

COUNTY OF SAN DIEGO
HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

CULTURAL COMPETENCE PLAN & THREE-YEAR STRATEGIC PLAN 2018



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 County's population was born in another country and 42% of children have one or more foreign born parents¹. In addition to ongoing immigration from Mexico, Central America, and South America, the 2015 Office of Refugee Resettlement report shows that the State of California had the second largest number of refugee arrivals in 2015. The recent immigrants/refugees have included people from the following five countries of origin (in order of the proportion of total arrivals): Burma, Iraq, Somalia, Democratic Republic of Congo, and Bhutan.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 of San Diego Health and Human Services Agency (HHS), whether it is through Public Health, Behavioral Health, Aging and Independence Services, or County Medical Services for persons receiving Medi-Cal and low income residents. The County of San Diego HHS 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 (BHS) and its contractors provide services through approximately 200 programs, over 400 school-based mental health sites, and over 700 Fee-for-Service practitioners under contract to the BHS' Administrative Services Organization.

BHS (composed of Mental Health Services and Substance Use Disorder Services) incorporates 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. BHS sees the creation of a truly culturally competent system as a continually developing process. Some of the needed steps require additional resources, whether it be funding for culturally specific programs or the growing of bilingual staff at all levels, and some require a shift and increase in administrative focus. The ground work 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 are getting access to needed mental health services, the BHS 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 inform BHS' strategies for addressing 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, Annual Report to Congress 2015. Retrieved from: <https://www.acf.hhs.gov/orr/resource/office-of-refugee-resettlement-annual-report-to-congress-2015>.

The data analysis began in FY 2001-2002. Through the Mental Health Services Act (MHSA) funding, adult and children's mental health services have been expanded to begin reducing the disparities noted in these reports, but there is always area for growth.

The Cultural Competence Plan summarizes where the BHS is now, and highlights future initiatives and next steps. 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

BHS METHODOLOGY IN EVALUATING ITS SYSTEM

To understand the needs of the whole County mental health population for MHSA planning, the BHS and the University of California, San Diego (UCSD) 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 three time points spanning across 8 years (Fiscal Years 2009-10, 2012-13, and 2015-16). The report provides breakdown information by age, gender, race/ethnicity, and diagnosis, as well as service utilization and service engagement, which is used to supplement the State required information.

Although BHS functions as a unified system, the focus of the services for children, youth, adolescents, families, adults, and older adults differs slightly, as is age appropriate. The Adult and Older Adult (A/OA) System of Care focuses on psycho-social recovery, while the Children, Youth, and Families (CYF) System of Care 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.

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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.

BHS 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:

- Training and Development Program (*Policy Number 1002*) – “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 competence is Embracing Diversity and Encouraging Respect, which the County strongly encourages each employee to take.
- Equal Employment Opportunity (*Policy Number 109*) – “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, disability, or any other status protected by law.”
- Employee Organizations (*Policy Number 902*) – “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.”

BHS Policies and Procedures

BHS has several policies and procedures in place to ensure culturally and linguistically appropriate services are available. These include:

- Culturally and Linguistically Competent Services: Assuring Access and Availability (*Policy Number 5994*). 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. BHS makes ongoing progress to assure that culturally and linguistically competent services are available to meet the needs of San Diego residents.
- Cultural Competence Resource Team (*Policy Number 5946*). 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 Families (CYF) BHS Systems of Care (SOC) on issues of cultural competence. 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.

- Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services (*Policy Number 5977*). 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.
- Written Information in English, the Threshold Languages, and Alternate Formats to Assist Clients in Accessing Specialty Mental Health Services (*Policy Number 6030*). 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.

BHS Principles That Support Cultural Competence

The County of San Diego has two systems of care: the Adult and Older Adult System of Care and the 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 BHS.

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

The AOA SOC is based on Biopsychosocial and Rehabilitation (BPSR) principles that have been shown 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 are 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 wellness for children, youth and families throughout their lifespan. The Mission is to advance systems and services to ensure that children and youth are healthy, safe, lawful, and successful in school and in their transition to adulthood, while living in nurturing homes with families. . There are 10 Guiding Principles of the CYF SOC, one of which is that services are culturally competent. The Principles are: four-sector collaboration; integrated care; child, youth and family driven; individualized; strength-based; community-based; outcome driven; culturally competent; trauma informed; and persistence. The CYF SOC incorporated Trauma Informed System in FY 2016-17 and Persistence in FY 2017-18. The CYF SOC Guiding Principles were approved in May of 2018 and 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 the *Live Well San Diego* Vision. BHS has integrated community outreach; MHSA coordination; suicide prevention and stigma reduction planning; primary, secondary, and environmental prevention activities for Substance Use Disorder and Mental Health contracts and initiatives; and all strategic planning, advisory board coordination, legislation tracking and media activities under the PPU.

Community Services and Supports (CSS) Vision Statement and Guiding Principles

In addition to the Systems of Care described above, BHS 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 competence items such as:
Outreach to and expansion of services to client populations to more adequately reflect the prevalence estimates and the racial and ethnic diversity within counties, as well as 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 BHS. CCISC Training is available to County and contracted behavioral health staff to help ensure programs become "dually diagnosed capable or enhanced" and work collaboratively across systems to improve services. With support from the Behavioral Health Advisory Board (BHAB), BHS 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 competence, an approach to engage all people served, all staff, and those encountered 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, HHSa 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. Uphold a policy that, on an annual basis, each region and division within HHSa will conduct a scan, as well as develop and implement an action plan addressing trauma informed systems integration across policies, language, environments, and client partner inclusion in decision making.

BHS Organizational Provider Operations Handbook (OPOH): Cultural Competence

BHS maintains the OPOH, which is an addendum to all provider contracts. The OPOH is updated at a minimum annually and serves as a way for BHS to keep its contractors up to date on new or changing requirements for the provision of services. The OPOH contains a “Cultural Competence” section which includes Culturally and Linguistically Appropriate Services (CLAS) 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. The full OPOH can be found on the Technical Resource Library: <https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/TRL%20Section%201/OPOH.pdf>

Uniform Clinical Records Manual (UCRM)

The UCRM includes a Behavioral Health Assessment which requires information on the client's race/ethnicity, language, support systems, alternative health practices, culture specific symptomatology/explanations for behavior, 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 SUD providers, is required to have a Cultural Competence Plan that demonstrates the policies and practices of culturally competent services for both mental health and substance use disorder 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)*

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

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

CCRT allocated time during several meetings to discuss the short- and long-term strategies and recommendations for the SDCBHS' culturally and linguistically appropriate services. The initial discussion focused on the County's policies, procedures, and practices that reflect steps taken to incorporate the recognition and value of racial, ethnic, and cultural diversity within SDCBHS.

To assist programs with developing a plan to enhance the cultural competence of their staff and their current capability for providing culturally competent services, the SDCBHS has developed a Cultural Competence Handbook (available in Appendix 5). The Handbook contains resources, tools, and assessments to assist the programs with the efforts to enhance cultural competence levels among staff. In FY 2016-17, the Handbook was revised to include new cultural competence assessments—The Cultural and Linguistic Competence Policy Assessment (CLCPA) and the Promoting Cultural Diversity Self-Assessment (PCDSA). The new tools replaced the Culturally Competent Program Annual Self-Evaluation (CC-PAS) and the California Brief Multicultural Competence Scale (CBMCS), respectively. Both tools were developed by Georgetown University's National Center for Cultural Competence and adapted by BHS to align with the expectations recommended by the CCRT and the National CLAS Standards. The goal of the CLCPA is to enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. The goal of the PCDSA is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. The new tools align with the CLAS standards that are now outlined in all contracts.

Other topics of discussion included the following: the addition of "Trauma-Informed" in the guiding principles, the establishment of a library of ethnic and cultural competence tools as a resource on the technical resource library on the County website, focusing on the target population of the LGBTQI, and diversity in the workforce including administrative staff. Stakeholders also recommended establishing translations for common MHSA terms and

concepts in the threshold languages that are culturally appropriate. By establishing translations, there will be consistency among the interpreters on those terms that may not exist in the specific languages. The conversation also included compensation, incentives, and recognition for bilingual staff.

As a strategic plan over the next three years and reviewing the community ideas received related to the SDCBHS commitment to cultural competence, the SDCBHS will focus on the implementation of the new evaluation tools and developing a program that focuses on the LGBTQI community. As the members of the CCRT are reflective of the community, a workgroup of CCRT members was created to identify replacement evaluation tools for the CC-PAS and CBMCS. The workgroup met in February 2016 to identify the replacement tools; and in March 2016 and every month thereafter, the workgroup met to review the identified evaluation tools and edit the context to align with the SDCBHS System of Care. The Promoting Cultural Diversity and Cultural Competency Self-Assessment was selected to replace the CBMCS, which will be administered every two years to all staff once implemented. The assessment is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices that foster such an environment. The Cultural and Linguistic Competence Policy Assessment (CLCPA) was selected to replace the CC-PAS, which will be administered annually to all programs for completion. The CLCPA is intended to support community health centers to improve health care access and utilization, enhance the quality of services within culturally diverse and underserved communities, and promote cultural and linguistic competence, as essential approaches in the elimination of health disparities. It is also intended to support community health centers to determine where they are doing well and where they can grow. Over the next few years, these interventions will be implemented to align with our Strategic Plan.

One of San Diego's most vulnerable populations, LGBTQI youth, often suffer as a result of non-supportive or even hostile environments in their homes, schools and communities. Research demonstrates that LGBTQI youth who do not have access to LGBTQI-affirming community environments are at higher risk for negative outcomes, including early high-school dropout, homelessness, negative mental health symptoms, increased drug and alcohol use, suicide and physical, emotional and/or sexual abuse (Center for American Progress, 2010). The full report can be found at <https://www.americanprogress.org/issues/lgbt/reports/2010/06/21/7983/on-the-streets/>. The SDCBHS has committed to establishing a new program, Our Safe Place, to provide direct clinical services, and three (3) drop-in centers which offer support with health and wellness activities, educational and vocational training, support groups for youth and caregivers, mentorship program, GED preparation, life skills training, and crisis support to LGBTQI youth. The program is projected to begin in July 2017.

Year 1 Achievements:

In order to openly recognize and better address disparities, such as higher rates of obesity, smoking, depression and anxiety, cardiovascular disease, suicide attempts, alcohol/other drug use, intimate partner and other violence and other social determinants of health, North County Health Services (NCHS), a SDCBHS contractor, has implemented Sexual Orientation and Gender Identity efforts to align with SDCBHS' efforts. NCHS has implemented a collection

of identifiers to acknowledge the North County LGBTQI community as a unique underserved population within the approximately 70,000 patients served by NCHS. Competency training has been provided to majority of their 700+ providers and staff to ensure sensitivity, effective, respectful, and often non-binary (gender connotation/reference) communication.

The SDCBHS established the Our Safe Place program to the CYF System of Care, and began offering treatment services in September of 2017. It offers behavioral treatment services to youth up to the age of 21 who identify as LGBTQ through an outpatient clinic. The program also has four (4) drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers. Additionally, through the CYF System of Care Training Academy, the Family Compassion and the Lesbian, Gay, Bi-sexual, Transgender, Questioning, Intersex, Asexual (LGBTQIA) Community training was delivered and well received and therefore projected to continue in FY 2018-19.

While strides were made to increase the support for the LGBTQI community, continued efforts need to be made to ensure providers understand the importance of respectful communication with this population. 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. This year, BHETA has updated their trainings on CLAS Standards and BHS cultural competence.

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.*

BHS 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 BHS 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 were available. 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 PPU, as well as the CDO, 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 1,000 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 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 (FSP) program which provides a range of behavioral health services to children and youth ages 5-21 years old. NVFS is a dual diagnosis enhanced program and is culturally sensitive to the community 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 culturally competent.
- **Palomar Family Counseling Services Prevention and Early Intervention (PEI) School-Based Component** provides social-emotional mental health evidence-based PEI services for elementary school age children at public schools in Escondido, Oceanside, and Valley Center school districts. The program targets underserved clients 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 have 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 FSP** 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 San Diego American Indian Health Center** serves at-risk and high-risk Urban American Indian and Alaska Native youth ages 10-24 and their families. They provide screenings, assessments, and individual counseling by counselors or Spiritual Advisors. The center serves as a central location for urban Native American 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 and 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 physical health, mental health and/or substance abuse issues.

- The **Breaking Down Barriers (BDB)** 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 to 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 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, vocational supports, 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. Heartland WRC also provides services to the County’s East Region Middle Easter refugees along with several other underserved communities.
- **Outpatient Services for Deaf and Hard of Hearing**, a program of Deaf Community Services, provides specialized, culturally, linguistically and developmentally appropriate outpatient BPSR and SUD 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 a 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 substance use disorder services and alcohol and drug counseling with the addition of experienced and certified Alcohol and Drug counselors who are 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 the faith-based programs. The Faith-Based Initiative was established in 2016 and primarily focuses on African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. The programs 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. The Faith-Based Initiative is divided into four Task Orders that target specific needs identified within the faith-based community.
 - **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.
 - **Innovative Mobile Hoarding Intervention Program (IMHIP)** is funded through MHSAs Innovations and focuses on diminishing long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior lived experience receiving treatment for hoarding behaviors to provide support and encouragement to IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participants'

overall quality of life. The program began providing services in April 2016 and was approved for an extension in October of 2017.

- **Roaming Outpatient Access Mobile (ROAM)** is funded through MHSAs Innovations to provide and operate a mobile mental health clinic for Native American transition age youth, adults, and older adults residing on tribal reservations in the East and North Inland Regions. The project is designed to decrease behavioral health symptoms and improve level of functioning of participants, as well as, improve care coordination and access to physical health care.
- **Urban Beats** is a program funded through MHSAs Innovations for Transition Age Youth (TAY) ages 16-25 who are at risk of or have SED/SMI. The goal of this program is to reduce stigma and increase access to services by exposing TAY to multiple models of artistic expression including visual arts, spoken word, music, videos and performances that contain anti-stigma and educational messaging by TAY for TAY. In December 2017, Urban Beats was enhanced to add an additional academy track, specifically for the purpose of providing this innovative programming to the East African TAY community, through cultural brokers. The program began providing these additional services in April 2018 through a subcontract with United Women of East Africa.

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.

BHS 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 sector partnership between youth/families, public agencies, private organizations, and education. The Council embraces the following Guiding Principles:
 - Collaboration of four sectors: Coordination and shared responsibility between child/youth/family, public agencies, private organizations and education.
 - Integrated: Services and supports are coordinated, comprehensive, accessible, and efficient.
 - Child, Youth and Family Driven: Child, youth and family voice, choice, and lived experience are sought, valued and prioritized in service delivery, program design and policy development.
 - Individualized: Services and supports are customized to fit the unique strengths and needs of children, youth and families.

- Strength-based: Services and supports identify and utilize knowledge, skills, and assets of children, youth and families and strengthen their connections to natural supports and local resources.
- Community-based: Services are accessible to children, youth and families and strengthen their connections to natural supports and local resources.
- Outcome driven: Outcomes are measured and evaluated to monitor progress and to improve services and satisfaction.
- Culturally Competent: Services and supports respect diverse beliefs, identities, cultures, preference, and represent linguistic diversity of those served.
- Trauma Informed: Services and supports recognize the impact of trauma and chronic stress, respond with compassion, and commit to the prevention of re-traumatization and the promotion of self-care, resiliency, and safety.
- Persistence: Goals are achieved through action, coordination and perseverance regardless of challenges and barriers.

The Council meets monthly and has member representation from the BHAB, Juvenile Probation and Juvenile Court, HHS Regions, Special Education Local Plan Areas (SELPA), First 5 Commission, San Diego Non-Profit Association (SDNA), Regular Education-Pupil Personnel Services, Substance Use Disorder Services Contractors Association, Youth served by the Public Health System, Managed Health Care Plans, Behavioral Health Services, Child Welfare Services, School Board, Mental Health Contractors Association, fee-for-service and organizational providers, San Diego Regional Center for Developmentally Disabled, Family Receiving Services, and 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. In April of 2018, the CSOC Academy held a conference that focused on the resources that support self-efficacy for children, youth and families experiencing homelessness. The title of the conference was Unpacking Hope: Understanding the Unique Needs of Children, Youth and Families Experiencing Homelessness. Last year, the Academy held a conference titled: Honoring the Journey-Partnering with Refugee Families.
- **The Family/Youth Liaison (FYL)** program has the primary duty of coordinating and advancing family/youth professional partnerships in the CYF SOC. The FYL Director works closely with CYF SOC administrative staff to ensure that family and youth voice and values are incorporated into service development and implementation plans.
- **National Alliance on Mental Illness San Diego (NAMI) Children, Youth, and Family Liaison Team** works to build resiliency in and connections with the communities they serve, sharing information on best practices, programs and support. Additionally, CYF Liaison offers free workshops, forums, webinars, training events, and focus groups on a regular basis.

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 groups are: **Adult Council, Older Adult Council, Behavioral Health Services Housing Council, and Transition Age Youth (TAY) Council.** These groups also have a voice in

making recommendations for policy development. Members are appointed from constituencies including: community organizations, BHAB, Community College District, TAY, primary health care, advocacy, National Alliance on Mental Illness (NAMI), Mental Health Contractors Association, Employment Services, Probation, Sheriff, Police Departments, fee-for-service mental health providers, Cultural Competence Resource Team (CCRT), Co-Occurring Disorders/Change Agents Developing Recovery Excellence (CADRE), Mental Health Coalition, hospital partners, underserved communities, long-term care representatives, 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% of 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 International, PAGs have established implementation guidelines across the AOA SOC in an effort to standardize this important vehicle for soliciting feedback to improve programs.
- **The Behavioral Health Advisory Board (BHAB)** addresses the unique and common needs of both mental health and substance use communities, and meets the needs of clients who are diagnosed with co-occurring disorders. The BHAB advises the Board of Supervisors, the Chief Administrative Officer, the Director of Health and Human Services Agency, and the Director of Behavioral Health Services regarding prevention, early intervention, treatment, and recovery services. The BHAB's efficiency and streamlined process 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 BHS system.
- **The Quality Review Council (QRC)** 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. 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.
- Through its CYF SOC, BHS has been working with **Project Save Our Children** to address disproportionality and disparities in serving youth and families in southeast San Diego, especially with African American youth. BHS 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. In November 2016, BHS spoke at one of the Project Save Our Children stakeholder meetings and presented on the racial/ethnic breakdown of children and youth served by BHS in different regions. The focus of the presentation was on the African American population.
- Through **NAMI San Diego**, the Family-to-Family program for adults ages 18 and older 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:

BHS has developed activities that involve community based organizations (CBO). Funded by Prevention and Early Intervention (PEI), Community Health Promotion Specialists and Aging Specialists bring mental health awareness to the general public and to those populations not normally seen within BHS 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 attend Health Fairs throughout the county to distribute information and talk about mental health with 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 Difícil 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 California 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.
- **Our Safe Place** is a behavioral health services program for Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQI) youth that began offering treatment services in September of 2017. It offers support with health and wellness activities, educational and

vocational training, support groups for youth and caregivers, a mentorship program, GED preparation, life skills training, and crisis support to LGBTQI youth. Additionally, the program has four drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers.

- As part of the Countywide effort to support a healthy, safe, and thriving region through the *Live Well San Diego* Vision, the County of San Diego focuses on the integration of a trauma-informed model in the philosophy, approach, and methods to become a fully trauma-informed organization and to more effectively engage all people served, staff, and others with whom the County conducts business. The goal is to enhance 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. BHS continues to lead efforts to assist the HHS in moving toward an integrated trauma-informed system. With the assistance of a consultant, BHS conducted an assessment of the trauma-informed competencies and leveraged the recommendations to begin the countywide implementation and change. This continued evaluation of system change will: build a better service delivery system; support staff, partners and families in making positive choices by providing appropriate training and resources; aid in the pursuit of policies and environmental changes that support healthy, safe, and thriving communities; and continue to enhance the County culture from within.

During FY 2016-17, BHS provided training to BHS providers on the Neurobiology of Trauma, assisted in the development of an e-Learning that will be provided to County staff by The Knowledge Center (TKC), continued to support employee wellness and self-care by offering regular onsite activities for staff (e.g., weekly physical fitness group class), and continued to include participation of individuals with lived experience of behavioral health challenges in community engagement forums, Council meetings, workgroups, and trainings.

- **Pathways to Well-Being** is the County of San Diego’s joint partnership between BHS CYF and Child Welfare Services (CWS), dedicated to collaboration in order to ensure safety, the promotion of a permanent living situation known as permanency, and well-being for youth in, or at imminent risk of placement in, foster care. Under the initiative, all youth entering the Child Welfare System are screened for mental health needs to receive appropriate services and support. Aligning with the Core Practice Model, 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, other system partners, and the youth and family. BHS, CWS, Probation, and family and youth partners work together to support a shared vision of the Pathways to Well-Being. As of July 2016, the state expanded Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) to be available to all children and youth under the age of 21 who are eligible for full scope Medi-Cal services and who meet medical necessity for these services.
- **I CARE** is a new program in the CYF System of Care and began its services in September of 2017. The program offers behavioral health treatment services to youth up to the age of 21 who are at risk for or are victims of commercial sexual exploitation (CSEC) through an outpatient clinic. The program also has a 7-day a week drop-in center that offers supportive services such as assistance with school and groups for youth and

caregivers. The program is well connected with other systems and County wide efforts to support sexually exploited children.

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.

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 (EMASS)** 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 who need the assistance.

County of San Diego’s Faith-Based Task Orders that were implemented in FY 2016-17 focus primarily on the African American and Latino communities in the Central and North Inland regions of San Diego County. The goal of the Task Orders is 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 substance use disorder services and other resources.

In FY 2017-18, another Innovation program, Urban Beats, was approved for expansion to the East African community population in response to the stakeholder concern about the escalated gang activity and increased mental health needs among the community members. Urban Beats formed a collaborative relationship with the United Women of East Africa and the Nile Sisters in effort to provide culturally competent services as well as engage East African TAY community through cultural brokers.

Housing for Mental Health Clients:

The Corporation for Supportive Housing (CSH) is a contracted housing technical consultant to SDCBHS. 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* vision 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, and Middle Easterners would be helpful.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

In one of the CCRT meetings, stakeholders discussed the topic of County practices and activities that demonstrate community outreach, engagement, and involvement efforts. The community again suggested focusing on the LGBTQI population, especially the youth in this community. The stakeholders' feedback also suggested cultural competence training to be a part of the entire County system and specifically for individuals that are first point of contact, managers, and medical staff. The discussion also included focusing on refugee communities, creating a LGBTQI campaign, and reviewing PERT curriculum for cultural competency. An additional recommendation was to develop the It's Up To Us campaign to include a more targeted approach to specific locations, populations, and subcultures.

With the community input received, the SDCBHS will focus on the implementation of Our Safe Place as noted in Section I above. In addition, SDCBHS plans to work with PERT to review their curriculum for cultural competency to ensure that crisis services are sensitive to individual needs.

Year 1 Achievements:

As mentioned in Section I above, the SDCBHS established the new program, Our Safe Place, to the CYF System of Care, and began offering treatment services in September of 2017. It offers behavioral treatment services to youth up to the age of 21 who identify as LGBTQ through an outpatient clinic. The program also has four (4) drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers.

In all county contracted trainings, providers and trainers are encouraged to use person first language and avoid clinical language, except when necessary for billing and medical purposes, to enhance the recovery environment within their programs and to reduce the stigma surrounding behavioral health. BHETA trainings continues to incorporate individuals with lived experience into the development and delivery of training.

The CYF Liaison is always seeking ways to engage families. The CYF Liaison started attending already established meetings that families attend to seek engagement of culturally and linguistically diverse clients. Examples of these meetings include: PTA meetings, North County Prevention and Early Intervention (PEI) parenting group engaged in County Behavioral Health Services. They also incorporated the Transition Age Youth (TAY) Troop and started hosting a monthly “meet up”.

CYF continuously seeks to enhance the client and family engagement through the CYF Council’s “Family and Youth as a Partners” Sub-committee which meets monthly. Additionally, due to success and effectiveness, the MHSAs Innovations 12 Family Therapy Participation project will transition to a MHSAs Full Support Partnership component on July 1, 2018. Priority will be given to engage underserved populations, such as Latinos and African Americans.

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 (ESM) 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 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 42,000 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 BHS Director and the Quality Improvement Unit. She also maintains close collaborative relationships with consumer and family organizations. An active advocate, she consults and maintains 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 DHCS. Additionally, Dr. Garcia was invited to speak at an international forum *Prevención de la Conductas de Autolesión y Suicidio en Jóvenes* in Tijuana, Mexico in May 2017 on suicide and self-harm reduction as part of the collaborative cross-border effort.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

After discussing the role and responsibilities of the ESM, Dr. Garcia stated that she will continue to fulfill the role and responsibilities of the ESM as described above. She provided examples of several ongoing developments that she will focus on in the next three years. The developments are listed as follows: engage newly arrived East African communities and consider enhancement of services for refugee populations, develop and implement an Innovations funded program for Native-Americans in rural communities, implement an LGBTQI program for adolescents, implement new staff and program cultural competence assessments, provide training and education on CLAS standards and how to implement at the program level, provide training and education on diverse communities, specifically East African refugee and LGBTQI communities.

Year 1 Achievements:

As mentioned in Section I above, the SDCBHS established the new program, Our Safe Place, to the CYF System of Care, and began offering treatment services in September of 2017. It offers behavioral treatment services to youth up to the age of 21 who identify as LGBTQ through an outpatient clinic. The program also has four (4) drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers.

