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San Mateo County Behavioral Health and Recovery Services Three Year Cultural Competence Plan

I. We have made a lot of progress:

- We are Behavioral Health and Recovery Services, an organization that merged mental health and alcohol and other drug systems.
- We have created a structure and organization for our cultural competence and cultural humility work through the Office of Diversity and Equity. There are stronger links among our initiatives and the Cultural Competence Council provides the glue.
- Through the BHRS culturally focused Health Equity Initiatives, we allowed participant-defined, decentralized efforts to emerge.
- We have begun to see the results of our efforts in our clinical sites and communities.

II. Highlights and future direction:

Our efforts and work have addressed the entire population we serve: Medi-Cal beneficiaries, Health Families, Healthy Kids, uninsured individuals and undocumented individuals. We have identified uniform strategies:

1) Strategies to continue to address disparities
    a. Welcoming as a strategy to engage people on their own terms.
    b. Improving linguistic access.
    c. Total Wellness for improving access.
    d. Addressing stigma of mental illness and substance abuse through understanding the role of culture and worldview.
    e. Increase efforts to train, recruit and retain a diverse workforce, including people with lived experience who identify as consumers/clients and family members.
2) Increased partnership and collaboration with agencies and community partners that have the pulse of the communities
    a. North County Outreach Collaborative.
    b. East Palo Alto Mental Health Partnership.
    c. Support and build community (internal) capacity to address identified needs (e.g. Heart and Soul, EPA peer-run Parenting Project and support group).
3) Implementation of measurement and outcomes to evaluate and assess effectiveness of cultural competence strategies to engage and work with diverse communities
    a. Analyzing local data to general population, poverty population, EQRO data on a regular basis.
    b. Culture shift toward completing surveys and evaluations to provide valuable feedback.
    c. Revision of training evaluations to assess effectiveness and retention of knowledge and skills (e.g. pre/post tests, training follow-up).
    d. Review of cultural competence language and requirements in contracts as well as monitoring these requirements.
    e. Experience by diverse clients of feeling welcomed and that treatment is effective for them.

Criterion 1
County Mental Health System
Commitment to Cultural Competence

I. County Mental Health System commitment to cultural competence

A. Policies, procedures, or practices that reflect steps taken to fully incorporate the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

Behavioral Health and Recovery Services (BHRS): Vision, Mission, Values and Strategies

Preface: These statements were developed out of a dialogue involving consumers/clients, family members, community members, staff and providers sharing their hopes for the newly formed Behavioral Health and Recovery Services Division. The members of the Behavioral Health and Recovery Services community agree to support the Vision, Mission, and Values, and to strive to demonstrate these concepts within our individual and collective responsibilities.

The Vision:
Individuals, families, and communities fulfill their promise and successfully pursue their dreams in a society where stigma and discrimination against those with mental illness and/or alcohol and drug addiction are remnants of the past.

The Mission:
We build opportunities for people with or at risk of alcohol and drug addiction and mental health challenges to achieve wellness and/or recovery through partnership, innovation, and excellence**.**

Our Values:
Person and Family Centered
We promote culturally responsive person-and-family centered recovery.

Potential
We are inspired by the individuals and families we serve, their achievements and potential for wellness and recovery.

Power
The people, families, and communities we serve and the members of our workforce guide the care we provide and shape policies and practices.

Partnerships
We can achieve our mission and progress towards our vision only through mutual and respectful partnerships that enhance our capabilities and build our capacity.

Performance
We use proven practices, opportunities, and technologies to prevent and/or reduce the impacts of mental illness and addiction and to promote the health of the individuals, families and communities we serve.

Overarching Behavioral Health and Recovery Services Strategies

- **Prevention and Early Intervention**: Implement prevention and early intervention approaches for mental health and alcohol and drug addiction problems among at-risk populations. Partner with ethnic and linguistic communities to develop culturally competent strategies for community education and outreach that reduce stigma and discrimination about behavioral health problems and promote early identification.
- **Reducing Cultural and Linguistic Disparities**: Improve access to mental health and alcohol and drug treatment for under/unserved populations. Promote organizational and individual cultural competency through education, training, workforce development, hiring strategies, and policy changes.
- **Welcoming and Engagement**: Create processes for entering behavioral health treatment that support a sense for clients and family members that "this is the right place"; are designed to maintain connection with services and supports; and are timely, culturally competent, and integrated with other services people need, for example health care, human services, the justice system, and education.
- **Empowering Clients and Families**: Partner with clients and family members to define recovery and wellness and to direct policy and services accordingly. Expand client and family self-help activities.
- **System of Care Enhancements and Supports**: Develop a full continuum of proven practices and supports (self-help, education, treatment, employment, housing, other) appropriate to individual need that promote life worth living in the community and recovery from mental illness, alcohol and drug addiction, and co-occurring disorders. Improve coordination of care among providers and the match between the level of care provided and the level of care and intensity of services needed by clients at any time.
- **Total Wellness****: Reduce disparities in access to health care for people with mental illness and alcohol and drug addictions. Improve their health outcomes through chronic disease prevention, early intervention, health care, and disease management approaches.

**Please note that San Mateo County applied for and received verbal notification of approval of a SAMHSA grant ($500,000 per year for four years) for our *Total Wellness* program. The purpose of the grant is to reduce preventable physical conditions and improve health outcomes for behavioral health clients. The strategy is to partner with key stakeholders to deliver integrated primary/behavioral care services. The target population is 600 Central and South County BHRS adult clients who are on newer atypical antipsychotic medication. Please see our SAMHSA Grant Application Abstract (Appendix A, p. 1).

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

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

1. Mission Statement;

Please refer to BHRS Mission, Vision, Values and Strategic Initiatives.

2. Statements of Philosophy;

Please refer to BHRS Mission, Vision, Values and Strategic Initiatives.

3. Strategic Plans;

Please refer to the BHRS Strategic Initiatives (Appendix A, pp. 2-6) and Alcohol & Other Drug Services *Strategic Directions 2010* available at www.smhealth.org/bhrs (click on Alcohol & Other Drug Services, then Publications).

4. Policy and Procedure Manuals;

Please refer to the BHRS Documentation Manual October 2009 developed by the Quality Improvement Committee available on the BHRS intranet (cover page in Appendix A, p. 7).

5. Human Resource Training and Recruitment Policies;

A hard copy of the information packet given to new BHRS personnel is available from Personnel & Payroll. The Employee Resource Book (February 2010) is available on the BHRS intranet (cover page and Letter of Welcome in Appendix A, pp. 8-9).

Please refer to the San Mateo Human Resource Department's Mission Statement, Goals and Values (Appendix A, pp. 10-11); San Mateo County EEO Policy (Appendix A, pp. 12-15); San Mateo County 2010 – 2013 Equal Employment Opportunity Plan (cover page and Table of Contents in Appendix A, pp. 16-18); and Bilingual Salary Differential Allowance Policy (Appendix A, pp. 19-20).

For recruitment advertising, the San Mateo County Human Resources Department indicates the County is an equal opportunity employer. For example, this text is used in recruitment advertisements "To learn more about the position and to apply online, please visit our website at www.co.sanmateo.ca.us/hr/jobs. Applications are only accepted online. EOE."

Some positions include a language requirement. For example, the Office of Consumer and Family Affairs-Office of Consumer & Family Affairs Mental Health Counselor - Spanish Speaking Required announcement included:

> Language Requirement: The ability to speak, read and write fluently in both English and Spanish.
> Supplemental Questionnaire: This position requires the ability to speak, read and write fluently in English and Spanish. Are you fluent in both English and Spanish? (A "No" answer will disqualify you from this recruitment.)
>
> ❑ Yes ❑ No

Additionally, depending on the position recruited for, the application supplemental questions and/or interview questions address working with a diverse population and cultural competence on the job, such as:

- "Describe your leadership experience ensuring culturally sensitive services are provided to children/youth/transitional age youth and their families."
- "Discuss your professional experience interacting with culturally diverse client groups. Be specific."
- "This position requires fluency in Spanish (or other language). Please explain how and when you have used your Spanish (or other language) speaking skills in a work setting."

6. Contract Requirements;

Our Request for Proposal (RFP) template language asks each prospective provider to provide evidence of the following in their program summary:

Cultural Competence - Describe how your agency/program will ensure cultural competence. This may include culturally relevant program features, staffing objectives that reflect cultural and linguistic diversity and education materials (as applicable) that value the cultural diversity of San Mateo County.

We do not have standardized requirements for cultural competence in our contracts. Contract requirements range from identifying annual cultural competence related training and listing ethnic breakdown of clients served to the more recent requirements of creating a budget for the use of interpreters or translation services. Monitoring of contract requirements tend to be dependent on the program monitors; no standardized process has been created. Contract requirements regarding cultural and linguistic competence for individual contracts are available from the Contracts Manager.

One example is a current Full Service Partnership contract and its reference to Culturally Competent Service Elements:

a. A culturally competent service provider or system acknowledges diversity and recognizes its value, is knowledgeable about cultural differences and can provide high quality services adapted to meet unique cultural needs.

b. Outreach and engagement strategies are designed to reach diverse communities where the populations identified in Paragraph II. A., Target Population, can be identified and engaged in services.

c. Successful teams engage and empower enrollees with plans that are appropriate to their needs, maximize the benefits derived from use of culturally appropriate strategies and supports and thus reduce under-utilization of services that puts the enrollees at risk of placement in more restrictive settings, including incarceration. Focusing on consumer-generated goals that are culturally relevant empowers enrollees to engage in services and maintain that engagement, extending the time the enrollee can live in a community setting.

d. Culturally competent services are sensitive to the client's cultural identity, available in the client's primary language and use the natural supports provided by the client's culture and community.

e. Goal setting and planning processes are culturally sensitive and build on an individual's cultural community resources and context. Individual, culturally focused community supports are identified and integrated into planning. Service plans reflect and respect the healing traditions and healers of each individual enrollee.

f. Culturally diverse and culturally informed staff incorporate culturally relevant strategies, including alternative therapies and the use of families and extended families to provide natural supports for enrollees. The use of these culturally relevant strategies also builds enrollee commitment to treatment and their individual service plans.

g. Services design will respect and engage each individual's family, extended family and community contingent on his/her wishes.

h. Team members are trained in culturally competent practices. Services are delivered by bilingual, culturally competent staff.

Another example is from our Request for Proposals (RFP) for Community Outreach and Engagement Program for North County Region and Pacifica. This RFP included Cultural Competency as one of seven Evaluation Criteria. The RFP included the following questions:

a. Describe the involvement of ethnic minorities, women and consumers in service delivery and planning.

b. Provide evidence of understanding and sensitivity to the cultural diversity of consumers in San Mateo County.

For agency contracts, the following Cultural Competency standards and requirements are included:

1. All program staff shall receive at least one (1) in-service training per year on some aspect of providing culturally and linguistically appropriate services. At least once per year and upon request, Contractor shall provide County with a schedule of in-service training(s) and a list of participants at each such training.

2. Contractor shall use good faith efforts to translate health-related materials in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall provide to County copies of Contractor's health-related materials in English and as translated.

3. Contractor shall use good faith efforts to hire clinical staff members who can communicate with clients in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall submit to County the cultural composition and linguistic fluencies of Contractor's staff.

The San Mateo County Mental Health Plan Outpatient Provider Manual (Individual Providers) of January 2005 is available at http://sanmateo.networkofcare.org/contentFiles/MHPOutpatientProviderManualJan2005.pdf and includes information regarding our commitment to cultural and linguistic competence (cover page and Table of Contents in Appendix A, pp. 21-23).

In addition, when proposals are received in response to an RFP, a review committee comprised of diverse individuals meets and evaluates the proposals. Reviewers specifically rate each proposal by how well they demonstrate and how they will ensure cultural competence within their program(s). The review committee uses a Proposal Rating Sheet that includes Cultural Competency (strengths and weaknesses) as a category along with other categories. Please refer to a sample Proposal Rating Sheet (Appendix A, pp. 24-25). The review committee may also include follow-up verbal questions about cultural competence during an optional interview process such as "What is the cultural composition of your staff?" and "What is the language capacity of your staff?"

7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

We acknowledge that integrating cultural competence in all levels of the Division is critical and at times can be quite a challenging and slow process. However, we remain very committed to our efforts and goals, and have also started to involve ourselves in other efforts of other divisions of the Health System and the

County. Please refer to these other key documents that demonstrate our ongoing efforts and participation:

- San Mateo County BHRS Alcohol and Other Drug Services (AOD) Provider Handbook - This online manual is a reference for contract providers of treatment and prevention services. The AOD Provider Handbook contains or provides access to documents specifying regulatory and administrative requirements to which all programs must adhere. This Handbook also includes the Charter Document that outlines the vision, principles and key actions for improving service delivery to persons with co-occurring disorders and contains several references to cultural competence. The Handbook is available at http://www.aodsystems.com/SMC/Index.htm (cover page and Charter Document in Appendix A, pp. 26-31).
- Healthy Communities San Mateo County *Roadmap for Alcohol, Tobacco and Other Drug Prevention (2006)* - This document provides a framework for working with communities and strengthening partnerships and is available at http://www.co.sanmateo.ca.us/vgn/images/portal/cit_609/28/52/701888455roadmap_for_atod_prevention_062006.pdf (cover page, Table of Contents, letter from Supervisor Rose Jacobs Gibson, and Executive Summary in Appendix A, pp. 32-36).
- San Mateo County BHRS Cultural Competence framework "The Fish" – This framework was developed in 2008 through multiple discussions within the Cultural Competence Council on how to meet the needs of San Mateo County's diverse communities. Embedded in our approach is cultural humility and cultural competence as the basis of all our work (Appendix A, p. 37).
- San Mateo Countywide Cultural Competence Committee (SMCCCC) - Countywide Cultural Competence Standards as Approved by the Board of Supervisors (BOS) on November 3, 2009 (Appendix A, p. 38). The San Mateo Countywide Cultural Competence Committee was convened by County Manager David Boesch in August 2009 to address diversity and cultural competence issues throughout the County. This committee is co-moderated by Jei Africa (BHRS) and Crispin Delgado (Health Policy and Planning). Since its formation, the committee has been involved with numerous activities and projects that culminated in the standards adapted by the BOS. These standards were created to provide cultural competence integration throughout the county. Other relevant materials include:
    1) San Mateo Countywide Cultural Competence Framework (December 2008) – Provides Definition; Vision including County Mission Statement and County Vision 2010; Values, Guiding Principles; Countywide Cultural Competence Standards for Organizational Accountability, Contractors, and Collaboration and Community Engagement; Benefits and Challenges (Appendix A, pp. 39-42).
    2) San Mateo County Cultural Competence Activities Ladder (December 2008) – The Ladder provides a Timeline and Stages that began in August 2007 "Moving Towards a Cultural Competence Framework" to 2009 "Implementing the Framework" (Appendix A, p. 43).
    3) The San Mateo County Cultural Competence Resource Inventory is categorized by Education and Training, Policy/Systems Change, Events Community Engagement, Collaboration, Communication, and Quality Improvement by Department and Department Activities/Resources (Appendix A, pp. 44-52). BHRS participated in a countywide cultural competence assessment as a way to link/measure and study the Division's programmatic efforts alongside other County efforts.

4) San Mateo County Health Department Cultural and Linguistic Competency Standards (Appendix A, pp. 53-55).

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

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

San Mateo County Behavioral Health and Recovery Services (BHRS) remains committed to involving and engaging diverse communities and individuals in planning processes in different levels of the Division. BHRS continues to encourage participation in various committees to larger community planning processes.

Mental Health Services Act (MHSA):
The MHSA is very much an ever present and vibrant part of BHRS' day-to-day business. The planning structure originally devised in 2005 by San Mateo County to seek input for the Community Services and Supports component of the Mental Health Services Act (MHSA) remains in place and has since framed all planning activities related to all components of the MHSA. The Mental Health Board (MHB), as a whole and through its committee structure, is involved in all MHSA planning activities providing input and receiving regular updates, as is the MHSA Steering Committee created in 2005. The meetings of these bodies are open to the public, and attendance is encouraged through various means: notice of meetings (flyers, emails and other publications) are sent to a broad, ever growing network of contacts including provider and County agencies as well as consumer and advocacy organizations; community partners (community based organizations, advocacy organizations, the general public) are notified via announcements at various meetings and venues; presentations and progress reports are provided by BHRS, and input is sought on an ongoing basis at the different committees of the Mental Health Board (they meet monthly); at the monthly Mental Health Board meeting; at meetings with community partners and advocates; and internally with line and management staff.

The MHSA Steering Committee comprises representatives from all BHRS stakeholder groups, including consumers/clients, family members, advocates, community partners serving the diverse San Mateo community, the education, law enforcement, criminal justice and probation communities, other government partners, staff, and top County executive leadership. The organization of the MHSA Steering Committee is being discussed and may be reorganized to include a smaller number of members. Please see the MHSA Steering Committee roster (Appendix A, p. 79).

Information is shared with stakeholders on an ongoing basis through progress reports, and by sharing overall and individual successes and challenges. All the information is made available to stakeholders on the Network of Care website, on the San Mateo County Behavioral Health and Recovery Services website – which contains an MHSA webpage, and in hard copy when requested.

