CASS presentations to CWS units, foster parent associations, and Council of Community Clinics. During FY 2015-16, Fred Finch Youth Center Wraparound conducted outreach at different community events, and staff presented on Narrative Therapy and Informal Supports at the 2015 California Mental Health Advocates for Children and Youth (CMHACY).

Palomar Family Counseling Services Inc. collaborates with external and internal school-based programs in Escondido, Vista, Oceanside and Valley Center school districts to ensure all students having difficulty in essential life areas are being served. Program administration participates in Network of Care (NOC) quarterly meetings with Vista and Oceanside Unified School District representatives to better serve the NINC schools in these areas. Additionally, program staff hosts parent trainings every quarter on Positive Effective Communication skills.

Cornerstone Outpatient – In FY 2015-16, the program joined the Center for Linguistic and Cultural Competency in Health Care to learn ways to enhance the implementation of the CLAS Standards. The program encouraged all staff to complete the CBMCS survey in October and to use the results to help identify training needs. Additionally, the program has three staff who are bilingual in Spanish, one therapist who is bilingual in Farsi, and the psychiatrist who is bilingual in Vietnamese. Youth and families are offered language assistance through Interpreters Unlimited, as needed. The program also participated in four hours of the San Diego Gang Culture and Awareness Training that was hosted by the San Diego Police Department. Lastly, the program reached out to and met with the College Avenue Baptist Church in effort to build a partnership with a faith-based community member and introduce the staff to the services offered at Cornerstone.

Kickstart (First Break) works in collaboration with the San Diego Policy Department gang unit and faith-based leaders to organize Opportunity Network meetings and outreach events focused on gang culture awareness and prevention, with Kickstart program director taking the lead on mental health resources for the Opportunity Network members and affiliates. Some of the additional outreach efforts have been setting up gatekeeper trainings at various locations, including libraries, Department of Justice, Starbucks, community centers and clinics, recreation centers, hospitals, and health centers. Specifically, program administration and staff have been consistently attending the San Diego Church of Nazarene in Point Loma in Central San Diego to hold trainings and collaborative education efforts with church attendees. In November of FY 2015-16, Kickstart collaborated with Catholic Diocese and held an event with nearly 30 faith-based leaders.

San Ysidro Health Center has provided presentations to Sweetwater School District High School Counselors and San Ysidro High School Teachers and Administrators regarding YES services and criteria for admission to program. In addition, program administration has outreach to librarians in San Ysidro, Imperial Beach and South San Diego to share resources in effort to increase awareness regarding services available in the community.

Catalyst Program continues to attend TAY workgroups, FSP Housing meeting, DCR meeting, ACT/CM, Clinical User Group, and Clinical Standards, in addition to the bi-annual joint CYF/AOA/TAY Workgroup Council meetings. Catalyst facilitates quarterly Family Connections forums for participants and their families to provide outside resources that can be utilized by both participants and their families, as well as facilitates an informal support network for attendees.

Innovations Programs provide novel, creative, and/or ingenious mental health practices/approaches that contribute to learning within communities through a process that is inclusive and representative of underserved individuals. The following are upcoming innovations programs for FY 2015-16:

- **Caregiver Wellness Program** is a countywide program serving age 0-5 with clinician and care coordinators that focuses on addressing the behavioral health needs of caregivers through direct care and comprehensive referrals.
- **Family Therapy Participation** utilizes parent partners to focus on increasing caregiver participation in family therapy.
- **Faith-Based Initiative** has four components: Outreach and Engagement to Faith-Based congregations; Community Education; Crisis Response; and Wellness and Health Ministries.
- **Ramp Up 2 Work** (**Noble Works**) aims to provide job readiness, training, and on-the-job paid apprenticeship, leading ultimately to paid competitive employment.
- **Peer Assisted Transitions** is a person-directed, mobile program that works in partnership with designated acute inpatient hospitals and provides alternatives to hospitalization through programs to engage and provide transition and support services to clients discharged back to the community.
- **Urban Beats** is intended to engage at-risk youth in wellness activities by providing a youth-focused message created and developed by youth.
- **Innovative Mobile Hoarding Intervention Program (IMHIP)** aims to diminish long-term hoarding behaviors among older adults.

UPAC Multicultural Community Counseling provides mental health therapy services to individuals in a meeting place of their choice where the environment is safe, comfortable and convenient, and clients can openly share their concerns. Services include individual, family and/or group therapy, behavioral, talk, play and/or art therapy, medical evaluation and management, case management, and collaboration with support persons and/or relevant agencies that are focused on the Asian, Pacific Islander, and Latino population, ages 5-20 years.