The SDCBHS has contracted with Southern Indian Health Council, Inc. (SIHC) and Indian Health Council (IHC) effective June 2018 for an MHA Innovations program named Roaming Outpatient Access Mobile Services (ROAM). ROAM will provide comprehensive wrap-around services to transition age youth with serious emotional disturbances, adults with serious mental illness, and those identified as having co-occurring disorders on rural, tribal reservations in San Diego County. Services will include the following: individual/group counseling, medication management, case management, peer and family support, care coordination, and Prevention and Early Intervention (PEI) services, as well as Substance Use Disorder (SUD) screening, referral

and linkage. Services are intended to combine culturally appropriate mental health services and the option for tele-psychiatry as part of comprehensive care; utilize Medication Assisted Treatment (MAT) to assist and support the recovery process for individuals with co-occurring disorders; utilize tele-health technology for follow up appointments and to coordinate care with a primary care physician; provide comprehensive mental health services, including screening, behavioral health assessment, treatment, case management and care coordination, medication management, monitoring, referral and linkages to appropriate resources, prevention, and early intervention. ROAM is currently in its implementation stage.

BHETA has offered numerous trainings that focus on key topics including refugees, working with families experiencing homelessness, the TAY community, working with immigrants, and an e-learning on the East African immigrant community.

Furthermore, CYF has supported the East African community by providing resource tables at their community events and Behavioral Health Services outreach materials for the following community events: “Use to Abuse” hosted by the African Advisory Committee for Mental Health held on August 11, 2017; and "Love Your Heart" hosted by Dunya Women's Health Collaborative held on February 14, 2018. Additionally, a program manager from the United Women of East Africa attended the 4th Annual Children's Mental Health Well Being Celebration held on May 2, 2018 at Azalea Park in Mid City.

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	431,750
Client Operated Peer Support Services	748,400
Mental Health Systems, City Star FSP	2,352,000
Union of Pan Asian Communities	1,706,777
Maria Sardinias Outpatient	2,480,639
Indian Health Council, Southern Indian Health, and SD American Indian Health Center	1,766,750
Pathways Community Services for TAY	4,379,170
McAlister Institute for Treatment and Education (MITE) – New Hope	422,000
Breaking Barriers, Mental Health Association (MHA)	437,800
Faith Based Task Orders – Community Health Improvement Partners, MHA, Neighborhood House Association, Total Deliverance Worship Center, and Urban League.	513,331

San Diego Youth Services Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) youth and young adults	1,500,000
Mobile Hoarding – University of California, San Diego (UCSD)	421,774

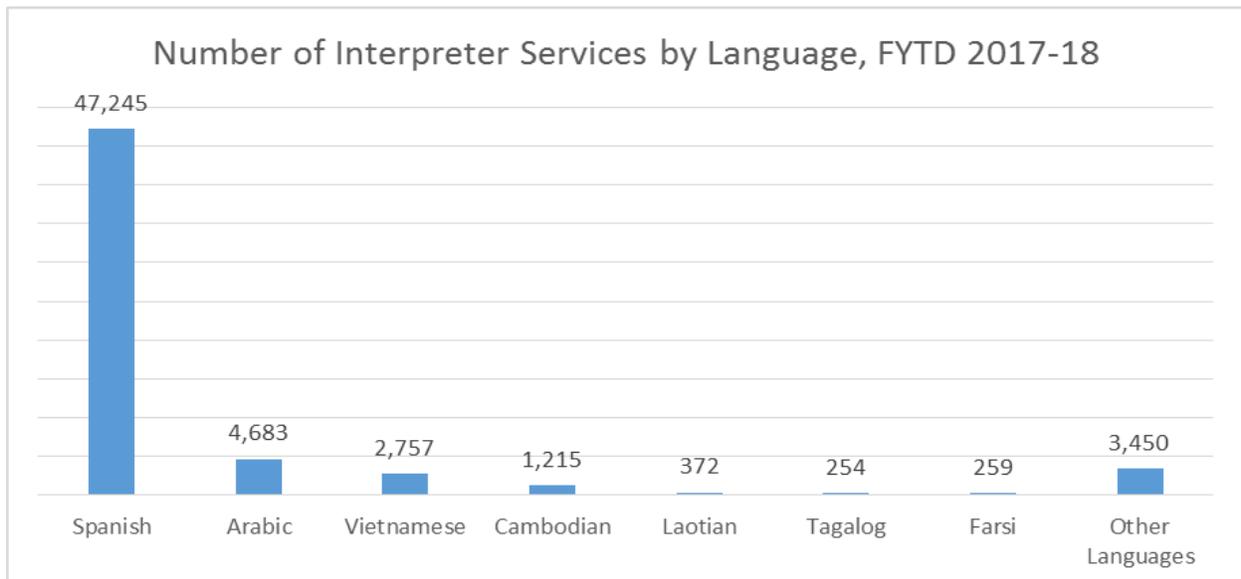
In addition to its ongoing programming, the SDCBHS has 157 contracts with programs through MHA CSS funding and 36 contracts with programs through PEI to help address disparities and provide more culturally competent activities for persons with mental health problems. There are currently seven active MHA Innovations programs, two of which were approved for extension in FY 2017-18. Additionally, four Innovations programs will begin operations in FY 2018-19.

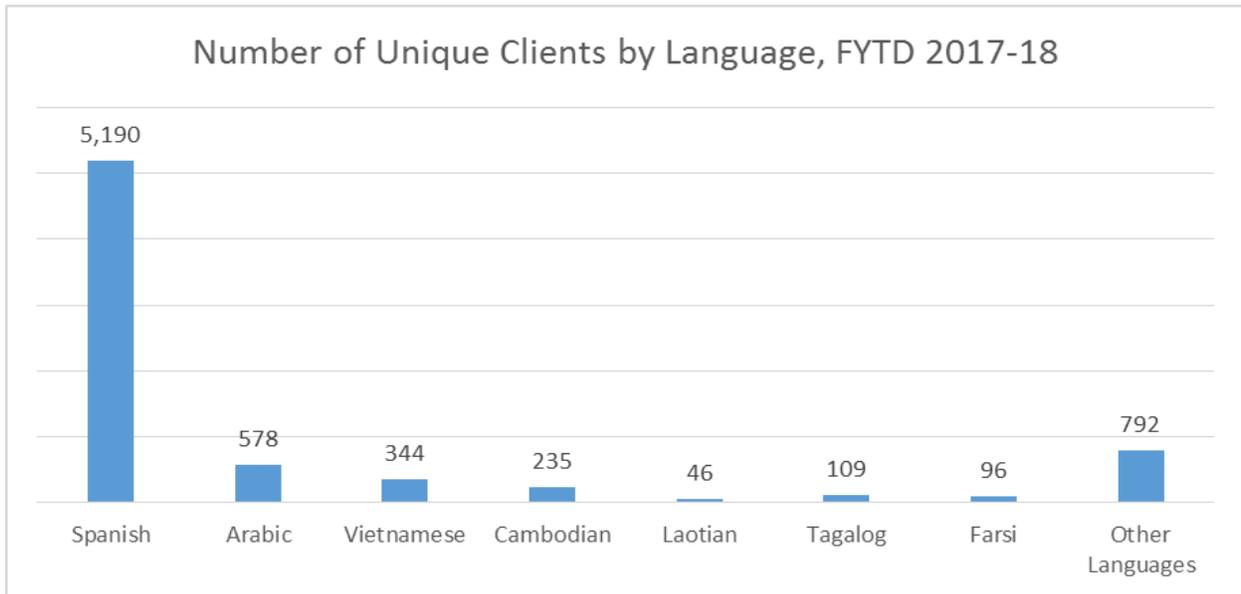
B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:

- 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.*

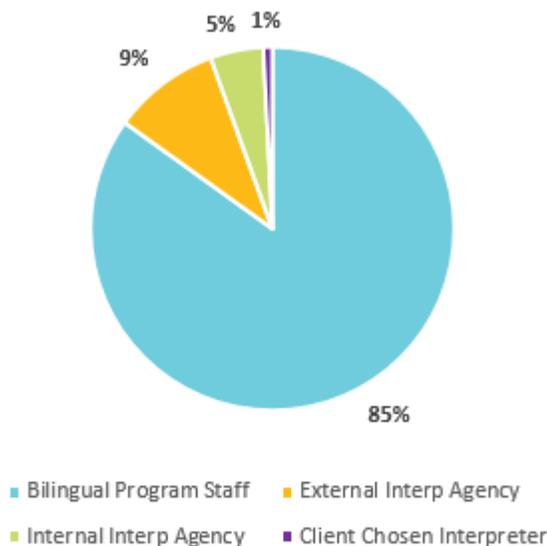
1. Interpreter and translation services

Beginning FY 2015-16, funding for interpreter utilization was decentralized with each contract being responsible for their own interpreter budget. Through the use of Cerner Community Behavioral Health (CCBH) and the San Diego Web Infrastructure for Treatment Services (SanWITS), SDCBHS is able to monitor services that are provided in languages other than English.





Interpreter Service Type, FYTD 2017-18



**Please Note: 6,549 of the 60,235 Interpreter Services were omitted from chart due to insufficient data entered regarding interpreter service type.*

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 other programs.

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

To increase access to children's services and reduce ethnic disparities, the SDCBHS began its effort to bring services to the community through the school-based programs. 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 400 schools throughout the County. In FY 2017-18, 54% of schools in the County had at least one school site treatment service.

The penetration rate among Hispanic youth clients rose from 2.8 percent in FY 2001-02 to 5.1 percent in FY 2015-16; it is expected that programs funded through MHSA and the recent increase in school-based programs 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.

One of San Diego's most vulnerable populations, LGBTQI youth, often suffer as a result of non-supportive or even hostile environments in their homes, schools and communities. Research demonstrates that LGBTQI youth who do not have access to LGBTQI-affirming community environments are at higher risk for negative outcomes, including early high-school dropout, homelessness, negative mental health symptoms, increased substance use, suicide and physical, emotional and/or sexual abuse (Center for American Progress, 2010). Our Safe Place, a behavioral health services program for LGBTQI youth, provides direct clinical services, and three drop-in centers which offer support with health and wellness activities, educational and vocational training, support groups for youth and caregivers, mentorship program, GED preparation, life skills training, and crisis support to LGBTQI youth.

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

Many of BHS programs reach out 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), LGBTQI, African, and African American communities.

In addition to the PEI programs, several Innovations programs were developed to reach hard to engage populations such as Native American and East African 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 Competence Training each year. In 2014, SDCBHS updated the Cultural Competence Handbook and incorporated the CLAS Standards. The Handbook contains tools to assist Behavioral Health providers with making improvements throughout the System of Care. The Handbook was updated one more time in 2017 with an addition of two new cultural competence assessment tools and additional resources.

Still other programs are targeted toward specific ethnic, cultural, or age groups. In FY 2016-17, 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, Farsi, 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During the discussion of budget resources targeted for culturally competent activities, the community provided feedback on what additional resources they would recommend to dedicate in the budget. The community input included adding resources for the expansion of services for the following: homeless youth specifically TAY, single parenting men, and refugees. It was also suggested to provide additional funding for the re-establishment of the Cultural Competence Academy (CCA). CCA provided integrated training on cultural responsiveness to improve the cultural awareness, knowledge and skills of staff providing services in SDCBHS. Previously, CCA had training tracks that were dedicated to specific populations. It was suggested to have a training track with multiple aspects of cultural competence, instead of having one track focusing on one population. With the change in the track type, it is believed that attendance would increase.

With the community input received, the SDCBHS has identified the homeless population, including the TAY population, as a key focus for our Cultural Competence Strategic Plan. Integrating mental health services to support individual needs is fundamental to these partnerships. Full Service Partnerships (FSP) refers to the “whatever it takes” philosophy of

ensuring individuals have what they need to succeed. This includes treatment, stabilization, housing, employment, and services to promote recovery. These comprehensive services build strong connections to community resources and focuses on resiliency and recovery. Assertive Community Treatment is a team approach designed to provide comprehensive, rehabilitation and support to persons with serious and persistent mental illness such as schizophrenia. The SDCBHS is proposing a Full Service Partnership Assertive Community Treatment program with supportive housing and strength based case management services in the North Coastal and North Inland regions of San Diego County.

Another key initiative to support the Strategic Plan is Project One For All (POFA). This is an extensive effort by the County of San Diego and its partners to provide intensive wraparound services, including mental health counseling and housing to homeless individuals with serious mental illness. The SDCBHS is also proposing Central and North Central Region FSP ACT programs, which aligns with POFA as they offer intensive case management and mental health rehabilitation services for homeless persons with serious mental illness. The FSP ACT programs noted above focuses on the regional approach, which takes into consideration the cultural needs of the community.

Year 1 Achievements:

The SDCBHS continues to work with BHETA to provide trainings that focus on the needs of the community. BHETA has offered numerous trainings that focus on key topics including refugees, working with families experiencing homelessness, the TAY community, working with immigrants, and an e-learning on the East African immigrant community.

The SDCBHS programs educate clients in order to reduce the stigma of receiving mental health services. For some clients, seeking professional assistance is not common as traditionally they go to family or religious figures. In addition, the SDCBHS programs offer services in the clients' preferred language in order to establish the comfort and trust to receive services based on their needs. Trainings are offered to increase providers' knowledge on different ethnic groups as well as empowering providers to discuss clients' values and how they have used their resources to get support.

The SDCBHS continues to focus on the enhancement of POFA through the implementation of regional FSP ACT Programs. There were two FSP ACT programs that started in July of 2017, the North Inland ACT (North Star ACT) and North Coastal ACT. Each program may serve clients from all regions of the County, but client are predominantly residents and/or are homeless in the North Coastal and North Inland region of the County. The programs provide intensive community-based services including psychotropic medication management, case management, rehabilitation and behavioral health services with a rehabilitation and recovery focus for adults ages 25-59 who are homeless or at risk of homelessness, have serious mental illness (SMI) and/or are high users of acute inpatient care and medical services. Additionally, the City Star FSP ACT program began serving clients in August of 2017. City Star serves the Central and North Central Regions of San Diego, and serves clients with SMI and are homeless or at risk of becoming homeless. The program is capable of serving up to 125 clients.

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 Estimated Population in 2016: 3,288,612					
Age Group		Race/Ethnicity		Gender	
<i>Under 5 years</i>	214,365	<i>White</i>	1,521,860	<i>Male</i>	1,653,866
<i>5-14</i>	392,302	<i>Hispanic</i>	1,098,537	<i>Female</i>	1,634,746
<i>15-24</i>	478,627	<i>African-American</i>	156,928	Median Age	
<i>25-59</i>	1,598,115	<i>Native American</i>	14,116		
<i>60-74</i>	418,612	<i>Asian/Pacific Islander</i>	391,049	35.5	
<i>75+</i>	186,591	<i>Other</i>	106,122		

Data Source: SANDAG Demographic and Socio-Economic Estimates, 2016 Estimates, San Diego Region

The overall population has increased by 2 percent in 2016, compared to the previous year. While the number of children under five years has increased by nearly 4,000, the number of youth and TAY (ages 5 through 24) has decreased. Additionally, the number of adults ages 60 and older has increased by 6.7% in 2016, compared to 2015. There was a decrease in the number of African-American, White, and Native American people in San Diego County; however, the number of Hispanic and Asian/Pacific Islander people has increased.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The County’s general population and potential changes to the population were discussed with the community. The community input suggested the County of San Diego may experience an increase in those seeking asylum and an increase in the refugee population. Among these two populations, it was of specific interest to assess those under eighteen years of age, those from Syria, and male youth. In addition, with an influx of older adults due to the baby boomers, there will be an increase of older adults with cognitive impairments and language barriers.

With the community input received, the SDCBHS will be building on the enhancement of services to refugee populations over the next three years, including increasing staff’s cultural competence to work with refugee populations, in alignment with the 2017 Children, Youth and Families System of Care Training Academy Conference - *Honoring the Journey: Partnering with Refugee Families*. This conference provided tools to enhance the participants’ journeys in

partnering with refugee families through culturally responsive services. Presentations addressed the impact of trauma, the recognition of resilience, the effects and challenges of forced migration, and identified culturally responsive interventions, tools and available resources for refugee families.

Year 1 Achievements:

The SDCBHS continues to work with BHETA to provide trainings that focus on the needs of the community. In FY 2017-18, BHETA offered a new training that focused on engaging the refugee community. “Engaging Refugee Communities” was a half-day informational and interactive training providing participants with an orientation to the term refugee and a deeper understanding into the journey of those currently coming to the U.S. and why they are making the journey. The presenters shared examples of challenges and successes they have experienced while working with and engaging the refugee community in the City Heights area of San Diego. Additionally, refugee parents and youth shared their personal stories of leaving one’s homeland and coming to San Diego. The training offered lessons learned, key insights, and responsive strategies for participants to utilize in their own work with the refugee community.

Additionally, the SDCBHS transitioned the Transition Age Youth (TAY) workgroup into a Council to prioritize the TAY population. Furthermore, a TAY Training Academy was implemented through BHETA, which offers trainings on TAY specific treatment modalities and best practices. The “Working with Transition Age Youth” series was designed to offer TAY service providers with the unique skills and practice needed to effectively work with the TAY population. This training series focused on the specific developmental and transitional supports required to assist TAY individuals to transition into adulthood, by addressing behavioral health needs. Participants had the opportunity to work directly with TAY peers during this training series.

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 CY16 by Race/Ethnicity		
Race/Ethnicity	Average Monthly Unduplicated Medi-Cal Enrollees*	Unduplicated Annual Count of Beneficiaries Served
White	198,672	13,491
Hispanic	338,736	10,866
African-American	58,403	4,074
Asian/Pacific Islander	139,892	3,687
Native American	4,150	380
Other	176,762	9,441
Total	916,615	41,939

**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 2016.

Data Source: EQRO Approved Claims Report, as of December, 2017.

Medi-Cal Data for San Diego County Mental Health Plan, 2016			
	Average # of Eligible per Month	# of Beneficiaries Served per Year	Penetration Rate
TOTAL	916,615	41,939	4.58%
AGE GROUP			
0-5	114,586	1,999	1.74%
6-17	223,463	12,188	5.45%
18-59	460,959	24,209	5.25%
60+	117,607	3,543	3.01%
GENDER			
Female	491,366	20,377	4.15%
Male	425,248	21,562	5.07%
RACE/ETHNICITY			
White	198,672	14,491	6.79%
Hispanic	338,736	10,866	3.21%
African-American	58,403	4,074	6.98%
Asian/Pacific Islander	139,892	3,687	2.64%
Native American	4,150	380	9.16%
Other	176,762	9,441	5.34%

Data Source: Table figures above obtained from EQRO Approved Claims Report as of December, 2017.

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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders provided feedback on the County's Medi-Cal population and potential changes in client utilization. It was discussed that due to the Patient Protection and Affordable Care Act (PPACA) there has been more access to healthcare, especially for Medi-Cal beneficiaries. Under the PPACA, undocumented immigrants and certain other immigrants without satisfactory status who meet all other Medi-Cal program requirements qualify for limited or restricted scope Medi-Cal coverage, which includes emergency services and pregnancy related services. In addition, under a new law (SB 75) that was implemented May 2016, children under 19 years of age are eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet the income standards. Thus, there is an expected increase in Medi-Cal utilization among the immigrant population, especially children. However, this may change again with the new Federal Government administration's proposed health care reform. The SDCBHS will continue to monitor activities in Washington DC related to this.

In addition, the older population will grow significantly in the future. This is because the older population is beginning to grow rapidly as the "baby boom" generation begins to reach age 65. With this growth, there is an expected increase in Medi-Cal and Medicare utilization among the older population.

With the community input received, the SDCBHS will focus on the potential impact to services and the populations served due to the current proposed changes to PPACA by the new Federal Government administration to ensure we are adequately able to address the Medi-Cal population service needs.

Year 1 Achievements:

To address the needs of San Diego County's older adult population, the SDCBHS is in the process of developing a Request for Proposals (RFPs) for residential behavioral health programs that will focus on psychosocial rehabilitative services. This RFP focuses on the development of an ACT program dedicated to step down services from long term care. The proposed start date for the programs is in January of 2019. Additionally, the SDCBHS has continued to fund provider training specific to serving the geriatric population. BHETA offered two Geriatric Mental Health Certificate booster trainings in FY 2017-18: Substance Use and Older Adults, and Cognitive Decline in Older Adults with Severe and Persistent Mental Illness. These booster trainings supported community mental health by providing awareness, knowledge and skills to mental health, aging, primary care, and allied professionals on substance use related issues of older adults and their families/caregivers.

An Ad Hoc sub-committee of the CYF Council started meeting in 2017 to review its vision, mission and principles. Its vision was approved in May 2018, which states: Wellness for children, youth and families *through their lifespan*.

In alignment with the County's Live Well San Diego Vision and 2017-2022 Strategic Plan, the expansion of Long Term Care (LTC) will ensure that specialized mental health services are

available on an ongoing basis, and that appropriate level-of-care facilities are available to meet the service requirements and specialized residential needs of seriously mentally ill persons. The SDCBHS expanded the contract with Crestwood Behavioral Health, Inc., an Institute for Mental Disease/Mental Health Rehabilitation Center (IMD/MHRC), and added 64 dedicated beds. Additionally, the contract with Changing Options, Inc., a Behavioral Health Residential Treatment Program, was also expanded, and added seven dedicated beds to provide services to clients in a recovery-orientated open residential environment with onsite services.

CYF embraces the County of San Diego Diversity and Inclusion initiative with different activities. For example, Diversion and Inclusion was integrated as an agenda item to all CYF Administrative Analysts meeting. The items presented/discussed are shared with the rest of the CYF staff and the A/OA staff.

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 2017 for the FY 2015-16, and notes the disparities that exist in San Diego County and how they compare to FYs 2009-10 and 2012-13. 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, 2016		BHS Clients		San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		BHS Clients	
	CYF Population				A/OA Population			
	Number	%	Number	%	Number	%	Number	%
White	34,144	13%	3,463	22%	81,229	22%	18,227	51%
Hispanic	190,351	71%	9,777	63%	226,968	60%	9,671	27%
African American	23,588	9%	1,691	11%	28,845	8%	5,211	15%
Asian/Pacific Islander	15,198	6%	519	3%	32,872	9%	2,283	6%
Native American	5,476	2%	95	1%	7,454	2%	309	1%
Total Clients	268,757	100%	15,545	100%	377,368	100%	35,701	100%

County of San Diego Behavioral Health Combined Population and Service Needs

In planning for services, the SDCBHS 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

www.sandiegocounty.gov/hhsa/programs/bhs/technical_resource_library.html (Section 6.1).

The FY 2015-16 Disparities Report identified the following disparities in SDCBHS:

Latino Adults may be underserved and not as easily engaged.

- The second lowest rate of service utilization across three fiscal years (4.3%).
- The lowest engagement rate (one service visit), compared to other racial/ethnic groups (12.1%).
- 24% of Hispanic adult clients identified Spanish as their preferred language.
- 23% of adult clients served were Hispanic, while the County population was 33%.
- 11.2% of adults had only one visit to an outpatient program.
- 49% of adults had fewer than nine visits.

Latino Children may be underserved and not as easily engaged.

- Decrease in service utilization from FY 2012-13 to FY 2015-16.
- Had the lowest engagement rates for extended services of 13+ sessions (46%).
- Almost 30% identified Spanish as their preferred language.
- More than half the children receiving MH services identified themselves as Hispanic.

- 32% had fewer than six visits to outpatient services. Additionally, 12% had only one visit.

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

- The highest prevalence rates of schizophrenia and other psychotic disorders (53%), compared to other racial/ethnic groups.
- More likely to receive services only in jail than other racial/ethnic groups (19%).

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

- Steady decline in penetration rate from FY 2009-10 to FY 2015-16 (from 10.9% to 7.2%).
- Decrease in service utilization from FY 2009-10 to FY 2015-16 (from 20.5% to 18.1%).
- More frequent use of Juvenile Forensic Services (JFS) without receiving any outpatient services, compared to other groups (8%).
- Less likely to have more than one session than other racial/ethnic groups (10.4%).

Asian/Pacific Islander Children were underserved.

- The lowest engagement rates for extended services of 13+ sessions (45.5%).
- More likely to use inpatient/emergency screening unit (ESU) services without receiving any outpatient services than other racial/ethnic groups.
- 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.
- 13.8% had only one visit.

Native American Adults were underserved.

- The lowest rate of service utilization (4.1%).

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

- Decrease in penetration rates from FY 2009-10 to FY 2015-16 (2.5% to 1.7%).

Other Factors Affecting Children's Usage of Mental Health Services

- 12% of children receiving mental health services were also involved with Child Welfare Services (CWS).
- The proportion of clients who received crisis stabilization services has been increasing since FY 2011-12 (from 2.2% to 4.8%).
- 10% of all CMHS clients were also open to the Probation System.
- Penetration rate among Transition Age Youth (TAY) has declined since FY 2009-10.
- The proportion of TAY who only received one service has almost doubled from FY 2009-10 to FY 2015-16 (10.1% to 19.8%).

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

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders discussed the County's 200% of poverty population and potential changes in client services utilization. As noted in Section I of Criterion 2, there is an expected increase in the older adult population, the refugee community, and those seeking asylum. It was discussed that there is a need for increased community based treatment options and more individualized/client centered services that will meet the needs of the unique population in our County.

With the community input received, the SDCBHS will focus on the older adult population and will work to establish a rapid response process to meet the individual needs of this population.