BHRS's e-journal, *Wellness Matters*, published the first Wednesday of each month and distributed electronically to over 700 stakeholders, is also utilized as an information and education tool. Please see

the July 2010 issue of *Wellness Matters* (Appendix A, pp. 56-67). Back issues are available online at www.smhealth.org/bhrs.

Office of Diversity and Equity:
The BHRS Office of Diversity and Equity (ODE) was established in late 2009 as BHRS was planning for Cultural Competence and Mental Health Summit XVI hosted by San Mateo County. Led by Health Equity Initiatives Manager, Dr. Jei Africa, ODE has become the BHRS hub for information and resources dedicated to advancing health equity by promoting cultural competence and addressing health disparities throughout the County. More than ever, we believe that creating opportunities for our clients and better health outcomes means a much stronger connection to broader social justice and equity efforts.

The beginnings of the ODE can be traced to the beginnings of the Cultural Competence Council (formerly Cultural Competence Committee) when over ten years ago, a few staff members informally met at lunchtime to discuss diversity issues in their clinical casework. At that time, clinicians were looking for a venue to obtain and provide support on cultural issues influencing their work. Currently the ODE provides overall oversight and support to the Cultural Competence Council and the Health Equity Initiatives.

ODE Values include:
- Cultural Competence and Cultural Humility.
- Shared and multicultural leadership.
- Building bridges and sustainability of partnerships.
- Forward and out of the box thinking.
- Advocacy and community capacity.
- Use of data to determine outcomes.

The ODE is also positioning itself to provide support to other services providers through cultural competence and health equity training and technical assistance. For example, the Health Equity Initiatives Manager has been providing consultation and support to community based providers who have been looking at their own cultural competence needs.
Two examples are:
Pyramid Alternatives - creation of their Striving for Cultural Competence Committee.
Caminar - implementation of their cultural competence goals.

BHRS Health Equity Initiatives - In 2007, the Mental Health Services Act provided funding to support and continue the burgeoning efforts of staff to address racial, ethnic, and cultural disparities within BHRS. These Initiatives were created to focus on health disparities in access and quality of care for under/unserved and inappropriately served cultural and ethnic communities as well as to identify the workforce development needs of staff representing these communities.

Led by BHRS staff, each Initiative plans and implements its activities in collaboration with other county staff, community partners, consumers/clients and family members and other stakeholders in the community. Initiative activities include: educational resources translated in different languages, facilitated trainings on culturally responsive practices, workshops and support groups, and community events and outreach. Participation is welcomed to all

Appendix A, p. 125 provides a brief summary of each Heath Equity Initiative's focus, number of members,

region, consumer/client and family member participation, youth participation, consistent CBO participation, policy, events, data gathering. This table was created as a baseline tool for future focus, objectives and goals. Please refer to www.smhealth.org/bhrs/ode (Appendix A, pp. 68-74) for more information about each Health Equity Initiative.

African American Planning Initiative

Vision: To improve health outcomes by reducing health disparities for the African-American community in San Mateo County through the training and education of all San Mateo County staff and through improved hiring, retention, and integration of San Mateo County's African-American Health department staff.

Mission: To educate, support, and collaborate with San Mateo County African-American communities by creating partnerships with existing county agencies and organizations that serve African-Americans and who are striving to improve the overall health of the African-American community in San Mateo County.

Since 2007, members of the African American Planning Initiative (AAPI) continue to work toward our vision of providing behavioral health services that promote wellness, equity and support for San Mateo County's African-American consumers/clients and their families. A secondary area for AAPI focus is outreach and engagement to the African-American community that has not utilized mental health and alcohol and drug services due to barriers in access, discomfort with service providers, or stigma associated with the services.

Our goal is to provide community members with the ability to obtain information and access to services for themselves and their family members that live with emotional disturbance/mental illness and/or substance abuse/dependence which often impact homelessness, incarceration, and hospitalization rates for African-Americans in the County.

In addition, members of the AAPI recognize that an emphasis on prevention and early intervention, specifically outreach, is an important aspect in serving members of the African-American community.

Chinese Initiative

In 2007, the Chinese Initiative was established as the Chinese Workforce Development Group funded by a Mental Health Services Act (MHSA) Community Services and Supports grant.

The group is committed to increasing awareness about behavioral health, reducing stigma, and improving access to services. Our goal is to strengthen culturally competent and linguistically appropriate services for the Chinese American community in San Mateo County.

The Chinese Initiative facilitates a monthly Chinese Family Support Group that is held in Cantonese and Mandarin.

Filipino Mental Health Initiative

Mission: The purpose of the Filipino Mental Health Initiative (FMHI) is to improve the well-being of Filipinos in San Mateo County. We work to link individuals to appropriate health, mental health and social services. We also work with providers to ensure culturally appropriate services to Filipino clients.

Slogan: *"Mindful of Our Community's Health*

The Filipino Mental Health Initiative (FMHI) grew out of a series of focus groups conducted in 2005 facilitated by Behavioral Health & Recovery Services of San Mateo County. Community members, providers, and interested individuals came together to discuss a broad array of issues pertaining to health and mental health, particularly the stigma associated with mental illness and the barriers that prevent Filipinos from obtaining appropriate services and treatment.

FMHI has been active in providing community outreach, parent event nights, provider trainings, the development and dissemination of 5,000 community directories, and the inclusion of over 35 agency representatives to be part of an oversight committee. The Filipino Mental Health Initiative has grown to include a diverse range of members and collaborative partners including staff from Behavioral Health & Recovery Services, Asian American Recovery Services, Pilipino Bayanihan Resource Center, Community Overcoming Relationship Abuse, San Mateo County Health System, community members and other stakeholders.

Latino Collaborative

Vision: The vision of the Latino Collaborative is to promote holistic practices designed to build safe, strong, resilient families with stigma-free equal access to health and social services inclusive of alternative practices regardless of insurance eligibility. We believe that intergenerational family values will foster healthy interdependence with appreciation of history, culture and language that embodies, spirit, mind and body.

Mission:

- Understand the Latino community from all perspectives by examining dynamically the social, cultural and history of Latinos.
- Provide Latino value based practices and advocacy that acknowledges the diversity of the Latino community and promotes services that nurtures and strengthens the health of the family as well as the individual.
- Develop new innovative ways to adapt our institutions and programs for the delivery of integrated service that addresses Latino heritage, culture and language.

We strive to eliminate stigma, oppression, racism and poverty.

With the support of the Mental Health Services Act, the Latino Collaborative was created in 2008. Since then, members of the Collaborative have been committed to give voice to the Latino Community through creative, innovative and collaborative efforts that promote integrated, culturally congruent holistic health.

Pacific Islander Initiative

The Mental Health Services Act initiated efforts to improve the delivery of mental health services to the Pacific Islander community. In May 2005, a needs assessment survey was conducted with a group of Tongans, randomly chosen from San Mateo and East Palo Alto. Later that same year, they were asked to participate in focus groups facilitated by BHRS to learn about the needs of the Pacific Islander community. The results of the forum and focus groups confirmed that the needs of the Pacific Islander population in San Mateo were not being addressed appropriately. Historically, this population does not

willingly seek help from available resources because of language barriers, lack of culturally sensitive services, fear of government institutions, inaccurate information about laws and immigration, and lack of knowledge about available resources and service

Since 2006, the Pacific Islander Initiative continues to build upon the needs that were identified by the needs assessment and focus groups by being actively present in the community. The Initiative engages the Pacific Islander community to be informed about health and wellness and participate in numerous activities such as trainings, youth summits, fishbowls, and parenting classes.

PRIDE Initiative
Vision: An inclusive environment based in equality and parity for lesbian, gay, bisexual, transgender, queer, questioning, and intersex (LGBTQQI) communities of San Mateo County.

Mission: The PRIDE Initiative is committed to foster a welcoming environment for the LGBTQQI communities living and working in San Mateo County through an interdisciplinary and inclusive approach.

The PRIDE Initiative is made up of individuals who are concerned about the well-being of the LGBTQQI communities in San Mateo County. This initiative is led by Behavioral Health & Recovery Services staff and funded through the Mental Health Services Act.

Spirituality Initiative
Mission: To build opportunities for clients/consumers, family members, providers and community members to collaboratively explore, increase awareness of, and support spirituality and its relationship to health and well-being, in particular, for those with and/or at risk of co-occurring alcohol/drug addiction and mental health challenges

Vision: Behavioral Health and Recovery Services fully embraces and integrates spirituality when working together with individuals, families and communities to facilitate one's wellness and recovery.

Our Values:

- Hope – We recognize that hope is the simplest yet most powerful tool in fostering one's healing.
- Inclusiveness – We recognize that spirituality is a personal journey and individuals should not be excluded based on their spiritual beliefs and practices.
- Cultural humility – We recognize that an attitude of respect and openness is necessary in creating a welcoming and inclusive space for everyone.

Suicide Prevention Initiative:
The Suicide Prevention Initiative started in 2010 is one of BHRS Strategic Initiatives that advances Prevention and Early Intervention. One of the Suicide Initiative committees is Cultural Competence because we know suicide disproportionately affects racial, ethnic, cultural and linguistic communities. The membership of committee is diverse and includes staff from Alcohol and Other Drug Services, Mental Health services, Caminar (community partner), and a representative from San Mateo County Transit District (SamTrans). Members are interested in developing a public service announcement (PSA) in different languages for radio, publication/advertisement in SamTrans, or distribution in "cultural venues" like

supermarkets, libraries, restaurants, community centers, and churches targeting Tagalog, Tongan, Spanish, and Chinese speaking communities.

The committee has researched an organization called "SAVE" (www.save.org) that has created PSAs as well as billboards and announcements and is exploring funding and PSAs using actual San Mateo County police, firefighters, and doctors. The goal is to deliver a culturally and linguistically effective message that suicide is preventable, that there is hope, that survivors are happy they lived, and in doing so, work towards de-stigmatizing suicide. Members of the Health Equity Initiatives are also being tapped to help create these culturally sensitive messages.

Gay/Lesbian/Bisexual/Transgender/Queer/Intersex (LGBTQQI) Activities and Services:
In addition to PRIDE Initiative meetings and events, BHRS provides funding for the following LGBTQQI groups and activities:

- LGBTQQI Group for Ages 16-25 every Monday at 4:00 p.m. at Edgewood Turning Point Drop-In Center.
- LGBTQ Adult Support Group 1st and 3rd Tuesday of the month at 5:30 p.m. at Heart and Soul (consumer run organization) in downtown San Mateo.
- Family Service Agency LGBT Senior Peer Counseling - Confidential, personal and supportive counseling to LGBT people facing the challenges and concerns of growing older. Services available to San Mateo County residents 55 and older. Services also available in Mandarin, Spanish and Tagalog.

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

BHRS strives to create, sustain and improve its relationship with numerous racial/ethnic/cultural/linguistic individuals and communities through a variety of formal and informal opportunities and venues.

The Mental Health Board (MHB) meets on the first Wednesday of each month (usually 3:00-5:00 p.m.) and occasionally rotates its meeting location to different regions of the county. The MHB is comprised of 14 members, 35% of which are from ethnic/racial/cultural and linguistic communities and represent different sectors of the local community. Their meetings are open to the public. The MHB is undergoing a name change to the Mental Health and Substance Abuse Recovery Commission and will increase its membership to 18 members to accommodate the integration of mental health and substance abuse into Behavioral Health and Recovery Services.

All members of the MHB are members of the MHSA Steering Committee (Appendix A, p. 79). The MHSA Steering Committee is comprised of at least three members who identify as consumers/clients, six members who identify as family members, and one member who identifies as both a consumer/client and family member. Approximately 15% of the 46 member Steering Committee are from diverse racial/ethnic/cultural/linguistic communities.

Individuals with diverse backgrounds and experiences are part of standing committees such as Quality Improvement Committee (Appendix A., p. 80), Cultural Competence Council (members listed on p. 59), and the Co-Occurring Initiative (over 170 members on the email distribution list, 115 of whom participated in an

event or meeting this past year). Through the seven Health Equity Initiatives, we create opportunities to for participants to engage in dialogue, receive information and involve diverse communities in the behavioral health planning process.

The BHRS Office of Consumer and Family Affairs (OCFA) is comprised of consumers and family members from different cultures and backgrounds. Of the four staff members, two are African American, one is Latino. Two members of the staff are Spanish bilingual and bicultural. Please see the OCFA brochure (Appendix A, pp. 75-76).

BHRS continues its strong partnership with NAMI (National Alliance for the Mentally Ill) San Mateo County. NAMI members participate in various BHRS planning activities. BHRS has partnered to provide the 10-Week NAMI Provider Education Program since 2008. This Program focuses on the bio-psycho-social model of collaborative treatment - the lived experience of people and families struggling with mental illness. We are starting the 5th NAMI Provider Education Program in September 2010 at the Silicon Valley Community Foundation. BHRS staff provides resources such as speakers for presentations, continuing education credits, and outreach. NAMI also offers support group meetings as well as the Family-to-Family Education Program, facilitated by one staff member of the BHRS Office of Consumer and Family Affairs, and the Peer-to-Peer Class (flyer for class starting in September 2010 at Heart and Soul in Appendix A, p. 81).

Anti-Stigma Initiative:
To Advance Prevention and Early Intervention, one BHRS strategy is to partner with ethnic, linguistic and cultural communities to develop culturally competent strategies for community education and outreach that reduces stigma and discrimination surrounding behavioral health problems and promotes early identification. On Saturday, October 24, 2009, the event "In the Shadows: Cultural Perspectives on Living with Addiction and Mental Illness," served as Behavioral Health and Recovery Services' Kick-off to the Anti-Stigma Project of the MHSA Prevention and Early Intervention Plan. Please refer to the event Program (Appendix A, pp. 77-78). Seven cultural teams (African American, Chinese, consumers/clients, Filipino, Latino, Pacific Islander, and young adult) created and performed vignettes that highlighted how stigma about mental illness manifests in and impacts their diverse communities. Not only did the skits provide a visual of the impacts of mental illness in diverse communities, it also provided an opportunity for participants to come together as members of their community to support each other.

The seven skits were prepared and presented by groups of volunteers: consumers, participants in long term recovery, family members, BHRS and other County agency staff, and community partner agencies. Many of the “actors” are members of the Health Equity Initiatives. The event was held and filmed at Peninsula TV’s (Ch. 26) studio, and the studio was filled to capacity with audience members and numerous volunteers. After the performances, the performers and audience shared lunch with ethnic food from the seven cultural groups which provided an opportunity for fellowship and conversation. Eventually, the film will be used as a tool to educate specific communities about mental illness and promote conversation and dialogue about how culture can be a vehicle to seek support and help.

The Office of Diversity and Equity encourages consumer/client involvement by distributing a Consumer Recruitment Form (available in Arabic, Chinese, English, Spanish and Tongan) at meetings and public events. The form is also available at www.smhealth.org/bhrs/ode.

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

The Office of Diversity and Equity (ODE) provides resources to community based organizations that need support in exploring and integrating cultural competence in their agency. The ODE has provided technical assistance and training to Youth and Family Enrichment Services (YFES), Caminar, Mental Health Association (MHA), Edgewood and Pyramid Alternatives to develop their own cultural competency framework, training activities or cultural competence committees. One example is a training with Caminar, *Towards Better Quality of Care: Applying Cultural Competence and Cultural Humility to Our Daily Work.* This presentation is available at www.smhealth.org/bhrs/ode, click on Past Presentations.

BHRS provided two California Brief Multicultural Scale (CBMCS) Multicultural Training Program four-day, 32-hour trainings in August-September 2009 and April 2010 to BHRS staff as well as community partners. There was no fee for this training and continuing education credits were provided for participants. BHRS will provide nine additional CBMCS trainings in FY 2010-2013. It is our goal to train most of BHRS direct service staff as part of the Cultural Competence Plan.

Voices of Recovery (VOR) is an advocacy group comprised of people in recovery and family members affected by addiction. Led by an African American with lived experience who identifies as a consumer in recovery, the group is comprised of and outreaches to diverse communities. Volunteers staff the Services Center and resource library, committees, and events; assist drop-in visitors; and facilitate workshops and groups. Currently, BHRS is supporting VOR with attaining 501(c)(3) non-profit status.

Pacific Islander Initiative Parenting Project - BHRS sponsored two Pacific Islander community leaders from East Palo Alto, one Tongan and one Samoan to attend The Parent Project 40-hour Facilitator Training. They facilitated a six-week parenting training in Tongan (one three-hour weekly evening session for six consecutive weeks) to approximately 15 participants starting in May 2010. BHRS contracted with them to expand the training to 10 weeks and facilitate these trainings for two more years. (BHRS staff are providing ongoing consultation and supervision as well as logistical support to the project). Participants enjoyed integrating Pacific Islander cultural aspects to the training. The next 10-week training series will begin in September 2010. Future parenting trainings may be provided in Samoan. Please refer to the flyer from this training in English and Tongan (Appendix A, pp. 82-83) as well as the course evaluation translated from Tongan (Appendix A, pp. 84-86).