Adult/Older Adult Mental Health Services QSRs:

The Union for Pan Asian Communities (UPAC) – During FY 2015-16, UPAC was regularly engaged with community outreach groups such as Japanese Christian Church, Dignity of Life in City Heights, Mesa College for outreach to TAY and FilAm Fest for Filipinos in South Bay to distribute information on services. In addition to these community fairs, staff participated in outreach at Alliant International University and Meeting of the Minds Conference. Geriatric Specialists and providers visited the Salvation Army, Las Flores Hotel, County HHSA Community Program Planning, Sharp Rees Steely Case Management program, and Plaza Village Assisted Living to inform community programs of their enhanced services.

UPAC Elder Multicultural Access and Support Services (EMASS) program participates in various meetings including: East County Intergenerational Council meeting, El Cajon Collaborative meeting, New Comers Collaborative meeting, Older Adult Mental Health Providers meeting, and North County Regional Providers meeting. EMASS has also participated in Town Hall meetings on Coordinated Care Initiatives and Behavioral Health Services Community Program Planning. Additionally, EMASS has partnered with We Get Around, a six-week Travel Program that has culminated and initially helped Latino seniors to feel confident in using public transportation.

UPAC Alliance for Community Empowerment (ACE Program) is a partnership of community organizations working together to address the effects of community violence. By strengthening families and empowering San Diego's Central Region youth, adults and families, we work together to make the community a safe place to live. Services include: The Mobile Response Team, Teen Empowerment (ages 12-17), Parent Empowerment, Strengthening Families (ages 10-14), and Grief Support Services.

Visions Clubhouse regularly attends meetings and provides outreach events to inform providers and the public of their enhanced services. Notable meetings and outreach activities include: Countywide Peer Liaison Meeting, Client Action Meetings and Interest Meetings, Wellness Celebration at East Corner Clubhouse, Meeting of the Minds, Old Town SD Dia los Muertos, and Recovery Innovations. In addition, Vision Clubhouse has regularly participated in Fresh Rescue Program of Feeding America, which serves 40-100 members to dispense program information to attendees.

Neighborhood House Association continues to participate in community fairs and speak to senior groups to expand its recognizability as a viable resource for community partners, individual families and clients to utilize when addressing geriatric mental health issues and concerns. Additionally, clinicians and staff have attended community fairs in order to provide counseling and outreach to older adults with mental health to the community.

Maria Sardiñas Center (MSC) continues to collaborate with faith-based organizations, such as San Diego Christian Fellowship, St. James Lutheran Church, Good News Bible Fellowship, and St. Charles Parish to educate and reach community members to engage with Geriatric Outreach Specialists. Additionally, clinicians at MSC continue to collaborate with certified American Association of Diabetes Educators (AADE) to develop monthly groups for clients in support of their mental health and diabetes management.

Mental Health Systems is a bio-psychosocial recovery-based, voluntary recovery-oriented program for adults with a psychiatric diagnosis. Mental Health Systems has provided stigma workshops in various parts of San Diego including First United Methodist Church, North County Providers, Crestwood Behavioral Health and Integration Summit in order to increase awareness of mental illness in the community and to educate community members on program's enhanced services.

Targeting All Populations QSRs:

Survivors of Torture, International (SURVIVORS) provides bio-psychosocial rehabilitation services in the community that are recovery and strength-based client and family driven, and culturally competent. Program administration regularly attends meetings and provides outreach events to inform providers and the public of their enhanced services. Notable meetings and outreach activities include: presenting service information to the California Lutheran Office of the Public Policy Advisory Board, tabling a booth at SDSU's International Peace Village, and meeting with the Council of San Diego Park and Recreation Department to exchange information about services.

Deaf Community Services of San Diego, Inc. (DCS) continues to work closely with DeafHope, McAlister Institute, Child Welfare Services (Deaf Unit), Minnesota Chemical Dependency Program, and the Bridgman Group Home to coordinate efforts and ensure a seamless system of care within the deaf community. DCS, additionally, is involved with the San Diego Sober Living Coalition and the National AA program to improve sober living options and self-help groups for the deaf community. In FY 2014-15, DCS has also joined the San Diego Schools Regional DHH Work Task Force and Rady Children's Hospital to coordinate support to provide psycho-education, outreach, and information and referral services.

Indian Health Council, Inc. has facilitated and participated in a significant number of community activities and events. Specific examples of community outreach are participation/presentations: Star Gathering at Campo and Barona Cultural Gathering to distribute materials on suicide prevention and awareness, Bike Rodeo at Campo Educational Center, "We R Native proud" Youth Meetings and events, Viejas Kumeyaay Family Gathering on Bullying, and Parenting Teenagers and National Council on Aging, Suicide Prevention and Older Adults Webinar.