Year 1 Achievements:

As mentioned above, the SDCBHS is in the process of developing a Request for Proposals (RFPs) for residential behavioral health programs that will focus on psychosocial rehabilitative services. This RFP focuses on the development of an ACT program dedicated to step down services from long term care. The proposed start date for the programs is in January of 2019. Additionally, the SDCBHS has continued to fund provider training specific to serving the older adult population. BHETA offered two Geriatric Mental Health Certificate booster trainings in FY 2017-18: Substance Use and Older Adults, and Cognitive Decline in Older Adults with Severe and Persistent Mental Illness. These booster trainings supported community mental health by providing awareness, knowledge and skills to mental health, aging, primary care, and allied professionals on substance use related issues of older adults and their families/caregivers. Other programs offered by BHETA that focus on the older adult population include: Introduction to Geriatric Mental Health (GCT) Series; Advanced Geriatric Mental Health Series; Cognitive Decline in Older Adults with Severe and Persistent Mental Illness; Deciphering the 3Ds: Dementia, Depression and Delirium; Psychopharmacology in Older Adults; and Senior Veterans. The SDCBHS continues to strive to provide services that focus on the older adult population. The Cognitive Rehabilitation and Exposure/Sorting Treatment (CREST) program offers a personalized and compassionate approach for helping older adults with hoarding behaviors and mental health needs. This community program has been extended by the Board of Supervisors to June of 2020, as well as has expanded to provide services countywide. In addition, CREST will now have a Spanish speaking clinician and Spanish translated curriculum available in the South region.

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 DHCS 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) (between 18 and 25)

- In San Diego County, the unserved TAY are identified as between ages 18 and 25 years 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 Transition 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 MHS-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 (TAY) 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	5,409	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*	1	0	42	125	346	6.4%	5,034	4%	13,013	4%

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	4,004	3,949	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	2,300	2,211	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.

Children and Youth (CYF)

Hispanic

- Almost two-thirds (63%) of children and youth clients served in FY 2015-16 were Hispanic.
- The proportion of clients who received JFS services in FY 2015-16 increased by 3.8% compared to FY 2012-13 (1.0% to 4.8%).

African American

- Penetration rates for African American clients have steadily declined since FY 2009-10 (10.9% to 7.2%).
- Compared to other racial/ethnic groups, African American clients were slightly more likely to receive 13 or more sessions (52.9% versus 45.5-52.2%*).
- Compared to other racial/ethnic groups, African American clients had lower utilization of outpatient services (90.9% versus 94.0-96.1%*) and higher utilization of only JFS (8.0% versus 2.8-4.8%*).
- A smaller proportion of African American clients were diagnosed with anxiety disorders (6.3%), compared to clients from other racial/ethnic groups (11.2-13.1%*).

Asian/Pacific Islander

- Asian/Pacific Islander clients were least likely to receive 13 or more sessions (45.5%), compared to other racial/ethnic groups (46.1-52.9%*).
- Compared to the other racial/ethnic groups, a greater proportion of Asian/Pacific Islander clients were diagnosed with depressive disorders (26.0% versus 17.7-22.4%*).

Native American

- Penetration rates for Native American clients declined since FY 2009-10 (2.5% to 1.7%).
- The proportion of Native American clients who received only JFS increased from 0.0% in FY 2012-13 to 4.2% in FY 2015-16.
- Fewer Native American clients were diagnosed with bipolar disorders (4.2%), compared to other racial/ethnic groups (6.8-7.7%*).

Adults and Older Adults (AOA)

Hispanic

- The proportion of Hispanic clients receiving outpatient services has increased since FY 2009-10 (69.1% from 59.1%).
- Penetration rates for Hispanic clients were relatively stable from FY 2009-10 to FY 2015-16.
- Hispanic clients had among the lowest penetration rates for all three categories of services across all three fiscal years (2.7-4.4%*).
- A greater proportion of Hispanic clients only received one service visit (12.1%), compared to clients in other racial/ethnic groups (6.7-11.6%*).

African American

- African American clients were less likely than those in other racial/ethnic groups to receive outpatient services (63.0% versus 66.4-78.2%*).
- African American clients were more likely to receive services only provided in jail than other racial/ethnic groups (18.5% versus 6.4-13.9%), but this proportion has decreased since FY 2009-10 (29.3% to 18.5%).
- A greater proportion of African American clients (52.5%) were diagnosed with schizophrenic disorders compared to other racial/ethnic groups (33.6-49.5%*).

Asian/Pacific Islander

- Asian/Pacific Islander clients were more likely to receive outpatient services (78.2%), and less likely to receive only services provided in jail (6.4%) than clients in the other racial/ethnic groups.
- A greater proportion of Asian/Pacific Islander clients were diagnosed with depressive disorders (27.4%) compared to clients in the other racial/ethnic groups (15.2-22.9%*).

Native American

- Native American clients had among the lowest penetration rates for all three categories of services across all three fiscal years (2.9-4.7%*).
- Utilization of inpatient/emergency services has decreased among Native American AOA clients since FY 2009-10 (20.1% to 15.9%).

Veterans

In order to measure disparities in mental health services among veterans in San Diego County, the number of A/OA veterans is being continuously monitored. When compared to FY 2012-13, the veteran admissions to inpatient facilities in FY 2016-17 have decreased by 23.5% (671 vs. 513), with the smallest number of A/OA veteran admissions being in FY 2016-17. The proportion of veteran admissions to the Full Service Partnership (FSP) programs in FY 2016-17

has slightly increased by 0.8% since FY 2014-15. This may be due to the increase in total FSP admissions during FY 2015-16 and FY 2016-17.

Veteran Admissions in A/OA System of Care, FY 2016-17

Year	FSP Admissions	Veteran Admissions	Veteran Percentage
FY 2012-13	1,201	92	7.7%
FY 2013-14	1,184	76	6.4%
FY 2014-15	1,356	41	3.0%
FY 2015-16	2,209	70	3.2%
FY 2016-17	1,938	74	3.8%

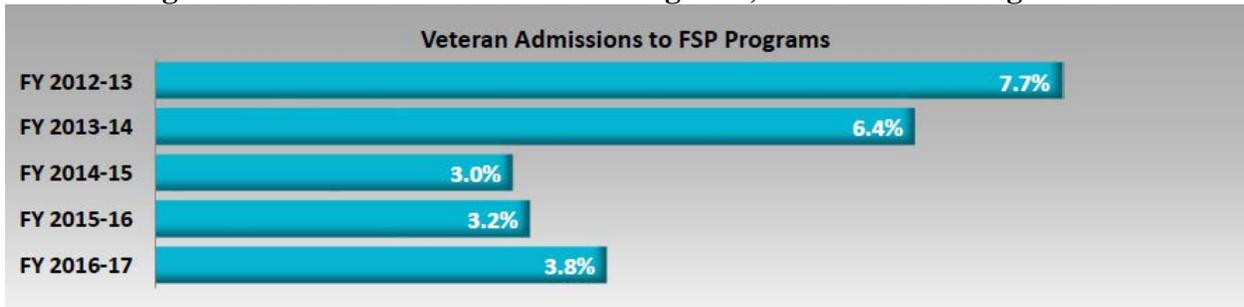
Year	IP Admissions	Veteran Admissions	Veteran Percentage
FY 2012-13	8,240	671	8.1%
FY 2013-14	9,050	659	7.3%
FY 2014-15	9,618	616	6.4%
FY 2015-16	10,123	627	6.2%
FY 2016-17	8,282	513	6.2%

Year	IP or FSP Admissions	Veteran Admissions	Veteran Percentage
FY 2012-13	9,441	763	8.1%
FY 2013-14	10,234	735	7.2%
FY 2014-15	10,974	657	6.0%
FY 2015-16	12,332	697	5.7%
FY 2016-17	10,220	580	5.7%

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 FYs 2012-13 through 2016-17 is shown below. In FY 2012-13, FSP programs served the most veterans (7.7%).

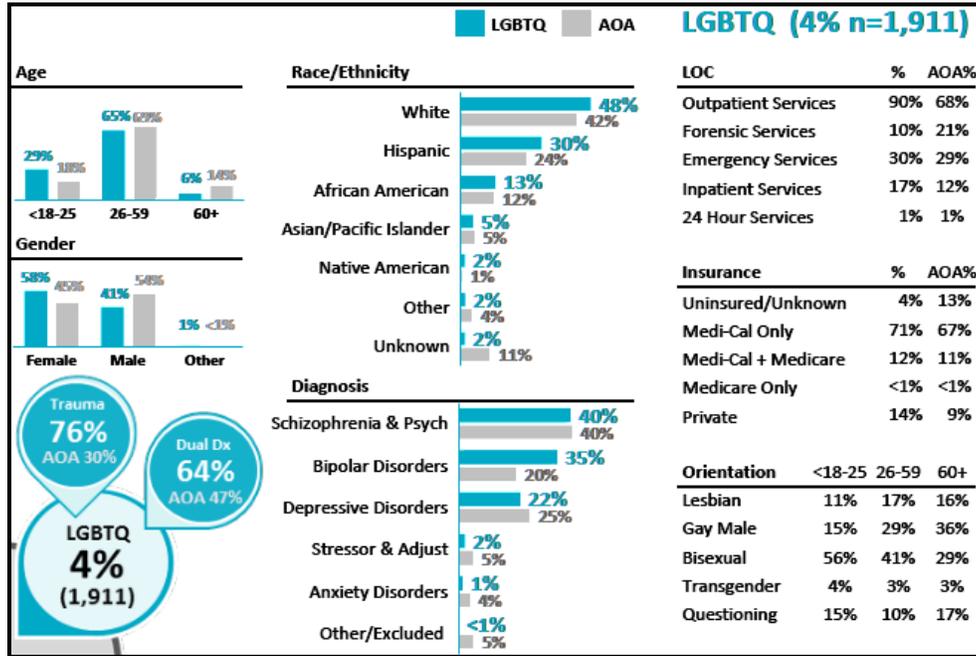
Percentage of Veteran Admissions to FSP Programs, FY 2012-13 through 2016-17



LGBTQI

To ensure that LGBTQI 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 2016-17, the sexual orientation variable

A/OA Client Sexual Orientation in FY 2016-17



Jail Population

Over the past years, San Diego County has implemented programs and conducted analysis on disparities in mental health services among the jail population. Overall, 9,143 adults ages 18 and older received mental health services in jail. This constitutes 19% of the total number of adults (48,963) who received mental health services. For children and youth, 1,411 children ages 0-17 received mental health services in Juvenile Forensic Services (JFS), which constitutes 8% of the total number of children and youth (18,897) who received mental health services. Men made up 76% of the jail population and 52% of the total mental health adult population, compared to women who made up 24% of the jail population and 47% of the total adult mental health population. Among the ages 0-17, men made up 76% of the JFS population and 55% of the total child and youth mental health population. Women made up 24% of the jail population and 44% of the total child and youth mental health population.

As shown below, there is a higher 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 clients ages 0-17 made up 20% of the population receiving JFS services, compared to 10% 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 2016-17
Demographics of JFS/Jail Population Compared to Overall BHS Population**

Table 1. Summary	JFS (Age 0-17)				Jail (Age 18+)			
	FY 2015/16		FY 2016/17		FY 2015/16		FY 2016/17	
Total Clients Receiving Jail/JFS Services:	1,519	8%	1,411	8%	8,869	18%	9,143	19%
Total Clients Receiving All MH Services:	18,897		17,331		49,172		48,963	

Table 3. By Gender	JFS (Age 0-17)				Jail (Age 18+)			
	FY 2015/16		FY 2016/17		FY 2015/16		FY 2016/17	
Gender	JFS Population	All BHS Population	JFS Population	All BHS Population	Jail Population	All BHS Population	Jail Population	All BHS Population
Female	25%	44%	24%	44%	24%	48%	24%	47%
Male	75%	56%	76%	55%	76%	52%	76%	52%
Unknown		0%	0%	0%	0%	0%	0%	0%

Table 4. By Race/Ethnicity	JFS (Age 0-17)				Jail (Age 18+)			
	FY 2015/16		FY 2016/17		FY 2015/16		FY 2016/17	
Race/Ethnicity	JFS Population	All BHS Population	JFS Population	All BHS Population	Jail Population	All BHS Population	Jail Population	All BHS Population
African American	20%	10%	20%	10%	20%	12%	20%	12%
Asian/Pacific Islander	3%	3%	2%	3%	3%	5%	3%	5%
Hispanic	57%	56%	56%	58%	26%	23%	28%	24%
Native American	0%	1%	0%	0%	1%	1%	1%	1%
White	17%	20%	18%	21%	45%	41%	44%	41%
Other	3%	11%	3%	8%	4%	18%	4%	18%

For clients who received services only in jail or JFS, 44% of White clients only received services in jail in FY 2016-17, compared to 46% in FY 2015-16. For the JFS population, this percentage has increased from 14% only receiving services in FY 2015-16 to 16% in FY 2016-17. The percentage of Hispanic clients receiving only services in jail has increased slightly in FY 2016-17 (28% vs 30%), while there was a slight decrease in receiving only services in the JFS setting (61% vs 57%). Additionally, there was a slight increase of 1% in African American clients seen only in a JFS setting than the previous fiscal year (19% vs 20%). The same proportion of African American clients were seen only in a jail setting as the previous year (18% each).

**Proportion of Jail/JFS Clients Receiving Behavioral Health Services
only in Jail/JFS Setting by Race/Ethnicity**

Table 6. JFS/Jail Clients Receiving Behavioral Health Services only in JFS/Jail Setting

Race/Ethnicity	JFS				Jail			
	FY 2015/16		FY 2016/17		FY 2015/16		FY 2016/17	
	Count	Pct	Count	Pct	Count	Pct	Count	Pct
African American	90	19%	90	20%	623	18%	627	18%
Asian/Pacific Islander	14	3%	9	2%	93	3%	115	3%
Hispanic	289	61%	252	57%	943	28%	1,068	30%
Native American	2	0%	2	0%	29	1%	24	1%
White	66	14%	72	16%	1,557	46%	1,537	44%
Other	11	2%	20	4%	150	4%	148	4%
Total:	472		445		3,395		3,519	

In FY 2016-17, the most common diagnosis among the JFS population was Stressor and Adjustment Disorders (26.2%), similar to the overall BHS population of clients ages 0-17 (24.3%), followed by Depressive Disorders (24.2%). Conversely, the most common diagnosis among the jail population was Schizophrenia and Other Psychotic Disorders (16.9%), compared to the overall BHS population of clients ages 18 and older where the most prevalent diagnosis was Depressive Disorders (22.4%).

Homeless Population

In 2018, the annual Point-In-Time-Count (PITC) identified 8,576 homeless individuals living on the streets or in shelters throughout San Diego County. The total number of homeless individuals represents a decrease of 5.9% over the PITC conducted in 2017. The County of San Diego is working to better coordinate services to help end homelessness. In FY 2015-16, 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) to 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.

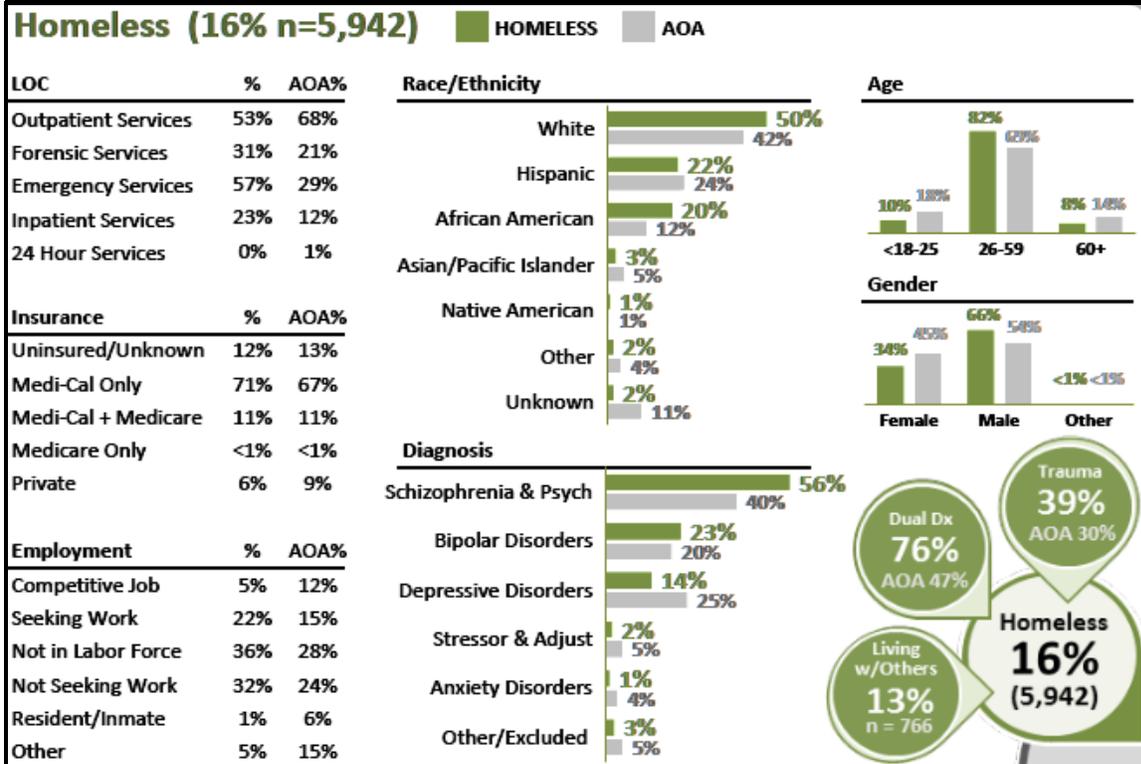
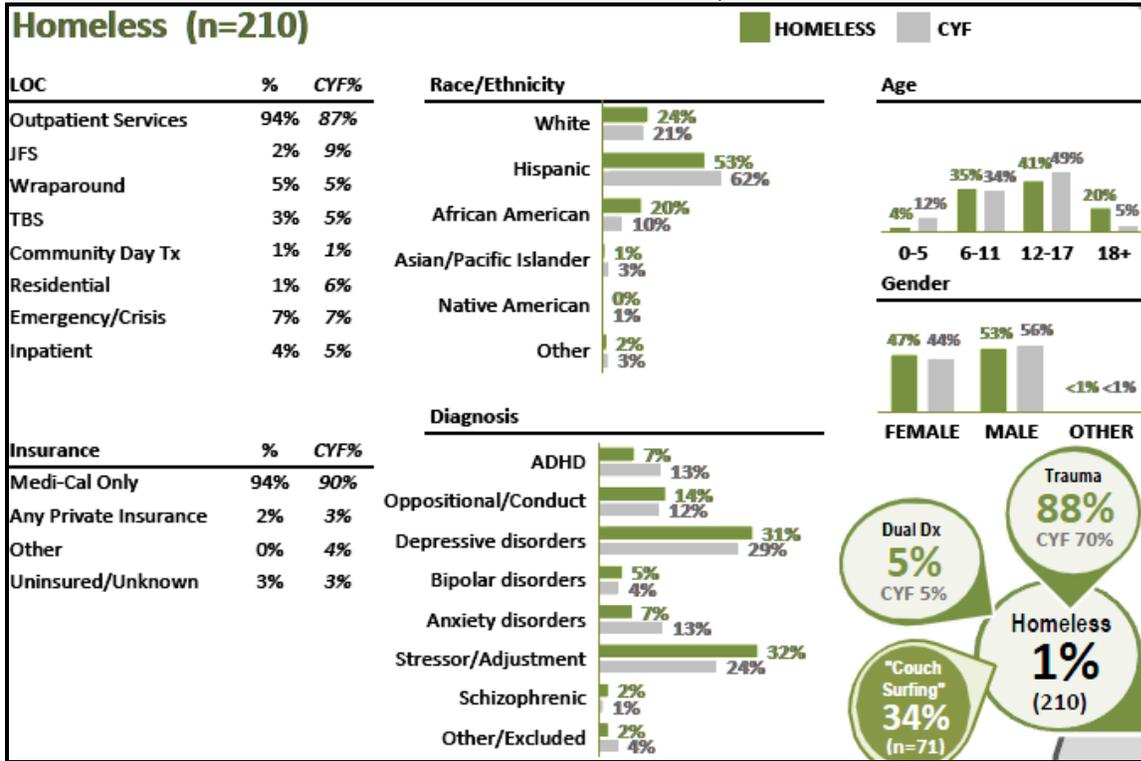
Additionally, Supervisor Cox announced the approval of the recommendation to launch “Project One for All” (POFA) which will support the seriously mentally ill homeless population. POFA is an effort to provide intensive wraparound services to homeless individuals with serious

mental illness (SMI) who are eligible for supportive housing. The four components of the POFA implementation plan include, outreach and engagement; treatment services; housing resources; and performance measurement. Behavioral health contracts were expanded in February 2016 to provide 300 outreach and engagement slots through a variety of mechanisms to assist people in accessing housing and services. Implementation of POFA relies on a coordinated approach that braids treatment and housing. Furthermore, in response to the growing need among the homeless individuals to have a better service delivery system and to facilitate implementation of POFA, the County integrated the Department of Housing and Community Development into the HHS in July 2016. The significant organizational change supports the County's efforts to address the needs of vulnerable residents, particularly homeless people with SMI. The realignment of services will better enable the County to take a more comprehensive, "whole person" approach to delivering services, one of the goals of the County's *Live Well San Diego* Vision for healthy, safe and thriving communities. The program was implemented in the City of San Diego and the unincorporated areas of the County. The goal of POFA is to reach 1,250 homeless individuals.

In FY 2016-17, BHS-contracted ACT programs spent more than 5.6 million dollars on client housing and housing-related supports. This included dedicated housing staff, client rental assistance, and non-rental assistance (such as deposits, utilities, application fees, and furniture). Two MHSA-funded permanent supporting housing developments opened in 2017. Atmosphere, which is located in downtown San Diego, is a 205-unit development that houses 31 adult clients who receive ACT services through the Community Research Foundation (CRF) IMPACT program. Mission Cove, which is located in Oceanside, is a 90-unit development that houses nine TAY clients who receive ACT services through Pathways Catalyst or Strengths-Based Case Management (SBCM) services through Mental Health Systems (MHS) Vista TAY. This is the first MHSA-funded development in San Diego to house SBCM clients. With the addition of these two developments, the number of MHSA-funded units in San Diego has risen to 241. Additionally, in June of 2017, HCDS requested the Board of Supervisors to authorize the allocation of rehabilitation funds to a North County housing project and to adopt a resolution authorizing application for and receipt of No Place Like Home (NPLH) funding from the State. The request was presented to the BHAB for their review and support.

The CSOC Academy's 2018 conference was held in May and focused on understanding the unique needs of children, youth, and families experiencing homelessness.

Homeless CYF and A/OA Clients, FY 2016-17



In FY 2016-17, the largest proportion of CYF clients identified as homeless were Hispanic (53%), were between the ages of 12 and 17 (41%), and were male (53%). The largest proportion of A/OA clients identified as homeless were White (50%), were between the ages of 26 and 59 (82%), and were male (66%).

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During a CCRT meeting, the community provided recommendations for target populations and services to focus on for the MHSA Community Services and Supports (CSS) Plan. As noted in Section I and II above, the identified target populations to have a suggested priority focus on included the following: homeless; youth and TAY; older adults; refugees; and those seeking asylum. There is an expected influx of the suggested target populations, including the influx of the Syrian population. Other suggested target populations for consideration were the LGBTQI population and older adults with cognitive impairments and language barriers.

There were two areas of focus recommended in the stakeholders' feedback. It was suggested to encourage more healing practices in the services provided. Healing practices take a holistic approach and addresses the whole person. For instance, it is common for immigrants and refugees to use traditional and religious healing methods before turning to western health care, or in combination with western health services. Service providers are encouraged to be aware of traditional and religious health and healing practices and be supportive when clients use these techniques. Providers can also support clients by encouraging traditional healing methods or integrating them into service plans.

Secondly, the other recommendation was for services to focus on psychoeducation as opposed to clinical practices. Psychoeducation refers to the education offered to individuals with a mental health condition and their families to help empower them and work toward recovery with their condition in an optimal way. A goal is for the client to understand and be better able to deal with his/her presented condition. Also, the client's own capabilities, resources and coping skills are strengthened and used to contribute to his/her own health and wellbeing on a long-term basis. Referring to the previous example, psychoeducation can help immigrants and refugees increase their knowledge and awareness of western mental health concepts and practices. It also has the potential to reduce stigma within immigrant and refugee communities.

With the community input received, the SDCBHS will focus on looking at new cultural competency assessment tools for both behavioral health staff and to assess the program providing the services. The SDCBHS will also focus on the enhancement of the Project One For All (POFA) Initiative, an extensive effort by the County of San Diego and its partners to provide intensive wraparound services, including specialty mental health services and housing, to homeless individuals with serious mental illness. Specifically, SDCBHS will implement regional FSP ACT programs targeting the Central and North Central Regions, to align with POFA as these programs will provide intensive case management and specialty mental health services for homeless persons with serious mental illness.

Year 1 Achievements:

The SDCBHS implemented new cultural competence assessment tools for both behavioral health staff and to assess the program providing the services in efforts to align with the system of care, its priorities, and populations served. The new tools replaced the Culturally Competent Program Annual Self-Evaluation (CC-PAS) and the California Brief Multicultural Competence Scale (CBMCS), respectively. Both tools were developed by Georgetown University’s National Center for Cultural Competence and adapted by SDCBHS to align with the expectations recommended by the CCRT and the National CLAS Standards.

The Cultural and Linguistic Competence Policy Assessment (CLCPA) was implemented in October of 2017 and will be administered annually. The assessment’s goals are to: enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. It is expected that improvement will be seen as staff advances in their cultural competence skills. The Promoting Cultural Diversity Self-Assessment (PCDSA) was implemented in February of 2018 and will be administered biannually. Its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The CLCPA is completed by the program managers, and the PCDSA is completed by all staff.

