

COVER SHEET

An original, three copies, and a compact disc of this report
(Saved in PDF and Microsoft Word format)

Due July 2015 to:

*Department of Health Care Services, Mental Health Services Division, Quality Assurance Section
1500 Capitol Ave.
Sacramento, California 95814*

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CHECKLIST OF THE 2014 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

- **CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE**
- **CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS**
- **CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES**
- **CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM**
- **CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES**
- **CRITERION 6: COUNTY'S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF**
- **CRITERION 7: LANGUAGE CAPACITY**
- **CRITERION 8: ADAPTATION OF SERVICES**



Mendocino County Health & Human Services
Behavioral Health & Recovery Services
Cultural Competence Plan
2015-2018

Table of Contents:

Section #	Title	Page Number
I.	Commitment to Cultural Competence	4
II.	Updated Assessment of Service Needs	14
III.	Strategies and Efforts for Reducing Disparities	21
IV.	Integration of the Committee within the County System	26
V.	Culturally Competent Training Activities	30
VI.	Growing a Multicultural Workforce	38
VII.	Language Capacity	41
VIII.	Adaptation of Services	47
Ref.	Statutes and Definitions	51

Attachments:

1. Statement of Philosophy
2. Human Resources Equal Opportunity Employer Policy & Training Policies
3. Mendocino County Contract Requirements
4. Mendocino County Cultural Competency Policies and Procedures
5. Mendocino County BHRS Organizational Chart
6. Cultural Competence Committee Meeting Minutes
7. MHSA 3-Year Plan/Annual Updates including all components
8. Consumer Satisfaction Survey (English & Spanish)
9. Organizational Chart

CRITERION 1

COUNTY BEHAVIORAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE

I. **Mendocino County Behavioral Health & Recovery Services commitment to cultural competence**

A. **The County has the following available on site during the compliance review:**

- Mission Statement;
- Statements of Philosophy;
- Strategic Plan;
- Policy and Procedure Manuals;
- Human Resource Training and Recruitment Policies;
- Contract Requirements;
- Outreach and Engagement Binder;
- Training Binder;
- Cultural Competency Committee Binder;
- Quality Improvement Committee Binder; and
- Quality Improvement and Quality Management Binder
- MHSa Three Year Plan including all components

B. **Copies of:**

1. **Mission Statements**

Mendocino County Behavioral Health & Recovery Services (BHRS) Mental Health program cares for the people of Mendocino County whose lives are affected by mental illness. Mental Health Services strives to:

- Deliver services in a respectful, responsive and efficient manner and with sensitivity to cultural diversity;
- Educate ourselves, individuals, families and the community about mental illness and the hopeful possibilities of treatment and recovery;
- Maximize independent living and to improve quality of life through community-based treatment;
- Maximize the resources available and attend to concerns for the safety of individuals and the community; and
- Manage our fiscal resources effectively and responsibly while insuring that productivity and efficiency are important organizational values which result in maximum benefits for all concerned.

Mendocino County Behavioral Health & Recovery Services Substance Use Disorders Treatment program is committed to providing services to residents of Mendocino County of diverse backgrounds. We offer a culturally competent, gender responsive, trauma informed system of care for adults and adolescents while striving to meet linguistic challenges. Utilizing holistic, person-centered recovery, we promote healthy behaviors

through prevention and treatment strategies that support our community's need to address alcohol and other drug abuse, addictions and related conditions.

2. Statement of Philosophy-

See MH Policy & Procedure No. I. A-1 Philosophical Principles & Goals

3. Strategic Plan:

Mendocino County's Strategic plan is undergoing completion it is scheduled for completion in 2015.

4. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within Mendocino County's Behavioral Health & Recovery Services System.

- County Policy # 10 Equal Employment Opportunity
- County Policy # 23 Sexual Harassment
- MH P/P No. I.A-1 Philosophical Principles/Goals
- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III.A-3 Services to Beneficiaries in Primary or Preferred Languages
- MH P/P No. II.B-5 Employment for Consumers
- MH P/P No. I.C-1 Role of the Cultural Competency Committee
- MH P/P No. III.C-2 Quality Improvement Committee
- MH P/P No. III.C-14 Code of Ethics
- SUDT P/P No.I.D-1 Americans with Disabilities Act Compliance Policy
- SUDT P/P No. I.E-1 Compliance with CLAS Standards
- SUDT P/P No. II.B-2 Code of Conduct & Ethics
- SUDT P/P No. I. D-1 ADA Compliance Policy
- SUDT P/P No. III.C-12 Staff Training
- SUDT P/P No. III.C-1 Program Review Procedure

5. Human Resource Training & Recruitment Policies

- See Attachment #2, Human Resources Policies.

6. Contract Requirements

- See Attachment #3, Contract Requirements.

7. Additional Key documents:

- Outreach and Engagement Binder (available during site visit);
- Training Binder (available during site visit);
- Cultural Competency Committee Binder (available during site visit);
- Quality Improvement Committee Binder (available during site visit); and
- Quality Improvement and Quality Management Binder (available during site visit).

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

A. Brief description (not to exceed two pages), of community outreach, engagement and involvement efforts, practices and activities:

Mendocino County is dedicated to providing community outreach, engagement, destigmatization efforts, trainings and education to all members of the county. The County continues to make changes and improvements in its ability to provide cultural competent specialized services to its Behavioral Health & Recovery Services clients. The County also provides culturally competent specialized services in its outreach and engagement of the underserved populations.

Over the last 2-years, Mendocino County has transformed its Mental Health delivery system to focus on culturally competent specialized services across the age continuum. Service delivery by age population and least restrictive level of care has become more integrated providing for an Integrated Coordinated Care Model of Mental Health Services. The integration of all programs including MHS Community Services and Supports promotes long term sustainability and leveraging of existing resources to make the entire system more efficient, integrated, coordinated, and to ensure that Evidenced Based Practices are used.

Mendocino County implemented the use of outcome measurement tools. For adults, all mental health plan providers are using the Adult Needs and Strengths Assessment (ANSA). The children and adolescent providers use the Children and Adolescent Needs and Strengths Assessment (CANS). The use of measurement tools will enhance services by allowing evidence based decision making when reviewing services, pre, during, and post treatment.

Mendocino County conducts Consumer Satisfaction Surveys and Consumer Perception Surveys. The surveys are offered in English and Spanish. The surveys allow clients to give feedback on the services being provided. The results allow the County to review its system of care and make necessary changes, as needed.

To increase the engagement and involvement from community members in regular meetings and events (MHS Forums, QIC meetings, Mental Health Advisory Board Meetings, Cultural Competency/Diversity Committee meetings, etc.) county staff and providers travel throughout the County to various communities. This provides a way for consumers who have little to no transportation options to participate in the forums/meetings/committees/events. The frequency of meetings are determined in response to the stakeholder groups and are anywhere from quarterly to monthly depending on the meeting. Toll free teleconferencing is offered to those that cannot physically attend.

We have added in 2014/15 Consumer Events that are targeted to behavioral health consumers that are not formatted as a meeting, but more of casual social event, to collect feedback from Behavioral Health (MHS in particular) consumers.

Since 2013, Mendocino County has facilitated a Suicide Prevention Awareness Week event. This event provides suicide prevention awareness, education, and training. Mendocino County has created a Suicide Prevention Awareness Story Board; a collecting of stories of individuals that have been affected by suicide. The Story Board, in addition to informational materials, is brought to a variety of locations and venues throughout the County during Suicide Prevention week.

In an attempt to reach out to isolated communities and further involve individuals that might not be aware of behavioral health issues, Mendocino County BHRS sends a Behavioral Health

staff person with the Book Mobile to remote areas, with resources, brochures, pamphlets, and other informational materials since 2013.

Additionally Mendocino County BHRS has been honoring May is Mental Health Month since 2014 by participating in Farmer's Markets throughout the county during the month of May, bringing resources, brochures, pamphlets, and other informational materials. By going to farmers markets we have reached a broader spectrum of the community with awareness raising and system navigation information.

B. Brief 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.

Mendocino County Behavioral Health & Recovery Services hosts the following meetings to collect stakeholder/community input:

- Mental Health Services Act (MHSA) Forums
- Innovation Meetings
- Workforce, Education & Training Meetings
- Cultural Diversity Committee Meetings
- Quality Improvement Committee Meetings
- Consumer Events

BHRS hold stakeholder input meetings at various locations throughout the County to increase participation and reduce stigma associated with behavioral health services.

Mendocino County BHRS providers have relationships with the following agencies: Laytonville Healthy Start, Action Network, Consolidated Tribal Health Project, Yuki Trails, Redwood Coast Senior Center, Ukiah Senior Center, Willits Senior Center, Coastal Seniors, Redwood Valley Rancheria Red Road Program, Ford Street Project, First 5, Mendocino County Aids/Viral Hepatitis Network, Arbor Youth Resource Center, Manzanita Services, Inc. and Nuestra Alianza. The County also works with the Mental Health Advisory Board.

Mendocino County BHRS provides services to individuals of all racial, ethnic, cultural, and linguistic groups. Services are provided to clients in their preferred language through bilingual staff or an interpreter. Providers track all service provisions so the County can review how service delivery compares with disparity measures.

Mendocino County and Consolidated Tribal Health Project work together to provide an annual training on culturally competent practices with Native Americans. The County intends to establish an annual training on culturally competent practices with Latinos during fiscal year 2015/16. In 2014, the County added two new components to our Cultural Diversity Committee Meetings: a culturally competent practices training review and speaker panel to hear directly from individuals of different ethnic, cultural, or linguistic groups (Latino & Native American panelists in 2014).

The community planning process for MHSA 3 - Year Plan & Annual Update is conducted throughout the year by having MHSA Forums and the other stakeholder events held in the various communities. This stakeholder and community input is culminated in the 30 day

review and public comment period. The MHSA 3 - Year/Annual Update is posted for 30 days each year. The plan is posted in all MHSA provider locations, on the website, and in other community locations that are willing to post it. Comments and questions are collected from stakeholders at community program planning processes and consolidated throughout the year to be included in the final MHSA plan document.

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.

Mendocino County Behavioral Health and Recovery Services (BHRS) held our first annual de-stigmatization and suicide prevention week event on 9/8/13 - 9/12/13. The event traveled to seven communities within the county with a mobile story board filled with stories, expressions, and experiences of those that have been affected in some way by suicide and/or mental illness. The event included a guest speaker from the American Foundation for Suicide Prevention who spoke about signs of suicide and suicide prevention. Wrist bands with the County slogan "Speak Against Silence" and educational materials, in Spanish and English, were available to the public. The collection of stories and experiences traveling to a variety of communities with a presentation on suicide prevention and awareness is now an annual Mobile Storyboard for Suicide Prevention Week event.

MC BHRS reached out to the communities in May 2014 to recognize May as Mental Health Month. MC BHRS staff participated in five farmers markets, one mental health fair, and one Big Time event; locations were throughout the county. The purpose of these May is Mental Health Month events were to provide education about mental health, suicide prevention education, and how to access services. Education material was provided to the community in creative and fun ways. Some of the materials were wrist bands with the slogans "Each Mind Matters" and "Speak Against Silence", pens, magnets, stickers, etc. Cards and brochures were offered to provide information on mental health services, how to access services, and suicide prevention. All materials were offered in Spanish and English. This is now an annual event. The 2015 May is Mental Health Month event included a presentation from a consumer provider, as well as mini training.

MC BHRS, with the help of the MHP providers, encouraged consumers to participate in the Cultural Competency Committee/Cultural Diversity Committee meetings to share their experiences, opinions, and suggestions for improvement. Public Service announcements were done in an effort to reach more of the community members. There was also an outreach to local school personnel and tribal agencies to attend meetings.

A Mental Health Awareness Survey, consisting of six (6) questions, was developed to elicit the public's knowledge about Mental Illness. The surveys were distributed to consumers and turned in to BHRS Quality Assurance/Quality Improvement to summarize and analyze. The goal was to determine the community needs in relations to mental health services. This is now conducted annually.

BHRS and Consolidated Tribal Health provided a training called Cultural Responsiveness for Better Health on 6/12/14 for Mental Health providers, Substance Use Disorders Treatment providers, community agencies, and stakeholders. The training focused on the culture, customs, and traditions of different Native tribes, as well as a discussion of historical trauma and institutional distrust. BHRS and Consolidated have worked together for several years to provide trainings to the community organizations on Native American culture.

MHP Providers increased their Spanish speaking staff. Redwood Quality Management Company's contracted providers have increased their number of bi-lingual clinicians to 11. Ortner Management Group contract providers have added 5 bi-lingual staff.

MC-BHRS has been providing outreach throughout the communities by inviting Latino agencies like Action Network and Nuestra Alianza to make presentations to the Cultural Competence Committee.