La Maestra provides culturally and linguistically competent primary care, specialty services including behavioral and mental health, chronic disease management and essential support services to men, women and children in San Diego's most culturally diverse and lowest income communities. Services are provided at four medical clinics, seven dental sites, three school-based health centers, and a mobile medical unit. LMCHC's main health center is located in City Heights, a community that is home to more than 90,000 residents, many of whom are recently settled refugees and immigrants from more than 60 countries with unique health and well-being needs.

It's Up to Us campaign is designed to empower San Diegans to talk openly about mental illness, recognize symptoms, utilize local resources, and seek help. People do not seek professional care and seek support, nor give support, because of the stigma that is associated with having a mental

illness. To combat stigma, It's Up to Us educates the community and provides easy access to local organizations and services. The goal of the campaign is to initiate change in perception, inspire wellness, and reduce the stigma surrounding mental health challenges.

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

a. Location, transportation, hours of operation, or other relevant areas;

As stated in the contracted Statements of Work, the following standards are required:

1. Sites shall be located within four blocks of a public transportation stop and shall meet all related state and local requirements.
2. Program hours of operation must be convenient to accommodate the special needs of the service's diverse population. In most cases, evening or weekend appointment hours for treatment services shall be available and scheduled as needed for a minimum of four hours per week.
3. The program site shall be welcoming to the various cultural populations in the community and to individuals with co-occurring disorders (COD) by providing materials, brochures, posters and other information regarding cultural competence and COD.
4. Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities.
5. Outpatient mental health services shall be provided in accordance with the County of San Diego's Cultural Competency Plan, Culturally Competent Clinical Practice Standards, and the MHSA Gap Analysis.
6. Cultural Competence: Contractor shall comply with cultural competence requirements as referenced in the OPOH and the BHS Cultural Competence Handbook, located at the TRL, and shall demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services (SDCMHS) Cultural Competence (CC) Plan located at the TRL.
   a. Contractor shall provide a Human Resource Plan that includes how contractor will recruit, hire, and retain bilingual and culturally diverse staff.
   b. Contractor shall identify a process to determine bilingual proficiency of staff at a minimum in the threshold languages for the County.
   c. 100% of staff shall participate in at least four (4) hours of cultural competence training per fiscal year.
   d. Contractors shall provide a CC Plan that is consistent with the SDCBHS CC Plan. This may be the Legal Entity's CC Plan.
   e. Contractor shall use the Culturally Competent Program Annual Self-Evaluation (CC-PAS) and the California Brief Multi-Cultural Competency Scale (CBMCS) as tools to determine the levels of cultural competency as a provider and staff person, respectively. These tools are found in the OPOH and the BHS Cultural Competence

Handbook. COR shall advise the Contractor when there is a need to use other evaluation tools.

f. Culturally and Linguistically-Appropriate Services (CLAS): To ensure equal access to quality care by diverse populations, each service provider receiving funds from this contract shall adopt the federal Office of Minority Health (OMH) Culturally and Linguistically-Appropriate Service (CLAS) national standards.

7. Mental health services are based on BPSR principles that have proven to be effective in reducing psychiatric hospitalization and assisting mental health clients to become more productive community members. BPSR guiding principles specify that services shall be client centered, culture centered, and built upon client's strengths.
8. Contractor's program and services shall be "trauma-informed" and accommodate the vulnerabilities of trauma survivors. Services shall be delivered in a way that will avoid inadvertently re-traumatizing clients and facilitate client participation in treatment. Contractor's trauma-informed program and services shall include: Screening of Trauma; Consumer Driven Care and Services; Trauma-Informed, Educated, and Responsive Workforce; Provision of Trauma-Informed, Evidence-Based and Emerging Best Practices; Safe and Secure Environments; Community Outreach and Partnership Building; and, Ongoing Performance Improvement and Evaluation.
   a. All clients shall use current screening and assessment tools that include questions regarding trauma upon admission.
9. Contractor shall perform linkage and referrals to community-based organizations including, but not limited to, primary care clinics and complementary healing centers and faith-based congregations, ethnic organizations and peer-directed programs such as Clubhouses.
   a. 100% of clients requesting to be linked to any faith-based congregation shall be connected to the client's organization of choice.

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

SDCBHS requires its services providers to comply with the facility standards as required in Statements of Work. Contractors' facilities must meet all related state and local requirements, including the requirements of the American with Disabilities Act (ADA) and California Title 24.

In addition, contractors shall comply with all applicable provisions of the Organizational Provider Operations Handbook. The specific requirement for facilities: *In order to present a welcoming appearance to unique communities, providers are required to ensure that their facility is comfortable and inviting to the area's special cultural and linguistic populations.*

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

Through MHSA, SDCBHS has funded programs that include co-location of services and/or partnerships with primary care services in non-threatening community settings, as well as non-traditional behavioral health settings in an effort to better connect with ethnic/racial groups who are often more comfortable seeing their family doctor. These efforts include:

The Council of Community Clinics is comprised of 17-member health centers and other safety-net providers operating more than 125 sites throughout San Diego, Imperial, San Bernardino, Orange, and Riverside Counties, including 14 Federally Qualified Health Centers, two Indian Health Centers, and one other member clinic organization. In FY 2014-15, the Health Center Partners served 753 unique BHS clients in San Diego.