Mental Health First Aid Certification Project – BHRS is sponsoring two community leaders, one African American pastor and one Latina city council member, to participate in the September 2010 40-hour (teacher) certification training by the National Council for Behavioral Health (NCBH). This training is aimed at teaching non-licensed, non-clinical individuals to be able to talk and educate others about behavioral health issues. BHRS believes that building community capacity and partnerships are crucial when working with diverse communities, in this case partnering with the faith based community and a local government official. (BHRS staff will again be providing ongoing consultation and supervision as well as other support to this project). Project details are still ongoing.

Mental Health First Aid is an evidence-based public education program and is the initial help given to a person showing symptoms of mental illness or in a mental health crisis until appropriate professional, peer, or family support can be engaged. Mental Health First Aid USA is coordinated by the National Council for

Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. They train and certify instructors to deliver the 12-hour Mental Health First Aid course in different communities.

East Palo Alto (EPA) - BHRS contracts with One East Palo Alto (OEPA) to provide technical consultation for the East Palo Alto Mental Health Community Advisory Group (EPAMHAG), mental health outreach and engagement services, and multicultural center services in East Palo Alto for consumers of mental health services. Outreach and community engagement services are provided through the East Palo Alto Partnership for Mental Health Outreach, a partnership of OEPA, El Concilio of San Mateo County, For Youth by Youth, Free at Last, and Pacific Tonga Ma'a Tonga. BHRS hosts regular trainings on topics such as Mental Health 101 and 102, Chronic Disease and Nutrition (with Health Policy and Planning Division), Stress, and Youth for outreach workers to help support them in their work with the community. These five agencies work closely with the BHRS clinic in East Palo Alto. Multicultural services are provided at the Barbara A. Mouton Multicultural Wellness Center in an environment that is welcoming to adult consumers and their families who are multi-racial, multi-cultural and multi-generational, with a particular focus in clients who are African American, Latino or Pacific Islander. Please see the Mouton Center's June 2010 program calendar (Appendix H, pp.1-4). In addition, BHRS provides training for different partner agencies when they request for a specific topic, such as eating disorders and motivational interviewing.

The Annual Family Awareness Night sponsored by the East Palo Alto Mental Health Advisory Group (EPAMHAG), convened by One East Palo Alto "Healthy Minds: Choices: Families & Community Physical...Mental...Spiritual...and how are the children?" was held on November 19, 2009, 5:30 - 8:30 p.m. at the Community Church of East Palo Alto. The event began with a holiday meal and featured a discussion of mental health as a very important component of good quality of life. More specifically, people discussed the health of youth and young adults in relation to their families and the broader community. Groups discussed access to quality mental health services and resources in EPA in terms of challenges and opportunities, as in previous years. Presenters highlighted what is currently being done by EPAMHAG members in partnership with BHRS to eliminate longstanding disparities (Appendix A, pp. 87-88).

North County Outreach Collaborative – BHRS contracted with the North County Outreach Collaborative (NCOC) comprised of community based agencies in North County and Pacifica, Asian American Recovery Services, Pyramid Alternatives, Daly City Peninsula Partnership, and the Filipino Mental Health Initiative to provide outreach and education services in collaboration with BHRS in the northern region of the County. The objective of these services is to identify and engage individuals who are currently underserved and need mental health services. In the targeted region, the most significant ethnic and linguistic underserved populations include the following: Filipino, Latino and Chinese. The NCOC hosted Community Parents Nights and presentation and outreach activities in schools. Similar to East Palo Alto, BHRS provides training on topics such as insurance, how to access County services to community partner staff, etc. In addition, BHRS shared resources with NCOC by "lending" a consultant to partner agencies to write a grant proposal and successfully secure a grant through Kaiser Permanente to supplement a contract with BHRS.

Please refer to the Outreach Form that is completed by a provider/clinician (Appendix A, pp. 90-91). The outreach information provided by the East Palo Alto Partnership for Mental Health Outreach (most recent quarterly report in Appendix A., pp. 92-103) and the NCOC (most recent quarterly report in Appendix A, pp. 104-113) is compiled and analyzed on a quarterly basis.

Co-Occurring Initiative Day of Partnering – The San Mateo County Change Agents coordinate regular Days of Partnering to bring together direct service providers to network and share resources and information. The 1st Day of Partnering: "What is Partnering?" was held in May 2009 at the Fred Finch Youth Center. The 2nd Day of Partnering: "Steps to Partnering" was on September 24, 2009 at the Cordilleras Mental Health Facility. Several agencies participated and took informative tours of Cordilleras, learned about partner strategies, and created ads for their agencies to highlight their strengths (what they can offer) and their needs (what they need from in a partner). The ads were featured throughout *Wellness Matters* in subsequent months. The 3rd Day of Partnering: "Partnering in Action" was hosted by Pyramid Alternatives on April 26, 2010. Please refer to the 3rd Day of Partnering flyer (Appendix A, p. 114). A 4th Day of Partnering is being planned that will focus on cultural competence and will be bringing together the BHRS Health Equity Initiatives as well as others (e.g. contractors and community based organizations) who are passionate diversity leaders in their own agencies.

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

We have created numerous opportunities for individuals to become involved because we feel people are passionate and interested in different practices and activities. We fully recognize that participation from individuals vary depending not only on priorities and interests but all also practical issues such as time commitment and scheduling issues.

For staff, we know that time and prioritization/balance of clinical and non-clinical work are critical issues. There are many meetings, so conflicting meeting times can be a problem. Clinicians focus on work with clients and need supervisor support to attend planning meetings and implement projects. With the exception of the Pacific Islander Initiative, there are no full-time staff members devoted to the Health Equity Initiatives. Staff usually "volunteer" as much as they can, often feeling overwhelmed with their real "work." This is the same sentiment we hear from community partners and other service providers.

Also, it is notable that developing capacity and shared leadership is needed to sustain engagement and involvement and success of the many Initiatives. Many "leads" are not always aware of which direction to take, and those who want to be more involved are apprehensive to step up because of feeling unprepared to take on the role.

Follow-through with contract requirements particularly in the area of cultural competence seems to also vary depending on the program monitor. We suspect that no attention or discussion has focused on our partner agencies or providers being accountable for their cultural competence efforts. We can discuss cultural competence requirements with program monitors and identify guidelines for our contractors.

E. Identify county technical assistance needs.

1. We would like to provide support so that others may become involved. We would like to identify appropriate incentives for successful multidisciplinary participation and provide the training necessary to develop the skills and competencies to support each Initiative.
2. We would benefit from resources to develop leadership skills especially looking at the influence of culture. Feedback and comments from many participants (and "leads") seem to center on the lack of experience leading meetings, developing year-long plans and timelines and navigating unfamiliar cultural nuances.

3. We discussed how to measure outcomes at the Cultural Competence Council's Annual Strategic Planning Meeting in April 2010 related to cultural competence and the work of the Health Equity Initiatives but learning more practical and (easy tools) to evaluate our efforts would be very helpful.

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

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

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

Please refer to the recruitment brochure for the Health Disparities Initiatives Manager. (Appendix A, pp. 115-118). This position has been occupied since 2007 by Jei Africa, PsyD., M.S.C.P., C.A.T.C.

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

Prior to 2006, the function and role of the Cultural Competence and Ethnic Services Manager had been associated with a Supervisor (Unit Chief). This dual role did not always work effectively because of the numerous challenges and often competing priorities that the two positions entailed (e.g. numerous meetings). The CC/ESM was integral in creating the framework for BHRS' MHSA CSS plan in 2005. In late 2006, the County elevated what had been a Supervisor role to a member of the Management team. San Mateo County BHRS' CC/ESM title became the Health Disparities Initiatives Manager (HDIM) (Clinical Services Manager I), and the HDIM provided leadership for all efforts related to diversity and cultural competence. In 2009, the CC/ESM title was changed again to Health Equity Initiatives Manager (HEIM) at a BHRS Leadership presentation to reflect a strengths-based approach and BHRS' Welcoming Framework.

HEIM responsibilities include: provide management level leadership for overall Health System and BHRS Division initiatives related to the reduction of health disparities experienced by communities, special populations or clients. This individual is responsible to plan, coordinate, implement and evaluate specialized health and mental health disparities initiatives and programs; assist in the development, implementation and evaluation of BHRS Division and Health System plans, goals, objectives, policies and procedures related to reduction of health and mental health disparities; monitor and ensure the provision of health and mental health programs that promote culturally sensitive and appropriate services; provide direct supervision and oversight for diversity initiative-related contracted and directly operated services. Please refer to the Health Disparities Initiatives Manager recruitment brochure (2007) regarding the position and qualifications (Appendix A, pp. 115-118).

BHRS has had a strong clinical training program for many years. However, the current HEIM identified a need to also integrate the policy and planning side of organizational service delivery. After numerous dialogues involving various individuals (and support from BHRS Leadership), the Health Equity Initiatives (HEI) Internship Program was established in 2008. This pilot internship was designed to provide work opportunities and practical learning experience for undergraduate college and graduate students to

enhance their academic preparation and expose them to public service at the county level. This unique opportunity provides the intern awareness and experience with programmatic and policy level issues. Interns work with both the Behavioral Health and Recovery Services and Health Policy and Planning Divisions. This internship focuses on different levels and areas of health disparities. Stipends to support the internship are funded through the Mental Health Services Act. Interns are exposed to MHSA activities, consumer/peer driven values and cultural competence and health equity initiatives. Please refer to the Health Equity Initiatives Internship Program flyer (Appendix A, p. 119).

The HEI Internship Program is an opportunity to learn about clinical (individual) issues as well as policy level (organizational or community level) issues. Due to the success of our pilot program (and the growing needs of the ODE, we are recruiting two interns for fiscal year 2010-2011.

Below is an article that appeared in the May 2009 issue of *Wellness Matters*, the BHRS monthly newsletter, by Mariam Kandil, our first HEI intern:

Perspective: Being in BHRS
As a Muslim Arab-American growing up in Post 9/11 America, I have definitely faced some challenges with regard to my identity and how people perceive me. The headscarf I wear automatically gives many people the right to assume things about me.

The number one question I get when I meet someone new is "where are you from?" I proceed to answer Virginia and this is usually followed by a sense of hesitation from the questioner who then asks "where are you originally from?" With a smile, I inform him/her that my parents are originally from Egypt but I was born and raised in the U.S. It's interesting because most people are surprised that I don't have an accent while a few inform me that I do! I have gotten used to the questions and am always open to talking to people in order to break down the stereotypes.

As I pursue my career in counseling psychology I am aware of the impact of perception - future clients may have certain views about me and may be wondering if I will be able to understand him/her because I may appear quite different from him/her. Therefore I hope to bring what I am learning from my internship here at BHRS (as a Health Disparities Intern) to the counseling/therapy field. I have realized that despite my heightened attention to biases and assumptions subjected towards me, I have also done the same to others unknowingly.

For example, I have always assumed that clients and consumers are completely different from "normal people" and that they must be in their own world unable to function in "real life." My participation in the NAMI Provider Education Course has shown and proven to me that many mental health consumers are not so different after all. They struggle with the very same issues in life that I struggle with. In addition, they also have to deal with the bombardment of assumptions imposed on them.

By hearing people's stories and really getting to know some consumers, I reaffirmed my belief against judging someone automatically. I learned that it is important to acknowledge my own assumptions and biases, and set them aside when interacting or working with them. Being a culturally competent practitioner is necessary and a critical skill to have - this will allow empathy to create safety and authenticity and hopefully will shift how I see my work.

Below is an article that appeared in the August 2010 issue of *Wellness Matters*, by Tori Nelson, our second HEI intern:

The Importance of Mindfulness
As the last days of my internship here in BHRS are quickly approaching, I have been reflecting upon this one phrase that I have often heard and often questioned "the whole is greater than the sum of its parts." Thinking back to all of the experiences that I have had and all the skills that I have learned, I have come to realize the importance of that one phrase. From a broader perspective, the world that we live in is often divided into mutually exclusive and clear cut categories where individuals are categorized based upon a number of different perceived and/or real traits and characteristics. However, by categorizing individuals solely by let's say culture, race, age, gender or even by illness and disease, we are not being mindful of the person as a whole.

My experience as a Health Equity Initiatives Intern has taught me a very valuable yet basic life skill, mindfulness. Whether it be drafting mission and vision statements, working with the different Health Equity Initiatives, doing research, or simply communicating with co-workers, I have learned that one of the only ways to break down those mutually exclusive and clear cut categories mentioned above, is to be mindful. To most, myself included, being mindful is something that seems routine and habitual; however, I have learned that being mindful requires one to be attentive and aware of the impact of one's actions and words. Most of us do not take the time to stop and think about whether our actions or words are mindful of the person or group of people that we are communicating with or advocating for.

After speaking with and listening to consumers and family members in the NAMI Provider Education Course, I have learned that mindfulness (especially in terms of the categorical language that is often used in clinical settings) can breakdown many of the barriers and labels that are placed upon individuals with mental illnesses, alcohol and drug addictions, and co-occurring disorders. Language is very powerful and it is important to be mindful of how language can indirectly categorize and label an individual. For example, in clinical settings it is fairly common to hear phrases such as "He's a schizophrenic" or "She's a manic depressive." It is very easy to place such labels on someone, and I myself am guilty for labeling people in such ways. Throughout the NAMI provider course and all my experiences in BHRS, I have learned that such language can be hurtful and insensitive when interacting with not only clients, but everyday people as well. The slightest language change from labeling a person as a "schizophrenic" to an individual "who has schizophrenia," requires one to be mindful of the negative impacts that language can cause. Although an individual might be diagnosed with schizophrenia they may also be a mother or father, daughter or son, an athlete or an artist, a Christian or Buddhist or anything and everything in between. By categorizing individuals by their illness or disease, other *parts* of the individual are not taken into account…*parts* that make up the greater whole.

IV. Identify budget resources targeted for culturally competent activities.

A. Evidence of a budget dedicated to cultural competence activities

The expectation is that cultural competence is embedded in all of our programs and services, thus, the Division's overall budget includes cultural competence activities. However, BHRS has budgeted for some specific activities, the sole focus of which is cultural competence. These budgets are per fiscal year:

1) Health Equity Initiatives - $100,000

Each of the seven Health Equity Initiatives prepares a proposed budget for its activities per fiscal year and submits it to the Health Equity Initiatives Manager and the Cultural Competence Council Steering Committee for review. Each initiative decides what activities and projects to work on for the fiscal year through during its planning process (Appendix A., pp. 120-121).

2) Multicultural Stipends for Interns - $100,000 for approximately 20 interns, including the Health Equity Initiatives Intern(s).

3) Outreach contracts with North County Outreach Collaborative and One East Palo Alto – Total $274,000

The NCOC is a group founded in January, 2008, by Pyramid Alternatives, Asian American Recovery Services, Mayor Julie Lancell representing the Pacifica Collaborative, Ed Barney from Daly City Partnership, and the Filipino Mental Health Initiative. It is the first collaborative of its kind where agencies in the North County have come together to discuss a community problem: health disparities specifically in the Asian (Chinese and Filipino) and Latino communities. The NCOC was formed following a Request for Proposal funded by the MHSA seeking community based collaborations to perform outreach to underserved populations. The NCOC founders saw this as a great opportunity to work together instead of being siloed within their own agencies. This marks a substantial departure for non-profits who traditionally work alone to conserve resources.

As mentioned above, BHRS contracts with One East Palo Alto (OEPA) to provide technical consultation for the East Palo Alto Mental Health Community Advisory Group, mental health outreach and engagement services, and multicultural center services in East Palo Alto for consumers of mental health services for the African American, Latino and Pacific Islander communities. Outreach and community engagement services are provided through the East Palo Alto Partnership for Mental Health Outreach, a partnership of OEPA, El Concilio of San Mateo County, For Youth by Youth, Free at Last, and Pacific Tonga Ma'a Tonga.

Please refer to the most recent quarterly reports for EPA and NCOC outreach (Appendix A, pp. 92-113).

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.

For FY 2008-2009 and FY 2009-2010, the contract with Avid Translation for interpreter and translation services was $158,000. The total spent in FY 2008-2009 was $65,107 and FY 2009-2010 was $90,184.

The Health System contracted with Avid Translation for interpretation services and viaLanguage and translation services for FY 2010-2013. Of the $450,000 contract with Avid Translation, $320,000 or 71% is budgeted for BHRS. Of the $150,000 contract with viaLanguage, $40,000 or $27% is budgeted for BHRS.

We would like to explore how to bill for interpretation services. Currently, we use realignment funds to pay for these services. Because of the growing need for interpretation services and budget challenges, we need to look for other funding sources.

2. Reduction of racial, ethnic, cultural and linguistic mental health disparities AND
3. Outreach to racial and ethnic county-identified target populations

Please refer to the Health Equity Initiatives budget in Criterion 1, Section IV., A. above.

4. Culturally appropriate mental health services

The expectation is that cultural competence is embedded in all of our programs and services, thus, the Division's overall budget includes cultural competence activities. Please see Criterion 1, Section IV., A. above.