The SDCBHS continues to focus on the enhancement of POFA through the implementation of regional FSP ACT Programs. As mentioned in Criterion 1, the City Star FSP ACT program began serving clients in August of 2017. City Star serves the Central and North Central Regions of San Diego and serve clients with SMI and are homeless or at risk of becoming homeless. The program is capable of serving up to 125 clients.

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 Behavioral Health Advisory 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 LGBTQI 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 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders discussed the San Diego County’s PEI Plan, along with the populations identified, and if there were any recommendations to change the process used to identify the PEI priority populations. Stakeholders did not identify any additional PEI priority populations as it was determined that all priority populations are identified in San Diego County’s PEI Plan. They did recommend continuing to enhance and expand services to current priority populations.

Additionally, according to the new Mental Health Services Oversight and Accountability Commission (MHSOAC) Regulations that went into effect July 2016, all PEI programs are required to collect participant demographic information and satisfaction with services, and track incoming and outgoing referrals. The PEI programs collect the referral information in a Tracking Log and submit it to the UCSD Health Services Research Center (HSRC) for continuous tracking and analysis. In an effort to evaluate referrals and connection to services post PEI contact, the participant information will be matched with the SDCBHS mental health electronic health record data annually beginning July 2017 for the previous fiscal year. This data will assist the County with determining if additional PEI priority populations need to be identified in the future, and which populations need additional assistance with connecting to specialty mental health services when referred.

Year I Achievements:

In FY 2017-18, the SDCBHS worked with HSRC to improve the tracking referral process. Starting, July 1, 2018, the PEI programs will collect the referral information in a referral tracking form and enter the data into the Mental Health Outcomes Management System (mHOMS). Analysis of these referral data, along with demographic data, will assist the SDCBHS with determining if additional PEI priority populations need to be identified in the future, and which populations need additional assistance with connecting to specialty mental health services when referred.

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 health care 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.

Children and Youth

Race/Ethnicity	Estimates of San Diego County Population (age 0 – 17)*	Target Population**	Actual Clients CYF SOC (FY 2015-16)
White (non-Hispanic)	26%	13%	22%
Hispanic	57%	71%	63%
African American	6%	9%	11%
Asian/Pacific Islander	9%	6%	3%
Native American	<1%	2%	1%

Adults and Older Adults

Race/Ethnicity	Estimates of San Diego County Population (age 18+)*	Target Population**	Actual Clients AOA SOC (FY 2015-16)
White (non-Hispanic)	51%	22%	51%
Hispanic	30%	60%	27%
African American	4%	8%	15%
Asian/Pacific Islander	14%	9%	6%
Native American	<1%	2%	1%

* Source: 2016 California Health Interview Survey (CHIS) data.

** Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

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 exist 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 three time points (Fiscal Years 2009-10, 2012-13, and 2015-16).

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 Advisory 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 enforcement agencies, education representatives, and County partners.

In addition to ongoing communication with the stakeholders, the SDCBHS conducts annual BHS Community Forums that serve as one of the most extensive sets of venues for gathering input from the community on important mental health and substance use disorder services issues. Feedback from the forums is subsequently compiled, analyzed, and integrated into BHS planning. In August and September of 2017, approximately 400 people participated in two community forums, one community tele-town hall, three population-specific focus groups, one innovative population-specific teleconference focus group, and one frontline worker tele-town hall. The focus groups identified five specific populations for targeted engagement: Clubhouse members, homeless Clubhouse members, justice-involved individuals, justice partners, and frontline staff. The objective of the community engagement process was to answer the question of how the San Diego community values the County of San Diego's behavioral health services and the impact those services have on consumers, in alignment with the goals of *Live Well San Diego*. This stakeholder feedback was also used to inform the BHS Ten-Year Roadmap, which is updated annually to incorporate new priorities from the community partners and HHSA/BHS leadership. This year's engagement approach used multiple innovative modalities to reach both the general community as well as targeted populations. Additionally, throughout the year, BHS stakeholder-led councils provided a forum for Council representatives and the public to stay informed of MHSA programs.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders provided feedback regarding identifying target populations that may change in Medi-Cal, CCS, WET, and PEI priority populations in San Diego County. With the transition to the new Federal government administration, the health care system, including Patient Protection and Affordable Care Act (PPACA) legislation, is currently being reviewed to be repealed and replaced. Previously under federal law, immigrants with satisfactory immigration status were restricted to emergency, limited-scope health services in accordance with Section 1011 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). As noted in Criterion 2, under the PPACA, SB-75 allows children under 19 years of age to be eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet the income standards. With PPACA being reviewed to be replaced under the new Federal government administration, immigrant children with satisfactory status are at risk of not being eligible for Medi-Cal or other health care coverage.

The community also discussed addressing the influx of special populations that may utilize Medi-Cal, such as the influx of the Syrian population, the refugee population, and those who are seeking asylum. As noted in Criterion 1, one of San Diego's most vulnerable populations, LGBTQI youth, often suffer as a result of non-supportive or even hostile environments in their homes, schools and communities. Thus, the LGBTQI population is another special population that was suggested to address.

Regarding the CSS population, stakeholders discussed how certain populations may change in the given years. Potential changes included an increase in the homeless population, the increased anxiety of refugee children with the new Federal government administration, an overrepresentation of communities of color in the jail system, and an underrepresentation of certain ethnic communities in FSP ACT programs. It was recommended that SDCBHS track the growth or change in targeted CSS populations with the addition of the East Region and South Region ACT FSP programs, as well as the recent CYF enhancements to programs to increase intensity and offer a "do whatever it takes" FSP approach, and the impact of the passing of Proposition 64, the California Marijuana Legalization Initiative.

Regarding the WET population in its target to grow a multicultural workforce, it was discussed to increase the diversity of clinicians to help aid in the language needs of the clients. In addition, it was recommended to address the needs of different communities who need support with enhancing skills of the behavioral health workforce. Regarding PEI priority populations, stakeholders suggested looking at the possible change in the populations of the children who are refugees, TAY at risk of the first psychotic break, TAY at risk of homelessness, and TAY with dual diagnoses.

With the community input received, the SDCBHS will also focus on the LGBTQI population and the homeless population within the Cultural Competence Strategic Plan. As noted in Section I of Criterion 1, the Our Safe Place program will provide direct clinical services, and three (3) drop-in centers which offer support with health and wellness activities, educational and vocational training, support groups for youth and caregivers, mentorship program, GED preparation, life skills training, and crisis support to LGBTQI youth.

Also mentioned in Criterion 1 Section IV, SDCBHS is proposing Full Service Partnership Assertive Community Treatment programs with supportive housing and strength based case management in the North Coastal and North Inland regions. The FSP ACTs include treatment, stabilization, housing, employment, and anything to promote recovery, and the ACT team approach is designed to provide comprehensive, rehabilitation and support to persons with serious and persistent mental illness. These comprehensive services build strong connections to community resources and focus on resiliency and recovery. The SDCBHS is also proposing the Central and North Central Region FSP ACT program which aligns with Project One for All (POFA) Initiative as it will provide intensive case management and specialty mental health services for homeless persons with serious mental illness.

Another special population within the CSS population on which SDCBHS will focus is clients who are 18 years or older who need psychosocial rehabilitative services; this will be accomplished by establishing a Transitional Residential Program and Adult Residential Facility. The program will be a 24-hour residential behavioral health program to transition clients with

severe mental illness from locked settings and integrating them back to the community. The program will work with adult residents, who are aged 18 and older, and provide psychosocial rehabilitative services in an unlocked transitional residential setting.

Year 1 Achievements:

As mentioned in Criterion 1, the SDCBHS established the Our Safe Place program to the CYF System of Care, and began offering treatment services in September of 2017. It offers behavioral treatment services to youth up to the age of 21 who identify as LGBTQ through an outpatient clinic. The program also has four (4) drop-in centers throughout the county that offer supportive services such as assistance with school and groups for youth and caregivers.

The SDCBHS is in the process of developing three Request for Proposals (RFPs) for residential behavioral health programs that will focus on psychosocial rehabilitative services. The RFPs are for three ACT programs that will focus on step down services from long term care, step down from services from acute care, and justice involvement. The proposed start date for the programs is in January of 2019.

Additionally, the SDCBHS continues to focus on the enhancement of POFA through the implementation of regional FSP ACT Programs. As mentioned in Criterion 1, the City Star FSP ACT program began serving clients in August of 2017. City Star serves the Central and North Central Regions of San Diego and serve clients with SMI and are homeless or at risk of becoming homeless. The program is capable of serving up to 125 clients.

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

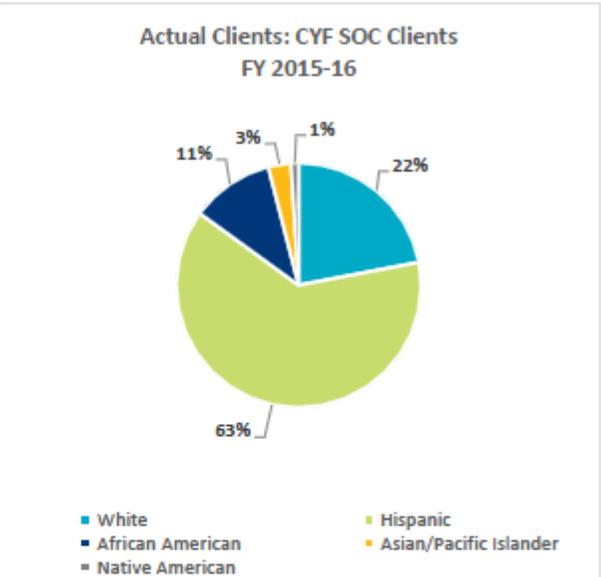
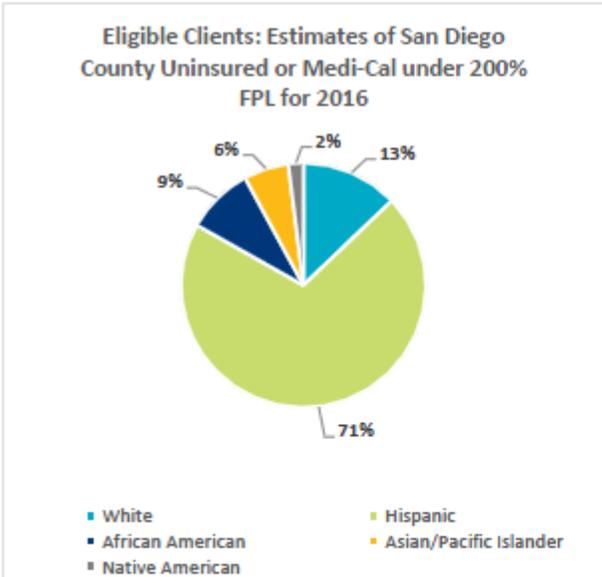
As mentioned earlier, the SDCBHS uses the triennial *Progress Towards Reducing Disparities in Mental Health Services* report as a guide on the current disparities that exist in the County and progress towards the reduction of the disparities over the years.

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 three time periods examined. The service engagement from FY 2009-10 to FY 2015-16 has increased for

all racial/ethnic groups for 10 or more visits. Service utilization has decreased among children, youth, and adults across the fiscal years, with an exception of Hispanic clients.

Target population (eligible clients*) versus CYF SOC clients FY 2015-16

Race/Ethnicity**	Eligible Clients*		Actual Clients	
	Number	%	Number	%
White (non-Hispanic)	34,144	13%	3,463	22%
Hispanic	190,351	71%	9,777	63%
African American	23,588	9%	1,691	11%
Asian/Pacific Islander	15,198	6%	519	3%
Native American	5,476	2%	95	1%
Total Clients	268,757	100%	15,545	100%

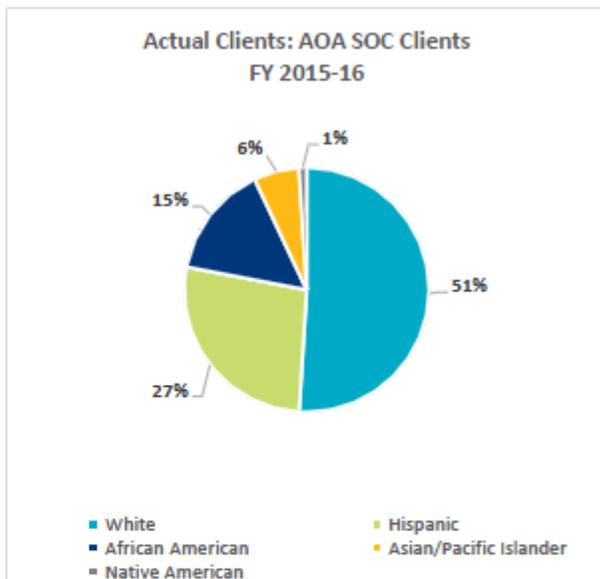
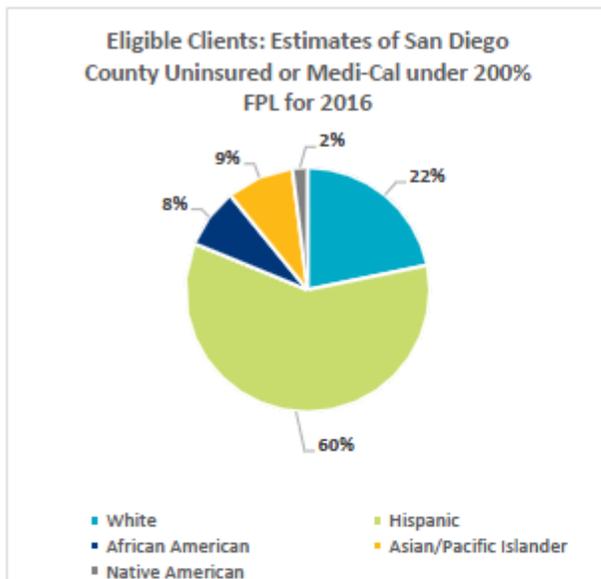


* Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (15,545 clients). An additional 1,756 (10%) were of Other or Unknown race/ethnicity.

Target population (eligible clients*) versus AOA SOC clients FY 2015-16

Race/Ethnicity**	Eligible Clients*		Actual Clients	
	San Diego County Uninsured or Medi-Cal under 200% FPL for 2016		AOA SOC Clients	
	Number	%	Number	%
White (non-Hispanic)	81,229	22%	18,227	51%
Hispanic	226,968	60%	9,671	27%
African American	28,845	8%	5,211	15%
Asian/Pacific Islander	32,872	9%	2,283	6%
Native American	7,454	2%	309	1%
Total Clients	377,368	100%	35,701	100%



* Estimates of target population (eligible clients) were derived from CHIS estimates applied against 2016 census population data estimates for San Diego County. Eligible clients were defined as San Diego County Uninsured or Medi-Cal under 200% federal poverty level (FPL) who could potentially have a serious mental illness.

** For purposes of the race/ethnicity analyses included in this report, only the five most prevalent race/ethnicity categories were reported (35,701 clients). An additional 7,104 (17%) were of Other or Unknown race/ethnicity.

Children 5 Years of Age and Younger:

- Were less likely than other age groups to receive 13 or more sessions.
- Were more likely to receive only one session, compared to clients ages 6-11, ages 12-17, and 18 and older.
- Had the lowest penetration rates across all three fiscal years, compared to other age groups.

Transition Age Youth ages 18-25:

- Had the lowest long-term engagement rates among AOA age groups.
- Were more likely than other age groups to use inpatient/emergency services or only use jail services.

Older Adults:

- Were more likely to receive outpatient services than inpatient or jail services.

- Had an increase in service utilization in FY 2015-16, compared to FY 2012-13.

African American Children and Youth:

- Had a steady decline in penetration rate from FY 2009-10 to FY 2015-16.
- Had a decrease in service utilization from FY 2009-10 to FY 2015-16.
- Had more frequent use of Juvenile Forensic Services (JFS) without receiving any outpatient services, compared to other groups.

African American Adults and Older Adults:

- Had the highest prevalence rates of schizophrenia and other psychotic disorders, compared to other racial/ethnic groups.
- Were more likely to receive services only in jail than other racial/ethnic groups.

The complete report is available in Appendix 1.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders provided feedback regarding disparities in the target populations for Medi-Cal, CCS, WET, and PEI priority populations in San Diego County. The community stated there is an expected increase in the homeless population, an overrepresentation of ethnic communities in the jail system, and an underrepresentation of certain ethnic communities in FSP ACT programs. In addition, there would be an increase in the overall SDCBHS population due to the addition of the East and South FSPs, the CYF enhancements, and the passing of Proposition 64. Lastly, SDCBHS works closely with the local refugee resettlement agencies and is aware that there is an expected influx of the Syrian population, the refugee population, and those who are seeking asylum.

With the community input received, the SDCBHS will focus on continuing to implement data driven decision making by utilizing reports such as the triennial *Progress Towards Reducing Disparities in Mental Health Services* scheduled to be released in October 2017. This report demonstrates the cultural representation of the individuals served by the type of program. In addition to utilizing reports, SDCBHS will enhance the Program-Level Databooks that are produced annually. These Databooks summarize program demographics and clinical outcomes by program. Assessing the outcomes of behavioral health services in valid and reliable ways is critical to the development, advancement, and maintenance of effective services.

Year 1 Achievements:

To address the influx of specific populations mentioned above, there has been improved collaboration and communication between SDCBHS and the ethnic community-based organizations (ECBOs) serving the refugee community. Additionally, BHETA has offered trainings that focuses on key topics including refugees, working with families experiencing homelessness, the TAY community, working with immigrants, and an e-learning on the East African immigrant community.

To further address the needs of the community, the SDCBHS added Farsi as one of the threshold languages for San Diego County services. In addition, as mentioned in Criterion 1, the SDCBHS

has contracted with Southern Indian Health Council, Inc. (SIHC) and Indian Health Council (IHC) effective June 2018 for an MHSAs Innovations program named Roaming Outpatient Access Mobile Services (ROAM). ROAM will provide and operate a mobile mental health clinic for Native American transition age youth, adults, and older adults residing on tribal reservations in the East and North Inland Regions. The project is designed to decrease behavioral health symptoms and improve level of functioning of participants, as well as, improve care coordination and access to physical health care.

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 MHSAs 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 MHSAs-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 MHSAs 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*  *combined for San Diego*

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 County administration has been working hand in hand with seven Medi-Cal approved health plans (Aetna Better Health, Care 1st Health Plan, Community Health Group, Health Net, Kaiser Permanente, Molina Healthcare, and United 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 Medi-Cal Managed Care Geographic Expansion process, two Medi-Cal Managed Care Health Plans recently joined San Diego County.

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. Furthermore, in April of 2018, County representatives attended the California Reducing Disparities Project to Advance Mental Health Equity Conference hosted by California Pan-Ethnic Health Network. The conference provided an opportunity for advocates, providers, consumers, and other community partners to collaborate and develop strategies for change.

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 157 CSS contracts 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, and approximately 17% 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 36 PEI contracts 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 six (6) 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders provided feedback regarding strategies for the CSS, WET, and PEI plans to reduce disparities. One suggested WET strategy was to develop a program similar to CADRE for cultural competency enhancement. CADRE San Diego has been training professionals to work with individuals with dual diagnoses (mental health and substance use disorders) for over a decade and there are now over 300 change agents. The ultimate goal of San Diego County CADRE is to help develop an entire system of care that is welcoming, recovery-oriented, integrated, trauma-informed, and culturally competent. In addition, CADRE seeks to most effectively meet the needs of individuals and families with multiple co-occurring conditions of all types. The community suggested developing a similar training program for SDCBHS mental health professionals, along with a mentorship program to focus on culturally competent services.

Regarding CSS strategies, it was suggested to continue the Project One For All (POFA) Initiative. As noted in Criterion 1 Section IV, POFA is an extensive effort by the County of San Diego and its partners to provide intensive wraparound services, including specialty mental health services and housing, to homeless individuals with serious mental illness. This effort uses a coordinated approach that includes a mechanism for County treatment resources to be matched with individuals in need and a method for cities, local housing authorities and non-profit organizations to pair with County resources. POFA is partnering with the Regional Continuum of Care Council, housing authorities, cities, and the private sector to establish housing region-wide for homeless individuals with serious mental illness by adding capacity for an additional 1,250 housing opportunities over the next two years.

A few recommended PEI strategies included developing a basic skills training for clients such as mindfulness training, and developing a behavioral health screening form specific to refugees and

immigrants to obtain additional background and history information when conducting outreach, prevention and early intervention activities. Another suggestion from the group was to develop training on how to address screening questions in a cultural competent way.

Another group of stakeholders met to discuss goals of the older adult population specifically. One recommended goal from this group was to identify what services are available to the older adult population, including access to those services and quality of service. Stakeholders also discussed creating an action or strategic plan to become one of the leading systems of care in the nation. Lastly, the group discussed the development of an integrated network or model. The exchange of information is in need of improvement to reduce psychiatric inpatient readmission rates and length of stay for the older adult population. An integrated network can focus on connection and quality of care.

With the community input received, the SDCBHS has prioritized continued collaboration with Aging and Independence Services (AIS) to review data and strategize effective interventions for the older adult population, taking into account the cultural factors such as isolation and increased needs for integrated care. SDCBHS has also committed to furthering discussions regarding the needs of the older adult population with Medi-Cal managed care partners in San Diego County in an effort to meet both behavioral health and medical care needs.

Year 1 Achievements:

As mentioned in Criterion 2, to address the needs of San Diego County’s older adult population, the SDCBHS is in the process of developing a Request for Proposals (RFPs) for residential behavioral health programs that will focus on psychosocial rehabilitative services. This RFP focuses on the development of an ACT program dedicated to step down services from long term care. The proposed start date for the programs is in January of 2019. Additionally, the SDCBHS has continued to fund provider training specific to serving the geriatric population.

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.

- **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 and 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 response to the national initiative, the SDCBHS has developed several adult and older adult programs that aim to reduce the number of people with a mental illness in jails. As part of the effort, the County has recently enhanced the Public Defender's Office with two clinicians to screen and refer individuals to the appropriate Behavioral Health programs and levels of care. Additionally, a Faith Based Innovations program was established in July 2016 in North County and Central regions. It aims to provide in-reach services in jails to clients in acute care or outpatient services in an effort to coordinate transitions and connection to Behavioral Health programs and social services. Furthermore, Project In-Reach was enhanced in October 2016 to address individuals in the psychiatric and step down units within the jail.
- 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. The Faith-Based Initiative was established in 2016 and primarily focuses on African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services. The programs 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. The Faith-Based Initiative is divided into four Task Orders that target specific needs identified within the faith-based community.

- **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 San Diego American Indian Health Center** 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 urban Native American 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.
- **Innovative Mobile Hoarding Intervention Program (IMHIP)** is funded through MHSAs Innovations and focuses on diminishing long-term hoarding behaviors among older adults through participation in a multi-faceted intervention, which combines an adapted cognitive behavior rehabilitation therapy with training and support. A key feature of this program is the use of peer support partners with prior lived experience receiving treatment for hoarding behaviors to provide support and encouragement to IMHIP participants. Additionally, IMHIP services are provided in the home of the participant, which is expected to facilitate participation in the program and provide opportunities for more direct service provision of the home environment. This intervention is expected to reduce hoarding behaviors and improve the participants'

overall quality of life. The program began providing services in April 2016 and was expanded to other regions in the fall, 2017.

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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The community stated that they felt the same strategies noted above in Section III of this Criterion can be applied to all programs, not limited to the MHSA funded programs.

For annual achievements, refer to Section III of this Criterion.

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 MHSAs 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 three time points (Fiscal Years 2009-10, 2012-13, and 2015-16), 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 or YSS for CYF clients and Mental Health Statistics Improvement Program or MHSIP 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 often 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, housing, 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 has been working with the software vendor (Cerner) to develop the Access to Services Journal Design document for Cerner Community Behavioral Health (CCBH) in an effort to better assess the timeliness of access to services across San Diego County. The Access to Services Journal was implemented in October, 2017 allowing for a more efficient workflow for the clinicians and a more meaningful way of data interpretation.
- 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.
 - Reviews the Cultural Competence Staffing and Training reports 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

When discussing strategies for reducing the disparities in current CSS, WET, and PEI plans, the community suggested reviewing the PEI survey questions San Diego implemented when PEI programs were first developed. The four standard PEI program survey questions are the following: 1) Overall, satisfied with services received, 2) Better able to handle things, 3) More comfortable seeking help, and 4) Know where to get help when need it. It was suggested to revise the questions to ask more specific questions.

As noted in Criterion 1 Section 1, providers stated that the current cultural competency evaluation tools required of programs and staff, the CC-PAS and CBMCS, did not completely reflect the program's cultural competence. In looking at identified strategies and actions, SDCBHS discussed replacing the current required tools with new ones in an effort to better reflect the CLAS standards that are outlined as a requirement in all BHS provider contracts.

With the community input received, SDCBHS will focus on the implementation of new cultural competency evaluation tools. As noted in Criterion 1 Section 1, The Promoting Cultural Diversity and Cultural Competency Self-Assessment was selected by the Cultural Competence Resource Team to replace the CBMCS, which will be administered to all staff every two years. The assessment is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. The Cultural and Linguistic Competence Policy Assessment (CLCPA) was selected to replace the CC-PAS, which will be administered annually to all programs. The CLCPA is intended to support programs to improve access and utilization, enhance the quality of services within culturally diverse and underserved communities, and promote cultural and linguistic competence, as essential approaches in the elimination of health disparities.