- The clients were seen for the following behavioral health conditions: Depression Disorders (53%), Anxiety Disorders (38%), and Other Disorders (9%).
- The African American client population comprised 3.3%, and the majority of the clients served were Hispanic (52.5%).
- Nearly three quarters of the clients were between the ages of 25 and 59 (74.1%).
- Clients visited the centers a total of 2,453 times, receiving therapy and medication treatment along with case management, and rehabilitative services.
- The Peer Promotora Component of the project visited 2,537 sites and 16,069 contracts with potential clients

San Diego Youth Services encompasses a family-focused approach that engages families in their child's school success. School-based interventions are coordinated and designed to improve school climate, educational success, and child/parent social and emotional skills. The program focuses on school-age children and their families, as well as underserved Asian/Pacific Islanders and Latinos in order to reduce family isolation and stigma associated with seeking behavioral health services, increase resiliency and protective factors for children, reduce parental stress, and improve school climate for children to thrive at school. Services include: Positive Behavioral Support (PBS), screening and early identification of at-risk children, community outreach to families, and education and support.

SmartCare (Vista Hill) prevents patients in rural community clinics from developing an increased level of behavioral health issues, severe mental illness, or addiction. SmartCare specifically focuses on children, adolescents, transition age youth, adults, and older adults in community clinics located in the rural areas of San Diego and provide assessment and short-term interventions in rural community clinics for individuals who may be at risk for or in the early stages of mental illness. Services include: assessment, brief intervention, education, and mobile outreach.

Project In-Reach primarily focuses on at risk African American and Latino citizens who are incarcerated adults or Transition Age Youth (TAY) at designated detention facilities and will be released in San Diego County. Project In-Reach program is designed to help incarcerated individuals with substance abuse and/or mental health disorders as they prepare for re-entry into the community by becoming educated about addiction and learning new coping mechanisms. Project In-Reach can also assist in the successful linkage to community resources and services pre and post release, guiding in the transition process and assisting in a positive new beginning.

Native American Integrated Services in San Diego County has integrated mental health services into primary care settings targeting Native Americans. Examples of programs that target prevention and early intervention to Native Americans are:

- **Sycuan Medical/Dental Center** provide primary health, dental, specialty and specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the Sycuan Band of Kumeyaay Nation and its Tribal Council. The Sycuan Medical/Dental Center focuses on at-risk and high-risk children, TAY, adults and older adults and aims to increase community involvement and education through services designed and delivered by Native American community members.
- **San Diego American Indian Health Center** provides specialized culturally appropriate PEI services to Native American Indian/Alaska Native (AI/AN) Urban youth and their families who are participants at the Youth Center. The goal of San Diego American Indian Health center is to reduce the significant health disparities of San Diego's urban American Indian population by increasing access to care and improving the quality of that care, resulting in increased life expectancy and improved quality of life.

ADAPTATION OF SERVICES

III. Quality of Care: Contract Providers

The County shall include the following in the CCPR:

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

As discussed in Section II.D., above, provider contract language contains the Standard Service Delivery Requirements which include:

> "Contractor shall demonstrate knowledge and application of the MHSA Gap Analysis when describing the target population, with specific reference to culturally diverse populations in the geographic area who suffer from health access disparities."

The Cultural Competence Handbook states:

- **Cultural Competence Plan**

  To address these issues in the 2015 Cultural Competence Plan, the MHP set the following objectives to improve cultural competence in the provision of mental health services:

As stated in the contracted Statements of Work, the following standards are required:

1. Continue to conduct an ongoing evaluation of the level of cultural competence of the mental health system, based on an analysis of gaps in services that are identified by comparing the target population receiving mental health services to the target population receiving the Medi-Cal and the target population in the County as a whole.
2. Continue to compare the percentage of each target population with provider staffing levels.
3. Investigate possible methods to mitigate identified service gaps. Enhance cultural competence training systemwide.
4. Evaluate the need for linguistically competent services through monitoring usage of interpreter services.
5. Evaluate system capability for providing linguistically competent services through monitoring organizational providers and FFS capacities, compared to both threshold and non-threshold language needs.
6. Study and address access to care issues for underserved populations.

- **Current Standards and Requirements**

To meet State and County requirements, providers are required to maintain and reflect linguistic and cultural competence through all levels of their organization and in their policies, procedures, and practices. Providers must ensure that program staff is representative of, and knowledgeable about, the clients' culturally diverse backgrounds and that programs are reflective of the specific cultural patterns of the service region.