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

BHRS provides a salary differential for bilingual, bicultural staff as well as contracted network private providers. Please refer to Mental Health Policy No.: MH 01-08 (January 2002), Subject: Bilingual Salary Differential – Spanish and Tagalog Speaking Staff (Appendix A, pp. 122-124). Private providers are reimbursed at rates between 9.7%-10.3% higher for providing bilingual services (e.g. individual therapy reimbursed at $96 per hour for bilingual services compared to $88 per hour for services provided in English). Please also refer to our Beneficiary Provider List and their language capacity (Appendix H, pp. 6-32).

Please refer to the MHSA Workforce Education and Training Plan (WET Plan) online at www.smhealth.org/bhrs/mhsa (Appendix A, pp. 126-185). These Actions below include financial incentives, scholarships and stipends to attract culturally and linguistically competent providers:

1) Action #8: Attract prospective candidates to hard to fill positions through incentives.
2) Action #14: Expand existing effort and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system.
3) Action #17: Stipended Internships to Create a More Culturally Competent System.

Providers who contract with the Mental Health Plan (MHP) provide reimbursable services and this does not include services provided by non-traditional providers and/or natural healers at this time.

The Youth Services Center (YSC), which includes a juvenile detention facility, provides many programming options while at the YSC, ranging from cognitive skills workshops to folk dancing. One program is the Mind Body Awareness Project (MBA) which focuses youths' attention through mindfulness and meditation teaches coping skills that youth can take with them back to their communities. Other programs offered at the YSC include: pro-social skills, expressive painting, and knitting.

Criterion 2
County Mental Health System
Updated Assessment of Service Needs

In Criterion 2, we use a variety of data sources to explore the extent to which disparities exist in the BHRS system. We use data available from the State, our own analysis of billing records, and content from outside agencies who perform data analysis for us (e.g. EQRO).

Over the past two years, the Cultural Competence Council (CCC) at BHRS has been actively exploring disparities within the system. Due to the extent of the analysis we have performed, we will present our findings in a slightly different format than suggested. We will report on the first three suggested sections as requested: the general population, the Medi-Cal population and the 200% of poverty population. However, we will combine requested data on the MHSA CSS plans and PEI plans within a larger section looking at the BHRS population as a whole. Much of the data in these reports (CSS and PEI) are based on our entire population, so we combined this information with other self-generated data to make the material more clear.

Note: The reference page numbers are from the original reports. The page numbers in parentheses refer to the page numbers of the reports found in Appendix B.

I. General Population

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

According the California State Department of Finance population projections, the population of San Mateo County is approximately 736,667 in 2010. The largest racial/ethnic groups are White/Caucasian (42.6%), Hispanic/Latino (25.6%) and Asian (24.0%). Other groups make up a much smaller proportion of the population: Black and Pacific Islanders are both 3.6%; Multirace is 2.4% and American Indian/Native populations are 0.2%. Youth age 19 and younger make up a quarter of the county's population (24.5%), adults age 20–59 comprise slightly over half the population (56.6%) and older adults are about one fifth of the population (18.9%). (*Projected Population Demographic for San Mateo County - 2010 & 2020, p. 1 (53))*

Projections for 2020 suggest that the biggest changes will be an increase in the senior population (5 % increase), Hispanic/Latino population (3.3% increase), and Asian population (1.9% increase). The largest projected decrease is in the White/Caucasian population (5.8 percentage points). (*Projected Population Demographic for San Mateo County - 2010 & 2020, p. 1 (53))*

This data points to the increased need to focus on making services relevant and accessible to the Hispanic/Latino, Asian, and older adult populations.

II. Medi-Cal Population Service Needs (Use current CAEQRO data if available.)

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

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

To identify potential unmet need in the Medi-Cal population, we used EQRO analysis and our internal reports conducted over the last two years.

Regarding the entire Medi-Cal population, we have a better penetration rate (8.22%) than other medium sized Mental Health Plans (MHPs) (6.2%) and all other statewide (6.19%). However, our approved claims per beneficiary ($4,631) served is lower than the average medium sized MHP ($4,873), but higher than the statewide average ($4,451). *CA EQRO 2009, p. 16 (42)*

Ethnicity

Who is being served - Penetration Rates

One way to identify if we are serving people in an equitable manner is to explore the extent to which we are serving, if even briefly, the different populations.

1. Penetration rate for Medi-Cal population is similar to general population, except that Latinos are under-represented and White/Caucasians are over-represented. (see data points below).
2. Seniors who were Asian/Pacific Islanders, Latinos or had an 'unknown' ethnicity were least likely to meet the Medi-Cal targets – across regions. *R&E Regional Graphs 2009*
    - According to 07/08 data – BHRS has a general penetration rate of 8.6%. The highest penetration rates for African-Americans (18%) and European-Americans (20%). Japanese and Alaskan/Native American have high penetration rates (21% for both). The Latino population has a 5% penetration rate. Most Asian and Pacific Islanders have similar rates (between 2 and 7%). *R&E 2009 CC Report, p. 7 (5)*
    - Hispanic/Latino penetration rate low, but higher than medium MHPs and statewide. *CA EQRO 2009, p. 17, 24 (43, 47)*
    - Medi-Cal target rates – We identified Medi-Cal targets as serving between 7 and 14% of the Medi-Cal eligible population. We generally reached or exceeded these targets for youth and adults, across ethnicities. For seniors, targets were not met for Asian/Pacific Islanders, Latinos and 'unknown' – across regions. One exception – EPA Latino youth and seniors did not meet Medi-Cal targets. *R&E Regional Graphs 2009*

How well are they being served - Treatment Rates

1. For people new to BHRS in 06/07, there does not appear to be any glaring disparity, by ethnicity. Generally, 82% or more had five or more services. *R&E 2009 CC Report, p. 14 (11)*
2. However, the amount of claims approved for Hispanic/Latino client was lower than other similar sized MHPs and statewide average. Approved claims per beneficiary served for the Hispanic/Latino population ($3,653) is lower than both medium MHPs ($4,478) and statewide averages ($4,185). The differences have been shrinking over the past three years. *CA EQRO 2009, p. 17, 24 (43, 47)*

Gender

Who is being served - Penetration Rates

1. Women receive fewer Medi-Cal services than men, and have fewer approved claims. However, the disparities here are less than they are statewide. *CA EQRO 2009, p. 24 (47)*

Language

Who is being served - Penetration Rates

1. According to 07/08 data - English penetration rate was 15%. Spanish was 3%. Tagalog was 6%. *R&E 2009 CC Report, p. 7 (5)*
2. Asian languages are all under-represented across age ranges and regions. *R&E Regional Graphs 2009*
    - Across all age groups – English speakers are over-represented among the Medi-Cal population. Spanish speakers under-represented across the age ranges and regions. As with ethnicity, Spanish language speakers are under-represented in the Medi-Cal population. *R&E Regional Graphs 2009*
    - Outliers – East Palo Alto – Spanish speakers under-represented in Medi-Cal population in all age groups.
3. According to Medi-Cal targets (7 to 14%), seniors did not hit 7% across the board for Spanish and Asian/Pacific Islander languages. Adult Spanish language within 7 to 14% range by region. Youth Spanish language varies by region at getting into the range. East Palo Alto and South County are low. *R&E Regional Graphs 2009*

Medi-Cal vs. non-Medi-Cal

1. Follow-up rates after an inpatient discharge. Insured (50%) – Uninsured (18%). Medicare (14%) least likely to have follow-up after inpatient discharges. *Databook 2008, p. 54 (22)*

Age

Who is being served - Penetration Rates

1. According to 07/08 data – the lowest penetration rates were for youth age 5 and younger (2.2%) and seniors age 66 and over (2.5%). Also low were the age 16-20 year olds (6.6%). *R&E 2009 CC Report, p. 8 (6)*
2. The penetration rate for the Transition Age Youth (TAY) population was 10.3% in 2007. This was way above the Medium MHP (6.7%) and statewide (6.94%) averages. *EQRO 2009, p. 16 (43)*
3. Foster care population is also being served quite well. BHRS has a 95.5% penetration rate, compared to 57% for medium MHPs and 55% statewide. *EQRO 2009, p. 16 (43)*

How well are they being served - Treatment Rates

1. "For TAY beneficiaries, . . . approved claims are significantly higher than the associated benchmarks". *EQRO 2009, p. 19 (45)*
2. Foster care reimbursement rates (approved claims) per beneficiary is much lower than the medium sized MHP and statewide averages. *EQRO 2009, p. 19 (45)*

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

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

The Medi-Cal population is generally at less than 200% of the poverty level. This section of the report looks at BHRS's ability to serve clients ***above*** 200% of poverty.

In FY 2007-2008, there were 7,225 clients who ***did not receive*** any Medi-Cal services (56.6% of all served at BHRS that year). The rates of White/Caucasian and Hispanic/Latino people served were almost the same (34.7% Hispanic/Latino compared to 34.2% White/Caucasian). The next largest group of people served was African Americans (7.5%) and those with an unreported ethnicity (8.1%). Also in this population, 71.5% speak English, and 22.2% speak Spanish. The next largest category is 'unknown' at 4.3%. Around 30% of this population is under age 18, 64% are adults, and 5.7% are older adults (65 or older). 11.3% are in a TAY range (age 18-24). *R&E 2009 CC Report, p. 9-10 (7-8)*

One way to identify if there might be discrepancies in services is to compare the Medi-Cal population to those not receiving it. Those not receiving Medi-Cal were more likely to be Hispanic/Latino, and slightly less likely to be African American or White/Caucasian. Similarly, they were more likely to be Spanish speaking (22.2% vs. 13.9% of Medi-Cal), and TAY age range (11.3% vs. 7.8% of Medi-Cal) *R&E 2009 CC Report, p. 9-10 (7-8)*

Another way to assess how BHRS is doing with this population is to look at how we are doing at addressing the mental health needs of this population countywide. CPES Estimates generated for the DMH identify estimated number of people above 200% poverty who have mental health needs, by race, age, and gender. Comparing the rate of prevalence of mental health need in the community and the number of those we serve in the population (non-Medi-Cal), shows where we are making strides and where we are not.

On the whole, 3% of the 200% above poverty population is considered in need of mental health services, with 6.27% of youth needing services, and 2.13% of adults. Among the youth population BHRS is best addressing the Pacific Islander (6.02%), African American (4.85%) and Hispanic/Latino population (3.32%). We are also doing best at reaching those age 12-17 (3.59%). Groups we are serving the least are Asian youth (0.15%), White/Caucasian youth (0.78%) and those of multi-ethnicity (0.76%). BHRS is also serving males (1.84%) at a slightly higher rate the females (1.25%). Youth under age five appear to have the lowest rate compared to other youth age categories (0.32%). *(CPES Estimates of Need for Mental Health Services for California - San Mateo County 2007, p.1 (54))*

In the adult population who is at 200% above poverty level, BHRS has the highest rates of serving Pacific Islanders (3.49%), African-Americans (2.83%) and young adults (age 18-20 is at 2.16% and age 21-24 is at 1.58%). The lowest rates of service are for Asians (0.12%), older adults (age 65+ is 0.48%), and White/Caucasians (0.82%). Females (1.12%) are served at a slightly higher rate than males (0.89%). *(CPES Estimates of Need for Mental Health Services for California - San Mateo County 2007, p. 1-2 (54-55))*

Another way to assess disparities is to look at the treatment rates – the number of services people receive. In general, the non-Medi-Cal clients were much more likely to stop services after receiving one or two services, compared to the Medi-Cal population (R&E 2009 CC Report, p. 14 (11)) even though there is no difference in locus score distribution among Medi-Cal and non-Medi-Cal clients (*Databook 2008*, p. 16 (18)). Pacific Islanders had the smallest percentage of people receiving five or more services (20%). Hispanic/Latino clients had the most (54%). *R&E 2009 CC Report, p. 14 (11)*

Entire BHRS Population and Service Needs

For the past two years, BHRS has been using client service and billing data to identify areas of need and disparity in order to address inequities in the system. We have looked at data such as who has been served, rates of service, extent of service, by ethnicity, race, language and gender. In cases where we have looked specifically and Medi-Cal or non-Medi-Cal clients, we have reported these findings in those sections. This section looks at data where the entire population of people we served are assessed. The CSS population assessment and PEI assessments are included in here. We present the data in this aggregated manner since the CSS data generally focuses on the entire population (not separating out Medi-Cal clients), it is older and we have replicated some of that analysis with more recent data, and the PEI reports have often referred to information from the CSS report.

Ethnicity

Who is being served - Penetration Rates

1. Comparing clients to the *population of San Mateo County as a whole*, African Americans and Latino clients make up a larger proportion of the clients compared to their proportion of the county population (overrepresentation of Latinos is mostly in youth and transition age clients). Asian Americans are generally under-represented. White/Caucasian population is under-represented.
2. Comparing clients served to (Holzer) targets of people who need mental health services, San Mateo is exceeding the targets with the White/Caucasian and African American populations, close to meeting the targets with the Asian/Pacific Islander and Native American population, and not meeting the targets with the Latino populations. Comparison of Holzer Targets, (58-59)
3. San Mateo County is meeting these targets better than the state as a whole, who appears to be underserving people of every ethnicity, with a huge deficit in the Latino population (San Mateo's discrepancy between the target number and those served is much less). *Comparison of Holzer Targets, (74-75)*
4. In comparison to the poverty population, White/Caucasian and African Americans are overrepresented, Asian & Pacific Islanders and Latinos are underrepresented.
    a. According to 06/07 data - BHRS has provided services to 5.7% of the African American population and 2.4 % of the Hispanic/Latino population in the county. This is higher than the White/Caucasian (1.1%), Native Hawaiian & Pacific Islander (1.29%), American Indian or Alaskan Native (1.23%) or Asian (0.48%). In other words, the overall penetration rate – countywide compared to the entire population, African Americans and Latinos are overrepresented, and Asians are underrepresented – compared to other ethnic groupings. *R&E 2009 CC Report, p. 6 (4)*
    b. Low penetration rate of Asian and Pacific Islanders in North County. CA EQRO 2009 ,p. 32 (50)
    c. " . . . it can be concluded that the current Mental Health Services Division does not serve the Latino, Asian and Pacific Islander populations at the levels we would expect to see them in our consumer population." CSS Report, p.74 (36)
    d. By age group
        i. The African American population is represented in a greater proportion than the San Mateo County or poverty population – this is true across age groups (child & youth, transition age youth, adult, older adult)
        ii. The Asian/Pacific Islander population is underrepresented compared to the general

San Mateo County population and the poverty population. This is true among all age groups.

iii. In youth and transition age youth groups, the Latino population served at BHRS is over-represented of the general population, but underrepresented in the poverty population. For adults and older adults, they are barely overrepresented in the general San Mateo county population.

iv. The White/Caucasian population is underrepresented in the San Mateo county population, but overrepresented in the poverty population – this is true across age groups.

v. "African American population is represented in a greater proportion (11%) than they are represented in either the general San Mateo County population or the poverty population. The Asian/Pacific Islander population (5%) is underrepresented both in regard to the general population (20%) and the poverty population (15%). The Latino population (39%) is greater than the general population (31%) but underrepresented in regard to the poverty population (56%). The White/Caucasian population (29%) is overrepresented in regard to the poverty population (18%) while underrepresented in regard to the general population (39%). Overall, 42% of the clients were underserved - this ranged from 34% of the Asian/Pacific Islander population to 47% of the Latino Population (Whites were 35%)." CSS Report, p. 81 (40)

e. Transition Age Youth

i. "The African American population is represented in a great proportion (10%) than they are represented in either the general San Mateo County population (3%) or the poverty population (4%). The Asian/Pacific Islander population (9%) is under-represented both in regard to the general population (20%) and the poverty population (15%). The Latino population (40%) is greater than the general population (31%) but under-represented in regard to the poverty population (56%). The White/Caucasian population (31%) is overrepresented in regard to the poverty population (18%) while underrepresented in regard to the general population (39%)." (41)

<u>How well are they being served - Initiation and Engagement, Treatment Rates & Level of Service</u>

1. Latino (41%) and African American (42%) populations have higher percentage of those who meet initiation and engagement standards than White/Caucasian clients. Least likely to meet them are those identified as some 'other' (28%), 'unknown' (29%), and White/Caucasian (35%). Chinese clients were the 4th lowest – at 39%. Highest levels – American Indian/Alaskan (59%), Pacific Islander (51%) and Other Asian (43%) populations. *Databook 2008, p. 24. (20)*
2. After inpatient discharges - Chinese and those identified as some "other" ethnicity were most likely to have no follow up (25% and 34%). This is much higher than the next highest level – 17% for "Other Asian" and 16% for "Unknown." *Databook 2008, p. 54 (22)*
3. After an initial ICI received in 08-09, Chinese and 'Other Asian' clients were most likely to receive one or more services (56% and 45%) or four or more services (44% and 43%). The lowest percentage of people to receive one or more services was 'Other Pacific Islanders' (8%) and 'unknown' (24%). Most people fell in a follow-up percent range from 37% (Filipino) to 43% ('Other'). Latino clients had a 43% rate, African Americans (40%), and White/Caucasian (38%). *Follow-up Service Received After Initial ICI Visit, p. 1 (56)*