BHRS has provided Mental Health Outreach & Informational activities through MHSA. MHSA has been providing information and brochures at locations throughout the county, at farmers markets and Health Fairs. Once a month, they travel with the bookmobile to various locations. They supply information for all organizations within the county which provide Mental Health Services.

BHRS provided ongoing Cultural Awareness to staff, providers and community. Karen Lovato presented on: Collaboration of Care as a culturally competent practice, Whole person/explanatory model vs. Disease focused model, broad cultural factors to be aware of in the Asian/Pacific Islander, Latino, Native American, African American and LGBTQ groups, Promotoras Model, Native American Traditional Healing, and Innovative models for fighting stigma, providing culturally tailored programs. [Resource: Cultural Comp. plan 2013-2014]

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

The County of Mendocino has continued to improve procedures and processes to optimize its community outreach, engagement and involvement efforts with cultural communities with mental health disparities. Some of these efforts are as follows:

- Conducting meetings in remote areas to improve participation by cultural communities living outside of the population centers of the County. i.e., Covelo, Philo, etc. has been met with tremendously positive responses. Attendance by our remote communities is low at this time, but we are reaching individuals that had not previously been able to attend meetings.
- Going to farmer's markets, and other venues that are not associated with behavioral health services has been met, almost universally, with positive response. Most community members are happy to see the Behavioral Health Team, often we hear personal stories that appear not to have come to light in other venues. We occasionally hear complaints that might not have been aired if we were not present in these settings.
- We have improved and learned more about considerations for the cultural traditions of the hosting community when developing the agenda for a meeting scheduled in a specific area. We have been responsive to requests for adjustment of start and end time, whether or not bringing food is useful (when possible), and who the best promoters or advertisers are for the event (County staff versus local agency staff or local community members.)
- We have learned to partner with community organizations with close ties to the particular ethnic groups centralized in different areas to promote successful outreach, engagement and involvement efforts.
- Respond to feedback from community planning and stakeholder meetings by adapting and expanding programs, documents, and resources to include the feedback.
- We have learned, through feedback in some cases, that we have a long way to go in some areas of outreach and service provision, and we are working on implementing changes to respond to that feedback (e.g. services to Latinos provided in Spanish by bi-cultural staff, holding events / meetings in locations other than BHRS provider locations).

- Community Planning Processes for MHSA have given us significant feedback that more consumer feedback is desired. We added the Consumer Events to help with that goal, and are hopeful that as we consistently provide these events, attendance will increase. We are working with our stakeholders and community partners on helping to increase the communication about, assistance getting to, and developing understanding of the self-advocacy role with our consumers.
- Additionally, Mendocino County Behavioral Health & Recovery Services has used the SB82 grant funding and Intergovernmental Transfer Funds to develop a project that responds to urgent needs in our outlying and remote communities, and to help individuals connect to services in their community and through the integrated service coordination system.

E. Identify county technical assistance needs.

The County’s technical assistance needs relating to improvement of its community outreach, engagement and involvement efforts with identified racial, ethnic, cultural, linguistic and other relevant small county cultural communities with mental health disparities could involve the following:

- Assistance in identifying most common barriers to participation in stakeholder or community planning processes by local tribal, ethnic and linguistic groups, especially consumer and consumer family representation;
- Assistance in identifying the most effective and economical ways to remove barriers to participation;
- Strategies for improving Promotoras Models of service delivery for multiple cultural groups;
- Resources for providing Promotoras Model trainings in our local community; and
- Suggestions for methods with which to improve our bilingual service provider capacity (in addition to pay differentials which are already offered).

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

A. Cultural Competence/Ethnic Services Manager:

Karen Lovato, Program Manager; is the designated Ethnic Services Manager. The position was appointed in 2014, by the Assistant Director of Health Services. As a program manager involved with both Mental Health and Substance Use Disorder Treatment Programs the ESM is positioned to ensure the cultural and linguistic needs of all the Behavioral Health programs.

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

- Ensure completion of the Cultural Competence Plan
- Ensure adherence to cultural and linguistically appropriate standards and regulations
- Ensure facilitation of Cultural Competence/Cultural Diversity meetings
- Review, update, and maintain Policy & Procedures that pertain to diversity and cultural competence
- Ensure & document facilitation of trainings in cultural competence
- Monitor disparities in services to cultural, ethnic, or linguistic groups and develop strategies to minimize barriers
- Participates in the development of the MHSA Plan
- Regularly meets with members of the Quality Improvement team
- Serve as liaison and work in collaboration with behavioral health service providers and

key community groups

IV. Identify budget resources targeted for culturally competent activities

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

- Interpreter Services:
 - Language Line Solutions for any language translation services: Approximate annual usage in the amount of \$1500 for FY 15/16.
 - Contract with Communique for sign language translation services: (14/15 contract not to exceed \$30,000).
 - Pay differential for bilingual staff that use language services in the course of duties.
- Cultural Competency Training
 - Contract with Consolidated Tribal Health Project for annual training: Eight thousand dollars (\$8,000).
 - Additional funding set aside for trainings identified by the Cultural Diversity Committee meeting as priority: Ten thousand dollars (\$10,000).
- Special treatment Services toward the reduction of disparities:
 - MHSAs funds targeted at services therapeutic to Native American individuals: Consolidated Tribal Health Project Contract (Not to exceed \$32,000 when combined with outreach).
 - MHSAs funds targeted at therapeutic services to Latino individuals: Through Administrative Service Organizations, relationships are being developed for the 15/16 Fiscal year with Nuestra Alianza (\$40,000 combined with outreach).
 - Additional MHSAs funded programs through Administrative Service Organizations to Laytonville Healthy Start Family Resource Center, Tapestry Family Services, Action Network, Yuki Trails, and Full Service Partnerships.
- Special Outreach Services:
 - MHSAs funds for targeted outreach to remote and rural Native American Individuals: (Not to exceed \$32,000 when combined with therapeutic services).
 - MHSAs funds targeted at therapeutic services to Latino individuals: Through Administrative Service Organizations, relationships are being developed for the 15/16 Fiscal year with Nuestra Alianza (\$40,000 combined with outreach).
 - Additional MHSAs funded programs through Administrative Service Organizations to Laytonville Healthy Start Family Resource Center, Tapestry Family Services, Action Network, Yuki Trails, and Full Service Partnerships.
- Financial Incentives for culturally and linguistically competent providers
 - Workforce Education and Training (WET) funds are being prioritized by the WET subcommittee workgroup for distribution. Prioritization will be for culturally and linguistically competent providers, and peer providers.

See Attachment #7 MHSAs Plan for evidence.

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

Mendocino County Behavioral Health & Recovery Services makes every effort to use bilingual and bi-cultural staff for meeting the needs of a culturally and linguistically diverse population. In the event that bilingual and bicultural staff isn't available language line and translations services are used. Mendocino County Behavioral Health and Recovery Services recognize the concerns and challenges of using consumer friends and family members for translation.

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

Mendocino County Behavioral Health & Recovery Services requires all providers to be responsive to cultural and linguistic needs. In addition we partner, wherever possible, with community based providers that have targeted services to various cultural and linguistic populations. Some of these partnerships include: Yuki Trails, Consolidated Tribal Health, Laytonville Healthy Start Family Resource Center, Action Network, and Nuestra Alianza.

3. Outreach to racial and ethnic county-identified target populations; Consolidated MHSAs funds

Mendocino County Behavioral Health & Recovery Services requires all service providers to report on the outreach and engagement to ethnic minorities in particular our target ethnic populations of Latinos and Native Americans. Mendocino County Behavioral Health engages in partnerships with programs that provide services to these ethnic groups in order to facilitate outreach.

4. Culturally appropriate mental health services;

Mendocino County Behavioral Health & Recovery Services trains annually to Culturally Competent Services. In addition to the annual training additional opportunities for training, discussion, review of populations reached, and education are offered through the Cultural Diversity Committee Meetings, Quality Improvement Committee Meetings, and additional trainings. We are constantly working to improve and expand these trainings.

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

Mendocino County Behavioral Health & Recovery Services Workforce Education and Training (WET) component has been delayed due to the reorganization and implementation of the Integrated Care Coordination Service Delivery Model. The WET subcommittee has discussed significantly the need for stipends, scholarships, and other financial incentives for culturally and linguistically competent providers, peer providers, and traditional healers. The implementation of these planning discussions will begin in 2015.

Service	Service Type	Funding Source	Time Frame	Amount
Language Line Solutions	Interpreter	BHRS Administrative	Annual	As Needed/Varies (approx. 1500 in FY 14/15)
Communique	Interpreter	BHRS Administrative	Reviewed annually	As needed (not to exceed 30,000)
Staff Pay differential	Interpreter	BHRS Administrative	Continuous	Varies
Consolidated Tribal Health Project	Targeted Treatment & Outreach	MHSA	Reviewed annually	32,000
Consolidated Tribal Health Project	Training	MHSA	Reviewed annually	8,000
Nuestra Alianza	Targeted Treatment & Outreach	MHSA	New- will be reviewed annually	40,000
Undesignated Cultural Competency Training	Training	MHSA	Reviewed annually	10,000
Community based, culturally appropriate, services	Targeted Treatment & Outreach	MHSA	Reviewed annually	Varies defer to MHSA 3-Year plan
Undesignated scholarships	Workforce scholarships and training Incentives	MHSA-WET	By F/Y 2018-19	Defer to MHSA WET component

CRITERION 2

COUNTY MENTAL HEALTH SYSTEM UPDATED

ASSESSMENT OF SERVICE NEEDS

I. General Population

A. Summarize the county's general population by race, ethnicity, age, and gender.

Based on United States Census Bureau data & extrapolations from that data. Please note that because of overlapping data and approximations based on rounding of percentages, these total numbers will not add to the total population.

	Mendocino County Total number	Mendocino County Percentage	California
Total Population estimate(2014)	87,869	0.22%	38,802,500
Female (2013)	44,022 approx.	50.1%	50.3%
White alone (not Latino)(2013)	58,872 approx.	67.0%	39.0
White alone (including Latino) (2013)	76,094 approx.	86.6%	73.5
Black/African American alone (2013)	878 approx.	1.0%	6.6%
American Indian/Alaska Native (2013)	5535 approx.	6.3%	1.7%
Native Hawaiian/Pacific Islander alone (2013)	176 approx.	0.2%	0.5%
Asian alone (2013)	1,845 approx.	2.1%	14.1%
Hispanic/Latino (2013)	20,649 approx.	23.5%	38.4%
Two or more races (2013)	3,427 approx.	3.9%	3.7%
Under 18 years (2013)	19,067 approx.	21.7%	23.9%
Over 65 years (2013)	15,992 approx.	18.2%	12.5%

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).

Mendocino County is a large rural county in Northern California with 3,510 square miles of land- equal in size to Puerto Rico and a 2014 US Census Bureau population estimate of 87,869. The County seat is in Ukiah, which can be more than two hours away on 2 lane mountain highway roads from other communities. Some remote areas can be isolated during inclement weather. Public transportation is minimal.

Mendocino County Population is predominantly white and Latino. According to US Census

data from 2013, 67.0% of the population identifies as white alone and 23.5% of the population identifies as Hispanic/Latino. The census captures a designation of White that does not distinguish from Latino/Hispanic, and the percentage of the population that identifies that way is 86.6%. In addition, 6.3 % of Mendocino County residents identify as Native American, 2.1% identify as Asian, 1% identifies as African American, 0.2% identifies as Pacific Islander and 3.9% identify as having two or more races. In comparison with California population rates, Mendocino County has a higher percentage of Native Americans than the State rates. Mendocino County also has a higher percentage of individuals that identify as white than the California rates. Mendocino County has lower percentages of individuals that identify as African American, Pacific Islander, Asian, and Latino than the California rates.

Mendocino County has a relatively balanced gender concentration with 50.1% of the population being female which is very similar to the State rate of 50.3%. The census does not currently collect data on other gender designations besides male and female, but it is the intent of Mendocino County Behavioral Health and Recovery Services to collect data on additional designations of gender in order to be able to report out on services to those of non-binary gender identities.

Mendocino County's population has more individuals over the age of 65 at 18.2% than the California rate of 12.5%. The population of those under 18 is 21.7% compared with 23.9% for California's Population rate. Mendocino County strives to collect data on more targeted age groups in line with the Mental Health Services Act (MHSA) age designations of: Child (0-15), Transition Aged Youth (16-25), Adult (26-59), and Older Adult (60+).

*Note: Statewide Penetration Rates are from APS Healthcare data from 9/9/13 CAEQRO Report.

**Note: APS Penetration Rate data age ranges are from 18-59 and 60+ which are different from the other rates in this table and may skew attempts to compare data.