The Culturally and Linguistically Appropriate Services (CLAS) Standards have replaced the Culturally Competent Clinical Practice Standards. All Statements of Work include the language on the requirement of the programs to implement the CLAS Standards. The CLAS Standards are a series of guidelines that are intended to inform and facilitate the efforts towards becoming culturally and linguistically competence across all levels of a health care continuum. The CLAS Standards were originally developed by the Health and Human Services Office of Minority Health and are comprised of 15 standards.

The standards are as follows:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an on-going basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally, and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals, and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct on-going assessments of the organization's CLAS-related activities, and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs, and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

Diversity is sought in the Source Selection Committee (SSC) reviewing all proposals received. Also, input and feedback is sought in Industry Days for draft SOWs, stakeholder and community forums, and client and family focus groups provide input and feedback.

SDCBHS expects proposers to demonstrate a high level of achievement as an agency in providing culturally competent and culturally relevant services through the submittal requirement in the Requests for Proposals (RFPs) process. Proposers are also required to describe how the work specified in the Statement of Work, including meeting cultural competence requirements, will be accomplished.

ADAPTATION OF SERVICES

IV. Quality Assurance

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

The County shall include the following in the CCPR:

A. List if applicable, any outcome measures, identification, and description of any culturally relevant consumer outcome measures used by the County.

One way to ensure that services are responsive to consumer needs is to collect information from the clients about their satisfaction with services and their perspectives on the quality of services. Data on consumer satisfaction is collected through the semi-annual Youth Services Survey (YSS) which is completed by all youth (ages 13+) and all available parents/caregivers, and the Mental Health Statistics Improvement Program (MHSIP), which is completed by adults and older adults (ages 18+ clients). During the most recent survey period (November 2015), the survey yielded the following results on the cultural and linguistic competence of the programs and services:

State Survey Question	YSS "Agree/Strongly Agree" Responses		MHSIP "Agree/Strongly Agree Responses" *Adult/Older Adult Clients (N=2,061)*
	Youth Clients (N=1,173)	*Family Members (N=2,212)*	
Staff were sensitive to my cultural/ ethnic background.	85.6%	95.8%	89.7%

Additionally, the survey evaluated the clients' and the family members' perception of the availability of materials in their preferred language, and the results below are for two most recent survey periods:

Youth Clients ("yes" answers)		
YSS State Survey Questions	***May 2015***	***November 2015***
Services received were provided in the preferred language.	95.9% (N=1,194)	97.0% (N=1,049)
Written information was available in the preferred language.	94.1% (N=1,139)	93.5% (N=983)
Parents/Caregivers ("yes" answers)		
YSS State Survey Questions	***May 2015***	***November 2015***
Services received were provided in the preferred language.	98.4% (N=2,152)	98.3% (N=2,043)

Written information was available in the preferred language.	97.3% (N=2,093)	97.5% (N=2,011)

Adult/Older Adult Clients ("yes" answers)		
MHSIP State Survey Question	***May 2015***	***November 2015***
Were the services you received provided in the language you prefer?	97.4%	96.0%

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

Culturally Competent Program Annual Self-Evaluation (CC-PAS)

One of SDCBHS' Quality Improvement strategies is to survey all programs to assess for culturally competent service provisions. Accordingly, all County and County-contracted programs are required to complete the Culturally Competent Program Annual Self-Evaluation (CC-PAS) on an annual basis. The CC-PAS tool was developed by SDCBHS to be used by programs to rate themselves on their current level of competence for providing culturally competent services. The CC-PAS protocol is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and endorsed by the Quality Review Council (QRC). The comprehensive 2012 Cultural Competence legal entity evaluation has served as a baseline for future program activities related to cultural competence. The majority of programs indicate that they are satisfactorily meeting the standards of cultural competence. In April 2015, SDCBHS QI Unit requested that each contracted program manager complete a clinical or non-clinical survey, based on the services their programs provide. The program managers were asked to complete the survey—one response per contract—by reviewing 20 cultural competence standards and determining if their program has Met, Partially Met, or Not Met each standard using the description of the standard noted for each category. Additionally, the respondents had the opportunity to indicate if they would like to receive technical assistance on any competency standard. Each response is assigned a score (5 points for Met Standard, 3 points for Partially Met Standard, 1 point for Standard Not Met) and summed up for each program. There are a total of 20 standards, and the highest possible score is 100. In 2015, the average score for clinical MHS programs was 89.1% (N=103), and the average score for non-clinical MHS programs was 83.1% (N=53).