Year 1 Achievements:

As mentioned in Criterion 2, the SDCBHS is working with providers to rate their own agency's cultural competence through the CLCPA. The CLCPA was implemented and administered in October of 2017 as a replacement to the CC-PAS. The SDCBHS Quality Improvement (QI) Unit requested that each contracted Mental Health Services (MHS) and Substance Use Disorder (SUD) Services Program Manager complete the assessment. The Program Managers were asked to identify the main cultural groups that their program serves predominantly so they could refer to them as they completed the survey. They also had the opportunity to request technical assistance with becoming familiar with the items in each of the eight sections: Knowledge of Diverse Communities; Organizational Philosophy; Personal Involvement in Diverse

Communities; Resources and Linkages; Human Resources; Language and Interpretation Services Access; and Engagement of Diverse Communities.

Staff competence can also be measured by a biennial administration of the Promoting Cultural Diversity Self-Assessment (PCDSA), a replacement to the CBMCS. PCDSA was implemented and administered in February of 2018, and its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement over time as they learn about various cultural groups via available training opportunities.

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 #5946 (Cultural Competence Resource Team, see Appendix 8) establishes the BHS Cultural Competence Resource Team (CCRT) to advise the Deputy Directors of CYF and A/OA Systems of Care on issues of cultural competence. 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.

The CCRT is an advisory board operating at the behest of the Behavioral Health Services (BHS) 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 for one and a half hours on the first Friday of each 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 CCRT'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 BHS Director. Inactive membership and Honorary members can be designated by the CCRT Chairperson and the BHS Director.

- C. Candidates can become active members in one of three ways:
 - i. Direct appointment by the BHS Director;
 - 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 the SDCBHS 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 both 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, announcements, and newsletters.

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

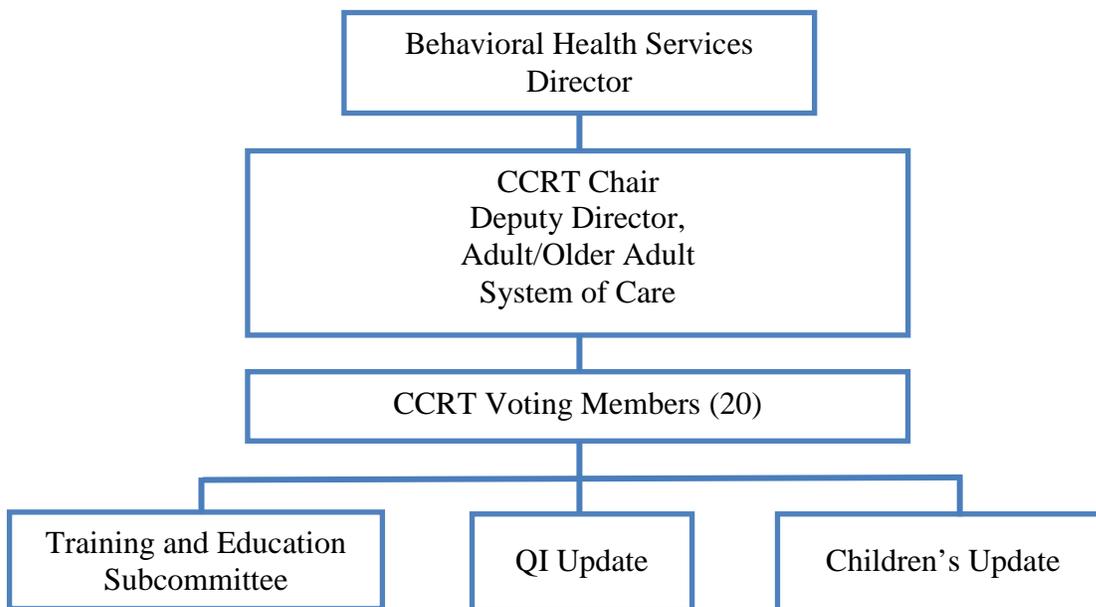
B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including County management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other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

Policy #5946 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, SDCBHS Quality Improvement Unit, the Clinical Staff Association, the Mental Health Contractors Association, and the BHAB will be requested to be appointees.

C. Organizational chart

Cultural Competence Resource Team (CCRT)



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

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

Member	Organization
Akwanya, Awichu	United Women of East Africa
Alami, Mahvash	Survivors of Torture, International
Altamirano, Leon	North County Health Services
Andrews, Laura	Mental Health America
Baker, Patrice	Harmonious Solutions
Barnett, Elisa	Behavioral Health Education and Training Academy (BHETA)
Camarena, Juan	San Diego State University (SDSU)
Clark Manson, Minola	BHETA
Galapon, Dixie	Family Health Centers of San Diego
Garcia, Piedad	BHS - A/OA SOC
Haddad, Shadi	San Ysidro Health Clinic - Chaldean Middle Eastern Social Services (CMSS)
Hagos, Susan	The Nile Sisters Development
Harris, Karen	The Knowledge Center (TKC)
Heller, Rick	HSRC
Hunter, Celeste	CASRC
Katsanis-Semel, Kat	Mental Health America
Ly, Michelle	Union of Pan Asian Communities (UPAC)
McAleer, Nicole	TKC
Miles, Liz	BHS - QI
Mohamed, Jama	United Women of East Africa
Mohler, Edith	BHS - CYF SOC
Pizarro, Leo	National Alliance Mental Illness (NAMI) - CYF Liaison
Ramos, Nilanie	BHS - CDO
Rodriguez, Nancy	County Case Management
Santos, Jennifer	BHS - CDO
Valencia, Dalila	Recovery Innovations (RI) International
Vilmenay, Ann	BHS - AOA SOC
White-Voth, Charity	BHS - AOA SOC
Young, Jessica	Neighborhood House Association - Project Enable (TAY)

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The community provided feedback on the organizational structure, functions, and role of the Cultural Competence Committee known as the Cultural Competence Resource Team (CCRT). It was recommended that representation of the CCRT be present at other System of Care Council meetings, as well as have program managers attend CCRT meetings. With these potential changes it is agreed that the guiding principles of CCRT can aid in executive decision-making. With the community input received, the SDCBHS will ensure continued diversity on the CCRT to accurately represent the community served. In addition, efforts will be made to ensure CCRT members who sit in other councils, community meetings and stakeholder events relay information from the CCRT in their capacity.

Year 1 Achievements:

The CCRT led program and organizational related efforts throughout FY 2017-18. Efforts include the following: explored and implemented a cultural competent curriculum with PERT Director; the CCRT Chair and other County representatives met with East African and Refugee communities multiple times to gather input on service needs and gaps; reached out to special and/or hard-to-reach populations at BHS MHSA Community Forums to gather input; and provided recommendations to Behavioral Health Education Training Academy (BHETA) on potential webinars, e-Learnings and classes.

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 #5946 (Cultural Competence Resource Team) and Policy #5994 (Culturally and Linguistically Competent Services: Assuring Access and Availability) demonstrate that the CCRT is integrated within the Behavioral Health System through the charges and activities outlined in the Appendix 9.

The charge of the CCRT is to serve as the “eyes, ears and conscience” of the SDCBHS system regarding the development of cultural competence in the delivery of behavioral health services to culturally diverse populations and systemwide adherence to the local Cultural Competence Plan. The CCRT is a formal mechanism for providing to both organizational and contracted individual providers input and feedback on cultural competence (#5946). Members provide such input collectively and bring the message of the CCRT to the community organizations, committees, councils, and advisory boards to which they belong.

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 in effort to provide context on proposed changes and issues facing the SDCBHS for CCRT members.

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; and other pertinent topics.

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, including staff linguistic and cultural proficiency, participation in cultural competence trainings, and consumer satisfaction survey results.
- CCRT has been participating in the developing of the three-year strategic plan for the Cultural Competence Plan.
- 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 to review its current ethnic/racial and cultural composition and considers strategies 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 CCRT reviewed and provided input on the 2017 Cultural Competence Plan and a Three-Year Strategic Plan.
- The CCRT played a vital role in providing input, reviewing, and approving the new Cultural Competence assessment tools.
- The CCRT reviewed and provided input on the Cultural Competence Handbook, including a recommendation to make the Survey for Clients to Assess Program's Cultural Competence more client-friendly and comprehensive.
- Updated the Cultural Competence Handbook to reflect changes in the existing tools. The CCRT also provided feedback to the CYF SOC Council on the Guiding Principles.
- The CCRT participated in the 2018 External Quality 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 Chair and other County representatives met with the East African and Refugee communities to gather input on service needs and gaps.
- The CCRT identified a need for a comprehensive list of resources for the providers to learn about various cultural groups and worked to update the list.

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. Chief of 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.

Additionally, Quality Improvement is a standing item on the monthly CCRT agenda, and the following topics are discussed: organizational and individual cultural competence evaluation tools; SDCBHS Annual Databook; outcomes reports; Annual EQR; Cerner Community Behavioral Health (CCBH) EHR System training; the implementation of the Medicaid Managed Care Final Rule (Mega Regs); and other topics.

CCRT members informally report on updates and pertinent information gathered at various Councils, meetings and conferences they attend, thus enhancing the CCRT's and QI Unit's knowledge of the community. CCRT members are given an opportunity to share handouts from other meetings as well as 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 Reference #5994).

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 evidence-based practices (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 the needs of ethnically diverse clients are met by the BHS system.

The CCRT has also participated in ongoing input and review of the development and implementation of all phases of the MHSA Plans, and 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 ethnically, racially, and culturally diverse populations. 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 was carried into multiple phases of the MHSA process, through member participation on the CYF, A/OA, Older Adult, and Housing Councils, TAY Council, and other stakeholder and work groups. In 2014, the CCRT, through its members and through its Ethnic Services Coordinator, participated in the review of the State's CRDP recommendations for the five target populations and proceeded to make recommendations of which programs would align

with the local culture and community needs. Furthermore, they have worked to engage community leaders, mental health providers, and clients to provide feedback and recommendations for culturally and linguistically specific programs to address underserved populations. There have been multiple programs developed to include culturally and linguistically specific services, specifically addressing the five target populations, which align with the local culture and community needs. The following programs address adult and older adult clients demonstrating community outreach, engagement, and involvement efforts with the five identified racial, ethnic, cultural, and linguistic communities (Latino, African American, API, LGBTQ, and Native American). While there was a focus on the five target populations, SDCBHS is mindful of San Diego's diversity, specifically with immigrant and refugee communities, and have included programming outside of the five target populations: Project In-Reach, Breaking Down Barriers, the Fotonovela Project, clubhouses, Bio-Psychosocial Rehabilitation (BPSR) Wellness Recovery Centers (WRC), Outpatient Services for Deaf and Hard of Hearing, Survivors of Torture, International (SOTI), Innovative Mobile Hoarding Intervention Program (IMHIP), Our Safe Place, Roaming Outpatient Access Mobile (ROAM), and two Behavioral Health Services (BHS) and Faith Based Community Dialogue Planning Groups. In addition to the programs mentioned above focusing on the five target populations, SDCBHS has also been responsive to the needs of the East African refugee community, which has increased in population within San Diego County. SDCBHS has augmented the contract with the United Women of East Africa to provide greater support and access for the community in regards to mental health treatment and prevention services.

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 QI Chief, who can directly relay recommendations from the CCRT to the BHS Director.

The CCRT works with the QI Unit 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 Reference #5946).

5. Participates in and reviews County MHSa planning process.

The CCRT provided input during 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

CYF, A/OA, and Older Adult Councils. Additionally, the views of the CCRT are also reflected by the Ethnic Services Coordinator, ADDs and the QI Unit in all Executive planning committees.

6. Participates in and reviews County MHSa stakeholder process;

As discussed above, the CCRT 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 CYF, A/OA, Older Adult, and Housing Councils, the TAY Workgroup, and other meetings.

On the Committee level, the CCRT Education and Training Sub-Committee provided input on education and training needs for culturally and linguistically diverse populations.

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 an 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 and run programs. Members of two leading client/ family operated agencies—Recovery Innovations International and NAMI serve on the CCRT, bringing their unique expertise to all discussions. Additional representatives from UPAC, Southern Indian Health Council, Mental Health America, Deaf Community Services, the Research Centers, 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 DHCS, as can be seen in Policy #5946, included in the Appendix 8.

In 2015, the CCRT participated in the revision of the CCPR (2015), devoting time in each meeting to give input, feedback, and final review of portions of the CCPR, as they became available.

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, including but not limited to:

- 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 in 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?*
 - a. If yes, explain why the county considers them successful.*
 - b. If no, what are the next steps?*
- iii. Reviews and recommendations to County programs and services;*
- iv. Goals of cultural competence plans;*
- v. Human Resources report;*
- vi. County organizational assessment;*
- vii. Training plans; and*
- viii. Other County activities, as necessary*

- i. The 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. The CCRT continues to set new goals and objectives as they relate to enhancing the services to be culturally and linguistically appropriate, and trauma informed. The 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: providing input to the QI team on the Three-Year Strategic Cultural Competence Plan; reviewing and implementing new cultural competence assessment tools in the BHS system; and updating the Cultural Competence Handbook.
- 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 the CCRT.
- iv. The Training and Education Sub-Committee met monthly throughout FY 2017-18 to identify, review, and implement new cultural competence assessment tools, in effort to align with the BHS system, its priorities, and populations served.
- 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 2016 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 developed a triennial *Progress Towards Reducing Disparities in Mental Health Services* report that covered three time points (Fiscal Years 2009-10, 2012-13, and 2015-16). 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. In FY 2017-18, representatives from the Research Centers presented key findings from the report at one of the CCRT meetings. Additionally, CCRT leveraged the 2016 Workforce Assessment to assist the committee with developing specific strategies that focus on developing a culturally competent workforce. The Disparities Report is continuously referenced as new goals and strategies are discussed and developed at monthly CCRT meetings.
 - 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 2017-18 included such topics like: cultural competence, integrating faith-based communities, and working with hard-to-engage populations, especially the criminal justice involved population.
 - x. For other activities discussed at CCRT, please see the meeting minutes in Appendix 10.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders provided feedback on the policies, procedures, and practices of the Cultural Competence Resource Team. They recommended as part of the new hire orientation, new SDCBHS employees attend, at minimum, one CCRT meeting. Additionally, it was suggested to have a connection with Contracting Officer’s Representatives (CORs) on an ongoing basis to continually monitor contracted programs’ cultural competence as well as to receive feedback and updates from CORs regularly. Also, cultural competence was recommended to be one standing agenda item at all System of Care Council meetings. Lastly, recommended practices included COR presentations of programs and how cultural competence is implemented, reviewing training contracts and monitoring cultural competence outcomes.

With the community input received, the SDCBHS will focus on enhancing COR training in monitoring for cultural competency. Within the Cultural Competence Strategic Plan, efforts will be made to identify training opportunities for all CORs to assist them with the monitoring of

cultural competence. In addition, Quality Improvement will continue to review the cultural competence policies to ensure the alignment with the program cultural competency requirements.

Year 1 Achievements:

As mentioned above, the CCRT led program and organizational related efforts throughout FY 2017-18. The CCRT explored and implemented a cultural competent curriculum with PERT, which included working with the PERT Director on integrating cultural competence in PERT trainings and PERT team members participation in community engagement groups. There was also an East African refugee community panel at their 3-day PERT Academies, and the PERT Director has been participating in their community leadership groups as well.

The SDCBHS is working with providers to rate their own agency's cultural competence through the Cultural and Linguistic Competence Policy Assessment (CLCPA). The assessment was implemented in October of 2017 as a replacement to the Cultural Competence Program Annual Self-Evaluation (CC-PAS). The assessment's goals are to: enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to eliminate disparities. 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 Promoting Cultural Diversity Self-Assessment (PCDSA), a replacement to the California Brief Multicultural Competence Scale (CBMCS). PCDSA was implemented in 2018, and its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The CLCPA is completed by the program managers, and the PCDSA is completed by all staff.

Additionally, the SDCBHS continues to encourage new SDCBHS employees to attend, at minimum, one CCRT meeting.

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 and for County operated facilities.

- 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 Clinical Directors Office track completion of the required four hours of training on a regular basis (see page 106 for the complete report).

To ensure continued compliance, a three-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 the County of San Diego HHSA's training unit, The Knowledge Center (TKC).

Cultural Competence Trainings Offered by The Knowledge Center:

FY 2013-14

- 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

FY 2014-15

- 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 Health Care Interpreters

FY 2015-16

- LGBTQI Population
- Filipino American Population
- Disability Etiquette
- Deaf and Hard of Hearing Culture

FY 2016-17

- Diversity & Inclusion
- Middle Eastern & East African Cultures
- Multiple Generations in the Work Place
- Microaggressions
- African American Culture
- Native American Culture
- The Role of Migration on the Identity of Latina Women
- Self Awareness and Implicit Bias
- Poverty
- Gender Identity and Sexual Behavior
- Disability Awareness and Etiquette

FY 2017-18

- Diversity & Inclusion
- Cultural Competency Overview
- Middle Eastern & East African Cultures
- African American Culture
- Native American Culture
- Middle Eastern Culture
- Filipino-Americans and Mental Health
- Gender Differences in the Workplace
- Understanding Diversity in Homelessness
- Engaging Multiple Generations in the Workplace
- Working with Hispanic/Latino Older Adults
- Disability Awareness Training
- Cross Cultural Encounters Bridging Worlds of Difference
- Microaggressions

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 competence 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 that 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 competence trainings to County and contracted BHS staff. BHETA offers instructor-led classroom trainings and e-learning courses. In November 2014, 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. In FY 2016-17, BHETA collaborated with subject matter experts from SDCBHS and San Diego State University (SDSU) to develop an e-learning on CLAS Standards. Additional information on specific trainings provided by BHETA and the Geriatric Education Center—a program within the Academy for Professional Excellence—is included in Appendices 11 and 12. In May of 2018, BHETA updated its three-hour e-learning on cultural competence. The "Cultural Competence as a Process" e-learning meets two-and-a-half hours of the annual requirement. This e-learning provides an introduction to cultural competence and resiliency in behavioral health, an overview of culture, introduces a method of self-assessment, including the use of cultural assessment in treatment.

Third Prong: WET Workforce Building Activities

The goal of the WET Plan has been to build an education and training framework or infrastructure that supports growing and maintaining a public behavioral health workforce consistent with the MHSA and WET fundamental concepts. A second goal is to ensure a 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 the County of San Diego's public behavioral health workforce. The training modules outlined support the core competencies for the public behavioral 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. In accordance with this consideration, training has been aligned with targeted population groups to include Early Childhood, Youth, Transition Age Youth, Adults, and Older Adults, as well as culturally, linguistically, and ethnically diverse communities.

Public Behavioral Health Training: 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 behavioral health workforce. The training programs are intended to be collaborative and community-based. It focuses on two distinct, but related, pathway tracks that lead to certification, skill development, and employment in the public behavioral health workforce.

- 1) Public Mental Health Academy 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 which 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 entry-level personnel already working in the field.
- 2) Peer Specialist Training programs have been implemented to assist consumers and family members to become members of the public behavioral health workforce. These programs include: Peer to Peer Recovery Education; Peer Specialist Training; and Peer Advocacy Training. A local university partners with various organizations that provide these trainings, which has facilitated the translation of six existing certificate programs into academic credits. In addition, this partnership provides mentoring and other support to assist individuals in achieving their educational and employment goals.

Both pathways have been designed to create an avenue for professionals with lived experience to deliver services based on the principles of recovery, wellness, and consumer and family involvement.

Community Psychiatry Training Tracks: The SDCBHS has partnered with a local School of Medicine/Department of Psychiatry to include training programs for general community psychiatry residents and psychiatric and mental health nurse practitioners for child and adolescent psychiatry. The program fosters the development of leaders in Community Psychiatry, and provided medical and nursing students and psychiatry residents with instruction on principles of Community Psychiatry and exposure to the unique challenges and opportunities within this context. Community Psychiatry fellows, residents and nurse practitioners work with the County of San Diego’s public behavioral health system to gain clinical, administrative, managerial, leadership and policy exposure.

Psychiatric Nursing Training: The SDCBHS has partnered with local clinical psychologists to support the psychiatric nurses staffed at San Diego County Psychiatric Hospital (SDCPH). The purpose of these training tracks is to enhance knowledge of psychiatric treatments and diagnoses for nursing staff at SDCPH with the following:

1. This training program focuses on psychological disorders. The goal of the program is to train up to 100 nursing staff by providing four separate training cohorts, each over a

seven-week period. Each class addresses up to two topics, including diagnostic criteria, facts, formal treatment modalities, nursing staff intervention and practice vignettes. This program was provided from July 2017 through June 2018.

2. The goal of this program is to train up to 120 nursing staff addressing treatment of forensic patients separated into two teams. The training topics include: criminal behavior; connections and conclusions of mental illness; substance abuse violent offenders- violence risk and threat factors; why Forensic patients are in the hospitals, security/safety issues; acknowledging fear and how to use it within the hospital and community. This program was provided from March 2018 through June 2018.

Training and Development Forums; Commitment to Growing a Multicultural Workforce: The SDCBHS is committed to assist all behavioral health providers and professionals who serve San Diego communities and their members through educational and training forums from trained and qualified presenters/providers. These include the following:

1. *BHS Workforce Collaborative:* Through the BHS Workforce Collaborative, a presentation on community inclusion and integration within the public behavioral health workforce was delivered to County of San Diego's behavioral health stakeholders. The presenter spoke about community integration and how it closely ties with the workforce collaborative's mission. The mission of Behavioral Health Workforce Collaborative is to build, enhance and sustain a strong, culturally competent client/family member unit.
2. *Behavioral Health/Justice Services Forum:* Presentation at the BHS and Justice Services Forum provided current trends in collaborative efforts. This forum supported the County of San Diego's HHS and Public Safety Group and its commitment to partner with Community providers to increase understanding of client needs and provide training on evidence based practices for programs serving the justice involved population.

Cultural Competence Academy (CCA)

Through 2016, the CCA has successfully completed three cohorts and offered trainings focused on Native American, African American, Latino and LGBTQ populations to 262 staff. Of these participants, 112 have graduated having and completed the year-long training and practicum. The contract terminated on October 31, 2016. The CCA has been reprocured and is expected to be implemented in FY 2018-19.

- | |
|---|
| <ol style="list-style-type: none">3. <i>How cultural competence has been embedded into all trainings.</i> |
|---|

All trainings provided through the SDCBHS are required to have a cultural competence component. These trainings are conducted by BHETA, QI Unit, HHS, TKC, 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 BHS 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders had a discussion at a CCRT meeting that focused on SDCBHS’ annual cultural competence training requirement. It was recommended to research and identify specific topics for different levels for staff, such as having a specific training track depending on job classification. Additionally, another recommendation was providing one training course on multiple aspects of cultural competence. Previously, the County of San Diego contracted with BHETA (Behavioral Health Education and Training Academy) to offer a Cultural Competency Academy (CCA). The CCA provided extensive training on a multitude of diverse groups, focusing on one population per training series. Expanding the course to encompass multiple diverse populations within the same series may encourage more participants to attend. Lastly, it was suggested that SDCBHS expand the number of community representatives who assist in developing the cultural competence trainings made available to staff.

With the community input received, the SDCBHS will focus on the continued monitoring of the four hour required cultural competence training each year. As noted above, the County has contracted with a training provider, BHETA that offers free clinical, administrative, and cultural competency trainings to County and contracted BHS staff. SDCBHS will work with BHETA to review available cultural competence courses and consider the community representatives who participate in their training planning activities to determine if any changes/additions should be made as part of the SDCBHS CC strategic plan.

Year 1 Achievements:

As mentioned above, the CCA has successfully completed three cohorts in 2016 and offered trainings focused on Native American, African American, Latino and LGBTQ populations, which consist of year-long trainings and a practicum. The contract for CCA terminated on October 31, 2016. SDCBHS has reprocured the contract, and it is expected to be implemented in FY 2018-19. BHETA has also offered new trainings to focus on the needs of the community. The trainings included: East African Communities eLearning, Family Compassion for LGBTQIA, Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County, and Engaging the Refugee Community.

The Family Compassion for LGBTQIA workshop was intended to support professionals in their work with families to better understand how to support individuals who are dealing with sexual orientation and/or gender identity. Clarifying terminology, understanding risk factors and identifying resources were some of the topic areas discussed in the workshop.

Considering the highly diverse demographics in San Diego County, the County's designation as one of the nation's top refugee resettlement zones, and the proximity to the U.S./Mexico border (the largest point-of-entry for asylum seekers in the nation), service providers in San Diego encounter individuals from diverse backgrounds and countries of origin who require specialized and culturally-sensitive services. BHETA offered "Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County", a half-day training, that provided definitions, demographics, background information, and suggestions for working with and engaging the immigrant community. Training participants received education, information, insight, and suggestions for engaging the immigrant community, providing culturally responsive services, and practicing Trauma-Informed Care.

BHETA also hosted a half-day informational and interactive training, "Engaging the Refugee Community", which provided participants with an orientation to the term refugee and a deeper understanding into the journey of those currently coming to the U.S. and why they are making the journey. The presenters shared examples of challenges and successes they've experienced while working with and engaging the refugee community in the City Heights area of San Diego. Additionally, refugee parents and youth shared their personal stories of leaving one's homeland and coming to San Diego. The training offered lessons learned, key insights, and responsive strategies for participants to utilize in their own work with the refugee community.

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. The FY 2016-17 report is available on page 106 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. Starting in October of 2018, the SDCBHS will require contractors to report on trainings attended by staff through a report template as an attachment to the annual CLCPA.