	County Pop	Medi-Cal Eligible	Medi-Cal Beneficiaries Served	Penetration Rate	Statewide Penetration Rate*
Race/Ethnicity					
White	60,131	13,169	905	6.87%	9.73
Hispanic	18,046	8,207	173	2.11%	3.88
African-American	584	250	36	14.40%	10.51
Asian/Pacific Islander	1,343	304	53	17.43%	7.58
Native American	3,744	1755	110	6.27%	9.39
Other	0	1278	26	2.03%	1.67
Total	83,848	24,963	1,193 (unduplicated)		
Age					
0-5	6,687	4,367	54	1.24%	1.87
6-17	12,643	6,561	684	10.44%	7.67
18-54	39,760	10,734	502	4.68%	7.28**(age 18-59)
55+	26,951	3,310	63	1.90%	3.42**(age 60+)
Gender					
Female	43,059	13,648	644	4.72%	5.26
Male	42,981	11,313	659	5.83%	6.60

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

Based on the information listed above, Mendocino County Behavioral Health and recovery Services has significantly higher penetration rates than the statewide penetration rates among African Americans and Asian/Pacific Islanders, and also higher penetration rates of individuals that identified as having an ethnicity other than those listed. Mendocino County Behavioral Health & Recovery services have lower than statewide penetration rates for White, Hispanic, and Native American ethnicities. Mendocino County Behavioral Health & Recovery Services has lower than statewide penetration rates for all age groups except 6-17 year olds. Please note, that the penetration rates between Mendocino County and Statewide are calculated for different age ranges. Mendocino County BHRS has lower than Statewide Penetration rates for both male and female genders.

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

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).

Race/Ethnicity	200% Poverty (minus Medi-Cal)	Clients Served "not covered by Medi-Cal"
White	65	89
Hispanic	9	16
African-American	0	0
Asian/Pacific Islander	0	1
Native American	6	7
Unknown	8	11
Other Race	0	2
Age		
0-17	1	28
18+	88	98
Gender		
Female	45	62
Male	36	56
Unknown	4	8

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

Mendocino County's poverty rates for 2013 were estimated at 17,947 for all age groups and 5,329 for children / youth 0-17, per the USDA.

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

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).**

Children and Youth (Ages 0-18)											
	Fully Served**		Underserved or Inappropriately Served**			Total Served (total identified as needing SMI percentage is of the population?)*		County Poverty Population*		County Population	
	Male	Female	Male	Female	Other	#	%	#	%	#	%
TOTAL	8	2	161	148	4	4,988	7.91	10,743	8.84	87,869	100
RACE/ETHNICITY (Note: underserved data not reported by gender as of 2015 report)											
African American	0	1	11			16	7.98	110	8.96	878	1.0
Asian Pacific Islander	0	0	0			19	15.68	88	*	176	0.2
Latino	4	0	79			582	8.28	4,831	8.91	20,649	23.5
Native American	1	0	13			99	8.4	824	8.86	5,535	6.3
White	3	1	150			751	7.55	4,468	8.72	58,872	67.0
Other (two or more races)	0	0	60			63	8.22	421	9.16	3,427	3.9

* Note County Poverty data from the DHCS website:

<http://www.dhcs.ca.gov/provgovpart/Documents/CaliforniaPrevalenceEstimates.pdf> Severe Mental Illness Prevalence Rates. Data is provided separately for Asians and Pacific Islanders, and the Percent was not combined and is determined from the total population.

**Fully Served= Full Service Partnership Data. Under/Inappropriately Served = Outreach & Engagement data.

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

For the 0-18 age group gender breakdown analysis, the Full Service Partners are predominantly male. In the Outreach & Engagement services, the number of population served are more balanced at 51.4% male, 47.3% female, and 1.3% identifying as a gender other than male or female. It is believed that the earlier age of mental health first break is contributing to the higher rates of males being enrolled in full service partnerships than females.

For the 0-18 age group ethnicity analysis, the data shows that we are serving Latino and White individuals more than all other groups combined, and at about the same rate. The low rate of Native Americans served with Full Service Partnerships is concerning. Native Americans are a prioritized group. More research needs to be analyzed to determine whether Native Americans have a low rate of services across the Mental Health Plan or just in relations to MHSA Full Service Partnerships. The outreach and engagement services indicate that White individuals make up approximately half of those served in outreach & engagement, and Latinos make up approximately a quarter of those served. Those of multiple races/ethnicity make up approximately a quarter of that population, with

Native Americans and African Americans each making up approximately 4%. Again the low rates of Native Americans served in this age group is concerning since they are a priority population, and make up over 6% of the total population and approximately 9% of the county poverty population. The rates of service in both Full Service Partnerships and Outreach and Engagement Services indicate that Latinos are being served at a comparable rate to the County population of 23.5%.

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

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 or experiencing juvenile justice involvement

Project and Agency	Target Population
CalMHSA	1,2,3,4,5,6
North Bay/Mendocino County Suicide Prevention Project	1,2
Child, Family & Transition Age Youth Programs	
Education, De-Stigmatization & Peer Support	1,2,3,4,5,6
Prevention Collaboration	1,2,3,4,5,6
Support Services	1,2,3,4,5,6
Katie A Program	1,2,3,4,5,6
Child & Adolescent Substance Abuse Outreach	1,3,4,5,6
Adult and Older Adult Programs	
Education De-Stigmatization & Peer Support	1,2,3,4,5,6
Senior Peer Counseling	1,2

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

Mendocino County has used the Consumer Planning Processes for selecting and prioritizing projects through MHSA. These include Stakeholder Forums, Mental Health Advisory Board feedback, Public Hearings, Quality Improvement Meetings, Consumer Feedback events, and individualized feedback from consumers and stakeholders. We have also employed awareness surveys, beneficiary satisfaction surveys, and a Needs Assessment survey.

Mendocino County has small rural communities that can take an hour or two in travel time from the primary service centers. Several of the PEI projects were prioritized to provide services,

supports, and awareness to those needing education and early intervention in remote settings.

- CalMHSA- Mendocino County supports funding for the statewide prevention and early intervention projects. These projects promote mental health, reduce the risk of mental disorders, and diminish the severity and negative consequences associated with the onset of mental, emotional, and behavioral disorders in accordance with the statewide PEI Implementation Work plan, Phase 2.
- North Bay/Mendocino County Suicide Prevention Project- Mendocino County is participating in the CalMHSA North Bay Suicide Prevention Project (NBSP), managed by Family Service Agency of Marin. The goal of the project is to actively engage the community to promote mental health, prevent suicide, and reduce stigma across the lifespan. A committee made up of County Mental Health staff, Mental Health Plan providers and other local stake holders meet regularly to determine the community's unique needs and develop action plans tailored to fit the needs of the community, with an emphasis on reaching out to the bilingual, culturally diverse and remote populations.
- Education, De-stigmatization & Peer Support- The Education, De-stigmatization, and Peer Support program is a contracted service that provides prevention and early intervention services to students throughout Mendocino County by using Interactive Education Modules and Peer Support Groups. Youth workers deliver "Breaking the Silence" education curriculum including Spanish program materials for the middle school levels. Youth who may benefit from receiving additional services are offered the opportunity to participate in on campus groups developed under the direction of a program director, clinical supervisors, school counselors, and the youth workers.
- Prevention Collaboration- The PEI Groups in Schools is a project of the Mendocino County Behavioral Health and Recovery Services in cooperation with a Mental Health Plan Provider and various schools and school districts throughout Mendocino County. The project's goal is the early identification and treatment of young people experiencing the first signs of a serious mental illness. The PEI Groups in schools are led by Mental Health Plan providers. These groups provide therapy, rehabilitation, and prevention. These groups are designed to meet the particular needs of the students and to fit with the skills of the clinicians, rehabilitation specialists and prevention specialists. The group leaders use the Brief Screening Survey, which was developed jointly with local pediatric psychiatrists and the MHSA PEI workgroup, for the detection of symptoms of psychosis or serious mental illness.
- Support Services- Mental Health Plan providers provide outreach and support services for Children, Youth, and Families throughout Mendocino County who have been screened using the Brief Screening Survey for Adolescents and Young Adults for symptoms of serious Mental Illness, have been determined to show early signs for serious mental illness, and are in need of Mental Health treatment services but are not eligible for Medi-Cal other covered services.
- Katie A Program- The Katie A. Class Action Lawsuit, after over 11 years of negotiations, has been implemented in Mendocino County. It mandates Mental Health and Child Welfare Services (CWS) to work in collaboration to provide Mental Health services when a child qualifies for services based on the Katie A. subclass criteria. Mendocino County has redesigned the service delivery through collaboration with Child Welfare Services. This redesign of the existing service expands and introduces a proactive

component in assessment, treatment, and care plan development of the children / youth in the Child Welfare System. This is a key component that has been introduced by the Core Practice Model as required by Katie A. legislation.

- Child & Adolescent Substance Abuse Outreach- This is a new program developed based on the need identified in MHSA stakeholder Forums. Mendocino County will facilitate outreach, prevention, intervention and counseling programs that enhance the internal strengths and resiliency of children and adolescents while addressing patterns of substance abuse. These programs will include prevention and education groups, individual and group counseling, and a variety of clean and sober health activities, including community service projects.
- Senior Peer Counseling- Senior Peer Counseling program is a project to decrease client risk factors for depression, decrease isolation, decrease psychiatric hospitalizations, and identify and appropriately respond to client indicators of suicide risk through training and clinical supervision. Mendocino County Health Plan Providers provide these services inland and on the coast. Supervision and training is provided by licensed clinicians experienced in the Senior Peer Counseling model to at least 20 Senior Peer Counselors to recognize signs of self-neglect, elder abuse, substance abuse, medication misuse/nonuse, suicide risk, depression, anxiety, and other mental illness. Through the Peer support model the volunteer counselors can help the at risk seniors to overcome barriers, reduce risk factors, and become more involved in self-care and wellness. Currently there are Senior Peer Counselors serving Ukiah, Willits, and Fort Bragg area. During the Fiscal Year 14/15 Mendocino County Mental Health Plan Providers began planning for expansion of Sr. Peer Counseling to the South Coast through Coastal Seniors and will be implementing services in FY 15-16 through the Coastal Senior Center. Mendocino County plans to expand Senior Peer Counseling further as resources allow. Supervision of Peer Counselors is provided by licensed clinicians experienced with the Senior Peer Counseling model who provide training and support.

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

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:

A. Community Services Support (CSS) population:

Mendocino County Behavioral Health & Recovery Services CSS population consists primarily of Full Service Partnership consumers. Full Service Partnership clients are those with severe and persistent mental illness, that are at risk for higher levels of care if not provided a “whatever it takes” care management approach to help them connect with behavioral health / mental health service delivery. Prioritization is given to those with co-occurring disorders, of underserved ethnic populations, homeless individuals, those involved in the criminal justice system, the uninsured, and those living in remote and outlying areas of the County with barriers to accessing services. Additionally, Community Services and Supports population include Outreach and Engagement services such as Wellness and Resource Centers for education, information, and stigma reduction, targeted therapeutic outreach to populations unlikely to seek therapeutic services through system entry points.

B. Workforce, Education, and Training (WET) population:

Mendocino County Behavioral Health & Recovery Services aims to grow a multicultural and multilingual (bilingual Spanish in particular) workforce that is competent in recovery and peer provider models. The Workforce Education and Training subcommittee has focused on developing training and educational processes to build the workforce locally, as well as to provide scholarships and stipends for local providers and students to expand and increase their training and education. Prioritization is given for those that are bilingual, bicultural, and those with lived experience.

C. Prevention and Early Intervention (PEI) priority populations:

These populations are county identified from the six PEI priority populations. Latino and Native American cultures are identified as our underserved cultural populations based on disparities. LGBTQ individuals are believed to be underserved, though there is not the data to support this at this time. Youth and seniors are identified as individuals experiencing onset of serious psychiatric illness, youth with first break psychosis, and seniors at risk for depression and suicidal thought related to loss. Children and youth in stressed family, trauma exposed youth, and children and youth at risk of school failure and juvenile justice involvement are served through the education, de-stigmatization and peer support programs and Prevention Collaboration projects in targeted school districts.

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

In all categories Latino and Native American ethnic groups are identified as groups with

known disparities.

E. 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).

Mendocino County Behavioral Health chose to identify programs that would serve multiple PEI priority populations rather than choosing the top priority of PEI priority populations to develop targeted programs to. For example, The Prevention Collaboration that involves services to remote and rural school districts helps screen and provide early intervention to youth in schools, and so identifies the priority populations of children that may be experiencing the onset of psychiatric illness, children who may be in stressed families, potentially trauma exposed individuals, and children at risk of both school failure and or juvenile justice involvement. Because the targeted school districts are in areas that are more heavily populated by our underserved cultural groups, we also meet that priority population objective.

II. Identified disparities (within the 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's priority/targeted populations).

Mendocino County Behavioral Health and Recovery Services identify our Latino, Native American, and White communities as the largest populations with the most significant underserved ethnic disparities. In order to address those disparities we have implemented prioritization in our CSS, WET, and PEI plans for Native American and Latino individuals, and we continue to increase our outreach and engagement activities to increase awareness and input on services in all areas.