4. For people ***new*** to BHRS in 06/07, White/Caucasian clients (49%) were less likely than African American (64%) or Latino (65%) clients to receive five or more services. The same trend holds for clients who receive 16 or more services (White=30%; Latino=39%; Black=40%). Asian and Pacific Islanders are in the middle of these poles. *R&E 2009 CC Report, p. 14 (11)*
5. According to DMH's analysis of days of service, Native Americans have the largest proportion of people receiving 16 or more days of service, both in San Mateo County (55.6%) and statewide ((29.5%). White/Caucasian (45.9%) and Asian/Pacific Islander (44.9%) clients have a larger proportion of those with 15 or more days of service, compared African Americans (41.1%) and Latinos (38.0%). Those with 'other' ethnicity were least likely to have more that 15 days of service (26.5%). Statewide, a smaller proportion of clients receive 16 or more days of service (all under 30%). The ranking of whom has the largest proportion of people getting 16 or more services is similar, except that Latino (26.6) clients get a more similar proportion to Asian/Pacific Islanders (26.1). <u>*Distribution of Clients Served by Days of Service*</u> *(67,83)*
6. A similar analysis of FY 2008-2009 data from BHRS billing records showed 55% of Native Americans had 16 or more services, and 51% of both White/Caucasian and African American clients received that many services. Chinese (53%) and Filipino (51%) clients also had large percentages with 16 or more services. Ethnicities with lower proportions of clients in this high service bracket were Latinos (40%), "Other Asian" (40%), "other" (31%) and Unknown (21%).
7. Latino clients make up comparably smaller proportions of those served in some type of residential services: 'residential' services (12%); long term care (8%); housing (14%); and the private provider network (14%). White/Caucasian clients make up the largest proportion of those who receive residential services: long term care (80%); housing (61%); 'residential' (53%). *R&E 2009 CC Report, p. 16 (13)*
8. Latino clients were most likely to be served in outpatient services (18%), intensive case management (11%); PES (10%); acute inpatient (8%) and Access (9%). *R&E 2009 CC Report, p. 17 (14)*

<u>Diagnosis</u>

1. Rates of receiving diagnosis are similar by ethnicity, except in the following cases. Latino clients much more likely to receive a 'no specific diagnosis' and much less likely than others to receive a 'psychotic' diagnosis. White/Caucasian clients more likely to receive a mood/affective diagnosis. *R&E 2009 CC Report, p. 19 (14)*

Language

<u>Increase over time – shows where need is</u>

1. Languages other than English have increased 55%. The number of Spanish speakers has grown significantly over the last few of years from 1,498 (in 04/05) to 2,359 (in 07/08). Tagalog speakers grew from 51 (in 04/05) to 96 (in 07/08). *Databook 2008, p. 9 (17)*

<u>Who is being served - Penetration Rates</u>

1. Across all age groups – English speakers are overrepresented among the general population (or sometimes equal to the general population). Spanish speakers are underrepresented across the age ranges and regions. As with ethnicity, Spanish language speakers are mostly representative of general population. Asian languages all underrepresented. *R&E Regional Graphs 2009.*
2. "Significantly fewer people of all ages were served in their primary language than may need it." *PEI Update 2008, P. 31 (52)*

How well are they being served - Initiation and Engagement, Treatment Rates & Level of Service

1. Initiation standard met pretty equally by those with English, Spanish, Tagalog or other language. Unknown language was below other by over 10 percentage points. "Other" a little more likely to meet engagement standard (44%). Other primary languages 36-39%. Unknown is 22%. *Databook 2008, p. 24 (20)*
2. Sixty-one percent of Spanish speakers received five or more services and 60% of Tagalog received this number of services. 54% of English speakers received this amount, and 51% of those with some 'other' language. *R&E 2009 CC Report, p. 15 (12)*

Age

Unmet need

1. It is believed that we are not reaching all the possible uninsured children and youth. *CSS Report p. 71-2 (33-34)*
2. TAY youth placed out of home are also assumed to not all be served. *CSS Report, p.72 (34)*
3. Lack of assistance for TAY parents *CSS Report, p.72*
4. Assumed adult jail population underserved. *CSS Report, p.73*
5. Underserved uninsured adults (assumed 3,134 adults in county, we served 804). *CSS Report, p.73 (35)*

Penetration Rate

1. According to 06/07 data – Children under age five (0.65%) and adults over age 65 (0.83%) have lower penetration rates than adults age 18 and older (1.82%). *R&E 2009 CC Report, p. 6 (4)*
2. According to Holzer Target populations of people who need services, San Mateo county is not meeting the need of those ages 0-5 and ages 6 -11. However, the county is meeting the targets for those ages 25 – 44, and exceeding the targets for all other age groups. Statewide, none of the targets are met. *Comparison of Holzer Targets (63, 79)*

How well are they being served - Initiation and Engagement, Treatment Rates & Level of Service

1. Youth new to the system in 06/07 were much more likely to get 16 or more services (45%), compared to those age 18-59 (28%) and age 60 and over (23%). Those with five to15 services are similar. *R&E 2009 CC Report, p. 15 (12)*
2. The DMH analysis of Distribution of Clients Served by Days of Service shows that TAY age group (18-24) has the lowest proportion of people receiving five or more services, along with those age 25-44, age 65 and up, and age 0-5. *Distribution of Clients Served by Days of Service (71)*
3. Hours of Service by Locus score
   - Seniors had the least number of services for those with highest locus scores, compared to adults (with residential services) and youth. We do not know how to compare this to adults with no residential services (which is lower than seniors, but not factored out for seniors). *Databook 2008, p 18*. (19)
   - "For adults and older adults, median hours are relatively flat, no matter the level of care (adult, from 12.9 to 17.6) and older adults (12.4 to 12.3)" *CSS Report, p.78*

Gender

Who is being served - Penetration Rates

1. Males were over-represented for all four age groups. The largest disparity was among children and youth (61% to 52%). There were only three and four percentage point differences in the TAY and

adult groups. The difference almost disappears in older adult groups. *CSS Report P. 82 (41)*
2. Transition age males were more likely than females to be fully served (males 68%, females 64%).
3. San Mateo County is doing a better job at meeting Holzer Targets with males than females. However, targets are met in the county for both genders. Statewide, the targets for both males and females is not met. *Comparison of Holzer Targets (60, 61, 76, 77)*

How well are they being served - Initiation and Engagement, Treatment Rates & Level of Service

1. Males and females received a similar proportion of services in San Mateo County. Statewide this trend holds true as well. *Distribution of Clients Served by Days of Service (69, 85)*

Provider

Initiation and Engagement

1. North County and Central County Adult have the lowest initiation and engagement percentages for adults:
   North – I=32%; E=14%; Central – I=37%; E=16%. For Youth, Central/South County has lowest initiation (59%) and engagement (46%) with Hillcrest the *lowest. Databook 2008, p. 26 (21)*

Other

1. Insurance – people without insurance have greatest unmet need – *PEI Update 2008, p. 55*
2. Disabled older adults considered to be un-served. *CSS Report p. 70 (32)*
3. Farm worker families are assumed to be un-served. *CSS Report p. 70 (32)*
4. "We conclude that a substantial proportion of the homeless population is un-served." *CSS Report p. 70 (32)*

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

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

Please refer to the population assessment from San Mateo County's approved CSS Plan (Appendix B, pp. 23-41). The data from the CSS Plan is several years old and includes data from FY 2003-2004.

We analyze utilization data from the annually updated San Mateo County BHRS Databook and presented it to the Mental Health Board, BHRS Leadership, the CCC Steering Committee and the CCC.

We are providing utilization data from the FY 2007-2008 San Mateo County BHRS Databook of May 2009.

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

A. Which PEI populations did the County identify in their PEI Plan?
   1. Underserved cultural populations
   2. Individuals experiencing onset of serious psychiatric illness
   3. Children/youth in stressed families
   4. Trauma-exposed

5. Children/youth at risk of school failure
6. Children/youth at risk of experiencing juvenile justice involvement.

B. Describe the process and rationale by the county in selecting their PEI populations(s).

Guided by high standards for community involvement and participation, San Mateo County's MHSA planning processes are specifically designed to facilitate meaningful participation from stakeholders, including un/underserved communities.

The Director of the Behavioral Health and Recovery Services Division (BHRS) provided overall guidance and direction to the project, while the Director of Alcohol and Other Drug (AOD) Services and the MHSA Coordinator (BHRS) planned and supported the PEI planning process. All three constitute the Core BHRS PEI Planning Design Group.

Like CSS, the PEI planning process was also structured around age-focused workgroups: 0 to 5; 6 to 17; 18 to 25; Adults; and Older Adults. We reviewed the prevention-related results of the extensive community outreach process conducted in 2005 for CSS as well as the recommendations of the age-focused Work Groups that developed the State-approved MHSA CSS Plan for San Mateo County. In addition, we identified related County strategic initiatives and Board of Supervisors recommendations that needed to be factored into the planning process. Examples are: *the Roadmap for Alcohol, Tobacco and Other drug (ATOD) Prevention*; the Community Health Assessment; Linguistic Access Study; the Adolescent Report; among others[1]. The development of the planning process took into account and reflected a much larger countywide effort of assessment and identification involving un/under-served populations.

The strategies utilized in CSS for the determination of community needs and target populations were also utilized for the selection of key mental health needs and priority populations for PEI. This determination involved data and community and expert input gathered through the many outreach activities. For PEI, we actualized and updated the relevant CSS data pieces; we also incorporated new information that supplemented the original data sets, with information that became available after our CSS proposal was approved. In addition, more than 100 persons provided additional input via meetings, focus groups, and surveys conducted for PEI, enhancing and refocusing the outreach done for CSS.

The participants in the PEI planning process analyzed in detail all the pieces of information described above, as well as the new information gathered for the PEI planning process that supplemented the information obtained during CSS. All these elements informed the selection of the key mental health needs and priority populations.

[1] These reports can be located at http://www.plsinfo.org/healthysmc/

Criterion 3
County Mental Health System
Strategies and Effort for Reducing Racial, Ethnic, Cultural, Linguistic Mental Health Disparities

I. Identified unserved/underserved target populations

A. List identified target populations with disparities within each of the selected populations
- Medi-Cal population
- Community Services Support (CSS) population: Full Service Partnership population
- Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations

Medi-Cal
The information below is from Criterion 2, Section II., A. for target populations with disparities within the Medi-Cal population.

Ethnicity
Who is being served - Penetration Rates
One way to identify if we are serving people in an equitable manner is to explore the extent to which we are serving, if even briefly, the different populations.
Penetration rate for Medi-Cal population is similar to general population, except that Latinos are under-represented and White/Caucasians are over-represented. (see data points below).

1. Seniors who were Asian/Pacific Islanders, Latinos or had an 'unknown' ethnicity were least likely to meet the Medi-Cal targets – across regions. *R&E Regional Graphs 2009*
2. According to 07/08 data – BHRS has a general penetration rate of 8.6%. The highest penetration rates for African-Americans (18%) and European-Americans (20%). Japanese and Alaskan or Native American has large penetration rates (21% for both). The Latino population has a 5% penetration rate. Most Asian and Pacific Islanders have similar rates (between 2 and 7%). *R&E 2009 CC Report, p. 7 (5)*
3. Hispanic/Latino penetration rate low, but higher than medium sized Mental Health Plans (MHPS) and statewide. *CA EQRO 2009, p. 17, 24 (43, 47)*
4. Medi-Cal target rates – We identified Medi-Cal targets as serving between 7 and 14% of the Medi-Cal eligible population. We generally reached or exceeded these targets for youth and adults, across ethnicities. For seniors, targets were not met for Asian/Pacific Islanders, Latinos and 'unknown' – across regions. One exception – EPA Latino youth and seniors did not meet Medi-Cal targets. *R&E Regional Graphs 2009*

How well are they being served - Treatment Rates

1. For people new to BHRS in 06/07, there does not appear to be any glaring disparity, by ethnicity. Generally, 82% or more had five or more services. *R&E 2009 CC Report, p. 14 (11)*
2. However, the amount of claims approved for Hispanic/Latino clients was lower than other similar sized MHPs and statewide average. Approved claims per beneficiary served for the Hispanic/Latino population ($3,653) is lower than both medium MHPs ($4,478) and statewide

averages ($4,185). The differences have been shrinking over the past three years. *CA EQRO 2009, p. 17, 24 (43, 47)*

Gender

Who is being served - Penetration Rates

1. Women receive fewer Medi-Cal services than men, and have fewer approved claims. However, the disparities here are less than they are statewide. *CA EQRO 2009, p. 24 (47)*

Language

Who is being served - Penetration Rates

1. According to 07/08 data - English penetration rate was 15%, Spanish was 3%, and Tagalog was 6%. *R&E 2009 CC Report, p. 7 (5)*
2. Asian languages are all under-represented across age ranges and regions. *R&E Regional Graphs 2009*
3. Across all age groups – English speakers are over-represented among the Medi-Cal population. Spanish speakers under-represented across the age ranges and regions. As with ethnicity, Spanish language speakers are under-represented in the Medi-Cal population. *R&E Regional Graphs 2009*
4. Outliers – East Palo Alto – Spanish speakers under-represented in Medi-Cal population in all age groups.
5. According to Medi-Cal targets (7 to 14%), seniors did not reach 7% across the board for Spanish and Asian/Pacific Islander languages. Adult Spanish language within 7 to 14% range by region. Youth Spanish language varies by region at getting into the range. East Palo Alto and South County are low. *R&E Regional Graphs 2009*

Medi-Cal vs. non-Medi-Cal

1. Follow-up rates after an inpatient discharge. Insured (50%) – Uninsured (18%). Medicare (14%) least likely to have follow-up after inpatient discharges. *Databook 2008, p. 54 (22)*

Age

Who is being served - Penetration Rates

1. According to 07/08 data – the lowest penetration rates were for youth age 5 and younger (2.2%) and seniors age 66 and over (2.5%). Also low were the age 16-20 year olds (6.6%). *R&E 2009 CC Report, p. 8 (6)*
2. The penetration rate for the Transition Age Youth (TAY) population was 10.3% in 2007. This was way above the Medium sized MHPs (6.7%) and statewide (6.94%) averages. *EQRO 2009, p. 16 (43)*
3. Foster care population is also being served quite well. BHRS has a 95.5% penetration rate, compared to 57% for medium MHPs and 55% statewide. *EQRO 2009, p. 16 (43)*

How well are they being served - Treatment Rates

1. "For TAY beneficiaries, . . . approved claims are significantly higher than the associated benchmarks". *EQRO 2009, p. 19 (45)*
2. Foster care reimbursement rates (approved claims) per beneficiary is much lower than the medium sized MHP and statewide averages. *EQRO 2009, p. 19 (45)*

Community Services and Supports (CSS) Population: Full Service Partnership

Child/Youth/Transition Age Youth Full Service Partnership (FSP) - Priority populations to be served by the program are: 1) Seriously emotionally disturbed children, youth and their families, who are at risk of out-of-home placement or returning from residential placement, with juvenile justice or child welfare involvement; 2) Seriously emotionally disturbed and dually diagnosed transition age youth at risk of or returning from residential placement or emancipating, with juvenile justice or child welfare involvement; 3) Seriously emotionally disturbed children, youth and transition age youth with multiple psychiatric emergency services episodes and/or frequent hospitalizations and extended stays are also eligible, including homeless youth and youth exiting school-based, individual education program (IEP)-driven services; 4) In addition to these children and youth that are known to one or more of the systems, the program also serves newly identified transition age youth that are experiencing a "first break". The programs are open to all youth meeting the criteria described above, but **targeted to Asian/Pacific Islander, Latino and African American children/youth /transition age youth as they are over-represented within school drop out, child welfare and juvenile justice populations. Asian/Pacific Islander and Latino populations are underrepresented in the mental health system.** As of June 30, 2010, the race enrollees were: 41% Caucasian, 17.5% African American, 29% Latino, 7.5% Asian/Pacific Islander and 5% mixed race, serving 40 enrollees in each Child/Youth and Transition Age Youth FSPs. BHRS contracts with Edgewood to provide Youth and TAY FSP services.

Adult Full Service Partnership - Population to be served: Seriously mentally ill adults who may also have co-occurring disorders to be served by the FSP include: 1) Those eligible for diversion from criminal justice incarceration if adequate multi-agency community supports can be provided; 2) Currently incarcerated individuals for whom early discharge planning and post-release partnership structure and support may prevent recidivism and/or re-hospitalization; 3) Individuals placed in locked mental health facilities who can succeed in the community with intensive supports; and 4) Individuals whose mental illness results in frequent emergency room visits, hospitalizations, and homelessness that puts them at risk of criminal justice or institutional placement. **The program focuses on engagement of Latino, African American and Pacific Islander populations that are over-represented in the criminal justice system and underrepresented in the mental health system**. BHRS contracts with Telecare and Caminar to provide Adult and Older Adult FSP Services.

Older Adults/Medically Fragile Transition Age Adults Full Service Partnership - This Full Service Partnership serves seriously mentally ill older adults and medically fragile individuals who are either at risk of institutionalization or currently institutionalized and who, with more intensive supports, could live in a community setting. In any instances these individuals have co-occurring medical conditions that significantly impact their ability to remain at home or in a community-based setting. **The program outreaches especially to Asian, Pacific Islander and Latino individuals, as these populations are under-represented in the current service population**.