- 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, LGBTQI, 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 (BHETA)

Instructor-led and E-Learning Training Topics Provided by BHETA in FY 2017-18	Number of Participants/Trainees
Introduction to Geriatric Mental Health Series	15
Advanced Geriatric Mental Health Series	17
East African Communities	<i>To be offered in June 2018</i>
Family Compassion for LGBTQIA	31
Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County	28
Unpacking Hope: Understanding the Unique Needs of Children, Youth and Families Experiencing Homelessness – Conference (<i>through CYS SOC Training Academy</i>)	214
CLAS Standards eLearning	190
Cultural Competence as a Process eLearning	604
Introduction of African American Populations eLearning	199
Introduction to Latino Populations eLearning	268
Introduction to LGBTIQ Populations eLearning	114
Introduction to Native American Populations eLearning	90
Senior Veterans eLearning	45

Cultural Competence Academy (CCA)

Since inception, the CCA has successfully completed three cohorts and offered the training to 262 staff. Of these participants, 112 have graduated having and completed the year-long training and practicum. In FY 2015-16, CCA offered the Native American and African American tracks with 35 staff in attendance. Although, the program terminated in October of 2016, SDCBHS reprocurd the contract and the program is expected to be implemented in FY 2018-19.

The Knowledge Center

The Knowledge Center has offered the following cultural competence classes over a span of six fiscal years:

FY 2011-12				
Title	Hours	CEUs	Enrolled	Completed
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				
Title	Hours	CEUs	Enrolled	Completed
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				
Title	Hours	CEUs	Enrolled	Completed
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	<i>Not available</i>	16
Disability Etiquette	4	4	25	22
African-American Populations	4	4	34	28
FY 2014-15				
Title	Hours	CEUs	Enrolled	Completed
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				
Title	Hours	CEUs	Enrolled	Completed
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	<i>Not available</i>	<i>Not available</i>
Sexual Orientation and Gender Assessment	4	4	<i>Not available</i>	<i>Not available</i>
FY 2016-17				
Title	Hours	CEUs	Enrolled	Completed
Diversity & Inclusion Training	2	2	17	17
Middle Eastern & East African Cultures	4	4	31	31
Diversity and Inclusion at the County of San Diego	2.5	2.5	18	18
An Overview of Middle Eastern Culture (offered twice, 4 hours each)	4	4	29	29
Multiple Generations in the Work Place (offered twice, 4 hours each)	4	0	34	34
Microaggressions	4	4	34	34
Gender Differences in the Workplace	4	4	32	32
Introduction to African American Culture	4	4	34	34
Person Centered Care Planning and Case Management	4	4	21	21

Cultural Competency Overview	4	0	24	24
Introduction to Native American Culture	4	4	28	28
The Role of Migration on the Identity of Latina Women	4	4	24	24
Healing the Healer	6	6	39	39
Self Awareness and Implicit Bias	7	7	<i>Not available</i>	<i>Not available</i>
Gender Identity and Sexual Behavior Assessment: Best Practices for all Orientations	4	4	<i>Not available</i>	<i>Not available</i>
Disability Awareness and Etiquette	4	0	<i>Not available</i>	<i>Not available</i>
A Look at Poverty	4	4	<i>Not available</i>	<i>Not available</i>
FY 2017-18				
Title	Hours	CEUs	Enrolled	Completed
Introduction to Diversity and Inclusion	2	0	30	30
Cultural Competency Overview	4	0	18	18
African American Culture	4	4	21	21
Middle Eastern & East African Cultures	4	4	23	23
Native American Culture	4	4	32	32
An Overview of Middle Eastern Culture	4	4	36	36
Filipino-Americans and Mental Health	4	4	30	30
Gender Differences in the Workplace	4	0	26	26
Understanding Diversity in Homelessness	4	0	37	37
Disability Awareness Training	3	0	21	21
Engaging Multiple Generations in the Workplace	4	0	27	27
Working with Hispanic/Latino Older Adults	5	5	17	17

Cross Cultural Encounters Bridging Worlds of Difference	7	6	21	21
Microaggressions	4	4	30	30

FY 2016-17 Staff Cultural Competence Training

Category	% Completed CC Training in FY 2015-16	% Completed CC Training in FY 2016-17	Change
Unlicensed Mental Health Direct Services Staff	90.22%	89.79%	-0.43%
Licensed Mental Health Direct Services Staff	94.95%	90.18%	-4.77%
Other Health Care Staff	81.66%	84.57%	2.91%
Managerial/Supervisory Staff	93.95%	80.54%	-13.41%
Support Staff	88.63%	83.82%	-4.81%
TOTAL AVERAGE	89.88%	85.78%	-4.10%

Fiscal Year	Category	CYF MHS Programs			
	MHS	Total FTE	Total Unduplicated Individuals	# Completed Training	% Completed Training
2016-17	Unlicensed Mental Health Direct Services Staff	440.47	521	473	90.79%
	Licensed Mental Health Direct Services Staff	80.27	95	83	87.37%
	Other Health Care Staff	31.63	49	48	97.96%
	Managerial/Supervisory Staff	99.41	182	158	86.81%
	Support Staff	73.57	139	110	79.14%
Total	2,418	725.35	986.00	872.00	88.44%

Fiscal Year	Category	A/OA MHS Programs			
	MHS	Total FTE	Total Unduplicated Individuals	# Completed Training	% Completed Training
2016-17	Unlicensed Mental Health Direct Services Staff	481.12	649	576	88.75%
	Licensed Mental Health Direct Services Staff	88.30	129	119	92.25%
	Other Health Care Staff	70.40	113	90	79.65%
	Managerial/Supervisory Staff	152.56	262	198	75.57%
	Support Staff	85.55	131	117	89.31%
Total	2,418	877.92	1,284.00	1,100.00	85.67%

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The community had a discussion in one of the CCRT meetings on the SDCBHS' annual cultural competence training requirement. It was recommended to ensure that trainings were in alignment with the County's Diversity and Inclusion Initiative. Diversity and Inclusion (D&I) is the County's long-standing commitment to diversity and inclusion that is reflected in the County's Strategic Initiative of Operational Excellence as well as the values of Integrity, Stewardship and a Commitment to Excellence. The D&I mission is to continually seek ways to create an inclusive

culture that embraces diversity so employees feel valued and fully engaged to support a workplace and community that is safe, healthy and thriving.

Another recommendation was to review the diversity of each region and research ways to include programs that address the emerging populations. As noted in Criterion 4, the CCA training series were dedicated to specific populations. It was again suggested to have a training track that consisted of multiple populations to enhance staff's cultural competence, instead of having one track focusing on one population. Partnering with the community and ensuring community representation is present during the development of the training tracks was also discussed as essential components to identifying disparities to address. Overall, it was recommended that SDCBHS continue to examine data and reports, such as the "Progress Towards Reducing Disparities in Mental Health Services" triennial report, through a cultural competence lens.

With the community input received, the SDCBHS will focus on continuing to implement data driven decision making by utilizing reports such as the triennial "Progress Towards Reducing Disparities in Mental Health Services" scheduled to be released in October 2017. As noted in Criterion 3 Section II, this report demonstrates the cultural representation of the individuals served by the type of program. In addition, as noted above, SDCBHS will work with BHETA to review available cultural competence courses and consider suggested training criteria.

Year 1 Achievements:

As mentioned above, the CCA has successfully completed three cohorts in 2016 and offered trainings focused on Native American, African American, Latino and LGBTQ populations, which consist of year-long trainings and a practicum. The contract for CCA terminated on October 31, 2016. SDCBHS has reprocurd the contract, and it is expected to be implemented in FY 2018-19. BHETA has also offered new trainings to focus on the needs of the community. The trainings included: East African Communities eLearning, Family Compassion for LGBTQIA, Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County, and Engaging the Refugee Community.

As mentioned in Criterion 2, the SDCBHS transitioned the Transition Age Youth (TAY) workgroup into a Council to prioritize the TAY population. Additionally, a TAY Training Academy was implemented through BHETA, which offers trainings on TAY specific treatment modalities and best practices. The "Working with Transition Age Youth" series was designed to offer TAY service providers with the unique skills and practice needed to effectively work with the TAY population. This training series focused on the specific developmental and transitional supports required to assist TAY individuals to transition into adulthood, by addressing behavioral health needs. Participants had the opportunity to work directly with TAY peers during this training series.

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 health care professionals should receive training in cross-cultural communication—or cultural competence—as one of multiple strategies for addressing racial/ethnic disparities in health care. This recommendation emerged from robust evidence highlighting the fact of health care 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 (BHSTEC) have been working together to create coursework curricula to address disparities as outlined in the Cultural Competence Training Plan.

Need: In FY 2015-16, approximately 65% 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, 2013, and 2016. 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 in 2013 and a recent assessment conducted in 2016.

Race/ Ethnicity	2013 Workforce	FY 2012-13 Mental Health Clients	2016 Workforce	FY 2015-16 Mental Health Clients	2016 Comparison*	Change from 2013 to 2016
<i>White</i>	41%	39%	37%	36%	+ 1%	- 4%
<i>Hispanic</i>	25%	33%	28%	32%	- 4%	+ 3%
<i>African American</i>	11%	12%	8%	11%	- 3%	- 3%
<i>Asian/ Pacific Islander</i>	10%	4%	10%	5%	+ 5%	0%
<i>Native American</i>	0.9%	0.6%	0.5%	0.6%	- 0.1%	- 0.4%
<i>Other/ Unknown</i>	12%	10%	16%	15%	+ 1%	+ 4%
* +/- indicates that a race/ethnicity is more/less represented in the workforce than the proportion of clients in the mental health system.						

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. TKC and BHETA utilize pre/post-tests routinely for cultural competency courses. CRF, MHS, and New Alternatives provide their own cultural competence trainings for their staff.

3. Summary report of evaluations; and

Since almost 1,000 trainings (both web- and classroom-based) took place throughout San Diego 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: TKC retains the evaluation data on all cultural competence 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 and Linguistic Competence Policy Assessment (CLCPA). The assessment was implemented in October of 2017 as a replacement to the Cultural Competence Program Annual Self-Evaluation (CC-PAS). The assessment’s goals are to: enhance the quality of services within culturally diverse and underserved communities; promote cultural and linguistic competence; improve health care access and utilization; and assist programs with developing strategies to

eliminate disparities. 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 Promoting Cultural Diversity Self-Assessment (PCDSA), a replacement to the California Brief Multicultural Competence Scale (CBMCS). PCDSA was implemented in 2018, and its goal is to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The CLCPA is completed by the program managers, and the PCDSA is completed by all staff.

2017 CLCPA Report

In October 2017, the SDCBHS QI Unit requested that each contracted Mental Health Services (MHS) and Substance Use Disorder (SUD) Services Program Manager complete the assessment. The Program Managers were asked to identify main cultural groups that their program serves predominantly so they could refer to them as they completed the survey. They also had the opportunity to request technical assistance with becoming familiar with the items in each of the eight sections: Knowledge of Diverse Communities; Organizational Philosophy; Personal Involvement in Diverse Communities; Resources and Linkages; Human Resources; Language and Interpretation Services Access; and Engagement of Diverse Communities. A total of 193 programs completed the survey: 141 (73.1%) MHS and 52 (26.9%) SUD programs.

The results show that:

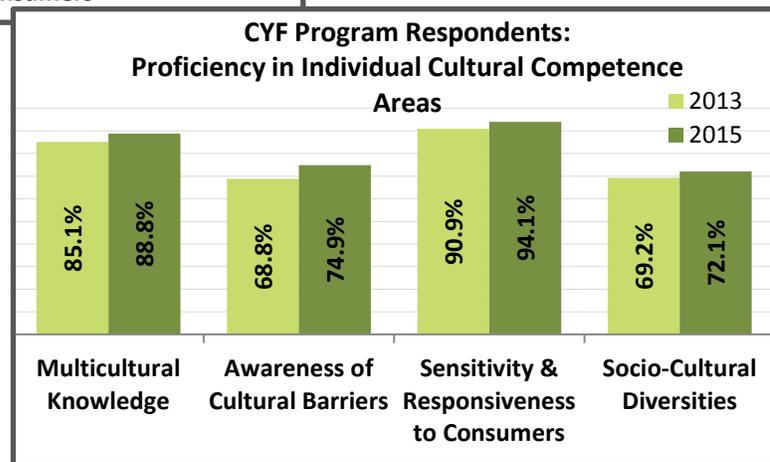
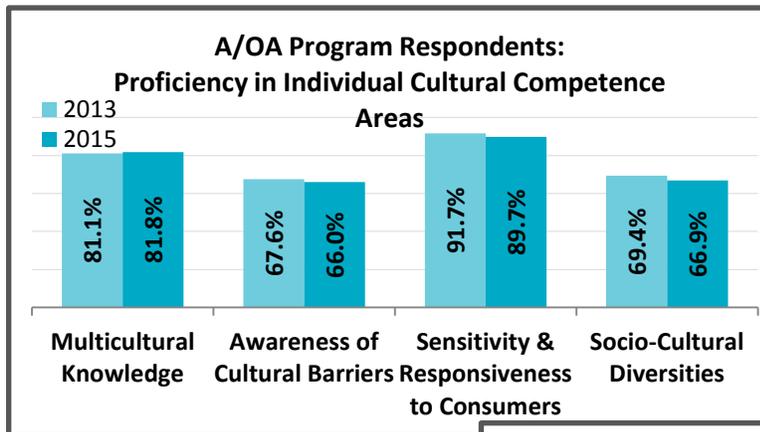
- The respondents are fairly or very familiar with the diverse communities and the demographic makeup of their service areas.
- There was a relatively wide distribution of levels of personal and program staff involvement in the communities' culturally diverse activities.
- Nearly half of the respondents' organizations do not have procedures to achieve the goal of a culturally and linguistically competent workforce that includes either staff recruitment, hiring, retention, or promotion.
- The organizations' staff are relatively diverse culturally and linguistically, with the Peer Support Specialists and Support staff being the most diverse, while the board members and the executive management being the least diverse.
- The programs use trained medical interpreters more regularly than the certified medical interpreters or sign language interpreters. However, nearly a quarter of the respondents indicated that their organizations never or seldom evaluate the quality and effectiveness of these services.
- A large number of the technical assistance requests were related to the CLAS Standards, beneficiary materials, community resources, and training opportunities.

The 2017 CLCPA Report is available in the Appendix 14.

As the PCDSA was administered in February of 2018, the analysis is not available at this time. The following is the most recent data from the CBMCS:

2015 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.



The 2015 CBMCS Report is available in the Appendix 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 CLCPA, the PCDSA, the CLAS Standards, and entity-specific Cultural Competence Plans to measure change in the levels of cultural competence on provider and staff levels. To measure the effectiveness of cultural competence training over time, the Disparities Report, as discussed previously, 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 CLCPA annually, and all program staff are required to complete the PCDSA every two years. These requirements are outlined in each program’s contract.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders focused on the relevance and effectiveness of cultural competence training in one of the CCRT meetings. Topics included ways SDCBHS can track if the staff’s skills are advancing in the area of cultural competence. One recommendation was the incorporation of questions on cultural competence in the Prevention and Early Intervention satisfaction survey questions. The

Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funding gives counties a unique opportunity to implement programs to help prevent the onset of mental illness or to provide early intervention to decrease severity. Each contractor collects information on the demographics of their participants and their satisfaction with the services provided. As noted in Criterion 3, there are four standard satisfaction questions, where participants rate their overall satisfaction with services received, if they are better able to handle things, if they are more comfortable seeking help, and if they know where to get help when needed. It was suggested that in addition to the standard questions, incorporation of questions on areas of cultural competence should be added to the survey.

With the community input received, the SDCBHS will focus on researching the feasibility of enhancing the PEI satisfaction questions. In addition, to focus on identifying effectiveness of cultural competence trainings for staff providing specialty mental health services, SDCBHS will review the Youth Services Survey (YSS) and the Mental Health Statistics Improvement Program (MHSIP) State Survey satisfaction data relevant to cultural competency. Data on consumer satisfaction is collected through the YSS and the MHSIP, where the YSS is completed by all youth (ages 13+) and all available parents/caregivers, regardless of the youth/client age and the MHSIP State Survey is completed by the adults and older adults.

Year 1 Achievements:

While the County providers requested that no additional PEI satisfaction questions be added, the SDCBHS now requires the reporting of additional demographic information. Required demographic information includes the following: military status, disability, primary language, gender identity, gender assigned at birth, and sexual orientation. Additionally, the SDCBHS continues to meet with UCSD, administrators of the consumer satisfaction surveys, to enhance the quality of the reports.

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 National Alliance on Mental Illness (NAMI) to provide trainings on adult client culture. The 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, Farsi, Vietnamese, and Arabic. Peer education materials are available in English and Spanish.

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;*

NAMI San Diego's Family Education Services program provides countywide family education build around the challenges experienced by family members who have a loved one living with mental illness. In FY 2017-18, the program offered 17 family support groups in English & Spanish throughout San Diego County, along with other cultural competent workshops in the African American, Native American, and Hispanic communities. Additionally, NAMI San Diego offered 20 Family-to-Family classes to graduate over 350 family members. These Family-to-Family classes were conducted in English, Spanish, Vietnamese, and Arabic in the six regions designated by the County of San Diego (East, North Inland, North Coastal, South, Central and North Central).

- 2. Navigating multiple agency services; and*

Training on navigating resources and services is part of the trainings and outreach efforts at RI International, NAMI, and through BHETA.

- 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Time was allocated in a CCRT meeting to discuss the incorporation of Client Culture Training and how SDCBHS can build cultural competency around a client's personal experience. It was suggested to develop training on lived experiences. Suggested concepts included how to recognize one's own tone, words used, and how much one accommodates for lived experiences. This also includes language sensitivity during interpretation. Awareness and sensitivity for cultures that do not have language equivalent will aid in building cultural competency around a client's lived experience.

Another training suggestion was cultural sensitivity training among peers. Not only do clients have lived experiences, but the workforce also has lived experiences. It was also suggested that SDCBHS develop and implement implicit bias training. An implicit bias test measures attitudes and beliefs that people may be unwilling or unable to report. It measures the strength of associations between concepts and evaluations or stereotypes, and may be especially interesting if it shows that an individual has an implicit attitude about which he/she did not know. Having training discussing implicit bias and potentially administering an implicit bias test may assist on building on staff's cultural competency around a client's personal experience.

With the community input received, the SDCBHS will focus on working with BHETA to research the suggested training based on clients' lived experiences. In addition, SDCBHS will work with BHETA, program managers, and CORs to explore potential trainings recognizing peers' lived experiences and cultural sensitivity. An additional area of training that SDCBHS is exploring is the concept of implicit bias and how one's attitudes or stereotypes affect our understanding of others. Incorporating discussion around implicit bias will enhance the quality of training and staff's cultural competence.

Year 1 Achievements:

The SDCBHS strives to provide trainings that focus on the needs of the community, and continues to collaborate with BHETA to develop such trainings. As mentioned above, BHETA offered new trainings in FY 2017-18 that include the East African Communities eLearning, Family Compassion for LGBTQIA, Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County, and Engaging the Refugee Community.

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. A follow-up assessment was conducted in 2013 and, most recently, in 2016. The results of a 2016 assessment are summarized below.

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 31% of the total workforce. From 2013 to 2016, the workforce of the County-operated programs grew by 29%. 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 Unlicensed Mental Health Direct Staff (30.9%), followed by Licensed Direct Staff (24.8%) and Support Staff (22.1%). 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 186.23 authorized FTEs in 2016.

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 37% Caucasian, 28% Latino/Hispanic, 8% African American, 10% Asian/Pacific Islander, and 1% Native American. Similarly, the client diversity is as follows: 36% Caucasian, 32% Latino/Hispanic, 11% African American, 5% Asian/Pacific Islander, and 1% Native American.

In comparison with 2013, the current public mental health workforce is generally more ethnically and culturally diverse; however, some cultural and ethnic groups remain under-represented. For example, 32% of the mental health client population is Hispanic/Latino which is 4% higher than the total Hispanic/Latino workforce.

Race/ Ethnicity	2013 Workforce	FY 2012-13 Mental Health Clients	2016 Workforce	FY 2016-17 Mental Health Clients	2016 Comparison*	Change from 2013 to 2016
<i>White</i>	41%	39%	37%	38%	- 1%	- 4%
<i>Hispanic</i>	25%	33%	28%	35%	- 7%	+ 3%
<i>African American</i>	11%	12%	8%	12%	- 4%	- 3%
<i>Asian/ Pacific Islander</i>	10%	4%	10%	5%	+ 5%	0%
<i>Native American</i>	0.9%	0.6%	0.5%	0.6%	- 0.1%	- 0.4%
<i>Other/ Unknown</i>	12%	10%	16%	13%	+ 3%	+ 4%
* +/- indicates that a race/ethnicity is more/less represented in the workforce than the proportion of clients in the mental health system.						

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.

The number of specifically designated consumer/family positions in the public mental health workforce tripled from 54.2 FTEs in 2008 to 163.8 FTEs in 2013. It decreased slightly in 2016, but the number of the Peer Support Specialists increased by 16%.

Position with Lived Experience	2013 # of FTEs	2016 # of FTEs
<i>Peer Support Specialists</i>	18.7%	23.4%
<i>Family Support Specialists</i>	34.6%	17.8%
<i>Managerial/Supervisory</i>	9.6%	3.4%

Language Proficiency

The threshold languages for San Diego County are English, Spanish, Vietnamese, Tagalog, Farsi, and Arabic. In addition to these threshold languages, multiple other linguistic needs were previously identified, including: Chaldean, Hmong, Cambodian, Laotian, Somali, Russian, and Swahili. According to the 2016 workforce assessment, 27% of the workforce speaks Spanish. Additionally, contracted programs employ staff fluent in over 20 unique languages.

The table below shows the breakdown of languages spoken by staff from the 2016 workforce assessment.

Language Spoken by Staff	Level of Staff	2016 # of FTEs
Spanish*	Direct Service Staff	322
	Others	133
Tagalog*	Direct Service Staff	20
	Others	5
Vietnamese*	Direct Service Staff	12
	Others	3
Arabic*	Direct Service Staff	9
	Others	2
Russian	Direct Service Staff	8
	Others	1
Cambodian	Direct Service Staff	3
	Others	3
Sign Language	Direct Service Staff	3
	Others	2

**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.

As outlined above, in comparison with 2013, the current public mental health workforce is generally more ethnically and culturally diverse; however, some cultural and ethnic groups remain under-represented. For example, 35% of the mental health client population is Hispanic/Latino which is 7% higher than the total Hispanic/Latino workforce.

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 bilingual skills that are needed by the mental health population.

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 Behavioral Health Services 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 A/OA client surveys in the threshold languages at the time of distribution (English, Spanish, Vietnamese, Tagalog, and Arabic) and 700 family member surveys, 60 stakeholder meetings, and ongoing input from CYF, A/OA, and Older Adult Care Councils.

Target Reached:

Developed a workforce needs assessment

- Contracted with SDSU Research Foundation Academy for Professional Excellence (APE) to lead the 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 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, and others. 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

There was a community discussion in one CCRT meeting that focused on the County's recruitment, hiring, and retention of a multicultural workforce. It was recommended for SDCBHS to attend resource fairs and career fairs for recruitment from different communities, including recent graduates. One suggestion was for SDCBHS to present at undergraduate programs to spark interest in the students. It was also discussed that the application process for the County of San Diego is challenging. Along with the resource fairs and career fairs to provide information regarding programs, utilize the Employee Resource Groups and its members who are familiar with the application process to explain and provide guidance through the application process.

The County of San Diego is committed to valuing diversity and practicing inclusion because the diverse workforce is its greatest asset and their customers are their number one priority. The County has implemented the Diversity & Inclusion Initiative (D&I), with a mission of continually seeking ways to create an inclusive culture that embraces diversity so employees feel valued and fully engaged to support a workplace and community that is healthy, safe and thriving. It was suggested to partner with the D&I for the recruitment, hiring, and retention of a multicultural workforce.

Several current SDCBHS Workforce Education and Training (WET) objectives include the following: develop training curricula, incorporate cultural competency in all training and education programs, increase mental health career development opportunities, expand

postsecondary education capacity, expand loan repayment scholarship programs, and create stipend programs. Currently, the State provides funding for second year stipend programs, which may limit individuals who need financial assistance during the first year of the program. Funding for stipend programs is crucial to encourage multicultural students to pursue degrees. It was suggested to have County-funded programs designed to allow students to work while pursuing their education and to have a workforce development program at local universities.

Year 1 Achievements:

The SDBHS has been in discussion with the County of San Diego Department of Human Resources (HR) to analyze the specific hard-to-fill positions within Behavioral Health Services. HR has begun to allow more flexibility with pay scales and are exploring options such as flexible schedules to enhance the quality of applicants.

The SDCBHS continues to embrace the County's Diversity and Inclusion (D&I) initiative. The SDCBHS has an operational goal of 100% of BHS staff to complete four hours of cultural competence training annually. To assist with this goal, the SDCBHS hosted staff meetings where culturally specific speakers presented to enhance the understanding of multiple cultures. Examples include a presentation from Deaf Community Services of San Diego to discuss the deaf and hard of hearing community and a presentation from the Nile Sisters Development Initiative on the East African cultures.

Additionally, one priority for the SDCBHS as indicated in the Ten Year Roadmap is the workforce. The Ten Year vision for workforce states: "Our system of care has a skilled, adaptive and diverse workforce that meets the needs of those we serve". Strategies for achievement include the following: advocate for policies and processes that establish innovative recruitment, hiring and retention of a skilled and diverse workforce; pursue team based care and innovative workforce solutions to increase access, improve outcomes and increase efficiency; and develop a career ladder for assisting individuals with lived experience in competitive employment as well as designated peer positions. In FY 2016-17, year one of the Ten Year Roadmap, the SDCBHS has many accomplishments regarding the workforce priority, which include: conducted the third biennial workforce assessment survey in September 2016 to describe current workforce and identify areas of need; transitioned the UCSD Community Psychiatry Program into a residency track model to further enhance interest in working within the public behavioral health system; contracted services to offer recovery-oriented, countywide training to transition age youth, adults and older adults to become Peer Specialists for the County of San Diego public behavioral health system; developed an enhanced training curriculum for psychiatric nurses staffed at our inpatient psychiatric hospital; provided three educational events for community-based primary care providers to support their integrated and team based care behavioral health services; and individuals with lived experience participated in a focus group to assess current job satisfaction in the BHS system of care and discussed best practices/challenges.