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.

CSS Strategies to reduce disparities: Mendocino County BHRS prioritizes services to Latino and Native American individuals in the prioritization criteria for Full Service Partnerships. CSS programs are expected to prioritize and identify the clients served by ethnicity, so we can identify the progress made in addressing disparities.

WET Strategies to reduce disparities: Mendocino County BHRS prioritizes applicants for scholarships and stipends based on multicultural and multilingual capacity. Trainings and educational opportunities offered through WET will be prioritized to Latino and Native American individuals as well as LGBTQ individuals.

PEI Strategies to reduce disparities: PEI funding through the Prevention Collaboration is targeted to schools and school districts that are populated more heavily by those of Latino and Native American ethnicity.

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

II. Medi-Cal population-

All Mendocino County Behavioral Health & Recovery Services Medi-Cal service providers are required to track the demographic and linguistic information on the clients they serve. Mendocino County BHRS requires providers to offer materials & services in the threshold language(s) of the County, and provide translation services for other languages. Regular review of the statistics will help to determine where disparities continue to exist. Participation in Quality Improvement Committee and Cultural Diversity Committee meetings will present the opportunity to discuss and learn about strategies to reduce disparities. Regular trainings in cultural competency are offered by the County. BHRS SUDT programs have a staff person that can aid in helping clients that are eligible for Medi-Cal connect and become enrolled as part of a collaboration with Employment and Family Assistance Services (EFAS).

IV. MHSA/CSS population-

Full Service Partnerships- A Mendocino County BHRS strategy to reduce disparities in the Full Service Partnerships is to prioritize those ethnic and cultural groups that continue to show that they have disparities. Full Service Partnerships uses the partnership model of including all supports that the client identifies such as partners, natural and traditional supports. By providing a “whatever it takes” care management model, all attempts are made to engage the client in services and include natural and traditional, familial, or cultural supports as is appropriate and desired by the consumer.

CSS Outreach & Engagement- Mendocino County BHRS strategy to reduce disparities in our Outreach & Engagement Services, is to ask these program providers to provide documentation of the clients they serve, and to track the disparities over time. Discussions are held during the Community Planning Process events around how to improve penetration rates and outreach.

- V. PEI priority population(s)** selected by the county, from the six PEI priority populations Mendocino County Behavioral Health chose to identify programs that would serve multiple PEI priority populations rather than choosing the top priority of PEI priority populations to develop targeted programs to. For example, The Prevention Collaboration that involves services to remote and rural school districts helps screen and provide early intervention to youth in schools, and so identifies the priority populations of children that may be experiencing the onset of psychiatric illness, children who may be in in stressed families, potentially trauma exposed individuals, and children at risk of both school failure and or juvenile justice involvement. Because the targeted school districts are in areas that are more heavily populated by our underserved cultural groups, we also meet that priority population objective.

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.**

Additional PEI services that are targeted to underserved Latinos are two CalMHSA sponsored

Each Mind Matters & Know the Signs projects. The first are fotonovelas: picture books for families in English and Spanish that describe the benefits of talking about feelings and discussing stigma around mental illness. The second are Rotofolio trainings, which are a brief suicide awareness and prevention trainings done in Spanish.

We have expanded the training budget for 2015-16 and will be increasing the number and types of trainings offered. We will be collecting Cultural Diversity Committee stakeholder feedback on which trainings to prioritize, beyond those that address our underserved ethnic populations. We conducted a survey of Cultural Diversity Committee stakeholders to request initial suggestions for training topics.

Additionally, in 2015-16 we intend to improve the response to feedback and surveys and to ensure a broader understanding of the cultural and linguistic composition of behavioral health staff in Mendocino County. We also intend to add more evaluations and surveys to meetings and trainings to help with increasing the amount of feedback we are able to collect.

B. 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.

Mendocino County BHRS has received a lot of positive feedback for the strategy of having meetings and consumer feedback opportunities travel throughout the County. Anecdotally, we are seeing an increase in communication with individuals and agencies that were not previously participating in stakeholder feedback. However, we still get the feedback that we aren't reaching enough consumers of services. With that feedback we continue to expand the number of and types of meetings that are mobile. We are also working on maximizing the locations chosen for these meetings, prioritizing consumer friendly and easily accessible locations. And finally, we are enlisting stakeholder support in bridging communication with consumers, as we anticipate that stakeholders that attend meetings will become the promoters for other consumers to feel comfortable attending and self-advocating.

We feel that we have improved the frequency and content of conversations with community providers that target services to our underserved cultural and linguistic populations. In the coming year we would like to continue to improve the relationships, funding, and data collection from those agencies.

We have received feedback requesting more data, and so intend to increase the data reporting made available through our programs.

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

The county shall include the following in the CCPR:

A. 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.

Mendocino County Behavioral Health Plan providers will collect and provide demographic data on consumers served including but not limited to: gender/sexuality, age, ethnicity, primary language. This data will be reported quarterly for consumer and community stakeholders at Cultural Diversity Committee Meetings, Quality Improvement Meetings, as well as summarized in the annual Cultural Competency plan updates.

Mendocino County BHRS will ensure the regular collection of demographic data, and will work to increase the quantity of data provided in stakeholder forums.

Mendocino County BHRS will review and measures the numbers and percentages of clients served as well as penetration rates compared to state penetration rates to determine and monitor the reduction or elimination of disparities. By comparing the number of clients served with the population rates in Mendocino County of various groups, we can determine if we are adequately addressing ethnic, gender, or age disparities.

The Cultural Diversity Committee Meetings will review, discuss and address strategies being utilized as well as new strategies needed to address disparities in our service delivery.

C. Identify county technical assistance needs.

- Training and support in interpreting and describing consumer friendly analysis of disparity and penetration rates
- Training and support in developing effective small county strategies to reduce disparities
- Training and support in effective small county strategies to increase bilingual populations
- Trainings and resources on developing collaborations with community based groups of ethnic, linguistic, or other cultural groups
- Trainings and resources on developing additional funding streams, grants, etc. toward the development of culturally competent programs and practices.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

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

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

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. Cultural Diversity Committee Meeting:** The Cultural Diversity Committee meeting meets regularly (monthly to quarterly depending on feedback from stakeholders, schedule determined annually). The Cultural Diversity Committee is a chance for stakeholders comprising of Behavioral Health & Recovery Services providers, clients, and concerned community members to discuss cultural competency in provider agencies, disparities, culturally competent practices, and trainings to be brought to Mendocino County.
- 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;**

See Attachment 6 for the following Policies and Procedures:
MH P/P No. I.C-1 Role of the Cultural Competency Committee

C. Organizational chart; See Attachment # 9, Organizational Chart

D. Committee membership roster listing member affiliation if any.

Name	Organization
Javier Chavez	Action Network
Melanie Ulvila	Consolidated Tribal Health Project
Anita Toste	Hopland Band of Pomo Indians
Todd Harris	Integrated Care Management Solutions
Wynd Novontny	Manzanita Services, Inc.
Waldi Helma	Mendocino Coast Hospitality Center
Patient's Rights Advocate	Mendocino County Behavioral Health & Recovery Services
Tom Pinizzotto, HHSA Assistant Director of Health Services,	Mendocino County Behavioral Health & Recovery Services
Jenine Miller, Deputy Director	Mendocino County Behavioral Health & Recovery Services
Barbie Svendsen, Quality Assurance Supervisor	Mendocino County Behavioral Health & Recovery Services

Quality Assurance Manager	Mendocino County Behavioral Health & Recovery Services
Karen Lovato, Ethnic Services Manager	Mendocino County Behavioral Health & Recovery Services
Art Davidson, SUDT Supervisor	Mendocino County Behavioral Health & Recovery Services
Hilary James, SUDT Supervisor	Mendocino County Behavioral Health & Recovery Services
Medical Director	Mendocino County Behavioral Health & Recovery Services
Natasha Carter	Mendocino County Office of Education
Serena Jones	Mendocino County Youth Project
Dina Ortiz	Mental Health Advisory Board
Maureen O'Sullivan	Mental Health Advisory Board
Donna Moschetti or designee	NAMI
Dina Hutton	Nuestra Alianza
Louisa Acosta	Nuestra Casa
Mark Montgomery	Ortner Management Group
Danielle Lower	Redwood Community Services
Tim Schraeder	Redwood Quality Management Company
Denise Gorny	State Council on Developmental Disabilities
Kevin Powers	Tapestry Family Services
Consumer and community participants	Varies
Otis Brotherton	Yuki Trails/Round Valley Indian Health Center

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

Review of 2014/15 Goals:

Goal 1) To develop culturally appropriate strategies to destigmatize behavioral health for consumers and family members.

This goal was met through the development of the following destigmatizing events: May is Mental Health Month outreach to farmer's markets and health fairs, Behavioral Health resources shared with the Bookmobile, Suicide prevention week, Suicide Prevention Awareness wristbands, the addition of participation in as needed health fair requests, the addition of Consumer events targeted toward collecting feedback from consumers and family members, and the distribution of a Mental Health Awareness Survey. The MHSA team has requested increased involvement and possible strategies from local culturally focused and bilingual programs, and intends to further develop those relationships.

While this goal is considered successfully met for developing strategies, there will be continued next steps to progress in additional objectives toward improving destigmatizing behavioral health for consumers and family members.

Goal 2) To develop and maintain guiding principles and expectations of culturally competency based services.

Mental Health Awareness and self-assessment tools were created to evaluate and track knowledge and desired trainings. There is an increased expectation of behavioral health

providers to address disparities and penetration rates. Additional trainings have been offered to increase providers competency.

Goal 3) To raise the penetration rate for Hispanic/Latino consumers from current level of 2.9% to 3.8 %

The penetration rate for Hispanic/Latino consumers did improve from 2.9 to 2.11 in this fiscal year. The rates of 0-18 year old Hispanic/Latino consumers also shows the increased efforts to both outreach and engagement services and in providing full service partnership services to Hispanic/Latino consumers. However, we still have a ways to go to improve these penetration rates.

We do have additional strategies in process to continue to increase this rate, such as establishing additional relationships with community based service agencies which provide targeted services to Latinos in Spanish, in an attempt to increase de-stigmatized outreach and therapeutic services. Through Each Mind Matters and Know the Signs, we will be disseminating fotonovellas which are awareness raising tools in English and Spanish. Also, from Each Mind Matters and Know the Signs we are offering Rotofolio brief suicide intervention and awareness training in Spanish.

Goal 4) To identify an Ethnic Services Manager

Karen Lovato, Program Manager was appointed to Ethnic Services manager in August of 2014.

2015/16 Goals

Mental Health Reducing Health Disparities 201 WORKPLAN							
Goal	Description	Measure	Person Responsible	Method	Completion Date	Completion Criteria	
Improve and Monitor Linguistic Access							
1.	Complete Cultural Competence of Workforce Survey.	Survey of BHRS workforce identifying ethnic, linguistic, and cultural composition of BHRS workforce, to be conducted annually.	Annual make up of BHRS workforce by service provider.	Karen Lovato, Ethnic Services Manager	Survey Monkey	12/2015	Survey disseminated to service providers with at least a 75% return rate.
2.	Finalize Training Schedule with Cultural Diversity Committee.	Obtain committee feedback on prioritized trainings.	Completed training list for 2015/16 and outline for future years.	Karen Lovato, Ethnic Services Manager	Research, prioritize with committee and select	12/2015	Training Schedule proposed and approved by Committee as reflected in Committee minutes.
3.	Implement Annual training on	Develop contract with trainer	Contract completed and	Karen Lovato, Ethnic	Research potential trainers.	12/2015	Contract with trainer approved and reflected in

	Latino history and culturally competent practices.	agency on providing an annual training in Latino history and services.	approved for Fy15/16, with intent to be annual if training satisfactory.	Services Manager, in coordination with Contracts unit and Cultural Diversity Committee for approving which provider/trainer to contract with.	Present options to committee to select trainer. Draft contract. Propose contract to County for approval. Implement training by end of fiscal year (ideally closer to Hispanic Heritage Month)		committee minutes and BOS Agenda minutes.
4.	Improve penetration rate of services to Native American individuals to the state penetration rate.	Raise penetration rate from 3.27% to 9.39%	Penetration Rates as provided by CAEQRO	Behavioral Health Providers: Mendocino County BHRS, Redwood Quality Management Company, Ortner Management Group	Improvement of outreach and engagement with Native American Communities.	6/2018	Penetration rate increased to state rate.
5.	Improve penetration rate of services to Latino individuals to the state penetration rate.	Raise penetration rate from 2.11% to 3.88%	Penetration Rates as provided by CAEQRO.	Behavioral Health Providers: Mendocino County BHRS, Redwood Quality Management Company, Ortner Management Group	Improvement of outreach and engagement with Latino Communities.	6/2018	Penetration rate increased to state rate.