In the Caminar REACH program, of 30 clients, the ethnicity/race is as follows: Caucasian 53%, African American 20%, Middle Eastern 6.6%, Filipino 6.6%, Filipino/Guamanian 3.3%, Hispanic/Latino 3.3%, Mixed/Non-Hispanic 3.3%, and British/German/Thai 3.3% (as of June 30, 2010).

In the Telecare FSP for Adults and Older Adults, of 142 clients, the ethnicity and/race is as follows: Caucasian/White 58%, African American 22%, Hispanic/Latino 6%, Pacific Islander 4%, Asian/Asian American 3%, Native American 2% and Other 2% (as of June 30, 2010). Please refer to the quarterly

reports (April 1- June 30, 2010 from each respective FSP provider (Appendix C, pp. 5-9).

Workforce, Education and Training

The following information is from San Mateo County's MHSA Workforce Education and Training Component Three-Year Program and Expenditure Education and Training Plan submitted in November 2009 and approved in March 2010. The Plan may be viewed at www.smhealth.org/bhrs/mhsa (Appendix A, pp. 126-185).

III. Language Proficiency

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3). Note: The number of those who are proficient (2) was collected by a self reported staff survey (and not by a standardized language proficiency test) and the additional number who need to be proficient (3) was calculated by using a formula provided by DMH.

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish	Direct Service Staff 238 Others 96	Direct Service Staff 227 Others 187	Direct Service Staff 465 Others 283
2. Tagalog	Direct Service Staff 14 Others 22	Direct Service Staff 39 Others 62	Direct Service Staff 53 Others 84
3. Mandarin	Direct Service Staff 17 Others 3	Direct Service Staff 48 Others 8	Direct Service Staff 65 Others 11
4.	Direct Service Staff Others	Direct Service Staff Others	Direct Service Staff Others
5.	Direct Service Staff Others	Direct Service Staff Others	Direct Service Staff Others

Spanish is the County's only threshold language per Medi-Cal. However, the County's five identified priority languages include Spanish, Tagalog, Chinese, Russian, Tongan. However, we have seen a dramatic increase in Arabic, Burmese, Hindi, and Vietnamese in from interpretation services requests FY 2008-2009 to FY 2009-2010 (Appendix G, p. 2).

BHRS has been involved in numerous conversations about improving linguistic capacity within the Health System. These ongoing discussions through the Health System Cultural Competence Steering Committee (HSCCSC) include updating bilingual pay testing content, procedure and scoring. Recommendations include the County adopting a standardized language test, with some customizable components, which should cover, at a minimum: oral interpretation, vocabulary identification and text translation.

Administration and scoring criteria should be clearly delineated and discussed with the language tester before the test is given.

The Bilingual Employee Pilot (BEP) Advisory Group developed and piloted a sample Russian bilingual test during the course of the pilot (June 2009-February 2010). Please see a BEP Advisory Group sample meeting agenda and minutes from September 2009 (Appendix C, pp. 1-3). The pilot clearly reflected an appropriate fluency level needed to effectively interact with Limited English Proficient Russian clients. This test is being recommended for consideration as a template for all other language tests. The County is also ensuring that all language testers possess the necessary oral and written proficiency to assess language ability. Within the San Mateo County Health System, each division may customize the test by adding terms or vocabulary relevant to their programs. Additionally, divisions may also waive the written translation component if they do not foresee the need for translation skills. Staff who are expected to perform document translation and translation review will be required to take the translation component of the exam.

From WET Plan:
Shortages by occupational category: County analysis of population and prevalence data revealed that the County is significantly under-serving the Hispanic/Latino and Asian populations and over-serving both the white and African American populations; that said, over-serving the African American population does not necessarily mean that we are serving this group in a culturally competent fashion. If the Hispanic/Latino and Asian populations were fully served, an additional 400 Hispanic/Latino and 500 Asian consumers would receive services, which would significantly impact current staff caseloads. The County has been making inroads in serving these populations more effectively, particularly the Hispanic/Latino community, as the number of Hispanic/Latinos served has risen from 3,000 to 4,000 in the last two years. To fully serve these individuals would require an increase in staffing with an emphasis upon recruiting to improve the diversity of the existing workforce to better reflect the population served.

Comparability of workforce, by race/ethnicity, to target population receiving public mental health services: There is a significant difference in the composition of the workforce and the consumers that this workforce serves, with a significant over-representation of White and Asian staff and a significant under-representation of both Hispanic/Latino and African American staff, particularly Hispanic/Latino staff. Clearly the most significant gap in workforce cultural composition is in relation to Hispanic/Latinos, a gap that is more noteworthy and critical as the County is more successful in engaging a larger proportion of the Hispanic/Latino population into treatment. The present proposal aims, among other things, to develop a systematic approach to introducing communities of color to the behavioral health profession and facilitating access to training and education that would enable more individuals of color to consider a behavioral health career in San Mateo County.

Positions designated for individuals with consumer and/or family member experience: San Mateo County has long been committed to consumer involvement in system planning and operation, and has a number of initiatives that have facilitated recruitment and placement of a significant number of consumers and family members in positions within the behavioral health system. The push now is to move beyond hiring consumers as peer partners and family members as family partners and to build career ladders that enable experienced consumers and family members to assume positions not explicitly designated for consumers and family members. The County has developed a highly collaborative relationship with the College of San Mateo, Vocational Rehabilitation Services (VRS) and community-based organizations to develop career paths for consumers and family members. Funding from the MHSA Community Services and Supports Plan

created peer operated centers that employ consumers as peer partners. There are currently nine (9) Peer Partner/Community Worker positions and one additional vacant position. Our Peer Partners are diverse and represent our priority ethnic/racial/linguistic communities (African American, Chinese, Latino, Tongan). They have offices in regional clinics/offices but serve consumers/clients throughout the County. VRS has developed part-time positions (25 placements FY 2009-2010) for consumers in a variety of business roles outside of behavioral services, e.g. janitorial, food service and medical records technicians. While these non-behavioral health care positions are not included in the totals above, they represent a significant advance for consumers, enabling them to move from positions within behavioral health care to other positions, greatly expanding career alternatives.

Language proficiency: The staff survey conducted for this process generated a surprising result with over 330 staff indicating proficiency in Spanish. This represents almost 50% of the entire workforce. It is believed that this is a significant over-statement of Spanish-speaking capacity as focus groups, staff planning meetings, and other input processes have consistently indicated that there is a significant need for more Spanish speakers in all positions, but particularly in peer and family roles and treatment positions. This does not mean that we are serving the clients in a culturally competent manner as a system and at different levels of care. For example from our data, Latino clients make up comparably smaller proportions of those served in some type of residential services and Latino clients are much more likely to receive a 'no specific diagnosis.' (see Criterion 2, IV. above). The extent to which the Hispanic/Latino community is under-served is, no doubt, in part is a result of the lack of sufficient Spanish speaking staff but also bicultural skills or someone who knows Hispanic/Latino culture. Focus groups participants also identified the need for more bilingual staff in Chinese, Tagalog, Samoan and Tongan languages as these communities continue to grow and outreach has been focused on them in the last few years.

From Prevention and Early Intervention (PEI) Plan:
All PEI Projects have been aimed to address underserved racial/ethnic and cultural populations.

The age 0 to 5 Work Group identified families at risk due to demographics, children in families with known risk, and ultimately all families among their priority populations.

The PEI workgroup that focused on ages 6-25 worked in subgroups focused on ages 6-17 and 18-25. They identified students at risk, youth who are unserved or underserved, and those experiencing early onset of psychotic illnesses among their priority populations.

The PEI workgroup that focused on adults identified individuals who are in other service systems, those who are at-risk/stressed/traumatized, those who are disconnected, and those who are unidentified but need intervention among their priority populations.

The PEI workgroup that focused on older adults identified individuals who are isolated, who are unserved or underserved, and those experiencing deteriorating health and cognition (which puts them at risk of serious psychiatric illness) among their priority populations.

Currently, BHRS has released the following four Requests for Proposals with deadlines between end of July and end of August 2010:

Early Childhood Community Team - The team will serve young families with children birth to three as well

as formal and informal child care settings in a designated community. The team should be targeted to serve a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support young families. The initial Team site will be **targeted to serve a community with a high proportion of Latino, or isolated farm worker families, or a community experiencing a significant degree of interpersonal and community violence**, which has significant impact on families and young children. If additional funding were to become available in the future, more teams might be feasible in other communities. Proposers must identify the community(ies) they will target, justify that choice, and describe their experience serving that particular community(ies)/geographic area.

"Teaching Pro-Social Skills" for Children Age 6 to 9 - Teaching Pro-Social Skills (TPS) addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Students are at risk due to issues such as growing up poor; peer rejection; low quality child care and preschool experiences; after-school care with poor supervision; school failure, among others. Teaching Pro-Social Skills is based on Aggression Replacement Training (ART). The initiative will be open to all **at-risk children 6 to 9 years of age being served in the sites selected as locations of service. However, it is targeted to Asian/Pacific Islander, Latino and African American children.**

"Project Success" for Children/Adolescents - Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students) is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services. Project SUCCESS is a research-based program that builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective factors. The initiative will be open to all at-risk **children and youth ages 10 to 18 in the community based sites (schools) selected as locations of service. However, it is targeted to Asian/Pacific Islander, Latino and African American children.**

"Seeking Safety" for Transition Age Youth - BHRS will contract with community based agencies to provide population and group based interventions to **at-risk youth ages 18 to 25.** Seeking Safety is an approach to help people attain safety from trauma/PTSD (Post Traumatic Stress Disorder) and substance abuse. The initiative will be open to all at-risk youth being served in the community based sites selected as locations of service. However, it is **targeted to Asian/Pacific Islander, Latino and African American children/youth who experience or have experienced trauma.**

1. From the above identified PEI population(s) with disparities, describe the process and rationale the county used to identify and target the populations with disparities.

All PEI Projects address underserved racial/ethnic and cultural populations. Please refer to Criterion 2, V. B. regarding the process and rationale the County used to identify and target the population(s) (with disparities).

II. Identified disparities (within target populations)

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

B. List the strategies identified for each targeted area as noted in criterion 2 in the following sections: Medi-Cal, 200% poverty, MHAS/CC, PEI priority populations.

We have explored the target populations of those receiving Medi-Cal services, those at 200% of poverty, and the general population served by BHRS as a whole. We present our data in this manner, and have not highlighted disparities specifically for the CSS, WET and PEI groups, since we do not differentiate our services among MHSA and non-MHSA clients. We believe our analysis fully covers our entire population – allowing us to create a plan based on comprehensive data.

Medi-Cal target population
The primary disparities noted in the Medi-Cal population are among seniors (particularly among Asians and Latinos), the Latino population and some Asian groups. Although the Latino population is underrepresented, we are proportionally serving more than other Mental Health Plans (MHPs) of similar size, or others statewide. However, we are billing less for them, compared to other MHPs.

Seniors, particularly those who are Asian and Latino, are served much less than others. These groups did not meet our identified desired standard (at least 7% of the San Mateo County Medi-Cal eligible population), for all the provider regions in the county.

Other disparities noted are for women, who are underserved compared to men. Spanish speakers and those speaking Asian languages are also under-represented.

200% of Poverty (minus the Medi-Cal population)
Comparing our penetration rate to the estimated prevalence rate of mental illness in San Mateo County also identified potential disparities. In the youth population, Asians, White/Caucasians and those of multiple ethnicities received services at the lowest rates. Similar to the Medi-Cal population, males had higher rates of service compared to females. Among the adult populations, Asians, older adults, and White/Caucasians were again the least likely to have services. In this instance, females were served at a higher rate than males.

When looking at the number of services received, non-Medi-Cal clients (assumed above 200% poverty) generally had fewer services than those with Medi-Cal. Pacific Islanders had the smallest percentage of people receiving five or more services, and Latino clients had the most (in this case).

Entire BHRS Population
Regarding ethnicity, the Asian American, Pacific Islanders and Latino populations tend to be under-represented, compared to the general population. According to Holzer targets, San Mateo County is meeting the 'need' in the Asian/Pacific Islander community. However, these are estimated targets, and they are not being served in a representative way. It would seem prudent to consider that Asians and Pacific Islanders as underserved.

When looking at how well people are being served, White/Caucasian clients are less likely to meet the initiation and engagement standard that the Latino or African American populations. Chinese clients stand out compared to other Asian ethnicities as having low initiation and engagement levels, as well as having less follow-up after inpatient discharges. The "Other Asian" group also had much less follow-up after PES discharges than other groups.

Please note we define "Initiation and Engagement rates" in our Databook as clients starting new episodes having a second visit within 14 days and having a 3rd and 4th visit within the following 30 days.

When exploring the number of services "new" clients receive within a year, again White/Caucasian clients are least likely (except for "other" and "unknown") to have 16 or more services, whereas Latino, African American and Native American populations have the highest percentages. However, this trend changes when looking at number of services, or dates of services, clients received within a fiscal year. Both the DMH and BHRS analysis show White/Caucasian clients being more likely to have 16 or more services. The BHRS analysis (for a more recent fiscal year) shows African American clients having a similar proportion of services to White/Caucasian clients. Latino clients have the smallest proportion of services (except for those coded as "other" or "unknown"). This difference may be due to White/Caucasian clients being more likely than others to be served in residential facilities – and that clients in residential services are also likely to be in the system for long periods of time (and so are excluded from the new client analyses).

Similar to ethnic disparities, those that speak Spanish or an Asian language are underrepresented. However, Spanish speakers are most likely to receive five services or more compared to those with other languages.

Seniors also have some of the largest disparities. They have a lowest penetration rate, and receive the fewest services for those with the highest Locus scores. Even though Holzer targets are met in San Mateo County for this population, these are estimates and it still seems more appropriate to consider them as underserved (since they are according to the population at large).

Males are over-represented among all age groups, though the largest disparity is among those younger than 18.

III. Identified strategies/objectives/actions/timelines

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

The following information is from the Mental Health Services Act (MHSA) Fiscal Year 2010/2011 Annual Update to the Three-Year Program and Expenditure Plan of March 24, 2010:

CSS
Full Service Partnership – Child/Youth/Transition Age Youth
Community Services and Supports Work Plan
This program helps our highest risk children and youth with serious emotional disorders (SED) remain in their communities, with their families or caregivers while attending school and reducing involvement in juvenile justice and child welfare. Specialized services to transition age youth (TAY) aged 16 to 25 with serious emotional disorders are also provided to assist them to remain in or return to their communities in safe environments, support positive emancipation including transition from foster care and juvenile justice, secure safe and stable housing and achieve education and employment goals. The program helps reduce involuntary hospitalizations, homelessness, and involvement in the juvenile justice system. The 80 initial slots were divided between two 40-slot teams, one for children/youth and one for transition age youth. The current proposed expansion will add a total of 50 new slots. Supervision of both teams by a single person

assures consistent vision across both teams and collaboration between them, which intends to create a more seamless relationship between services for children and services for adults. Enrollees do not experience multiple transitions between programs as they age; they have access to the expertise across teams and the entire continuum of resources for children, youth and transition age youth as their needs change over time. Enrollees benefit from the shared resources across the program including the cultural and linguistic diversity of staff, parent partners, the existing collaborative relationships with Juvenile Justice, Child Welfare, Education, Housing and Employment Services, and the expertise of individual clinicians in co-occurring disorders as well as on other evidence based practices. The program reflects the core values of the Wrap Around model: to partner with families and other important people in developing service strategies and plans; to assess family, child/youth and community strengths rather than weaknesses; to assist children/youth and families in becoming the authors of their own service plans; to encourage and support a shift from professionally-centered to family-centered practice and resources; and to also assess child/youth and family needs and areas of growth. Embedded in these core values is recognition of the importance of the family's cultural values as a strength, a source of resilience, and an integral component of service delivery. It is worth noting that the transition age youth team emphasizes the individual consumer's role in developing their own wellness and recovery plan. This FSP also offers a drop-in center and supported education to engage TAY, which serves the FSP participants as well as other SED transition age youth in the community that are receiving mental health services. The focus is to provide self-help supports, social activities, and skill building, as well as support for those seeking to enter the college system, all aimed at enhancing ability to manage independence. Emphasis is placed in outreaching to LGBTQQI SED youth. As noted above, BHRS contracts with Edgewood to provide this Full Service Partnership.

Full Service Partnership – Adults
Community Services and Supports Work Plan
The Full Service Partnership for Adults offers "whatever it takes" to engage seriously mentally ill adults, including those who are dually diagnosed, in a partnership to achieve their individual wellness and recovery goals. Services are focused on engaging people on their terms, in the field and in institutions. While services provided through this program address the individual's underlying mental health and behavioral health problems that may have led or contributed to involvement in the criminal justice system and institutionalization, a wide range of strategies and supports beyond mental health services are essential. The overall goal of the program is to divert from the criminal justice system and/or acute and long term institutional levels of care (locked facilities) seriously mentally ill and dually diagnosed individuals who can succeed in the community with sufficient structure and support. The program is grounded in research and evaluation findings that demonstrate that diversion and post incarceration services reduce incarceration, jail time and re-offense rates for offenders whose untreated mental illness has been a factor in their criminal behaviors. The program also follows the model and philosophies of California's AB2034 Homeless Mentally Ill Adult programs and the assertive community treatment approach, aiming to use community based services and a wide range of supports to enable seriously mentally ill and dually diagnosed adults to remain in the community and to reduce incarceration, homelessness, and institutionalization.