Furthermore, the Behavioral Health Workforce Collaborative represents a joining of Behavioral Health Administration; Behavioral Health Providers; Primary, Secondary, Post-Secondary, and Graduate Education; Safety; Workforce Development; and service recipients. Its mission is to build, enhance, and sustain a strong, culturally competent client/family member and wellness-driven Public Behavioral Health Workforce. The goal is to assist with recommendations to develop a Behavioral Health Services (BHS) career ladder; develop an eLearning for supervisors

of peers and family partners; provide multiple training and information seminars on current public behavioral health issues; provide opportunities for educators, program staff and peers to have policy discussions; initiate the development of a public behavioral health job board that was picked up and expanded to the Southern California Regional Partnership (SCRP) JobsinSoCal.com job board; and produce the Building Access to Leadership Careers for People with Lived Experience Conference.

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 WET 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/MHSACERTIFIED3YearPlanFY17_20.pdf.

To specifically address building bilingual staff capacity, the following programs have been developed and implemented. While the programs below were funded through WET, there are several programs that will continue through CSS funding: the San Diego Community College District Public Mental Health Academy, and the Community Psychiatry Fellowship and Child Psychiatry Fellowship, which also include the Nursing Partnership for Public Mental Health Professionals. WET funds were received as a one-time allocation and the balance of WET funds has been fully expended; therefore, the need for additional WET funds will be evaluated annually. In FY 2018-19, CSS funds will be transferred to the WET component to continue funding programs.

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.”

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 (RI) International, 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."

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."

The Program completed its RFP process, 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."

The Community Psychiatry Fellowship program (*actions 6 & 7 combined*) 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."

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

2016 WORKFORCE NEEDS ASSESSMENT		
III. Language Proficiency		
<i>Language, other than English</i>		<i>Number who are proficient</i>
1. Spanish	Direct Service Staff	322
	Others	133
2. Tagalog	Direct Service Staff	20
	Others	5
3. Vietnamese	Direct Service Staff	12
	Others	3
4. Arabic	Direct Service Staff	9
	Others	2
5. Russian	Direct Service Staff	8
	Others	1
6. Cambodian	Direct Service Staff	3
	Others	3
7. Sign Language	Direct Service Staff	3
	Others	2
8. Lao	Direct Service Staff	N/A
	Others	N/A
TOTAL <i>(All languages other than English)</i>	Direct Service Staff	377
	Others	149

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:

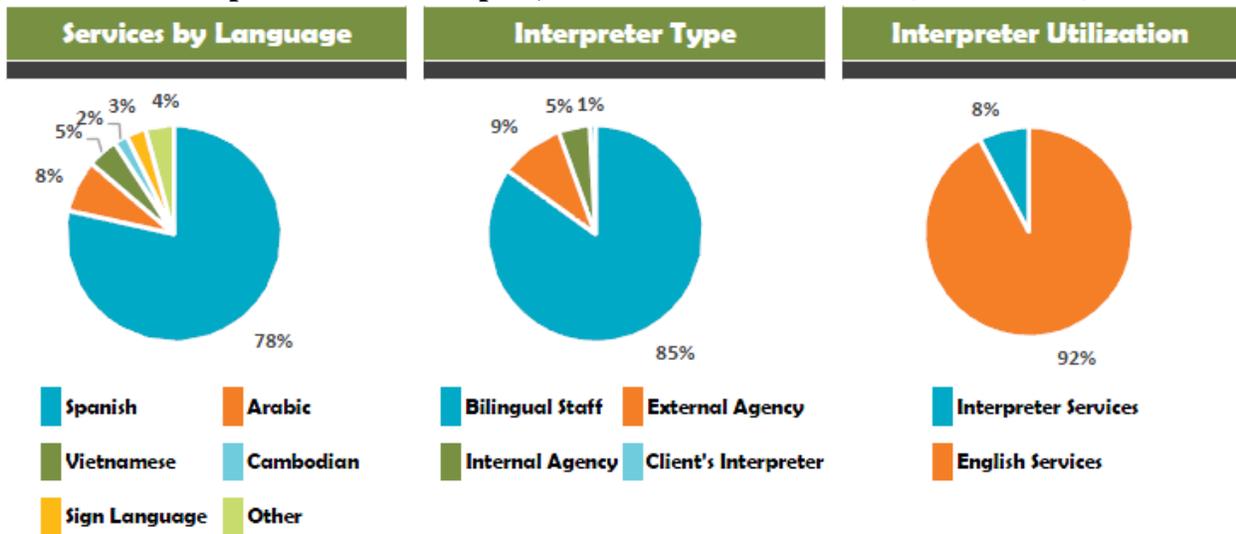
- **Health Center Partners (previously Council of Community Clinics)** focuses on primary health and mental health integration for Latinos in their communities through care provision in 11 community-based, primary-care clinics. Five of the clinics utilize Promotoras to engage Latinos with diabetes and 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. In FY 2016-17, 234 clients were served by this program.
- **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 Asian/Pacific Islander (API) populations. This program, with its cultural and language specific services, provides mental health services to seriously emotionally disturbed (SED) Latino and 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. As of Quarter 3 of FY 2017-18, there were 60,235 interpreter services provided to 7,080 unique clients. The largest proportion of services was provided in Spanish (78.4%), followed by Arabic (7.8%).

Interpreter Services Report, FY 2017-18 Year-to-Date (as of 5/30/18)



Services	Language	Clients
47,245	Spanish	5,190
4,683	Arabic	578
2,757	Vietnamese	344
1,756	American Sign Language	93
1,215	Cambodian	235
695	Other Non-English	176
372	Laotian	46
228	Hmong	189
254	All Filipino Dialects	109
206	Chinese Languages/Dialects	39
259	Farsi	96
122	Russian	75
130	Korean	47
105	French	25
59	Armenian	57
57	Japanese	11
27	Other Sign Language	21
7	Thai	7
8	Polish	4
1	Hebrew	1
4	Portuguese	4
4	Italian	4
37	Samoan	35
1	Turkish	1
3	German	3

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

In a CCRT meeting, stakeholders had a discussion regarding the additional resources and strategies the County can undertake to grow bilingual staff capacity. One main concern for recruitment and retention of bilingual capacity was the appropriate compensation for bilingual services. Although a differential pay rate is established for bilingual staff, there remain concerns about salary levels. For programs that do not have the bilingual capacity to provide services in a primary language requested, the County allocates funding to programs specifically for interpreter services to meet the needs of clients.

With the community input received, the SDCBHS will focus on surveying contractors to determine how many have bilingual premium pay for qualified staff to gather baseline data. Also as part of the strategic plan, SDCBHS will work with contracted Legal Entities to ensure

the focus on bilingual workforce capacity is a priority for programs that serve bilingual populations. SDCBHS will work to enhance data collection methods to assist with the monitoring of the contracted providers’ ability to match bilingual staff capabilities to the primary languages requested at each program or to ensure access is available through an appropriate interpreter.

Year 1 Achievements:

The SDCBHS worked to develop new data collection methods for utilization of interpreter services. Through the use of Cerner Community Behavioral Health (CCBH) and the San Diego Web Infrastructure for Treatment Services (SanWITS), SDCBHS is able to monitor services that are provided in languages other than English. With the data collected, reports are created to display services that require interpreters compared to total services, services by language, unique client count by language, types of interpreter services used, and monthly breakdown of services by month and age category.

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 Competence Standards require 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. The Organizational Provider Operations Handbook (OPOH) 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).

In FY 2016-17, interpreter funding was decentralized.

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.

SDCBHS and the Cultural Competence Resource Team (CCRT) have identified the following methods that providers are encouraged to implement for evaluating cultural competence:

- 1) Use of the PCDSA;
- 2) Administration of a survey amongst their clients to determine if the program’s clinical and administrative services are perceived as culturally competent; and
- 3) Conducting a survey amongst their clients to determine if the program’s clinical and administrative services are perceived as linguistically competent. The PCDSA is available online and is administered to all staff every two years. Surveys that aren’t required (such as CLCPA and PCDSA) can be developed independently. If providers prefer samples of surveys, they are available in the Cultural Competence Handbook (Appendix 5).

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

In FY 2016-17, the Access and Crisis Line (ACL) received 57,855 calls, with monthly call volume ranging from 4,484 to 5,140 calls. Of those, approximately 3.0% were calls conducted in a language other than English and 0.2% were Hearing Impaired calls. Out of all calls that were conducted in a language other than English, 92.1% of them were in Spanish and 3.9% were in Arabic. The ACL is staffed by a highly trained staff, two-thirds of whom have an independent license and more than a quarter of them are license-eligible, registered interns. 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, 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 bilingual 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.*

Telehealth services is outlined in the Organizational Provider Operations Handbook (OPOH) and the purpose of this program is to assure timely access of urgent psychiatric services to reduce emergency and acute clients’ hospital inpatient services. Psychiatrists or Nurse Practitioners (NP) are to perform various psychiatric services via tele-video linkage when an on-site Psychiatrist or NP is unavailable; primarily due to illness or other scheduled absences or

vacancies; or other special needs as arranged. This practice also extends psychiatric services to clients in remote areas of the County. In FY 2016-17, there was a total of 2,087 telehealth services provided to 1,165 unduplicated clients.

Additionally, provider staff encountering clients whose service needs cannot be determined on-site because of language barriers can contact the Access and Crisis Line for linkage to brief phone interpretation service to determine the client's service needs. If program staff are not available to meet the language needs of a client, County contracted providers must have processes in place to be able to provide outside interpreter services as needed. County operated program staff can contact Interpreters Unlimited (for language interpreting) or Deaf Community Services (DCS) (for hearing impairment) to arrange for language assistance. In addition, written translation services are available through Accent on Languages.

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

The OPOH sets forth the protocol for implementing language access through the ACL. 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 ACL 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; and
- 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 ACL 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:

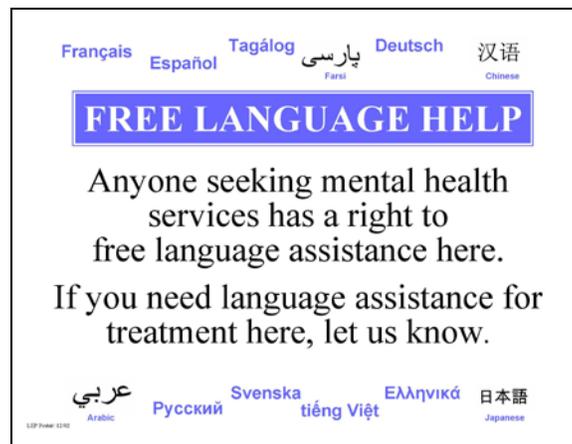
- Services in your preferred language or free interpreter services
- Providers with cultural/language specialties
- Culturally appropriate assessments and treatments
- Information in other languages and alternate formats for the visually and hearing impaired”

This Quick Guide is available in English, Spanish, Tagalog, Vietnamese, Farsi, and Arabic, as well as in an audio format in all threshold languages. It is available at all organizational provider locations and, upon request, through Behavioral Health Services Administration. Providers can request the Quick Guides and all other Medi-Cal beneficiary materials using a PDF form-fill available online. A copy of the request form is available in the Appendix 16.

Additionally, 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, Farsi, 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. You do not need to see your regular doctor first or get permission or a referral before you call.”

Furthermore, all County Mental Health 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, Tagalog, Farsi, 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 Interpreters Unlimited services, 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 pre- and post-session meetings 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.

SDCMHS 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.

- SDCMHS 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During the discussion of language capacity with the community, recommendations to the policies, procedures, and practices in place for meeting clients' language needs were discussed. It was suggested that contracted programs implement a bilingual program similar to the County's Bilingual Program for those qualified individuals who are proficient in a second language. The County's Department of Human Resources designed and implemented the Bilingual Program in order to monitor, coordinate, and review the program's administration. Upon assignment to a position which has been determined to require bilingual skills, a qualified employee is entitled to receive bilingual premium pay. The person being appointed to the authorized bilingual position must successfully complete a bilingual proficiency evaluation. It was recommended that contracted programs implement a similar bilingual program regarding bilingual premium pay.

Another recommendation from the community was to provide additional training for staff. Specific training topics included how to serve as an interpreter and how to work with an interpreter. It was suggested that more non-clinical staff can be trained on how to properly be an interpreter, as well as supervisors can be trained on how to appropriately ask staff to interpret.

Year 1 Achievements:

The County of San Diego continues to utilize the Bilingual Program for bilingual staff, and SDCBHS encourages programs to utilize bilingual staff. There has been struggles to allocate specific funding for the bilingual staff in contractor’s budgets as it is at the discretion of the program to allocate their staffing costs. Additionally, the Behavioral Health Services Training and Education Committee (BHSTEC) continues to review the training needs to the BHS system and the recommendations for the training focused on how to serve as an interpreter and how to work with an interpreter.

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 use of interpreter services.

As of Quarter 3 of FY 2017-18, there were 60,235 interpreter services provided to 7,080 unique clients. The largest proportion of services was provided in Spanish (78.4%), followed by Arabic (7.8%).

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. In FY 2016-17, interpreter funding was decentralized.

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

The 24-hour ACL has Spanish coverage (the County’s second most used language) during regular day operating hours. See a sample of their weekly schedule below. Clinicians who speak Spanish are highlighted in Red.

**CULTURAL COMPETENCE PLAN & THREE-YEAR STRATEGIC PLAN
CRITERION 7**

2018

■ Integrity ■ Compassion ■ Relationships ■ Innovation ■ Performance

SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		5:30a-4pm	Rag (10)	5:30a-4pm	Rag (10)	5:30a-4pm	Rag (10)	5:30a-4pm	Rag (10)	5:30a-4pm	Sheila (10)	5:30a-4pm	IC Vacancy (10) Heidi #751448 Spanish
5:30a-4pm	IC Vacancy (10) Heidi #751448 Spanish	5:30a-4pm	Kaitlyn (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	5:30a-4pm	Mychele (10)	6:30 AM - 5 PM	AC Vacancy (10) Enzo (Farsi) #764209
6:30am-5pm	Hilda (10)	6am-4:30pm	IC Vacancy (10) Heidi #751448 Spanish	6am-4:30pm	Sheila (10)	6am-4:30pm	Sheila (10)	6am-4:30pm	Sheila (10)	6am-4:30pm	IC Vacancy (10) Heidi #751448 Spanish	6:30 AM - 5 PM	Marg (10)
6:30am-5pm	Marg (10)	6:30am-5pm	Hilda (10)	6:30am-5pm	Hilda (10)	7am-5:30pm	Kaitlyn (10)	7am-5:30pm	Kaitlyn (10)	7am-5:30pm	Kaitlyn (10)	9:30 AM - 6 PM	Carolina (10)
9:30am-6pm	Carolina (10)	7:30am-4pm	Espi (8)	7:30am-4pm	Espi (8)	7:30am-4pm	Espi (8)	7:30am-4pm	Espi (8)	7:30am-4pm	Espi (8)		
		8 AM - 4:30 PM	Rebecca (8)	8 AM - 4:30 PM	Rebecca (8)	8 AM - 4:30 PM	Rebecca (8)	8 AM - 4:30 PM	Rebecca (8)	8 AM - 4:30 PM	Rebecca (8)		
		9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)	9 AM - 5:30 PM	Alejandra (8)		
SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		12:30 PM - 11 PM	Marg (10)	11 AM- 9:30 PM	Marg (10)								
		4:30-12 AM	Gracie (8)	4:30-12 AM	Gracie (8)	4:30-12 AM	Gracie (8)	4:30-12 AM	Gracie (8)	4:30-12 AM	Gracie (8)		
				2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	2:30 PM - 11 PM	Joanne (8)	1 - 9:30 PM	Joanne (8)
		2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)	2:30 PM - 11 PM	Greg (8)		
12:30 PM - 11 PM	Tiffany (10)	12 PM - 10:30 PM	Tiffany (10)	12 PM - 10:30 PM	Tiffany (10)	12 PM - 10:30 PM	Tiffany (10)	2:30 PM - 11 PM	AC Vacancy (8) Veronica #764197	12:30 PM - 11 PM	Paula Lintin (10)	12:30 PM - 11 PM	Paula Lintin (10)
2:30 PM - 11 PM	Velma (8)											2:30 PM - 11 PM	Velma (8)
2:30 PM - 11 PM	AC Vacancy (8) Veronica #764197											2:30 PM - 11 PM	AC Vacancy (8) Veronica #764197
SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		5 PM - 1:30 AM	IC Vacancy (8) Laura K.#	5 PM - 1:30 AM	IC Vacancy (8) Laura K.#	5 PM - 1:30 AM	IC Vacancy (8) Laura K.#			7 PM - 1:30 AM	IC Vacancy (8) Laura K.#		
3 PM - 1:30 AM	Daniel (10)							3 PM - 1:30 AM	Daniel (10)	3 PM - 1:30 AM	Daniel (10)	3 PM - 1:30 AM	Daniel (10)
6:30 PM-7 AM	Katie (12)	6:30 PM-7 AM	Nicole (12)	6:30 PM - 7 AM	Nicole (12)	6:30 PM - 7 AM	Nicole (12)	6:30 PM - 7 AM	Alice (12)	6:30 PM - 7 AM	Alice (12)	6:30 PM - 7 AM	Alice (12)
6:30 PM - 7 AM	AC Vacancy (12) Enzo (Farsi) #764209	6:30 PM - 7 AM	AC Vacancy (12) Enzo (Farsi) #764209	6:30 PM - 7 AM	Larry (12)	6:30 PM - 7 AM	Larry (12)	6:30 PM - 7 AM	Larry (12)	6:30 PM - 7 AM	Katie (12)	6:30 PM - 7 AM	Katie (12)
Clinicians 26.2													
SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	
		6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather	6:30 AM - 3 PM	Heather		
		7:30 AM - 4 PM	Jody	7:30 AM - 4 PM	Jody	7:30 AM - 4 PM	Jody	7:30 AM - 4 PM	Jody	7:30 AM - 4 PM	Jody		
3 PM - 11:30 PM	Jim	12:30 PM - 9 PM	Jim	12:30 PM - 3 PM	Jim	12:30 PM - 3 PM	Jim					3 PM - 11:30 PM	Jim
CACs 3.25													
11am-8:30pm	Jerry	6:30am-3pm	Veronica	6:30am-3pm	Veronica	6:30am-3pm	Veronica	6:30am-3pm	Veronica	6:30am-3pm	Veronica	11am-8:30pm	Jerry
		8:30am-5pm	Alyssa	8:30am-5pm	Alyssa	8:30am-5pm	Alyssa	8:30am-5pm	Alyssa	8:30am-5pm	Alyssa		
				5pm-1:30am	Maribel	5pm-1:30am	Maribel	5pm-1:30am	Maribel	5pm-1:30am	Maribel		
SUNDAY		MONDAY		TUESDAY		WEDNESDAY		THURSDAY		FRIDAY		SATURDAY	

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 bilingual 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).

SDCMHS 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 ACL):

“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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During the discussion of language capacity with stakeholders, the main concern regarding the policies, procedures, and practices in place for interpreter services offered was regarding data collection. Previous practices included client use of interpreter services being documented through the monthly invoices which SDCBHS received from a centralized interpreter services contractor. As of FY 2016-17, programs were allocated funds specifically for interpreter services and can utilize any appropriate sub-contractor for those services. With this shift to a decentralized funding model to assist providers with autonomy in accessing interpreter services, data collection on client use of interpreter services and languages requested has been difficult.

SDCBHS will focus on a new methodology for data collection to accurately capture this valuable data as part of our cultural competency strategic plan.

Year 1 Achievements:

As mentioned above, the SDCBHS worked to develop new data collection methods for utilization of interpreter services. Through the use of CCBH and SanWITS, SDCBHS is able to monitor services that are provided in languages other than English. With the data collected, reports are created to display services that require interpreters compared to total services, services by language, unique client count by language, types of interpreter services used, and monthly breakdown of services by month and age category.

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 #5977 – 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 SDCBHS OPOH 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;*
- 4. A client may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services;*
- 5. 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 (HHS) – 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. This process is established through Policy #5977 (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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During the discussion of language capacity in the CCRT meeting, there were no recommendations given regarding the topic of referring and linking clients who do not meet the threshold language criteria to culturally and linguistically appropriate services, as the County has a no wrong door policy and serves all clients regardless if they meet the threshold language criteria. According to Policy #5977 – Provision of Culturally and Linguistically Appropriate Services in Accessing Specialty Mental Health Services, clients have the right to a choice of providers whenever possible, and cultural and linguistic issues shall be considered in making appropriate referrals. At the point of entry into a program, the cultural and/or linguistic needs of an individual shall be assessed and all reasonable efforts made to accommodate, refer and/or link them to appropriate services reflecting those preferences. All persons with Limited English Proficiency (LEP) speaking threshold or non-threshold languages shall be informed in a language they understand that they have a right to free oral interpretation assistance and that

there is no expectation that family members provide interpreter services. In addition to this policy, the SDCMHS Organizational Provider Operations Handbook section on Cultural Competence states that services should be provided in the client’s preferred language. Some county and contracted programs are Mandated Key Points of Contact. As a Mandated Key Point of Contact, the program must have staff or interpretation available to clients during regular operating hours that are linguistically proficient in the mandated threshold languages. All other County and Contracted providers must at a minimum be able to link clients with appropriate services that meet the clients’ language needs whether the language is a threshold language or not.

Year 1 Achievements:

The SDCBHS strives to provide services in the clients’ preferred language. In FY 2017-18, SDCBHS provided 60,235 interpreter services and a total of 7,390 clients were served in a language other than English. According to the most recent satisfaction report for the Mental Health Statistics Improvement Program (MHSIP) State Survey administered in May of 2017, 97% of consumers reported that services were provided in the language they prefer.

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 QI 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 SDCBHS uses the mandated State satisfaction survey for all of its outpatient providers. Surveys are made available in threshold languages when requested by programs.

Summary reports of results of the Youth and Adult Satisfaction Surveys are in the Appendices 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 and native speakers 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 Microsoft Office grading system, and wording is modified to the maximum degree possible to keep materials at a sixth grade reading level.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The County's required translated documents, forms, signage, and client informing materials were discussed with the community during a CCRT meeting. It was stated that the "Client Plan Signature Form" is currently available in English only. It was recommended to have this form available in the other threshold languages. The community also discussed that, at times, there is not an equivalent translation from the English language to the client preferred language. When translating, certain terms and phrases are translated to the best of the ability of the interpreter. For example, the words "case manager" and "referral" do not exist in the Spanish language, which is difficult to translate and will be translated differently depending on the interpreter. It was suggested to establish translations for common terms and concepts in threshold languages that are culturally appropriate. By establishing translations, there will be consistency among the interpreters on those terms that may not exist in the specific languages.

With the community input received, the SDCBHS will focus on the following: explore expanding outside of threshold language for written documents based on data reflecting the most requested languages and have second reviews of documents by native speakers to ensure accuracy.

Year 1 Achievements:

The SDCBHS continues to update and provide written documents in the threshold languages. The SDCBHS Quality Improvement (QI) Unit reviews the format, alignment, and layout of the written documents. When available, the QI Unit conducts second reviews by native speakers to review grammar, vocabulary, and word usage in context with the purpose or message of the forms.

ADAPTATION OF SERVICES

- **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 (RI) International

RI International 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.

RI International 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.
- **CYF Liaison** serves as the MHSA Resolution Point-of-Contact for issues with the CYF System of Care. The program facilitates dialogue between families, Family Youth Partners, and providers. Families can attend Family Voice Meetings to talk about what is working well for them and where they need additional support within the CYF System of Care.

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 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.*

SDCMHS 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 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.

PAGs 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.

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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

During one of the CCRT meetings, stakeholders discussed the County's client-driven recovery and wellness programs and provided suggestions for additional programs. One recommendation was to provide skill-based training on prevention in the community. The training would focus on self-care, where participants have a new commitment to continue taking care of themselves by the end of the workshop. To further the community connection, it was recommended for SDCBHS to fund The National Alliance on Mental Illness in San Diego (NAMI San Diego) Peer-to-Peer Program. The NAMI Peer-to-Peer Program is a free, 10-session educational program for adults with mental illness who are looking to better understand their condition and journey toward recovery. The in-person group experience provided the opportunity for mutual support and positive impact. Participants experienced compassion and reinforcement from people who relate to their experiences. In addition through participation, there is an opportunity to help others grow. Funding from SDCBHS would allow for sustainability and expansion of this program.

Another suggestion from the community was regarding the age group after TAY. It was suggested to develop programs that specifically target the age group 26 to 35 years. Such programs will allow individuals who age out of the TAY services a place to go and serve as a seamless transition from TAY services. A specific need was identified for clubhouse services for the 26 to 35 year olds, as the non-TAY clubhouses tend to attract an older population. The community also suggested enhancing interpreter-led educational groups, which would focus on addressing mental health stigma and the communication of mental health issues in different cultures. Additionally, the importance of focusing on outreach to individuals who have not yet connected with SDCBHS programs was also discussed.