Sources of Information:

Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department.

CRITERION 5

COUNTY MENTAL HEALTH SYSTEM CULTURALLY

COMPETENT TRAINING ACTIVITIES

Rationale: Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).

1. 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:

Training Event	Description of Training	How long and often	Target Staff/Stakeholder type	Target Date of Training	Cultural Competence Topics Included
<i>Example</i> <i>Cultural Competence Introduction</i>	<i>Overview of cultural competence issues in mental health treatment settings.</i>	<i>Four hours annually</i>	<i>*Direct Services *Direct Services (County/Contractor) Support services *Administration *Interpreters *Mental Health Board *Community Organizations *Peers/Peer providers *Open to general Community</i>	<i>1/24/10</i>	Cultural Formulation Multicultural Knowledge Cultural Sensitivity Cultural Awareness Social Diversity Mental Health Interpreter training Training staff to use interpreters Family Focused Treatment Navigating multiple Agency services Resiliency

Mendocino County BHRS Cultural Competency Three Year Training Plan

Training Event	Description of Training	How long and often	Target Staff/Stakeholder type	Target Date of Training	Cultural Competence Topics Included
Native American History and Culturally Competent Practices	Overview of Native American History, culturally competent practices, disparities, and strategies to overcome.	Annually, 3-6 hours	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> 	June 2016 June 2017 June 2018	<ul style="list-style-type: none"> • Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Latino History and Culturally Competent Practices	Overview of Latino History, culturally competent practices, disparities, and strategies to overcome	Annually, 3-6 hours	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> 	October 2016 October 2017 October 2018	<ul style="list-style-type: none"> • Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Mini Training on Targeted disparities during Cultural Diversity Committee Meeting	Brief review of disparities, strategies	Quarterly, 20-60 minutes	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> 	4 per year for 2015-2018 Schedule confirmed by CDC	<ul style="list-style-type: none"> • Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Family Focused Treatment
Webinar Training on Targeted Cultural Competence issues	Focused cultural competency issues	As available	<i>Varies by Webinar, most made available to all stakeholders</i>	Varies	<ul style="list-style-type: none"> • Cultural formulation • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Family Focused Treatment • Navigating Multiple Agency Service • Resiliency
EI Rotofolio	Suicide Prevention Skills Training for Spanish Speakers	As requested, 8 hours	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> 	At least once per year for 2015-2018	<ul style="list-style-type: none"> • Multicultural Knowledge • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency • Interpreter Training
ASIST	Applied Suicide Intervention Skills Training	3 per year, 16 hours	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> 	3 per year for 2014-2018	<ul style="list-style-type: none"> • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency

Safe Talk	Suicide awareness for everyone	3 per year, 3 hours	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> • <i>General Community</i> • <i>Schools</i> 	3 per year 2014-2018	<ul style="list-style-type: none"> • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Peer Provider Training	Peer certification training	To be determined	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> 	As prioritized by CDC	<ul style="list-style-type: none"> • Peer Cultural awareness & sensitivity • Navigating Multiple Agency Services • Resiliency • Social Diversity • Family Focused Treatment
CLAS Standards Training	Review of the National Cultural and Linguistically Appropriate service Standards	Annually	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Interpreters</i> • <i>Peer Providers</i> 	July 2015 July 2016 July 2017 And upon new hire	<ul style="list-style-type: none"> • Cultural awareness & sensitivity • Navigating Multiple Agency Services • Training staff to use interpreters
Mental Health Awareness	Awareness raising event about mental health topics for the general community	Annually, Varies	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> 	Annually, May	<ul style="list-style-type: none"> • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Substance Use Awareness	Awareness raising event about substance use topics for the general community	Annually, Varies	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> 	Annually, April or October	<ul style="list-style-type: none"> • Cultural awareness & sensitivity • Social diversity • Navigating Multiple Agency Service • Resiliency
Minority Behavioral Health Awareness	Awareness raising event about behavioral health issues within the context of minority issues and cultural competence.	Annually, Varies	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Support Service providers</i> • <i>Administration</i> • <i>Mental Health Board</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> 	Annually, July	To be Determined
LGBTQ Culture Ally Training (with focus on youth and seniors)	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC (preferably around Pride May/June)	<i>To be Determined</i>

Katie A. Wraparound Training	Skills in Facilitation of ICC, IHBS, and Child, Family Team Meeting skills	Varies, Annual	<ul style="list-style-type: none"> • <i>Direct Service providers</i> • <i>Administration</i> • <i>Peers & Peer Providers</i> • <i>Community Orgs.</i> 	Annually, TBD	<ul style="list-style-type: none"> • Family Focused Treatment • Navigating Multiple Agency Service • Resiliency • Social diversity • Cultural awareness and sensitivity
Gang Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Marijuana Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
East Indian Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Thai Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Nepalese Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Russian culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Native American Two Spirit Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
African American Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Asian Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>
Veteran Culture	Requested in Survey 7/15, training details to be determined	As prioritized by Committee	<i>To be Determined</i>	As prioritized by CDC	<i>To be Determined</i>

1. Steps the county will take to provide required cultural competence training to 100% of their staff over a three year period.

Mendocino County BHRS will begin tracking staff attendance at cultural competence trainings. Staff are required to participate annually in the Culturally and Linguistically Appropriate Service (CLAS) Standards, and participation is tracked as a part of performance and supervision review. Attendance at (at least) one cultural competence training will be added to this list of annual review requirements.

Behavioral Health providers will be expected to report out annually in the Cultural Diversity

Committee the number and percentage of staff that have participated in a Cultural Competence Training within the 3 year plan period.

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

Cultural competence is embedded into all trainings in that trainers are expected to take into consideration the ethnic, generational, and gender differences of individuals and groups. Trainings are to be provided in a sensitive manner, and training topics are expected to include pertinent culturally appropriate topics and information.

3. Report of annual training for staff, documented stakeholder invitation, by stakeholder type:

For each cultural competence training or event stakeholders were invited in the following ways:

- Email invitation to all stakeholders (Stakeholders include, BHRS providers, board members, community providers, medical staff, law enforcement, and any community members that provided an email address upon signing in to a previous meeting;
- Public Service Announcement;
- Flier sent to emailed stakeholders;
- Flier sent to all Contract providers to be posted for public and consumer view;
- Event mentioned at stakeholder meetings preceding the event(such as MHSA, QIC, etc.), and fliers disseminated;
- Event added to MHSA calendar of events posted on the MHSA website;
- Event flier posted on BHRS QIC website.

All stakeholders were invited to all events provided in 2014/15.

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

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;
2. Navigating multiple agency services; and
3. Resiliency

Use the following format to report the above requirements:

Training Event	Description of Training	How long and often	Attendance by Function	No. of Attendees and Total	Date of Training	Name of Presenter
<i>Example</i> <i>Cultural Competence Introduction</i>	<i>Overview of cultural competence issues in mental health treatment settings.</i>	<i>Four hours annually</i>	<i>*Direct Services *Direct Services *Administration *Interpreters</i>	<i>15 20 4 2 Total: 41</i>	<i>1/24/10</i>	

Mendocino County BHRS Cultural Competence Trainings FY 14/15

Training Event	Description of Training	How Long and how often	Attendance by Function	Number of Attendees by function and total	Date of Training	Name of Presenter
Mini Training at Cultural Diversity Committee Meeting	Brief overview of culturally competent care and general behavioral health disparities among Native Americans.	1.5 hrs, Quarterly meeting	Direct Service Providers Administration Interpreters Community Total	17	11-20-14	Karen Lovato, Ethnic Services Manager
Providing Culturally Competent Services to Latino Immigrant Populations	Multidimensional factors faced by Latino immigrants including acculturation, socio-emotional development, family dynamics, spirituality, and barriers faced.	1.5 hrs, one time (Webinar viewing)	Direct Service Providers Administration Interpreters Community Total	6	12-2-14	Jaime Penaherra, MBS, MA
Effective & Meaningful Client and Stakeholder Participation	How to identify opportunities, develop skills in meaningful participation, promising practices.	Webinar only		Unknown who registered for the webinar	12/2/14	Camhpro & PEERS
Enhancing Emotional & Mental Health for Spanish Speaking Latinos in Rural Communities	Integration of Promotoras into a County Mental Health System, and over view on how PEI efforts to reduce stigma and promote well-being.	1 hour, one time (Webinar viewing)	Direct Service Providers Administration Interpreters Community Total	6	12-9-14	Center for Dignity, Recovery, and Empowerment
Working Effectively with Transgender Populations	Broad spectrum of issues related to gender identity, organizational challenges, and strategies for competent care.	1.5 hours, one time (Webinar viewing)	Direct Service Providers Administration Interpreters Community Total	2	12-17-14	Willy Wilkinson, MPH
Beyond the Beats & Lyrics: African American TAY Males and the Mental Health	Overview of social determinants which contribute to the creation of challenges	1.5 hrs One time (Webinar viewing)	Direct Service Providers Administration		1/20/15	California Behavioral Health Solutions, African

System in California	concerning African American TAY males.		Interpreters Community Total	1		American Health Institute
Mini Training at Cultural Diversity Committee Meeting	Brief overview of culturally competent care and general behavioral health disparities among African Americans	1.5 hrs, Quarterly meeting	Direct Service Providers Administration Interpreters Community Total	18	2-19-15	Karen Lovato, Ethnic Services Manager & Melinda Driggers
Mental Health Wellness Around the World	Representatives from various countries discussing concepts of mental health, wellness, and strategies for stigma reduction.	1 hr, One time (Webinar viewing)	Direct Service Providers Administration Interpreters Community Total	3	5-19-15	The Center for Dignity, Recovery & Empowerment:
Mini Training at Cultural Diversity Committee Meeting	Brief overview of culturally competent care and general behavioral health disparities for World Cultural Diversity & Development Day	1.5 hrs, Quarterly meeting	Direct Service Providers Administration Interpreters Community Total	6	5-20-15	Melinda Driggers
Cultural Responsiveness for Better Health	Overview of Native American History and Historical Trauma, ongoing issues, tips for strengthening multi-cultural health care practices	6 -8 hours, Annual	Direct Service Providers Administration Interpreters Community Total	53	6-18-15	Caleen Sisk & Atta Stevenson
Wraparound Facilitation	Principles and practices of wraparound facilitation	6.5 hrs, one time	Direct Service Providers Administration Interpreters Community Total	28	10-9 -15	Sharon Morrison & Jarred Vermillion, from The resource Center for Family-Focused Practice
Mini Training at Cultural Diversity Committee Meeting	Brief overview of culturally competent care and general	1.5 hrs, Quarterly meeting	Direct Service Providers Administration		9-24-15	Karen Lovato, Ethnic Services Manager

	behavioral health disparities among Latinos		Interpreters Community Total	6		
Beginning Wraparound	Introduction and overview of wraparound principles and practices	14 hours (7 hrs per day, two days), one time	Direct Service Providers Administration Interpreters Community Total	28	10-7 & 10-8-15	Sharon Morrison & Jarred Vermillion, from The resource Center for Family-Focused Practice
Intensive Care Coordination, Intensive Home Based Services Training, and the role of the Parent Partner	Katie A. Wrap Around Service training	1.5 hrs.	Direct Service Providers Administration Interpreters Community Total	16	10/20/15	Jenine Miller, Psy.D, & Masha McCarthy, LMFT Mendocino County BHRS

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

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

See WET component of MHSA 3 year Plan. Attachment #7

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.

Mendocino County is in the process of obtaining the WET Plan assessment data and will be analyzing that data with the general population, Medi-Cal population, and 200% of poverty data.

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.

Not Applicable at this time.

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

Funding Category	Action Items	WE&T Strategies/Objectives
Workforce Staffing Support	<ol style="list-style-type: none">1. Mental Health Loan Assumption program annually2. Prioritization tool for scholarships and Stipends in development	WET Coordination and Support Scholarships and Loan Assumption Workforce development and Collaborative Partnership Training
Training & Technical Assistance	<ol style="list-style-type: none">1. Workgroup prioritization of training	Career development and pathway collaborations WET Coordination and Support
Mental Health Career Pathways Programs	<ol style="list-style-type: none">1. Workgroup outline of pathway programs	Career development and pathway collaborations
Residency, Internship Programs	<ol style="list-style-type: none">1. Continue to make MHLAP available2. Finalize Scholarship	Scholarships and Loan Assumption

	assistance prioritization with Workgroup 3. Implement scholarship assistance program.	
Financial Incentive Programs	1. Workgroup prioritization of criteria 2. Delineating application schedule	Scholarships and Loan Assumption

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

Mendocino County as a small rural county has a significant challenge recruiting and retaining clinical staff. The higher the advanced degree, the more significant the barrier is in recruiting and retaining the staff. That barrier is compounded when we attempt to recruit staff of cultural minorities and bilingual or multilingual capacity. The challenge of finding bilingual clinical staff of the cultures we are targeting to reduce disparities, is shared throughout community providers.