The Full Service Partnership provides the full range of mental health services including medication support with a focus on co-occurring mental health and drug and alcohol problems. Staff is trained in motivational interviewing and develops dually focused programming, including groups. Medication services include psychiatry and nursing support for ongoing dialogues with consumers about their psychiatric medication choices, symptoms, limiting side effects, and individualizing dosage schedules. Staff is available to

consumers 24/7, and service plans are designed to utilize exceptional community relationships. Peer partners play a critical role, modeling personal recovery, helping consumers establish a network of peer, family, and cultural supports and, in particular, helping consumers connect with a non-profit network of peer-run self-help centers. BHRS contracts with Telecare and Caminar to provide FSP services for Adults and Older Adults.

Full Service Partnership – Older Adults/Medically Fragile Individuals
Community Services and Supports Work Plan

Similar to the FSP for Adults, the goal of this program is to facilitate or offer "whatever it takes" to ensure that consumers remain in the least restrictive setting possible through the provision of a range of community-based services and supports delivered by a multidisciplinary team. The program targets seriously mentally ill older adults and medically fragile individuals who either would be at risk of placement in a more restrictive setting without intensive supports or who could be moved to a less restrictive setting with these additional supports. The program works with board and care facilities and with consumers living in the community to prevent them from being placed in locked or skilled nursing facilities, and with residents of skilled nursing and locked facilities to facilitate their returning to a less restrictive setting. Referrals to the program are received from locked facilities, skilled nursing facilities, acute care facilities, board and care facilities, primary care clinics, Aging and Adult Services, community agencies, and from individuals/family members themselves. Services are available around the clock. For many of the consumers targeted by this Full Service Partnership, their mental illness impedes their ability to adhere to essential medical protocols, and their multiple medical problems exacerbate their psychiatric symptoms. As a result, these individuals need support and assistance in following up on medical appointments, medical tests/treatments, and close day-today supervision of medications. Difficulties managing these issues as well as shopping, meal preparation and other routine chores often lead to institutional placements so that these basic needs can be met. The goal of the FSP is to make it possible for the consumer's care to be managed and his/her needs to be met in a community setting. A full-time nurse enables the treatment team to more effectively collaborate with primary care providers and assist consumers in both their communications with their primary care doctors and in their follow-up on medical procedures and treatments. The licensed clinicians in the team oversee the completion of the multidisciplinary assessment and the development and implementation of a comprehensive service plan that involves all members of the team, the consumer and the family, contingent on the consumer's wishes. Peer Partners provide support, information and practical assistance with routine tasks, and cultivate a system of volunteer support to supplement what the Peer Partner can provide. Similarly, when a family is involved and the consumer is supportive of their involvement, a Family/Caregiver Partner works with the family to build their capacity to support the consumer. With these strategies, the Full Service Partnership helps to mobilize natural supports in the consumer's system and contributes to building those natural strengths to maintain the consumer in the least restrictive setting. In addition to the FSP staff, each FSP member receives the supports of their "virtual team" that includes the individuals/family members in their lives as well as any other needed health or social services supports for which they are qualified such as In-home Supportive Services, Meals on Wheels, senior centers/day programs, etc. These formal and natural supports are identified and integrated into the consumer's individual service plan.

For the most recent quarterly reports for the Full Service Partnership programs, please refer to Appendix C, pp. 5-9.

WET

BHRS Training Committee: During the months of December 2007 through March 2008 the BHRS Training Committee, which includes representation from management and direct service staff, consumer and family members, community-based agencies, supported education, education, among other stakeholders, discussed how to best address the educational and training needs of the Behavioral Health and Recovery Services Division. The intent was to develop a three-year training plan that identified the full-spectrum of BHRS staff education and training needs, including but not limited to those that would be funded through MHSA WET dollars. The Committee's efforts built upon, and expanded, the work of the Workforce Development Planning Group. Please refer to the Training Committee roster (Appendix C, p. 4). The Committee created a timeline for implementation of a wide range of training activities fully aligned with the vision, mission, values and principles developed through all other related planning processes. In the course of the discussions, the need emerged to delineate a framework that would set the philosophical foundation for the work of this group, which in turn guides the Training Plan and the elements included in it, as follows:

GUIDELINES FOR EDUCATION AND TRAINING (BHRS Training Committee, January 2008)

1. Consumers and family members are equal partners in the decision-making process around education and training.
2. Cultural and linguistic competence (fluency) are embedded in all phases of educational and training initiatives.
3. Our education and training initiatives increase the ability of all staff to provide wellness and recovery-based services.
4. Our initiatives support the education and training needs of staff and rely on staff input in the development of an education and training plan, with a broad definition of what constitutes education and training.
5. Best practices are at the core of our education and training plan in every aspect, including the type of training models used, the content of the training provided, and the evaluation tools to monitor the long-term effectiveness of the education and training activities.
6. Our education and training plan maximizes the effective use of resources – including, but not limited to, staff's time.
7. Partnerships and collaboration with the community and contract agencies in the planning and implementation of education and training initiatives is encouraged and prioritized.
8. All the above guidelines are in the service of providing effective and quality care to the individuals and families we serve.

These guidelines have been operationalized to create a checklist that will frame any and all training activities, and that signals the commitment of the group to remain true to its core values. In practice, this means that each one of these guidelines is brought to life every time a training activity is conceived.

The training plan includes a set of foundational or core trainings; specialized yearly trainings in different areas focused on annual priorities; ongoing co-occurring training; yearly required trainings for licensure and re-licensure; consultation; collaborative trainings with other agencies/organizations; support for off-site trainings and conferences for consumers and family members; among others as identified. The training plan also further delineates the role of the Workforce Development Director responsible for implementing the plan, the role of the Training Committee responsible for monitoring the plan's

implementation, and the criteria by which each training activity will be approved and evaluated. The Workforce Development Director works in conjunction with the Health Equity Initiatives Manager to ensure effective coordination and support of these efforts.

The following Actions are from the Workforce Mental Health Services Act (MHSA) Workforce Education and Training Component Three-Year Program and Expenditure Education and Training Plan of November 21, 2009. For each Action's Description of Training Experience(s), and Objectives, please refer to the WET Plan at www.smhealth.org/bhrs/mhsa (Appendix A, pp. 126-185).

WORKFORCE STAFFING SUPPORT
Action #1 – Title: Workforce Education and Training Plan Coordination and Implementation

TRAINING AND TECHNICAL ASSISTANCE
Action #2 – Title: Targeted Training For and By Consumers and Family Members
Action #3 – Title: Trainings to Support Wellness and Recovery
Action #4 – Title: Cultural Competence Training
Action #5 – Title: Evidence-Based Practices Training for System Transformation
Action #6 – Title: Expanded Site-Based Clinical Consultation

MENTAL HEALTH CAREER PATHWAY PROGRAMS
Action #7 – Title: Attract prospective candidates to hard to fill positions via addressing barriers in the application process
Action #8 – Title: Attract prospective candidates to hard to fill positions through incentives
Action #9 – Title: Promote mental health field in academic institutions where potential employees are training in order to attract individuals to the public mental health system in general, and to hard to fill positions in particular
Action #10 – Title: Promote interest among and provide opportunities for youth/Transition Age Youth (TAY) in pursuing careers in mental health
Action #11 – Title: Engage adult workers into the mental health workforce
Action #12 – Title: Increase diversity of staff to better reflect diversity of client population
Action #13 – Title: Retain diverse staff
Action #14 – Title: Expand existing effort and create new career pathways for consumers and family members in the workforce to allow for advancement within BHRS and in other parts of the County system
Action #15 – Title: Ongoing engagement and development of client and family workers

RESIDENCY, INTERNSHIP PROGRAMS
Action #16 – Title: Child Psychiatry Fellowship

FINANCIAL INCENTIVE PROGRAMS
Action #17 – Title: Stipended Internships to Create a More Culturally Competent System

PEI
Please refer to PEI Project Summaries Form No. 3 of the Prevention and Early Intervention Plan www.smhealth.org/bhrs/mhsa for each respective Project's strategies/objectives/actions and timelines as well as the currently released Requests for Proposals (RFP) outlined in Criterion 3., I.:

Early Childhood Community Team - The proposed Early Childhood Community Team project incorporates several major components that build on current models in our community, in order to support healthy social emotional development of young children. A Community Team would comprise a community outreach worker, an early childhood mental health consultant, and a licensed clinician. BHRS PEI funding will support at least one team; if additional partnership funding for community outreach worker(s) can be developed, there might be two teams, and if the model is demonstrated as successful, other funding sources might support replication with additional teams serving additional communities. Each team would be targeted to serve a specific geographic community within San Mateo County, in order to build close networking relationships with local community partners also available to support young families. Per the recommendation of our planning workgroup, the initial BHRS PEI team site will be targeted to serve a community with a high proportion of Latino and/or isolated farm worker families, or a community experiencing a significant degree of interpersonal violence, which has significant impact on families and young children.

Community Interventions for School Age and Transition Age Youth - This project will focus on school age and transition age youth, reaching out to them in non-traditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth focused and other organizations operating in communities with a high proportion of underserved populations. The project will use community based agencies to provide population and group based interventions to at-risk children and youth ages 6-25.

Primary Care/Behavioral Health Integration: IMPACT Model - We will use the proven IMPACT model to identify and treat individuals in primary care who do not have Serious Mental Illness, and are unlikely to seek services from the formal mental health system.

Total Wellness for Adults/Older Adults with Serious Mental Illness -The Total Wellness model has been designed to be parallel to the IMPACT model already described, using the current evidence based practices developed in the world of primary care to improve the health status of individuals with chronic health conditions, adapting these practices for use in the behavioral health system. It also builds upon and supports the practices of the nurse practitioners currently located in BHRS clinics, providing support and backup to their provision of general healthcare services in the mental health setting. The intent is to provide smooth and seamless collaboration among all care providers.

Total Wellness will assure universal screening and registry tracking for all BHRS consumers receiving psychotropic medications. Tracking will include blood pressure, Body Mass Index (weight), smoking status, as well as screening for glucose and lipid levels, at the time of psychiatric visits.

Anti-Stigma Initiative - There are several components to this initiative regarding stigma, which is designed to form the foundation for a long term effort to focus specific activities within San Mateo County, and not duplicate MHSA statewide initiatives and media campaigns.

Please note the consolidation of two or more existing programs below in the Mental Health Services Act (MHSA) Fiscal Year 2010/2011 Annual Update to the Three-Year Program and Expenditure Plan of March 24, 2010 below:

School-Based Services
Community Services and Supports Work Plan #5
Population to be served: This program identifies and serves seriously emotionally disturbed youth that are not receiving 26.5 (Individualized Education Plan [IEP]) or other mental health services, may have co-occurring disorders, and are at risk of school drop-out, gang involvement/ juvenile justice or child welfare involvement. The program **targets Asian, Pacific Islander, Latino, and African American youth in selected middle schools in un-served and underserved regions of the County. Asian, Pacific Islander and Latino populations are under-represented in the behavioral health system; African Americans are over-represented in child welfare and juvenile justice populations**. BHRS contracts with Asian American Recovery Services to provide these services.

Description:
Schools offer a normative environment that is community-based, culturally diverse, involves families, and focuses on resilience in all areas of life. Our School-Based program offers mental health services on-site at middle schools, eliminating barriers to access. Youth and their families are engaged in mental health services to enable staying at home and out of the juvenile justice or child welfare systems. Key aspects of the program:

- Identification of, and referral mechanisms for, seriously emotionally disturbed (SED) children and their families.
- Referral of those children eligible for 26.5 services.
- Mental health services to at-risk youth.

School staff initiates the process. Services are individualized and based on the youth's mental health assessment. Individual, group and family therapy is provided on an as-needed basis.

Community Interventions for School Age and Transition Age Youth
Prevention and Early Intervention Work Plan #2
Population to be served: Priority populations for this project as identified by the stakeholders during the planning process are school age children and youth and transitional age youth who are at risk, who are un-served or underserved, and those experiencing early onset of psychotic illnesses.

Description:
This project reaches out to children and youth (including transition age youth) in non-traditional settings such as schools and community based agencies, such as substance abuse programs, drop-in centers, youth-focused and other organizations operating in communities with a high proportion of underserved populations. The project comprises three interventions, as follows:

- The first intervention, Teaching Pro-Social Skills (TPS), addresses the social skill needs of students who display aggression, immaturity, withdrawal, or other problem behaviors. Teaching Pro-Social Skills is based on Aggression Replacement Training (ART). TPS has three key components: *Skillstreaming* (the behavioral component), which teaches what to do; *Anger Control Training* (the emotional component), which teaches what not to do; and *Moral Reasoning Training* (the values component), which teaches why to use the learned skills. This intervention targets 6 to 9 year old children.
- *The second intervention, Project SUCCESS (Schools Using Coordinated Community Efforts to Strengthen Students), is considered a SAMHSA model program that prevents and reduces substance use and abuse and associated behavioral issues among high risk, multi-problem*

adolescents. It works by placing highly trained professionals (Project SUCCESS counselors) in the schools to provide a full range of prevention and early intervention services. Project SUCCESS is a research-based program that builds on the findings of other successful prevention programs by using interventions that are effective in reducing risk factors and enhancing protective factors. Intervention strategies used are information dissemination, normative and prevention education, problem identification and referral, community based process and environmental approaches. In addition, resistance and social competency skills, such as communication, decision making, stress and anger management, problem solving, and resisting peer pressure are taught, both individually and in small groups.

- The third intervention, Seeking Safety, is an approach to help people attain safety from trauma/Post Traumatic Stress Disorder (PTSD) and substance abuse. Within this project, Seeking Safety targets Transition Age Youth through their contacts with community based organizations. Seeking Safety is a manualized intervention (also available in Spanish), providing both client handouts and guidance for clinicians. It is conducted in group and individual format; with diverse populations; for women, men, and mixed-gender groups; in a variety of settings; and for both substance abuse and dependence. It has also been used with people who have a trauma history, but do not meet criteria for PTSD.

Text in italics represents a PEI item to be expanded by moving the "Middle School Initiative" program from CSS to PEI. This program was originally funded under CSS.

B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:
   I. Medi-Cal population
   II. 200% of poverty population

One strategy is to increase insurance coverage among BHRS clients. We can stretch our limited resources much further for people who are uninsured and expand access to health care services if every client and family who is eligible for public or private insurance in San Mateo County enrolls in it. We are raising awareness among clients and families about these resources and linking those who are uninsured to Medi-Cal, Healthy Families, Healthy Kids, and CareAdvantage plans, and this was a priority for 2010. We have a Manager for Health Insurance Outreach and Coordination who assists clients and families as well as programs on the wide array of eligibility resources available. We are in the process of distributing an Insurance Survey to better understand our clients' insurance status (Appendix C, p. 10). Last year, staff was involved with numerous outreach activities, partnering with members of the various Health Equity Initiatives.

We also make efforts to empower clients to understand their own benefits and how to maintain them. Clients may lose benefits unnecessarily when they do not understand how to follow-up, are misled about what steps to take, or have difficulty navigating complex systems. Staff and individuals may schedule an information or consultation session with San Mateo County's VRS Financial Empowerment Project (FEP) regarding individual benefits, issues of children and youth and SSI. Some VRS staff are "stationed" in regional offices on different days and at other clinics/CBOs (e.g. Wellness Center in East Palo Alto). San Mateo County Legal Aid's Client Rights Advocate is another valuable resource for clients who need legal assistance problem-solving issues with Social Security and partners with FEP in providing education and outreach on these topics.