Year 1 Achievements:

The SDCBHS continues to work with NAMI San Diego to provide skill-based training on prevention to the community. In May of 2018, NAMI San Diego delivered a training at the County of San Diego's Knowledge Center that met both continuing education and cultural competency requirements. The training, Mental Health Awareness and Available Resources,

provided an interactive, comprehensive overview of mental health incorporating the Lived and professional experience of the 3 presenters: Peer, Family Member, and the Clinician. Additionally, NAMI San Diego has continued their outreach work within the community regarding mental health stigma through events such as the NAMI 5K walk and the Children's Mental Health Celebration Event. Their program, In Our Own Voice, also allows community members and those with lived experience to share their stories of recovery with others.

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).

Over the last decade, the SDCBHS has been 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. SDCBHS has been working to enhance the Provider Directory in response to the Medicaid Managed Care Final Rule Regulations. The Organizational Providers Operations Handbook (OPOH) 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 CYF 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 with the Union of Pan Asian Communities (UPAC) for over 20 years to provide services to the Asian and Pacific Islander populations.

As mentioned in Criterion 3 of the Cultural Competence Plan, SDCBHS has set up over 30 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 and the North Inland Regions. 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 Initiative was established in 2016 and primarily focuses on African American and Latino communities, who have traditionally been disproportionately served in the jail system and have had limited access to appropriate and culturally relevant BHS services.

The Access and Crisis Line (ACL) 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 Handbook (OPOH) to provide clients with language appropriate services. The County has provided services to persons with Limited English Proficiency (LEP) through the use of interpreter services. As of Quarter 3 of FY 2017-18, there were 60,235 interpreter services provided to 7,080 unique clients. The largest proportion of services was provided in Spanish (78.4%), followed by Arabic (7.8%).

In FY 2016-17, interpreter funding was decentralized.

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, Farsi, and Arabic, as well as in an audio format in all threshold languages. It is available at all organizational provider locations and through Behavioral Health Services administration. Providers can request the Quick Guides and all other Medi-Cal beneficiary materials using a PDF form-fill available online. A copy of the request form is available in the Appendix 16.

Additionally, 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, Farsi, 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.”

Furthermore, in the section “How Do I Get These Services?” the booklet refers to the ACL 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 #6030 (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 four other threshold languages to inform clients of what mental health services are and how they

can be accessed. The Quick Guides are also available in an audio format on a CD upon request. 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, two BHS Community Forums, one community tele-town hall, three population-specific focus groups, one innovative population-specific teleconference focus group, and one frontline tele-town hall were held to gather community feedback (see flyer in the Appendix 21). In addition, below are examples of evidence of outreach for informing underserved 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

The **Fred Finch Youth Center** Residential Outpatient Mental Health Services program for adolescents with a dual diagnosis of severe emotional disturbance and developmental disability strives to help program participants return to lower levels of care and function successfully in a community setting. Cultural competence related activities and outreach conducted in FY 2017-18, include the following, but are not limited to: trips to the post office; visits to the library; Dia de los Muertos art projects; a Halloween and costume party; a Thanksgiving feast; a holiday party; a sushi restaurant outing; and other educational field trips to the community like La Jolla Cove and the Balboa Park Photography museum.

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. Some of the cultural competence related activities and outreach conducted in FY 2017-18 include, but are not limited to:

- Ten Spanish speaking parents attended the Parent Advisory Group (PAG) held on February 22, 2018 and provided feedback about services, as well as received information about establishing household routines.
- On March 20, 2018, the program collaborated with Fallbrook Union Elementary School District to assist in district-wide presentation to parents titled "What I Wish My Parents Knew", which included issues such as social media's impact on mental health and how to monitor, protect against, and prevent misuse. Additionally, Palomar Family Counseling Services presented breakout sessions for both English and Spanish speaking parents. Presenters included the program manager, both bilingual case managers, and two clinicians (one English speaking and the other Spanish speaking). A resource booth was also staffed at the event.
- On March 31, 2018, the program staff collaborated with Jack E. Johns Fallbrook Family Health Center to participate in their "Annual Family Health and Wellness Fair" to

provide referrals and resource information while families participated in free vision, health, and dental screenings.

Pathways Community Services - Cornerstone is a Full-Service Partnership (FSP) program that provides school-based and outpatient behavioral health services. Cornerstone is currently partnered with fourteen area schools within the San Diego Unified School District. It provides services at these partner school sites, in addition to home, community, and clinic based services. Their clients are primarily elementary school aged, with most clients being 7 to 12 years of age. Though, Cornerstone also serves a small number of middle school aged clients and TAY. Three of the Cornerstone clinicians are bicultural Hispanic/Latino and are bilingual in English and Spanish. Additionally, Cornerstone has one clinician who is African-American, one clinician who is Filipino and bilingual in English and Tagalog, and their psychiatrist is bilingual/bicultural in Vietnamese. Our QI Coordinator and Family Support Partner are both bicultural Hispanic/Latino and are bilingual in English and Spanish.

Some of the cultural competence related activities and outreach completed in FY 2017-18 include, but are not limited to:

- Program Staff participated in a variety of Community Outreach/Summer BBQ events organized by San Diego Unified School District. All events were focused on providing education and information to potential client and families who live and attend school within Cornerstone's service area of Mid-City and Central San Diego.
- The program director attended the “Meeting of the Minds” Conference on September 29, 2018 and participated in Pathways agency outreach/resource table.
- On November 21, 2017, the program director and regional director met with a representative with the Nile Sisters to collaborate on ways the two programs can work together in the future to serve needs of East African refugee families in the immediate community.
- Staff participated in a variety of outreach efforts including, but not limited to: Family Time at Adams Elementary on October 4, 2017; Lewis Middle School Parent and Teacher Night on October 11, 2017; Garfield Staff presentation on October 13, 2017; Franklin Elementary Staff presentation on November 7, 2017; Joyner Conference outreach on (November 15, 2017); and Positive School Culture Outreach and Provider fair on (December 4, 2017).

Kickstart’s (First Break) Program Director continues to collaborate with Urban Street Angels and 8West regarding referrals for TAY to housing and to Kickstart and coordination of care between programs. The program also held a Fit4 Drums class for program participants and staff to support the *Live Well San Diego* vision. Additionally, Kickstart hosted Native American Cultural Competence training from Southern Indian Health Council.

San Ysidro Health Center’s Chaldean Middle–Eastern Social Services is an outpatient mental health program serving Arab-American and Chaldean children/youth, including the new Iraqi and Middle-Eastern refugee children who have recently resettled in San Diego County, predominately in El Cajon. Services include the following: mental health counseling (individual and family); groups (process and didactic); school-based services (eight-week acculturation

groups for newcomers); intake and screening; case management; community outreach; and crisis intervention.

Some of the cultural competence related activities and outreach completed in FY 2017-18 include: “Back to School Night” at El Cajon Valley Middle School; Providers Resource Fair at the San Diego County Office of Education School Summit; the 7th Annual Family Health & Wellness Fair in El Cajon that included several fun activities, presentations, and speakers focused on physical health and mental health; and the El Cajon Valley Unified School District Community Resource and Health Fair.

San Ysidro Health Center’s Youth Enhancement Services (YES) provides culturally competent community and school-based outpatient mental health services to children, adolescents, and their families that reside in the Southbay area, including the communities of San Ysidro, Imperial Beach and South San Diego. Clients range from ages 5-18 years old. Additionally, 100% of the YES staff is bilingual (English/Spanish) and bicultural. Some of the cultural competence related activities, including outreach, completed in FY 2017-18 include:

- Ella Southbay Magazine featured YES services in the August 2017 editions
- YES providers participated in the annual “Check your Mood: National Depression and Mental Health Screening Month” at San Ysidro Health Center.
- Participation at the San Diego County “Recovery Happens” annual event. YES interacted and provided information on its services.
- Participation in the Providers Resource Fair of the San Diego County Office of Education School Summit (September 15, 2017).

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 innovations programs will continue to be active in FY 2017-18:

- **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: Faith-Based Academy; Community Education; Crisis Response; and Jail-Based In-Reach.
- **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 Transition** 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 (MCC) provides intensive cultural and specific outpatient behavioral health services and case management for seriously emotionally disturbed (SED) children (ages 5-20) and families from Asian Pacific Islander (API) and Latino communities with an emphasis on API. UPAC MCC is a Full Service Partnership (FSP) program which utilizes case management to provide intensive services and supports as needed. Each client is assigned a therapist that provides culturally and developmentally appropriate clinical services. A Family Support Partner is available to provide intensive case management and rehabilitative services. As a function of the Full Service Partnership program, the Family Support Partners links the client to a primary care physician and completes a Wellness Notebook. MCC facility hours are Monday through Friday from 9am-6pm, with an after-hours line available to MCC clients outside of facility hours. In addition, MCC provides outreach engagements providing education on services and mental health. Multiple language abilities include Vietnamese, Spanish, Cantonese, and Mandarin. Referrals are from medical facilities, schools, Child Welfare Services (CWS), hospitals, other providers, word-of-mouth, drop-in, and other UPAC programs. Full-scope mental health services are provided at clients' homes, community sites and clinic. Throughout FY 2017-18, UPAC provided trainings and resources to community members and organizations, as well as participated in cultural festivals and fairs, including, but not limited to the following:

- Annual School Summit Provider Resource Fair
- Chinese Women's Association Training
- API Mental Health Empowerment Conference

Adult/Older Adult Mental Health Services QSRs

The Union for Pan Asian Communities (UPAC) has an ongoing relationship with Wesley United Methodist Church of San Diego as well as several local primary care physicians and Federally Qualified Health Centers (FQHCs). UPAC is also participating in the Blue Shield Shared Treatment Pilot with La Maestra Community Health Center.

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.

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. Additionally, the staff participated in the Recovery through Creativity event and took participants to a number of parks and spots around San Diego.

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, as well as to expand its visibility in the community as a viable resource.

Maria Sardiñas Center continues to collaborate with faith-based organizations on educating the community members to engage with Geriatric Outreach Specialists. Additionally, clinicians 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 OSRs

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.

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.

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. Its 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.

A. 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 Competence Plan, Culturally and Linguistically Appropriate Services (CLAS) 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 on the Technical Resource Library (TRL), and shall demonstrate integration of cultural competence standards described in the San Diego County Mental Health Services (SDCMHS) Cultural Competence Plan located on 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 Cultural Competence Plan that is consistent with the SDCBHS Cultural Competence Plan. This may be the Legal Entity's Cultural Competence Plan.
 - e. Contractor shall use the Cultural and Linguistic Competence Policy Assessment (CLCPA) and the Promoting Cultural Diversity Self-Assessment (PCDSA) as tools to determine the levels of cultural competence at an organizational and staff levels, respectively. These tools are referenced in the OPOH and can be found in the BHS Cultural Competence Handbook (Appendix 5). COR shall advise the Contractor when there is a need to use other evaluation tools.
 - f. Culturally and Linguistically Appropriate Services (CLAS) Standards: 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 CLAS Standards.
7. Mental health services are based on Biopsychosocial and Rehabilitation (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 shall 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 OPOH. 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:

Health Center Partners (previously Council of Community Clinics) is comprised of 17 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 2016-17, the Health Center Partners served 559 unique BHS clients in San Diego.

- The clients were seen for the following behavioral health conditions: Depression Disorders (49%), Anxiety Disorders (25%), Adjustment Disorders (11%), Substance Use Disorders and Other Addictive Disorders (5%), Psychotic or Bipolar Disorders (5%), and Other Disorders (5%).
- The African American client population comprised 3%, and the majority of the clients served were Hispanic (58.1%).
- Majority of the clients were between the ages of 25 and 59 (88.6%).
- Clients visited the centers a total of 2,005 times, receiving therapy and medication treatment along with case management, and rehabilitative services.
- The Peer Promotora Component of the project visited 2,450 sites and 30,376 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 provides 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:

- The **Southern Indian Health Council, Indian Health Council, and San Diego American Indian Health Center** provide primary health, dental, specialty and specialized culturally appropriate behavioral health Prevention and Early Intervention (PEI) services to the American Indian/Alaska Native (AI/AN) community in East San Diego County. They all focus 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

The community discussed potential changes to the treatment options available at the County that accommodate individual, cultural, and linguistic preferences. It was suggested to provide more educational trainings in other cultures, specifically around refugee populations. In addition, it was highly recommended to be more inclusive of culturally responsive treatment methods, and not limiting treatment methods to those covered by Medi-Cal. It was discussed that it is common for other cultures to use traditional and religious treatment methods before turning to western health care. Providers can support clients by encouraging traditional treatment methods or integrating them into service plans. With the community input received, the SDCBHS will focus on working with BHETA to design specific trainings that may accommodate individual, cultural, and linguistic preferences.

Year 1 Achievements:

The SDCBHS continues to work with BHETA to offer specific trainings that may accommodate individual, cultural, and linguistic preferences. In FY 2017-18, BHETA provided a variety of trainings that focused on individual, cultural, and linguistic preferences, including: TAY Culture, TAY Series, Engaging the Refugee Community, Working with Immigrant Communities: Meeting the Unique Behavioral Health Needs of Newcomers in San Diego County, Family Compassion in the LGBTQIA Community, San Diego Drug Trends and Teens, Geriatric Mental Health Certificate Booster: Substance Use and Older Adults, Geriatric Mental Health Certificate Booster: Cognitive Decline in Older Adults with Severe and Persistent Mental Illness, and CYFSOC Conference: Unpacking Hope: Understanding the Unique Needs of Children, Youth and Families Experiencing Homelessness.

ADAPTATION OF SERVICES

III. Quality of Care: Contract Providers

A. 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 2018 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 Fee-for-Service (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.

As discussed previously, the National 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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

In a CCRT meeting, the community discussed how a contractor's ability to provide culturally competent mental health services is taken into account in the County's selection of contract providers. It was suggested that the SDCBHS conduct contractor forums to seek out providers that do not usually contract with the County. In addition, there should be more flexibility with the background investigation during the hiring process, specifically for those with lived experiences. For example, in peer to peer programs, the lived experience is what makes the individual more qualified for the position, but the lived experience can hinder them from being hired due to the background investigation requirements. Continuing with the example of Peer Support Specialist positions, it was recommended to adjust the culture of productivity in the workplace for such employees. The amount of required paperwork at time of hire can also be overwhelming for the Peer Support Specialist. However, in discussion it was also realized that there is a balance required since peer employees should not be treated differently than other employees and should not have special accommodations based on their role. It was also recommended that supervisory training courses on how to supervise Peer Support Specialists be required for all programs that employ peers. The training should focus on those who supervise and/or are looking to hire Peer Support Specialists and would cover the essence of Peer Support, provide insight into Peer Employment Training, and assist employers in recruiting and retaining Peer Support Specialists. Lastly, the community discussed the importance of recruiting high quality fee-for-service (FFS) providers.

With the community input received, the SDCBHS will focus on collaborating with CORs to encourage participation in supervisory training.

Year 1 Achievements:

The SDCBHS contracts with RI International who provides training and consultation to help organizations transform to one that is driven by the goal of recovery. The Peer Employment Training is a 75-hour training for people with lived experience of recovery, from mental health and/or substance use challenges, to work in the service system as a peer support specialist. Training focuses on ways to use personal experience and skills to inspire hope in the lives of individuals receiving services. The Empowering Success training is for organizations and programs interested in working with or hiring Peer Support Specialists. Training provides information to further develop recovery culture in the mental health setting and will explore tools and strategies on how to lead and support Peer Specialists. This class helps the team understand the gifts that peers bring to the teams they join.

Additionally, the County of San Diego is considering the exploration of increasing Peer Support Specialists on County operated program sites.

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 parents/caregivers, and the Mental Health Statistics Improvement Program (MHSIP) Survey, which is completed by adults and older adults (ages 18 and older). During the most recent survey period (May 2017) for which the results are available, 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=2,037)
	Youth Clients (N=1,187)	Family Members (N=2,161)	
Staff were sensitive to my cultural/ethnic background.	85.7%	95.2%	84.6%

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 2016	May 2017
Services received were provided in the preferred language.	94.4% (N=1,054)	96.4% (N=1,086)
Written information was available in the preferred language.	92.4% (N=991)	93.2% (N=1,049)
Parents/Caregivers (“yes” answers)		
YSS State Survey Questions	May 2016	May 2017
Services received were provided in the preferred language.	98.0% (N=2,061)	98.4% (N=2,023)
Written information was available in the preferred language.	97.8% (N=2,016)	97.5% (N=2,023)

Adult/Older Adult Clients (“yes” answers)		
MHSIP State Survey Question	May 2016	May 2017
Were the services you received provided in the language you prefer?	97.0%	97.0%

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

Cultural and Linguistic Competence Policy Assessment (CLCPA)

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 CLCPA on an annual basis. The CLCPA was implemented in October of 2017. It was developed by Georgetown University’s National Center for Cultural Competence and was adapted by SDCBHS to be used by programs to evaluate their perception of their programs’ cultural and linguistic competence. The CLCPA is based on expectations and standards recommended by the Cultural Competence Resource Team (CCRT) and aligned with the CLAS Standards.

In October 2017, the SDCBHS QI Unit requested that each contracted MHS and SUD Services program manager complete the assessment. The program managers were asked to identify main cultural groups that their program serves predominantly so they could refer to them as they completed the survey. They also had the opportunity to request technical assistance with

becoming familiar with the items in each of the eight sections: Knowledge of Diverse Communities; Organizational Philosophy; Personal Involvement in Diverse Communities; Resources and Linkages; Human Resources; Language and Interpretation Services Access; and Engagement of Diverse Communities. A total of 193 programs completed the assessment: 143 (73.1%) MHS and 52 (26.9%) SUD programs. The results show that:

- The respondents are fairly or very familiar with the diverse communities and the demographic makeup of their service areas.
- There was a relatively wide distribution of levels of personal and program staff involvement in the communities' culturally diverse activities.
- Nearly half of the respondents' organizations do not have procedures to achieve the goal of a culturally and linguistically competent workforce that includes either staff recruitment, hiring, retention, or promotion.
- The organizations' staff are relatively diverse culturally and linguistically, with the Peer Support Specialists and Support staff being the most diverse, while the board members and the executive management being the least diverse.
- The programs use trained medical interpreters more regularly than the certified medical interpreters or sign language interpreters. However, nearly a quarter of the respondents indicated that their organizations never or seldom evaluate the quality and effectiveness of these services.

A large number of the technical assistance requests were related to the CLAS Standards, beneficiary materials, community resources, and training opportunities.

The 2017 CLCPA Report is available in Appendix 14.

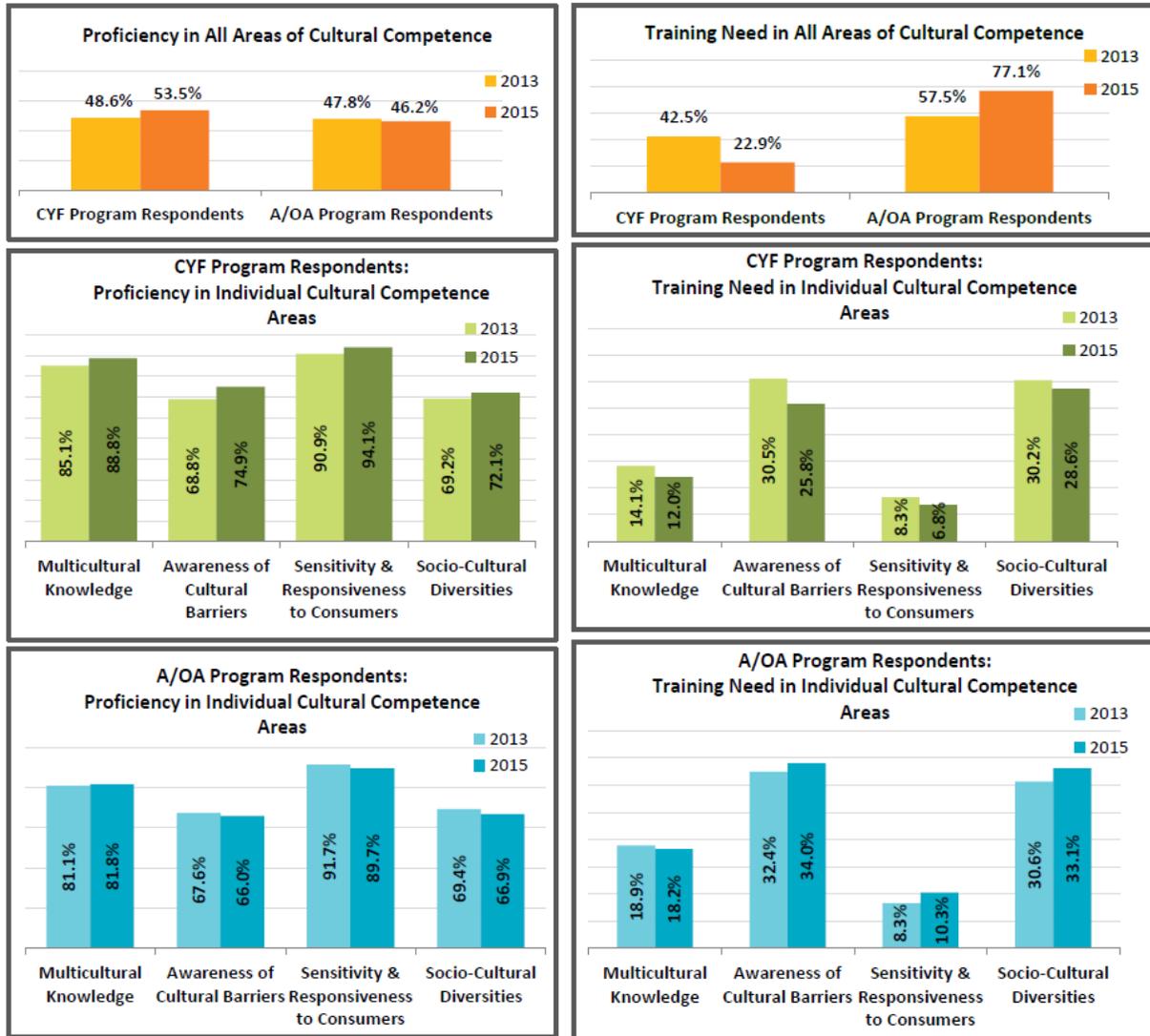
The Promoting Cultural Diversity Self-Assessment (PCDSA)

The self-assessment is administered every two years to all County-contracted and County-operated staff with a goal to heighten the awareness and sensitivity of program staff to the importance of cultural diversity and cultural competence. Staff scores should show incremental improvement as they learn about various cultural groups via available training opportunities. The PCDSA was implemented in SDCBHS in 2018, and the results were not available.

The California Brief Multicultural Scale (CBMCS) (replaced by PCDSA in 2018)

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 CBMCS. 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 2015) are highlighted below. More than half of the CYF program respondents (53.5%) and nearly half of the A/OA program respondents (46.2%) indicated proficiency in all four areas of cultural competence, with the largest proportion of the respondents' scores indicating proficiency in the area of Sensitivity & Responsiveness to Consumers. Overall, a very small proportion of the respondents' scores indicated a need for

additional training in all four areas of cultural competence (2.9% or 48) – a 20% increase from the last CBMCS period in 2013.



The 2015 CBMCS Report is available in the 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 22).

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.

The Organizational Provider Operations Handbook (OPOH) outlines the Beneficiary and Client Problem Resolution Policy and Process 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 MHP compliance with federal, state, and contract regulations.

SDCBHS 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 DHCS on an annual basis and as required.

In FY 2016-17, there were two (2) State Fair Hearings, 163 grievances, and no Appeals. No grievances were filed regarding cultural appropriateness or linguistic services.

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.

Three-Year Strategic Cultural Competence Plan (July 1, 2017 – June 30, 2020)

Stakeholders had a discussion regarding the County's policies, procedures, and practices to assess the quality of care provided for all consumers. One suggestion was to examine how the County can minimize the bureaucratic impact on providers, such as required paperwork. A second recommendation was regarding quality assurance for SDCBHS. The community discussed that there should be an evaluation process for SDCBHS to ensure that its policies are culturally competent. It was also suggested that in Requests for Proposals (RFPs), there should be specific line items for compensation for speaking additional languages versus allowing Offerors to include bilingual incentives but not requiring it. Lastly, there was concern expressed over the utilization management processes needing to occur after every thirteen individual treatment sessions for children and youth (the short-term treatment model), and suggested reevaluating the model.

With the community input received, the SDCBHS will focus on the implementation of Collaborative Documentation to assist with reduction of paperwork by incorporating the documentation of required information into each session. Collaborative documentation is a model that supports recording services on appropriate forms in cooperation with the person served, such as during the service for service planning and diagnostic assessments, and at the end of the service for Progress Notes. With this model, it is suggested that there are higher levels of client engagement with treatment, as client involvement with the full process can expand the clinical discussion and the treatment is more individualized and person centered. In addition, this model ensures accuracy of documentation and reduces documentation load.

The feedback received regarding the utilization management processes that occur in the Short Term Treatment Model (STTM) referenced above has been provided previously. As a result, in February 2015, the Child and Adolescent Services Research Center (CASRC) and the CYFBHS System of Care Outcomes Committee evaluated the impact of the system's transition to a short-term treatment model in FY 2010-11. Data were evaluated over time from pre-STTM (FY 2009-10) to post-STTM (FY 2012-13). Overall the outcome markers suggest that post-STTM, youth were spending less time in services but their clinical outcomes were similar. As the County looks at parity requirements and utilization management practices, the STTM will be reviewed again by SDCBHS.

Year 1 Achievements:

The SDCBHS worked with Community Research Foundation (CRF) to implement collaborative documentation into four of their outpatient clinics as a pilot. These clinics have fully implemented collaborative documentation and are experiencing benefits such as improved timeliness, productivity, and improved client engagement. The SDCBHS Quality Improvement (QI) Unit is conducting a deep dive analysis comparing the outpatient programs using collaborative documentation to those programs not using collaborative documentation.