In order to address this significant challenge, the WET subcommittee has prioritized the dissemination of WET funds to those with clinical degrees, those that are bilingual, particularly in Spanish, those that identify as Native American or Latino, and those that will be serving the Native American and Latino populations. Because we have a specific challenge of providing services to our remote small communities we have incentivized providing services to those communities. And, because we value the consumer/family perspective, we have incentivized those advancing their education or service provision for those that are consumer providers or family member providers.

The roll out process of our WET funds has been slower than anticipated. We attribute this to changing dynamics in our system delivery, which has affected the prioritization and implementation of our WET plan. The Mental Health Loan Assumption Program (MHLAP) application process has shown that we have limited numbers of clinical level bilingual direct service providers applying for scholarship assistance, which contributed to the broadening of our criteria for WET funds, to ensure that we would be able to utilize funding.

There is a noted trend in Mendocino County that interns and trainees come to work for Mendocino County providers while completing their internship hours, but once their certifications are complete, they leave Mendocino County for other counties with higher salaries. This seems consistent throughout the community providers. The WET subcommittee has been strategizing ways to incentivize and prioritize WET support to those from Mendocino County that intend to provide services in Mendocino County. The hope is that those with roots in the community, will be able to get support from the community to continue to provide services in the community, and Mendocino County will be able to “grow our own” advanced level providers with a commitment to the community.

The WET subcommittee and County MHSA providers have struggled with how to directly administer WET support to individuals. Our most significant advancement in this area to date, has been to cultivate a relationship with the Mendocino Community College to disseminate scholarships. The hope is that this plan will allow for a wider dissemination of WET support funds in a more efficient manner than individual contract allotments to individuals through the County processes. The MHSA team and WET stakeholder group will have input into the

selection of awardees to ensure that WET objectives and community WET needs are being addressed.

F. Identify county technical assistance needs.

- Support developing relationships with colleges that produce Masters level and higher degrees, that are able to provide distance learning support to Mendocino County residents.
- Strategies to provide scholarship Assistance and Workforce Development to underrepresented groups.
- Strategies for advertisement of opportunities that reach the most diverse group of potential applicants.
- Strategies to efficiently and adequately collect our missing WET data given our frequently changing workforce

CRITERION 7

COUNTY MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

Rationale: Accurate and effective communication between clients, providers, staff, and administration is the most essential component of the mental health encounter. Bilingual providers and other staff who communicate directly with clients must demonstrate a command of both English and the language of the client that includes knowledge and facility with the terms and concepts relevant to the type of encounter (CLAS, Final Report). DHCS will provide threshold language data to each county.

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 Workforce Education and Training Plan along with the Workforce Education and Training subcommittee has prioritized bilingual staff as one of the top prioritizations for WET resources. Refer to Attachment 12, MHSA Plan, WET component for evidence.

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

Due to the changing workforce and Mental Health System delivery, Mendocino County is in the process of updating the list of bilingual staff.

3. Total annual dedicated resources for interpreter services.

Mendocino County dedicates approximately \$45,000 annually to interpreter services in addition to bilingual staff. This amount is fluid as it depends on need. Please refer to section I. IV. A.

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: See Attachment 6 for Policies and Procedures.

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages

- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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.*

Mendocino County Behavioral Health & Recovery Services contracts with and uses the Language Line Solutions for all individuals when a bilingual provider is unavailable in their primary or preferred language. See MH P/P No. III.A-3 Services to Beneficiaries in Primary or Preferred Languages. Language Line trainings are done during new employee orientation, and annually thereafter. All providers have TDD or California Relay Service capability.

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

Mendocino County Behavioral Health & Recovery Services currently only use bilingual staff, translators, or the Language Line. We are interested in technical assistance for new technology capacity building. We are in conversations with the Superior Region Ethnic Service Managers on developing a Superior Region training for Mental Health Interpreters.

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

See Attachment 6 for Policies and Procedures.

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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.

See Attachment 6 for Policies and Procedures. Language Line trainings are done during new employee orientation and annually thereafter.

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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

See Attachment 6 Policies and Procedures.

- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

Mendocino County Beneficiaries are asked during intake of their primary or preferred language. Once identified all future interactions will have every attempt made to communicate in the identified primary or preferred language. Documentation of services will include the language the service was provided in and who/how translation was provided, when provided in a language other than English. Documentation will include that a beneficiary was offered, and whether the beneficiary declines.

B.Evidence that the county/agency accommodates persons who have LEP by using bilingual staff or interpreter services.

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages
- Mendocino County dedicates approximately \$45,000 annually to interpreter services in addition to bilingual staff. This amount is fluid as it depends on need. Please refer to section I. IV. A.

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

Mendocino County uses bilingual staff, language line services, and a contract translator for interpreter services, to accommodate those with limited English proficiency. Our experiences have been consistent with the best practice standards in that it is always best to have a live bilingual service provider with sufficient understanding of specialty industry terms for translation.

A bilingual provider is best practice as the relationship between the provider and client is established, and there is no third person for the client to connect with or be distracted by. The timeliness or thoroughness of services are not impacted by the time it takes to translate. The client is served in the language that is most comfortable to him or her. While this is the preferred method of service provision, it is the one we struggle most to provide due to the limited availability of bilingual providers in our area. We incentivize hiring of bilingual providers, by offering bilingual stipends; however we still are limited in the number of bilingual staff providing direct BHRS services.

In person translation with an interpreter familiar with behavioral health terms and concepts is also preferred to other methods of interpretation. We have found that a staff person/professional translating is preferred to a peer or family member of the client translating, due to the possibility of the client not fully disclosing information with a peer/family member in the room, and also the possibility that the family member/peer may filter what is translated. An in person translator tends to take more time to provide the service than a bilingual staff person. Additionally, there can be an effect on rapport when there is a translator, as the client can feel like the relationship is more established with the person of the same language, than the service provider. We have larger success with providing this form of interpretation, as there are staff (not necessarily direct service providers) that can provide translation. We would like to have more bilingual staff available for translation, as we still encounter situations where language line translation is necessary due to bilingual staff being unavailable at the time translation is needed.

Language Line translation has the benefit of accurate and formal translation. However, the use of the phone for translation tends to contribute to services taking longer to provide due to the time needed for explaining the circumstances and the time to translate. Additionally, there can be an effect on rapport as the phone translation service is even less direct than an in person translator and there is more distance between the client and the provider. This is a last resort translation option, however it is available 24-7 and in any language.

C. Identify county technical assistance needs.

- Mendocino County Behavioral Health & Recovery Services is interested in the use of

- new technologies such as video language conferencing.
- We would like technical assistance on how to use new technology to grow our language access.
- We would like technical assistance on effective ways to improve our bilingual workforce.
- We would like information and support around coordinating Mental Health/Behavioral Health translator trainings.

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. posters/bulletins) and/or bilingual staff for the languages spoken by community.

Mendocino County Behavioral Health providers post all required documentation in both English and Spanish (Mendocino County’s two threshold languages). Language Line language identification posters are posted prominently in each lobby. The poster includes a large list of languages, with the phrase “point to your language. An interpreter will be called.” This allows those that speak a language other than English or Spanish to still be served in their primary language.

Bilingual staff are called when available for interpretation.

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

Mendocino County Behavioral Health documents in chart notes what the client’s primary language is, and whether services were provided in a language other than English. If a client declines the use of interpreter services, this is documented in the chart note.

- Refer to MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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

Mendocino County Human Resources develops a list of questions obtained from the department related to the subject matter that would need to be translated. Human Resources then conducts a test by a bilingual staff person to test the accuracy of verbal translation prior to authorizing bilingual pay differential.

Mendocino County has begun conversations with the Superior Region Ethnic Services Managers to discuss the possibility of a regional Mental Health/Behavioral Health interpreters training.

IV. Provide services to all LEP clients not meeting the threshold language criteria who encounter the mental health system 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.

Mendocino County Behavioral Health & Recovery Services has policies and procedures in place to identify and provide services in their primary or preferred language, regardless of whether it is a threshold language. All providers are trained in CLAS standards and are trained to use the Language Line Solutions translation services. All key points of entry into services have a Language Line Solutions poster that lists various languages.

- MH P/P No. III.A-2 Translation Services and Written Material in Threshold Languages
- MH P/P No. III. A-3 Services to Beneficiaries in Primary or Preferred Languages

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.

Mendocino County Behavioral Health & Recovery Services trains all staff in Culturally and Linguistically Appropriate Standards (CLAS)

- SUDT P/P No. I. E-1 CLAS Compliance Policy.

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

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

- MH P/P No. III.A-3 Section 2 item D.

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.
- See MH P/P III.A-1 Translation Services and Written Material in Threshold Languages
Mendocino County Behavioral Health & Recovery Services currently has one threshold language other than English: Spanish.

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

Mendocino County Behavioral Health Charts indicate what language the service was provided in, if the service was provided in a language other than English. In addition to the language the services were provided in, the type of interpretation used is indicated.

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

Consumer satisfaction surveys are translated into Spanish (Mendocino County's threshold language).

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

Translation of Mendocino County documents is done by bilingual staff or contractors to ensure accuracy. Forms are read by a bilingual staff person for accuracy prior to posting.

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.

Mendocino County Behavioral Health and Recovery Services uses simple language in the translation of documents, so that it meets the appropriate reading level goal. Mendocino County has several bilingual staff review all translated documents to verify the language used meets the reading level. Should a concern be expressed by a provider or consumer in regards to the language used, the document will be re-evaluated and re-translated, if necessary.

CRITERION 8

COUNTY MENTAL HEALTH SYSTEM

ADAPTATION OF SERVICES

Rationale: Organizations should ensure that clients/consumers receive from all staff members, effective, understandable, and respectful care, provided in a manner compatible with their cultural health beliefs and practices and preferred language (CLAS Final Report).

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

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

- Wellness Centers: Manzanita Services, Inc. (with locations in Willits and Ukiah) & Mendocino Coast Hospitality Center- These are centers currently located in Ukiah, Willits, Fort Bragg, and during the FY 13-14 Mendocino County expanded our relationships with Resource Centers to include Family Resource Centers in Laytonville and Gualala, thus covering most of the county. The centers provide services for Full Service Partners and other individuals with symptoms of serious and persistent mental illness (SPMI). The centers also provide Outreach and Engagement and some Prevention and Early intervention services for those not already identified and engaged in services for the SPMI population. Services include linkage to counseling and other support services, life skills training, nutritional and exercise education and support, finance management support, patient navigation, dual diagnosis support, vocational education, educational support, health management support, self-esteem building and developing healthy social relationships. The Wellness Centers provide a safe environment that promotes peer support, self-advocacy, and personalized recovery.
- Family Resource Centers: The Arbor Youth Resource Center, Laytonville Healthy Start Family Resource Center, and Action Network Family Resource Center- Transition Age Youth are eligible to utilize the Youth Resource Centers, currently in Ukiah, Laytonville, Gualala and during the FY 15/16 it is the intention to open a new center in Fort Bragg. The Resource Center provides groups, classes, and workshops designed to promote life skills, independent living, vocational skills, educational skills, managing health care needs, self-esteem building, family and parenting skills, addressing substance use issues, developing healthy social skills and other topics as need arises from the youth. The Center also provides a safe environment to promote healthy appropriate social relationships, peer support, and advocacy. The Youth Resource Center is available to all youth falling in the TAY range, and so serves as an Outreach and Engagement support as well as providing Prevention and Education 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.

Mendocino County Behavioral Health and Recovery Services provides a provider brochure containing all the mental health plan providers covered by Medi-Cal. The provider list includes linguistic and cultural accommodations and specialties.

Mendocino County Behavioral Health and Recovery Services through MHSAs relationships engage with several agencies that are community based, with bilingual/bicultural providers, providing a variety of traditional and non-traditional services. These agencies include but are not limited to, Action Network, Consolidated Tribal Health Project, Laytonville Family Resource Center, Nuestra Alianza, and Yuki Trails.

Mendocino County Behavioral Health and Recovery Services is continuously working to increase relationships with a variety of service providers to increase the options available to consumers.

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.

Mendocino County Behavioral Health and Recovery Services provides a provider brochure containing all the mental health plan providers covered by Medi-Cal. Additionally, MCBHRS provides consumer resource brochures by area that include a broader spectrum of community based services; these include culturally appropriate and non-traditional services.

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)

Mendocino County Behavioral Health & Recovery Services engages in numerous outreach and engagement activities. During those events Behavioral Health Service provider brochures and events are shared, as are other events and informational materials surrounding behavioral health topics. These events include: traveling with the Bookmobile, May is Mental Health Month events, Suicide Prevention Week events, April is Alcohol Awareness Month events, MHSAs Consumer events, among others. These events travel to nontraditional service locations and into remote areas of the County in an attempt to reach underserved individuals and populations that may be more predominantly of different cultural groups.