CC-PAS Results MHS Non-Clinical Programs (CYF and A/OA) n = 53 in 2015 (46 in 2014)	Programs that *Met or Partially Met* Standard			Technical Assistance Requests		
	2014	2015	Results Change	2014	2015	Results Change
1. The program/facility has developed a Cultural Competence Plan.	97.8%	100%	▲	6.5%	17.0%	▲
2. The program/facility has assessed the strengths and needs for services in its community.	97.8%	100%	▲	13.0%	18.9%	▲
3. The staff in the program/facility reflects the diversity within the community.	100%	100%	–	4.3%	5.7%	▲
4. The program/facility has a process in place for ensuring language competence of administrative services staff who identify themselves as bi- or multi-lingual.*	91.3%	90.6%	▼	4.3%	9.4%	▲
5. The program/facility has a process in place for ensuring language competence of support staff who identify themselves as bi- or multi-lingual.	91.3%	86.8%	▼	4.3%	11.3%	▲
6. The program/facility supports/provides all staff training on the use of interpreters.	84.8%	75.5%	▼	6.5%	18.9%	▲
7. The program/facility uses language interpreters as needed.	93.5%	84.9%	▼	4.3%	13.2%	▲
8. The program/facility has a process in place for assessing cultural competence of all staff.*	93.5%	84.9%	▼	10.9%	18.9%	▲
9. The program/facility has a process and a tool in place for all staff to self-assess cultural competence.*	84.8%	84.9%	▲	23.9%	13.2%	▼
10. The program/facility has conducted a survey amongst its clients/target population to determine if the program is perceived as being culturally competent.	87.0%	75.5%	▼	10.9%	17.0%	▲
11. The program/facility conducted a survey amongst its clients/target population to determine if the program's services are perceived as being culturally competent.*	65.2%	77.4%	▲	2.3%	15.1%	▲
12. The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards.*	69.6%‡	90.6%	▲	2.2%	17.0%	▲
13. The program/facility supports cultural competence training of administrative services staff.*	91.3%	94.3%	▲	4.3%	3.8%	▼
14. The program/facility supports cultural competence training of support services staff.	95.6%	90.6%	▼	2.2%	3.8%	▲
15. Services provided are designed to meet the needs of the community.	97.8%	100%	▲	4.3%	5.7%	▲
16. The program has implemented the use of any evidence-based practices or best practice guidelines appropriate for the populations served.	78.3%‡	98.1%	▲	8.7%	15.1%	▲
17. The program collects client outcomes appropriate for the populations served.	80.4%‡	86.8%	▲	4.3%	3.8%	▼
18. The program conducts outreach efforts appropriate for the populations in the community.	91.3%	98.1%	▲	4.3%	5.7%	▲
19. The program is responsive to the variety of stressors that may impact the communities served.	97.8%	100%	▲	8.7%	9.4%	▲
20. The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.	97.8%	94.3%	▼	4.3%	15.1%	▲

** The wording of questions 4, 8, 9, 11, 12, and 13 was changed to make the questions more applicable to non-clinical programs. This might have accounted for the change in response rate from 2014, as well as the increase in technical assistance requests.*

‡ In 2014, questions 12, 16, and 17 contained a Not Applicable *option, which might have accounted for a lower response rate. The current non-clinical survey does not contain any questions with this option.*

Please note: Red arrows mean negative change, while green arrows mean positive change. The direction of the arrows indicates increase/decrease in responses.

CC-PAS Results MHS Clinical Programs (CYF and A/OA) n = 103 in 2015 (139 in 2014)	Programs that *Met or Partially Met* Standard			Technical Assistance Requests		
	2014	2015	Results Change	2014	2015	Results Change
1. The program/facility has developed a Cultural Competence Plan.	100%	100%	–	5.0%	1.9%	▼
2. The program/facility has assessed the strengths and needs for services in its community.	100%	99.0%	▼	7.2%	5.8%	▼
3. The staff in the program/facility reflects the diversity within the community.	100%	100%	–	2.2%	2.9%	▲
4. The program/facility has a process in place for ensuring language competence of direct services staff who identify themselves as bi- or multi-lingual.	99.3%	99.0%	▼	4.3%	2.9%	▼
5. The program/facility has a process in place for ensuring language competence of support services staff who identify themselves as bi- or multi-lingual.	98.6%	100%	▲	5.0%	1.9%	▼
6. The program/facility supports/provides direct and indirect services staff training on the use of interpreters.	92.8%	95.1%	▲	7.2%	7.8%	▲
7. The program/facility uses language interpreters as needed.	98.6%	96.1%	▼	3.6%	2.9%	▼
8. The program/facility has a process in place for assessing cultural competence of direct and support services staff.	96.4%	94.2%	▼	7.9%	5.8%	▼
9. The program/facility has a process and a tool in place for direct and support services staff to self-assess cultural competence.	92.8%	90.3%	▼	12.9%	6.8%	▼
10. The program/facility has conducted a survey amongst its clients to determine if the program is perceived as being culturally competent.	87.8%	92.2%	▲	8.6%	6.8%	▼
11. The program/facility conducted a survey amongst its clients to determine if the program's clinical services are perceived as being culturally competent.	86.3%	93.2%	▲	10.8%	6.8%	▼
12. The program utilizes the Culturally and Linguistically Appropriate Services (CLAS) Standards.	92.8%	96.1%	▲	8.6%	5.8%	▼
13. The program/facility supports cultural competence training of direct services staff.	100%	100%	–	1.4%	1.0%	▼
14. The program/facility supports cultural competence training of support services staff.	99.3%	98.1%	▼	1.4%	1.9%	▲
15. Services provided are designed to meet the needs of the community.	98.6%	100%	▲	2.2%	1.9%	▼
16. The program has implemented the use of any evidence-based practices or best practice guidelines appropriate for the populations served.	99.3%	100%	▲	2.9%	3.9%	▲
17. The program collects client outcomes appropriate for the populations served.	97.1%‡	96.1%	▼	2.2%	0%	▼
18. The program conducts outreach efforts appropriate for the populations in the community.	95.7%	96.1%	▲	2.2%	0%	▼
19. The program is responsive to the variety of stressors that may impact the communities served.	100%	100%	–	4.3%	0%	▼
20. The program reflects its commitment to cultural and linguistic competence in all policy and practice documents including its mission statement, strategic plan, and budgeting practices.	100%	100%	–	2.2%	2.9%	▲