- See Outreach Binder for evidence.

(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.)

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

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

Mendocino County Behavioral Health & Recovery Services ensures that services that are provided in the most populous areas (Ukiah, Fort Bragg and Willits) and work with clients served on accessing transportation to services. Full Service Partnership programs and Outreach and Engagement Programs assist clients in getting to and from services through the “whatever it takes” model. Both of these programs prioritize those from underserved ethnic and linguistic groups. Mendocino County Behavioral Health & Recovery Services contracts with providers that provide services in remote and rural areas in an attempt to decrease the need for transportation, and increase access to services for those culturally and linguistically diverse populations. Meeting times for consumer feedback are adjusted each year based on consumer feedback including later hours than business hours in order to accommodate differing needs for hours of operation.

Lack of public transportation and large distances between cities means that transportation and services in remote locations will be a constant challenge.

2. 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);

Mendocino County Behavioral Health & Recovery Services requires that all service providers including contracted provider locations are accessible to disabled persons. All providers are required to provide materials in threshold languages. All providers are invited to participate in an annual Cultural Competency training, and will be expected to provide evidence of all staff being trained in cultural competence during the three year plan period.

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.)

Mendocino County Behavioral Health & Recovery Services through the Integrated Care Coordination Service Model has expanded the number of settings that are consumer based, non-threatening, and not associated with “government buildings.” Many of these services are in remote and rural areas. We continuously explore options to expand the number of services provided in non-traditional environments that reduce stigma.

III. Quality Assurance

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

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

Child adolescent and Needs and Strengths (CANS), and Adult Needs and Strengths Assessment are completed on clients that are served through Specialty Mental Health services. Beneficiary Satisfaction Surveys are completed for all Mental Health services.

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 Competency staff surveys will be completed annually for all County staff, providers, contractors, and subcontractors during this three year plan.

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

Mendocino County Behavioral Health & Recovery Services make grievance forms available through both Substance Use Disorders Treatment and Mental Health service providers in the lobbies, on the websites, and upon receiving a verbal complaint. Additionally, Issue Resolution forms are also available for the resolving of issues related to Mental Health Services Act programs. These forms are made available in MHSA service provider lobbies, as well as on the website.

Historically data has not been collected regarding the ethnicity of complainants. This data is available for those that are formally enrolled in programs, but not all complainants' may be formally enrolled.

California State Statute

Welfare and Institutions Code (WIC), Section 4341 -- relates to DMH activities and responsibilities in implementing a Human Resources Development Program and ensuring appropriate numbers of graduates with experience in serving mentally ill persons. Subsection (d) states: "Specific attention shall be given to ensuring the development of a mental health work force with the necessary bilingual and bicultural skills to deliver effective services to the diverse population of the state."

WIC, Section 5600.2 -- relates to the Bronzan-McCorquodale Act and general provisions to organize and finance community mental health services. "To the extent resources are available, public mental health services in this state should be provided to priority target populations in systems of care that are beneficiary-centered, culturally competent, and fully accountable..."

WIC, Section 5600.2(g) -- "Cultural Competence. All services and programs at all levels should have the capacity to provide services sensitive to the target populations' cultural diversity. Systems of care should: (1) Acknowledge and incorporate the importance of culture, the assessment of cross-cultural relations, vigilance towards dynamics resulting from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. (2) Recognize that culture implies an integrated pattern of human behavior, including language, thoughts, beliefs, communications, actions, customs, values, and other institutions of racial, ethnic, religious, or social groups. (3) Promote congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities.

WIC, Section 5600.3—Relates to populations targeted for services. This section details the target populations that shall be served by mental health funds. Target populations include the following: Seriously emotionally disturbed children and adolescents, adults and older adults who have serious mental disorders, adults or older adults who require or are at risk of requiring acute treatment, and those persons who need brief treatment as a result of natural disaster or severe local emergency.

WIC, Section 5600.9(a) -- "Services to the target populations described in Section 5600.3 should be planned and delivered to the extent practicable so that persons in all ethnic groups are served with programs that meet their cultural needs."

WIC, Section 5802. (a)(4) -- relates to Adult and Older Adult Mental Health System of Care. "System of care services which ensure culturally competent care for persons with severe mental illness in the most appropriate, least restrictive level of care are necessary to achieve the desired performance outcomes."

WIC, Section 5807. – relates to Human Resources, Education, and Training Programs. Requires counties to work in an interagency collaboration (and public and private collaborative programs) to effectively serve target populations to assure service effectiveness and continuity and help set priorities for services.

California State Statute Cont.

WIC, Section 5813.5 (d)(3) – relates to distribution of funds, services to adults and seniors, funding, and planning for services. “Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers...to reflect the cultural, ethnic and racial diversity of mental health consumers.”

WIC, Section 5820. – relates to Human Resources, Education, and Training Programs. This section details “the intent to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.” A needs assessment is required of the mental health programs in each county that detail anticipated staff shortages where the county will need to fill positions in order to meet requirements in reducing discrimination and improving services for underserved populations as detailed in WIC, Section 5840.

WIC, Section 5822 (d) and (i) – relates to Human Resources, Education, and Training Programs. Relates to the State Department of Mental Health. Section 5822 (d) requires an establishment of regional partnerships among mental health and educational systems to expand outreach to multicultural communities and increase the diversity of the mental health workforce. Section 5822 (i) requires promotion of the inclusion of cultural competency in training and educational programs.

WIC, Section 5840 (b) and (b)(4) and (e)– relates to Prevention and Early Intervention Programs. This section requires programs to reduce discrimination and improve services for underserved populations. Additionally, this section requires the department to revise elements of the program to reflect lessons learned. “The program shall emphasize improving timely access to services for underserved populations.” “Reduction in discrimination against people with mental illness.” “In consultation with mental health stakeholders, the department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and intervention programs for children, adults and seniors.”

WIC, Section 5848– relates to the development of prevention and early intervention plans with local stakeholders. This section requires stakeholder participation in the development of the PEI plan.

WIC, Section 5855. (f) -- relates to Children’s Mental Health System of Care. “Cultural competence. Service effectiveness is dependent upon both culturally relevant and competent service delivery.”

California State Statute Cont.

WIC. Section 5865. (b) -- relates to the county System of Care Requirement in place with qualified mental health personnel within three years of funding by the state. “(b) A method to screen and identify children in the target population including persons from ethnic minority cultures which may require outreach for identification. (e) A defined mechanism to ensure that services are culturally competent.”

WIC Section 5878.1—relates to establishing programs that assure services are culturally competent. “It is the intent of this act that services provided under this chapter to severely mentally ill children are accountable, developed in partnership with youth and their families, culturally competent, and individualized to the strengths and needs of each child and their family.”

WIC. Section 5880. (b)(6) -- relates to establishing beneficiary and cost outcome and other system performance goals for selected counties. “To provide culturally competent programs that recognize and address the unique needs of ethnic populations in relation to equal access, program design and operation, and program evaluation.”

WIC, Section 14683 (b) -- requires the department establish minimum standards of quality and access for managed mental health care plans. This section sets forth a requirement that managed mental health care plans include a system of “outreach to enable beneficiaries and providers to participate in and access mental health services under the plans, consistent with existing law.”

WIC, Section 14684 (h) -- “Each plan shall provide for culturally competent and age- appropriate services, to the extent feasible. The plan shall assess the cultural competence needs of the program. The plan shall include, as part of the quality assurance program required by Section 4070, a process to accommodate the significant needs with reasonable timelines. The department shall provide demographic data and technical assistance. Performance outcome measures shall include a reliable method of measuring and reporting the extent to which services are culturally competent and age-appropriate.”

California Government Code (CGC) Section 7290-7299.8 – “This chapter may be known and cited as the Dymally-Alatorre Bilingual Services Act.” Relates to the Legislature’s findings and declarations regarding rights and benefits to those precluded from utilizing public services because of language barriers. This section details the need for effective community between the government and its citizens and describes legislative intention to provide for effective communication to those that either do not speak or write English at all or their primary language is other than English.

California Code of Regulations

California Code of Regulations (CCR), Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 10, Medi-Cal Psychiatric Inpatient Hospital Services, Article 1, Section 1704

“Culturally Competent Services means a set of congruent behaviors, attitudes and policies in a system or agency to enable effective service provision in cross-cultural settings.”

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.310 1(a-b) Implementation Plan. This section discusses how an MHP must submit an Implementation Plan with procedure details for screening, referral and coordination with other necessary services and “Outreach efforts for the purpose of providing information to beneficiaries and providers regarding access under the MHP.”

CCR, Title 9, Rehabilitative and Developmental Services. Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410 (a-e), Cultural and Linguistic Requirements. This section provides an in-depth listing of cultural and linguistic requirements. “Each MHP shall develop and implement a Cultural Competence Plan that includes...” provisions of the CCPR that work to improve cultural and linguistic competence. “The MHP shall submit the Cultural Competence Plan to the Department for review and approval in accordance with these timelines. “The MHP shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually.”

Cultural Competence Plan provisions in this section include but are not limited to the following: strategies and objectives, cultural and linguistic assessments, resource listing of linguistically appropriate services, and cultural and linguistic training for mental health workers. MHPs shall have a statewide, toll-free number, oral interpreters available, referrals for linguistic and cultural services the MHP does not provide, policies and procedures to assist beneficiaries who need interpreters in non-threshold languages, and general program literature in threshold languages

CCR, Title 9. Rehabilitative and Development Services, Division 1. Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2:

Definitions, Section 3200.100. Cultural Competence. This section provides an in depth definition of “Cultural Competence”. It identifies nine goals to incorporate in all aspects of policy- making, program design, administration and service delivery and assist in the development of an infrastructure of a service, program or system, as necessary in achieving these goals.

California State Statute Cont.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 2, Definitions, Section 3200.210. “Linguistic Competence” means organizations and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that structures, policies, procedures, and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy needs of the populations being served.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 3, General Requirements, Section 3300. Community Program Planning Process. This section provides requirements related to designated positions for community planning processes and details minimum Community Program Planning Process requirements. The planning process shall include opportunities for stakeholder participation of “unserved and/or underserved populations” and their family members as well as to “stakeholders who reflect the diversity of the demographics of the County, including but not limited to, geographic location, age, gender, and race/ethnicity.”

California Code of Regulations Cont.

CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14. Mental Health Services Act, Article 6, General Requirements, Section 3610 (b)(1). General Community Services and Supports. “The County shall conduct outreach to provide equal opportunities for peers who share the diverse race/ethnic, cultural, and linguistic characteristics of the individuals/clients served.”

MHSA Component Guidelines

Prevention and Early Intervention: Cultural Competence

“Improving access to mental health programs and interventions for unserved and underserved communities and the amelioration of disparities in mental health across racial/ethnic and socioeconomic groups are priorities of the MHSA. Therefore cultural competence must be emphasized in PEI programs.”

Cultural Competence means incorporating and working to achieve cultural competence goals into all aspects of policy-making, program design, and administration and service delivery. (Source: PEI, 2007, p. 2).

Workforce Education and Training: Cultural Competence

Guides counties for the “development and implementation of recruitment, retention and promotion strategies for providing equal employment opportunities to administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic cultural and linguistic characteristics of individuals with severe mental illness/emotional disturbance in the community.” “Staff, contractors and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and /or linguistic population or community they serve.” (Source: WET, 2007, p.4-5)

Workforce Education and Training: Objectives in the Five Year Plan

Guides counties in the “development of strategies for the meaningful inclusion of individuals with mental health client and family member experience, and incorporate their viewpoints and experiences in all training and education programs.” (Source: WET, 2007, p.6)

Workforce Education and Training: Workforce Needs Assessment

Guides counties to “establish a current, standardized baseline set of workforce data that depicts personnel shortages and the needs of ethnic/racial and culturally underrepresented populations.” (Source: WET, 2007, p.11)

Federal Statute

Title VI of the Civil Rights Act of 1964-“No person in the United States shall on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance” (42 U.S.C. 2000d).

As pertains to language access: Title VI of the Civil Rights Act prohibits recipients of federal funds from providing services to limited English proficient (LEP) persons that are limited in scope or lower in quality than those provided to others. An individual’s participation in a federally funded program or activity may not be limited on the basis of LEP. Since Medi-Cal is partially funded by federal funds, all MHPs must ensure that all Medi-Cal LEP members have equal access to all mental health care.

Executive Order 13160 of June 23, 2000. Nondiscrimination on the Basis of Race, Sex, Color, National Origin, Disability, Religion, Age, Sexual Orientation, and Status as a Parent in Federally Conducted Education and Training Programs. To ensure that persons with limited English skills can effectively access critical health and social services, the Office of Civil Rights (OCR) published policy guidance which outlines the responsibilities under federal law of health and social services providers who receive Federal financial assistance from HHS to assist people with limited English skills.

As pertains to language assistance to persons with limited English proficiency (LEP). The guidance explains the basic legal requirements of Title VI of the Civil Rights Act of

1964 (Title VI) and explains what recipients of Federal financial assistance can do to comply with the law. The guidance contains information about best practices and explains how OCR handles complaints and enforces the law.

Title 42 – The Public Health and Welfare, Chapter 126, Equal Opportunity For Individuals with Disabilities Section 12101. Findings and Purpose. [Section 2] -- to provide a clear and comprehensive national mandate, and a strong, consistent, enforceable standard, for the elimination of and addressing discrimination against individuals with disabilities. The Nation’s proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals.

Federal Standards/Guidelines

U. S. Department of Health and Human Services, Office of Minority Health (OMH), National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care. These national standards were to respond to: 1) the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner, and 2) a means to correct inequities that currently exist in the provision of health service and to make these services more responsive to the individual needs of all consumers. CLAS mandates (Standards 4, 5, 6, and 7) are current federal requirements for all recipients of Federal funds. Standards 1,2,3,8,9,10,11,12, and 13 are CLAS guidelines and are recommended by OMH for adoption as mandates for Federal, State, and national accrediting agencies. OMH recommends CLAS Standard 14 for adoption by healthcare organizations.

Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/underrepresented Racial/Ethnic Groups –Final report from working groups on cultural competence in managed Mental Health Care Services. Prepared by Western Interstate Commission for Higher Education. (These standards have not been mandated by CMHS.)

DMH Letter

DMH Information Notice: 94-17 issued on December 7, 1994 -- requests all counties applying to become a Mental Health Plan to submit a written Implementation Plan for Psychiatric Inpatient Hospital Services Consolidation by January 1, 1995. Counties were required to describe the process they would implement to improve cultural competence and age-appropriate services to Medi-Cal beneficiaries.

Federal Waiver Request

DMH Waiver Request Submission to Health Care Financing Administration (HCFA) states: MHPs will be required to develop and implement a plan for the provision of culturally competent and age appropriate services to beneficiaries. At a minimum this plan must include maintaining a statewide 800 number with linguistic capability that is available 24 hours a day, and must include goals for improving cultural competence. DMH will establish a task force to address linguistic and cultural competence issues and may set additional statewide requirements for MHPs as a result of task force findings and recommendations.

DEFINITIONS

BILINGUAL STAFF

Bilingual staff members have language capacity in both English and the specific non- English languages used by cultural groups in the target community.

CLIENT/CONSUMER

Client/consumer is a person with lived experience of mental health issues. (*Source: California Network of Mental Health Clients, 2002*).

COMMUNITY-DEFINED EVIDENCE

“Community-defined evidence” is a “set of practices that communities have used and determined to yield positive results as determined by community consensus over time and which may or may not have been measured empirically but have reached a level of acceptance by the community.” (*Source: Martinez (2008), The Newsletter of the National Latina/o Psychological Association, page 9*).

COMMUNITY ENGAGEMENT

Community engagement has been defined over the last two decades in multiple, evolving ways (1). One definition of community engagement is “the process of working collaboratively with relevant partners who share common goals and interests” (2). It involves “building authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the ‘win-win’ possibility” in the collaborative project (3). The emphasis on community engagement promotes a focus on common ground and recognizes that communities have important knowledge and valuable experience to add to the public stakeholder input debate.

CULTURAL BROKERS

Cultural brokers may be State and county officials working within county Mental Health Departments (such as Cultural Competence/Ethnic Service Managers) or outside county Mental Health Departments (such as public health, social services, and education) who have prior knowledge and trusting relationships with particular communities. In addition, cultural brokers may be community activists, advocates working at the State or county level, as well as county or State level non-governmental organizations (with established trust and credibility in particular communities). For Native American communities in particular, contact with appropriate tribal organization leaders is a critical first-step (*Source: University of California, Davis, Center for Reducing Health Disparities and CA Department of Mental Health (2007). Building Partnerships: Key Considerations When Engaging Underserved Communities Under the MHSA, UC Davis CRHD and DHCS, Page 3*).

CULTURAL COMPETENCE

Cultural competence is a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations (Adapted from Cross et al, 1989). (See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.100, Cultural Competence)

ENGLISH PROFICIENCY

Level at which a person can understand English and respond in English to explain their behavioral healthcare problems, express their treatment preferences and understand the treatment plan.

ETHNIC DISPARITY

The mental health system has not kept pace with the diverse needs of racial and ethnic minorities, often underserving or inappropriately serving them. Specifically, the system has neglected to incorporate respect or understanding of the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

EVIDENCE BASED PRACTICE

Evidence based practice is a prevention or treatment practice, regimen, or service that is grounded in consistent scientific evidence showing that it improves client/participant outcomes in both scientifically controlled and routine care settings. The practice is sufficiently documented through research to permit the assessment of fidelity. This means elements of the practice are standardized, replicable, and effective within a given setting and for particular populations. As a result, the degree of successful implementation of the service can be measured by the use of a fidelity tool that operationally defines the essential elements of the practice. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

FAMILY MEMBER

A family member is a parent or caretaker of a child, youth, adult, or older adult, who is currently utilizing, or has previously, utilized mental health services. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

GATEKEEPER

“Gatekeeper” means those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine; they may be trained to identify persons at risk for mental health problems or suicide and refer them to treatment or supporting services as appropriate.

HISTORICAL DISPARITIES

Historical disparities have been consistently found in and continue to exist among California's racial-ethnic populations including African-Americans, Latinos, Asian Pacific Islanders (API), and Native American. Any other population group(s) targeted in a county plan must be clearly defined with demonstrated evidence and supporting data to target them as having historical disparities in unserved, underserved and inappropriately served in mental health services. (Source: MHSOAC, (2008). *Cultural & Linguistic Competence Technical Resource Group Workplan.*)

INTERPRETERS

Interpreters are individuals with specific language skills and knowledge of health care terminology who are trained to communicate effectively with persons with limited proficiency with the English language.

INTERPRETER SERVICES

Interpreter services are methods in place to assist persons with limited English proficiency. This includes telephone interpreter services ("language lines"), interpreters obtained from a central listing maintained by agency or other source, trained volunteers from a target community with identified language skills.

KEY POINTS OF CONTACT (MANDATED/NON-MANDATED)

"Common points of access to Specialty Mental Health Services from the MHP, including, but not limited to, the MHP's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the MHP." (Source: CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 11, Medi-Cal Specialty Mental Health Services, Article 4, Section 1810.410, Cultural and Linguistic Requirements)

LIMITED ENGLISH PROFICIENT (LEP)

A diminished level of English language skills that calls into question the person's ability to understand and respond to issues related to their treatment.

LINGUISTIC COMPETENCE

The capacity of an organization and individuals working within the system are able to communicate effectively and convey information in a manner that is easily understood by diverse audiences including persons of LEP, those who have few literacy skills or are not literate; and individuals with disabilities that impair communication. It also means that the structures, policies, procedures and dedicated resources are in place that enables organizations and individuals to effectively respond to the literacy and language needs of the population being served. (See CCR, Title 9, Rehabilitative and Developmental Services, Division 1, Department of Mental Health, Chapter 14, Mental Health Services Act, Article 2, Definitions, Section 3200.210, Linguistic Competence.)

LINGUISTICALLY PROFICIENT

A linguistically proficient person is a person who meets the level of proficiency in the threshold languages as determined by the MHP.

MEDI-CAL BENEFICIARIES

Any person certified as eligible under the Medi-Cal program according to Title 22, Section 51001.

NON-TRADITIONAL MENTAL HEALTH SETTINGS

“Non traditional mental health settings” means systems and organizations not traditionally defined as mental health; i.e., school and early childhood settings, primary health care systems including community clinics and health centers, and community settings with demonstrated track records of effectively serving ethnically diverse and unserved or underserved populations.

PENETRATION RATE

The total number of persons served divided by the number of persons eligible.

PREVALENCE

The number of cases of the condition present in a defined population at a specified time or in a specified time interval (e.g., the total number of cases with a specific disease or condition, such as ischemic heart disease, at a given time divided by the total population at that time) (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

PRIMARY LANGUAGE

That language, including sign language, which must be used by the beneficiary to communicate effectively and which is so identified by the beneficiary.

PROMISING PRACTICE

“Promising Practice” means programs and strategies that have some quantitative data showing positive outcomes over a period of time, but do not have enough research or replication to support generalized outcomes. It has an evaluation design in place to move towards demonstration of effectiveness; however, it does not yet have evaluation data available to demonstrate positive outcomes.

RECOVERY

Recovery refers to the process in which people who are diagnosed with a mental illness are able to live, work, learn, and participate fully in their communities. For some individuals, recovery means recovering certain aspects of their lives and the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or elimination of symptoms. Focusing on recovery in service planning encourages and supports hope. (Source: California Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

RESILIENCE

Resilience means the personal qualities of optimism and hope, and the personal traits of good problem solving skills that lead individuals to live, work and learn with a sense of mastery and competence. Research has shown that resilience is fostered by positive experiences in childhood at home, in school and in the community. When children encounter negative experiences at home, at school, and in the community, mental health programs, and interventions that teach good problem solving skills, optimism, and hope can build and enhance resilience in children. *(Source: California Family Partnership Association, (2005). (Source: California Department of Mental Health (2002) Community Services and Supports Three-Year Program and Expenditure Plan Requirements).*

RETENTION RATE

A retention rate is the percent of new clients who receive 2, 3, 4, etc. follow-up day or outpatient services following an initial non-crisis contact with the mental health system. This measures the rate at which new clients in general are retained in the system for treatment.

SMALL COUNTY

Per California Code of Regulations Section 3200.260, “‘Small County’ means a county in California with a total population of less than 200,000, according to the most recent projection by the California State Department of Finance data.”

SPECIALTY MENTAL HEALTH SERVICES

Includes the following: rehabilitative mental health services, psychiatric inpatient hospital services, targeted case management, psychiatrist services, psychologist services, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services.

STAFF DIVERSITY

Staff who are representative of the diverse demographic population of the service area and including the leadership of the organization as well as its governing boards, clinicians, and administrative personnel. *(Source: CLAS, Final Report, Page 8).*

TARGET POPULATION

That part of the general population designated as the population to be served by the administrative or service delivery entity. *(Source: Chambers, Final Report: 2008: Cultural Competency Methodological and Data Strategies to Assess the Quality of Services in Mental Health Systems of Care, Page 42)*

Note: **DHCS** recognizes each MHS component has its own identified target population(s).

THRESHOLD LANGUAGE

The annual numeric identification on a countywide basis, of 3,000 beneficiaries or five (5) percent of the Medi-Cal beneficiary population, whichever is lower, whose primary language is other than English, for whom information and services shall be provided in their primary language.

TRANSLATION SERVICES

Translation services are those services that require “The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language.

Note: Translation refers to written conversions from one language into a second language, while interpreting refers to the conversion of spoken or verbal communication from one language into a second language.” (Source: California Healthcare Interpreters Association, 2002)

UNDERSERVED

Individuals who have been diagnosed with serious mental illness and children who have been diagnosed with serious emotional disorders, and their families, who are getting some service, but whose services do not provide the necessary opportunities to participate and move forward and pursue their wellness/recovery goals. This category would also include individuals who are so poorly served that they are at risk of situational characteristics such as homelessness, institutionalization, incarceration, out- of-home placement or other serious consequences (Source: Department of Mental Health (2002) *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

UNSERVED

Persons who may have serious mental illness and children who may have serious emotional disorders, and their families, who are not receiving mental health services. Examples of underserved populations described in the MHSA include older adults with frequent, avoidable emergency room and hospital admissions, adults who are homeless or incarcerated or at risk of homelessness or incarceration, transition age youth existing the juvenile justice or child welfare systems or experiencing their first episode of major mental illness, children and youth in the juvenile justice system or who are uninsured, and individuals with co-occurring substance use disorders. Frequently, unserved individuals/families are part of racial ethnic populations that have not had access to mental health programs due to barriers such as poor identification of their needs, provider barriers lacking ethno-culturally competent services, poor engagement and outreach, limited language access, limited access in rural areas and American Indian Rancherias or reservations and lack of culturally competent services and programs within existing mental health programs. (Source: *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

WELLNESS

A dynamic state of physical, mental, and social well-being; a way of life which equips the individual to realize the full potential of his/her capabilities and to overcome and compensate for weaknesses; a lifestyle which recognizes the importance of nutrition, physical fitness, stress reduction, and self-responsibility. Wellness has been viewed as the result of four key factors over which an individual has varying degrees of control: human biology, environment, health care organization (system), and lifestyle. (Source: *Community Services and Supports Three-Year Program and Expenditure Plan Requirements*).

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