‡In 2014, question 17 contained a Not Applicable *option, which might have affected the response rate. The current clinical survey does not contain any questions with this option.*

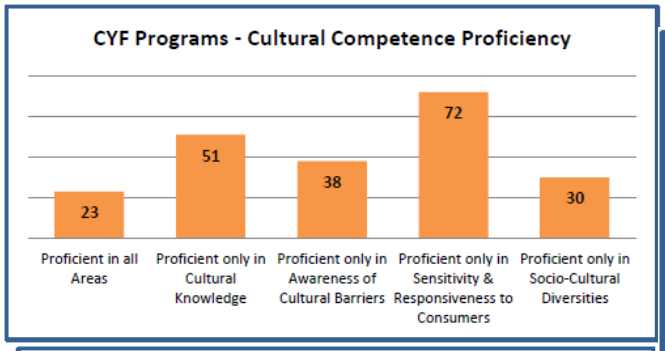
Please note: Red arrows mean negative change while green arrows mean positive change. The direction of the arrows indicates increase/decrease in responses.

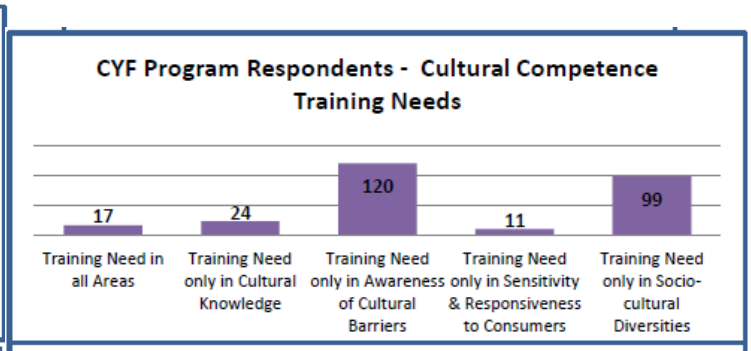
Additionally, 37.7% of non-clinical MHS programs and 26.2% of clinical MHS programs identified at least one cultural competence standard with which they would like technical assistance. The SDCBHS contract monitors use the individual program reports to discuss the results with the program managers and to offer technical assistance where it is requested.
The 2015 CC-PAS Report is available in Appendix 14.

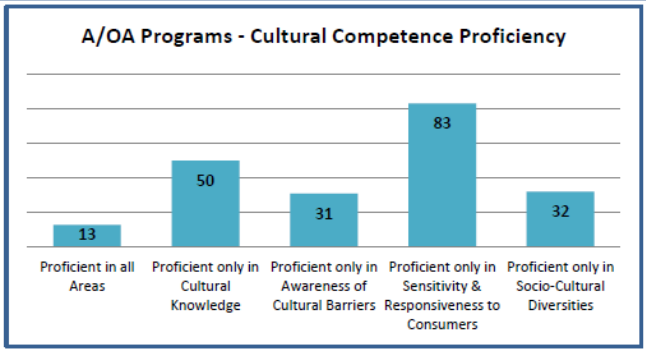
The California Brief Multicultural Scale (CBMCS)

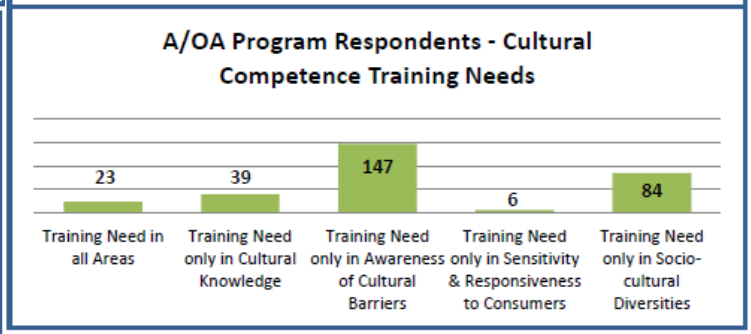
To assist programs in developing a plan to enhance the cultural competence of their staff and their current capability for providing culturally competent services, the SDCBHS uses the California Brief Multicultural Scale (CBMCS) survey. The survey was developed in response to the request of the California Mental Health Directors Association for a standardized cultural competency assessment tool. The evidence-based, replicable 21-item scale measures individual, self-reported multi-cultural competency and training needs of behavioral health staff in the following four areas: cultural knowledge; awareness of cultural barriers; sensitivity and responsiveness to consumers; and socio-cultural diversities. The staff are asked to complete the survey every two years, and the results from the most recent survey (October 2013) are highlighted below: 48.6% of CYF program staff and 47.8% of A/OA program staff indicated proficiency in all four areas of cultural competence. The results also show the greatest need for training in Awareness of Cultural Barriers for both CYF and A/OA programs, followed by Socio-cultural diversities.

A total of 36 BHS programs that responded had all of their respondents indicate proficiency in all four cultural competence areas (out of a total of 250). Among 112 CYF programs, more than half of the programs (64.3%) had all of their respondents indicate proficiency in Sensitivity and Responsiveness to Consumers while indicating a need for training in other areas. Similarly, among 138 A/OA programs, 60% of programs had all of their respondents indicate proficiency in Sensitivity and Responsiveness to Consumers while indicating a need for training in other areas.









The 2014 CBMCS Report is available in Appendix 15.

Mental Health Entity Cultural Competence Plans
In April 2012, MHS legal entities were required to submit Cultural Competence Plans to outline current status and future goals for cultural competence within their organizations. The QI Unit formed a committee to evaluate the plans, note any innovative practices, and provide feedback on any areas which might benefit from enhancement. The committee focused on how the entities tailor services to reflect ethnic, racial, cultural, and linguistic profile of their unique service areas, as well as plans for addressing and reducing any service disparities affecting the programs (see the Review Guidelines in Appendix 21).

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

Policy and procedures are in place through Policy MHS-01-06-207 (Grievances, Appeals, Expedited Appeals and State Fair Hearings: Monitoring the Beneficiary and Client Problem Resolution Process) (see copy in Appendix 22) to establish procedures for the monitoring of the Mental Health Plan (MHP) Beneficiary and Client Problem Resolution Process; to ensure that client rights are maintained to their fullest extent; and ensure MHP compliance with federal, state, and contract regulations.

SDCBHS Quality Improvement (QI) Unit is responsible for monitoring grievances, appeals, expedited appeals, and State Fair Hearings emanating from usage of the Beneficiary and Client Problem Resolution Process in order to identify trends and issues and make recommendations for needed system improvements. The QI Unit submits any required reports on grievances, appeals, expedited appeals, and State Fair Hearings to the California Department of Health Care Services as required.

In FY 2014-15, there were no State Fair Hearings, 99 grievances, and 27 Appeals. One grievance was filed regarding cultural competence or language barriers, but was resolved in a timely manner.

In order to ensure all client needs are met, unbiased contractor programs are available for clients to receive information about their inpatient and/or outpatient mental health services. Examples of contractor programs are below:

- **Jewish Family Service (JFS) Patient Advocacy** provides support for all inpatient mental health services JFS Patient Advocacy represents patients in inpatient psychiatric hospitals, responds to inpatient psychiatric grievances and complaints, provides residential advocacy, responds to inmate mental health concerns, advocates for minors' rights, and provides trainings. The Patient Advocacy Program works to improve the mental health system by monitoring San Diego County hospitals, reviewing and commenting on policies and practices which affect recipients of mental health services, providing consultation and generating policy questions for the State Office of Patients' Rights, coordinating with other advocates for system reform, analyzing state and federal

legislation and regulatory developments, and representing clients' interests in public forums.

- **Consumer Center for Health Education and Advocacy (CCHEA)** provides clients with information about their health plans and educates them about their rights, including information on the Affordable Care Act (healthcare reform) and how it affects them. The program also helps to advocate for those who have had their health services denied, reduced, or terminated, or who are unhappy with their health services and provides investigation of mental health patients' complaints. CCHEA is designated by SDCBHS as patients' rights advocate for outpatient mental health services.