III. MHSA/CSS population.

For Work Plans other than Full Service Partnerships, please refer to the Mental Health Services Act (MHSA) Fiscal Year 2010/2011 Annual Update to the Three-Year Program and Expenditure Plan of March 24, 2010 information below:

Outreach and Engagement
Community Services and Supports Work Plan #4
The main goal of our outreach and engagement efforts is to increase access to services for historically un-served and underserved populations and communities. The initiative builds bridges with ethnic, linguistic and cultural populations that experience health disparities and may experience the mental health system as unresponsive to their needs. Targeted populations include African American, Chinese, Filipino, Latino, Pacific Islander, and LGBTQQI individuals. Strategies include population-based community needs assessment, planning and materials development, hiring of community based "navigators", as well as primary care-based services to identify and engage diverse populations in services. Community Workers build relationships with neighborhood and cultural leaders to ensure that un-served and underserved communities are more aware of the availability of mental health services, and so that these leaders and their communities can have more consistent input about how their communities are served. A number of initiatives are included in this work plan, as follows:

- ***Navigator Program –*** *The model includes community-based workers who provide outreach to African American, Chinese, Filipino, Latino and Pacific Islander populations of all ages, with emphasis on differing groups in differing parts of the County. These outreach workers may be peers or parent partners, but the principal requirement is that they be bilingual, bicultural and connected to the community. Outreach workers can demystify the system, reduce stigma, and engage community leaders in supporting and directing people towards services. The initial work focused in un-served and underserved populations (African American, Latino, and Pacific Islander groups) in the South part of the County, with East Palo Alto as the epicenter. A second effort is underway in the North part of County and part of the Coast, with a focus on Chinese, Filipino, Latino and Pacific Islander populations. Future expansions may provide for this model in other areas.*
- **Health Equity Initiatives –** These Initiatives focus on capacity building in African American, Chinese, Filipino, Latino, and Pacific Islander, LGBTQQI communities, with consideration given to the differing approaches and needs of each one of those communities. The model involves community-driven/centered collaborations, outreach, planning processes, needs assessments, pilot projects, materials development, human resources development, specific service design and linkage-building into the behavioral health system.
- ***Crisis Hotline for Youth –*** *MHSA funds a licensed mental health clinician attached to an otherwise funded 24/7 suicide prevention hotline operated by Youth and Family Enrichment Services - a youth-focused community-based organization. The licensed mental health clinician provides clinical expertise and ensures follow-up and linkage to the behavioral health system.*
- **SMART –** The SMART program offers specially trained medics in a mobile van to respond to requests for ambulance transport to emergency departments for individuals that may be involuntarily detained. Commencing on FY 2009-2010, MHSA dollars will fund a clinical liaison position and a portion of this critical program.

Items to be moved to Prevention and Early Intervention are in italics. These were originally programs originally funded under CSS.

Pathways, a Mental Health Court Program
Community Services and Supports Work Plan #6
The Pathways Program serves seriously mentally ill (SMI) nonviolent offenders with co-occurring disorders -mental health and substance use/abuse. The program was designed to be appropriate to the issues and needs of African Americans, Latinos and Pacific Islander populations, as they are over-represented in the criminal justice system.

The Pathways Mental Health Treatment Court Program is a partnership of San Mateo County Courts, the Probation Department, the District Attorney, the Private (Public) Defender, the Sheriff's Department, Correctional Health, and the Behavioral Health and Recovery Services Division. Through criminal justice sanctions/approaches, and treatment and recovery supports addressing individuals' underlying behavioral health issues, offenders are diverted from incarceration into community-based services. The program aims at:

- Reducing recidivism and incarceration.
- Stabilizing housing.
- Reducing acute care utilization.
- Engaging and maintaining active participation in personal recovery.

Anyone can refer someone to Pathways, including self-referrals. Eligibility criteria are:

- San Mateo County residency.
- A diagnosis of a serious mental illness (Axis I), with functional impairments.
- Statutory eligibility for probation.
- Agreement to participate in the program voluntarily.

The referrals are sent to a centralized location in the Probation Department. They are then forwarded to the client's lawyer, at which point the client and the lawyer decide on whether they are interested in the Pathway services. If they are, the lawyer has the case directed to the Pathways Court calendar. Of the 140 referrals to Pathways in 2008, 72 of these were forwarded to the Pathways staff for consideration. Of the 72, 25 were enrolled in Pathways. Many people get screened out for not meeting the criteria for admission specified above or choose not to be considered for some of the following reasons:

- The lawyer presents the client with a "better deal" involving less jail/probation time.
- The person referred does not identify with being seriously mentally ill.
- The person referred has no desire to work towards substance abuse recovery.

Older Adults System of Care Development
Community Services and Supports Work Plan #7
Population served: Seriously mentally ill (SMI) older adults, including those served by specialty field-based outpatient mental health team, county clinics, community-based mental health providers, mental health managed care network providers (private practitioners and agencies), primary care providers, Aging and Adult Services, and community agencies that provide senior services. There is an emphasis on specific ethnic/linguistic populations for different regions of the County. For example, in the Coastside region the focus is on Latino populations, while in North County the focus is on Asian populations, and in South and Central County the focus is on African American, Latino, and Asian and Pacific Islander populations.

This program focuses on creating a coherent, integrated set of services for older adults, in order to assure that there are sufficient supports to maintain the older adult population with SMI in their homes and community, and in optimal health. The intent is to assist seniors to lead dignified and fulfilling lives, and in sustaining and maintaining independence and family/community connections to the greatest extent possible. Peer Partners provide support, information, consultation, peer counseling, and practical assistance with routine tasks such as accompanying seniors to appointments, assisting with transportation, and supporting social activities. They also recruit and participate in training volunteers to expand our existing volunteer-based senior peer counseling program in order to build additional bilingual/bicultural capacity. Senior peer counseling works with individuals and groups. "La Esperanza Vive"—a component of the current Senior Peer Counseling program, is a well-developed Latino-focused program in existence for over 20 years that recruits and trains volunteers, and provides peer counseling for Latino older adults. "La Esperanza Vive" provides a model for the development of other language/culture-specific senior peer counseling components. Senior Peer Partners serve homebound seniors through home visits and create or support the development of activities for mental health consumers at community sites such as senior centers. In addition, and as desired by SMI older adults, Senior Peer Partners facilitate consumers to attend client-run self-help centers described under System Transformation. Staff is bilingual and bicultural. The Senior Peer Counseling program has been expanded to include a Chinese-focused component, a Filipino-focused component and a LGBT-focused component. The field-based mental health clinical team provides in-home mental health services to homebound seniors with SMI. The team consists of psychiatrists, case managers, and a community mental health nurse, and provides assessment, medication monitoring, psycho-education, counseling and case management. The team partners with other programs serving older adults such as Aging and Adults Services and the Ron Robinson Senior Care Center with the goal of providing comprehensive care and to help consumers achieve the highest possible quality of life and remain living in a community-based setting for as long as possible.

System Transformation and Effectiveness Strategies
Community Services and Supports Work Plan #8
All populations served by Behavioral Health and Recovery Services benefit, with an emphasis on improving services to ethnic and linguistic populations that experience disparities in access and appropriateness of services, and assuring integrated and evidence-based services to those with co-occurring disorders.

Throughout the MHSA outreach and planning process, participants spoke about the need to fundamentally transform many aspects of the system to truly enact wellness and recovery philosophy and practice and engage un-served ethnic and linguistic populations more successfully in services. The System Transformation and Effectiveness Strategies Work Plan contains the elements identified as critical to the transformation in the planning process, including a focus on recovery/resilience and transformation; increased capacity and effectiveness of County and contractor services through an infusion of training, bilingual/bicultural clinicians, peers/peer-run services and parent partners; and implementation of evidence based and culturally competent practices. *Training initiatives included in this plan (soon to be funded through the MHSA Workforce Education and Training component) are a critical aspect of System Transformation, as follows:*

- *Multi-year integrated services program development and training for co-occurring alcohol, other drug, and psychiatric disorders for all providers (BHRS –Mental Health + AOD, and contracted providers) serving all ages*.
- Cultural competence training for all providers serving all ages.
- Family support and education training for all providers serving all ages.

- Wellness and recovery training including the SAMHSA wellness management and recovery toolkit, and Wellness Recovery.
- Action Plans (WRAP) for providers serving transition age youth, adults and older adults. Wellness and recovery training includes modules led by consumers and family members.
- *Supported employment and training for peer and parent partners.*

Other system transformation strategies include expanded family support/education services for children/youth/transition age youth, and peer supports for adults and older adults, as well as consumer self-help centers.

Items to be moved to Workforce Education and Training are in italics. These programs were originally funded under CSS.

IV. PEI priority population(s) selected by the county, from the six PEI priority populations.

Please refer to PEI Project Summaries Form No. 3 of the Prevention and Early Intervention Plan at www.smhealth.org/bhrs/mhsa for each respective Project strategies/objectives/actions and timelines as well as the currently released Requests for Proposals discussed in Criterion 3, I.

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

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

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

We fully recognize that engaging individuals and organization is hard work due to competing priorities, yet continue our efforts to encourage staff and non-staff to learn about BHRS' mission and vision and see if there is any place for them to be involved.

With many of our efforts, we notice that the direct financial cost is minimal but the human resource (staff) time takes tremendous planning, coordination and engagement. We feel that building partnerships and working collaboratively are key critical pieces in our work, constantly aiming to build community capacity as well as increasing the amount of community "ambassadors" and allies within the different cultural groups. We also admit that sometimes the outcomes are not easily measurable and quantifiable but we see important progress beyond engagement and retention through increased partnerships with communities, agencies and individuals.

For example, in creating the North County Outreach Collaborative (NCOC), we have brokered stronger partnerships between agencies: Pyramid Alternatives, Daly City Partnership, Pacifica Collaborative and Asian American Recovery Services. As the Executive Director of Pyramid Alternatives once said at a Mental Health Board presentation (about NCOC), "these four agencies who never spoke to each other…together are strong allies and partners in their communities." In East Palo Alto (EPA), we have developed partnerships between unlikely partners (i.e. those who normally would not have been sitting at

the table) within the community and those organizations view BHRS as a partner in their work – in advocacy and social justice. The agencies (e.g. community centers, faith-based agencies, etc.) have also provided credibility to our work with racial/ethnic/cultural/linguistic communities in EPA.

The Puente Clinic is another example of a collaborative effort, a partnership between San Mateo County Behavioral Health and Recovery Services, Golden Gate Regional Center, and the Health Plan of San Mateo to create a specialty clinic to meet the complex mental health and behavioral needs of the residents of San Mateo County with developmental disabilities. Please refer to the Puente Clinic brochure (Appendix C, pp. 11-12).

Creating systems change, we face many challenges on different levels. These challenges include adequate funding, effective prioritization of efforts and coordination (not siloing efforts and being able to connect to organizational goals) and outcomes. Similar to other counties, we are in constant need more bilingual/bicultural workforce and need to attract more diversity in our committees (e.g. those with lived experience, age, etc.) to help reach people we are not yet reaching.

Another noticeable challenge is that our non-BHRS participants continue to voice out their challenge of being able attend and participate on a regular basis. Many share that workload and priority issues in their caseload as agency priorities as the biggest barriers to their involvement, and that, this is in addition to their "real job."

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.)

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

We plan and monitor our efforts through a variety of quantitative and qualitative means: EQRO audits, annual Databook, and MHSA reporting to DMH; Workforce Development Director, MHSA Coordinator, Health Equity Initiatives Manager reports and presentations to Joint Policy, Leadership, Cultural Competence Council (CCC), Quality Improvement Committee, and Mental Health Board. The Health Equity Initiatives report to the CCC at the annual CCC strategic planning meeting.

Although cultural competence efforts are always being considered at every level, at every appropriate opportunity, we also target annual events to highlight cultural competence-related issues and activities. Every year, we bring updates to our monthly BHRS Leadership meetings; engaging supervisors, management, community based organizations and other stakeholders to learn about our efforts. We also have presented to the Mental Health Board and contractors (at the Contractor's meeting) to share with them not only available resources and numerous opportunities to be involved but also issues and challenges that we are facing in terms of cultural competence. Our goal is to consistently involve a diverse group of participants in all our efforts.

B. Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of

Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

At this time, our annual EQRO audit and Databook and MHSA reporting allow us to measure and monitor progress regarding the reduction of disparities.

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

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

C. Identify county technical assistance needs.

Our technical assistance needs include learning more about means to monitor and report processes and progress toward eliminating health disparities.

Criterion 4
County Mental Health System
Client/Family Member/Community Committee: Integration of the Committee within the County Mental Health System

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

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

The Cultural Competence Council (CCC) started as the Cultural Competence Committee more than ten years ago. The first meeting was held in a tiny room at Hillcrest, the Youth Services Mental Health Unit. Since then, the CCC has been involved in many of the opportunities to bring discussions of cultural competence in our work through CCC members participating in various committees and focused efforts such as the Quality Improvement Committee and the roll-out of eClinical Care, training (sponsoring or hosting), facilitation and networking. More recently, in collaboration with Health Policy and Planning, the CCC hosted film viewings and facilitated discussions of the social determinants of health using the documentary film *Unnatural Causes: Is Inequality Making Us Sick?*

Discussions in the CCC helped create the Office of Diversity (ODE) and the culturally focused Health Equity Initiatives. Many members of the CCC participate in the Initiatives, and the CCC's role has transformed into a glue to all our efforts -- a supporting and guiding body to the Initiatives.

There was an intentional shift from just looking at cultural competence from a clinical lens to integrating cultural competence into a larger organizational and social framework – including social justice and equity issues in policy and planning. This shift was reflected in the decision to host Cultural Competence and Mental Health Summit XVI with the chosen theme *Embracing Social Justice and Equity to Build Healthier Communities*. From the moment the planning committee started brainstorming, BHRS encouraged participants to look at the equity of resources and outcomes for all communities and address the issues of racism, discrimination, and oppression. CCC members, who were part of the Summit planning process, advocated for this shift to consider housing, employment, neighborhood, nutrition, etc. and its connection to behavioral health.

Early in 2009, the CCC also decided to nominate a non-BHRS staff Co-Chair in an effort to be more inclusive of our partner agencies as well as consumers/clients and family members participation in the CCC. The CCC also developed four subcommittees: Co-Occurring, Legitimization, Linguistic Access, and Workforce Development, in an effort to address very specific challenges and issues that were brought up by members. Subcommittees meet once a month, in addition to the regular CCC meetings. Below are the initial goals of the respective Subcommittees:

Co-Occurring Subcommittee – Led by BHRS Co-Occurring Program Specialist:
- Members attend training on motivational interviewing.
- Change Agent attend CCC meeting.

- Speaker present to the CCC on AOD related topic.
- Promote cultural lobby displays in different regions of the county.

Legitimization – Led by Office of Consumer and Family Affairs staff member who identifies as a consumer:

- Increase capacity building and legitimize the existence of the CCC.
- Change time of monthly meeting from lunchtime meeting to 11:00 a.m. – 12:30 p.m.
- Support consumer/client, family member and community based organization involvement in the CCC.
- Convene a CCC meeting at a community based organization.
- Create an orientation plan for new CCC members.
- Develop text for CCC marketing.
- Prepare a fiscal year work plan and budget.
- Annual training on cultural competence topic.
- Establish importance of representation from the CCC in the CCC Steering Committee, discuss issues in CCC first before CCC Steering Committee makes final decision.
- Formalize membership in productivity contract.
- Author at least one article on Cultural Competence for *Wellness Matters.*
- Collaborate discussions with other Health System divisions.
- Individual Cultural Presentation.

Linguistic Access Subcommittee - Led by San Mateo County Health Policy and Planning Community Health Planner:

- Formalize the process in which County employees translate and interpret.
- Staff training and testing to ensure high standards regarding language capabilities.
- Introduce differential pay for bi-lingual staff, pay code for translation services.
- Invite Health Policy and Planning to discuss Health System priorities.
- Connect with other county departments to make services more available for clients, including mapping of services.

Workforce Development - Led by BHRS Workforce Development Director:

- Review hiring policy.
- Work to increase diversity of BHRS providers.

Currently, we are reevaluating the effectiveness of the subcommittees as well as the overlap of the subcommittee goals with other committees within BHRS.

The CCC's Vision and Mission (2010): Vision: The Cultural Competence Council (CCC) is a guiding body with the passionate vision of embracing diversity, eliminating health disparities and advancing equity.

Mission: The Cultural Competence Council's goal is to coordinate, inform, support, advocate and consult with BHRS and its communities.

The CCC is currently Co-Chaired by a BHRS staff member and a staff member from a community partner agency and meets on the first Friday of every month for 90 minutes 11:00 a.m. - 12:30 p.m.

at the Youth Services Center.

The CCC Steering Committee meets monthly in the BHRS Director's Office and is comprised of the BHRS Director, the two CCC Co-Chairs, the Health Equity Initiatives Manager, the Director of the Office of Consumer and Family Member Affairs, the Pacific Islander Initiative staff member, and a rotating member from the CCC. The CCC Steering Committee and receives updates from the Health Equity Initiatives Manager, reviews data from Research and Evaluation and discusses issues related to cultural competence and work with underserved communities. The Steering Committee structure is being reviewed at the moment to explore effectiveness, appropriateness and shifting roles of the members.

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;

Membership in the CCC is open and encouraged to all. Members include management, line staff, consumers/clients and family members, and community partners. Health Equity Initiatives Co-Chairs attend CCC meetings and the Annual Strategic Planning event. The CCC encourages participation of consumers/clients and family members by providing stipends or honorariums for ongoing participation. In the past few years, a couple of consumers have joined and participated, but due to scheduling issues only, their participation has wavered. The ODE distributes a consumer recruitment flyer (available in Arabic, Chinese, English, Spanish and Tongan) at outreach presentations and events. *Wellness Matters* lists the CCC meeting location and time.

At our annual Intern Orientation, the Health Equity Initiatives Manager and members of the CCC present our cultural competence and health equity framework to the new interns. This unique opportunity also allows us to reiterate the significance of integrating cultural humility as part of one's clinical experience. Recently, we have also started to require interns who receive a cultural competence stipend to participate on the CCC or with one of the Health Equity Initiatives as a strategy to get more individuals involved.

<u>Policy</u>
Please refer to Mental Health Policy NO.: 97-03 (of February 1997) (Appendix D, pp. 1-2):
Subject: Committee Structure – Advisory
Purpose: To identify advisory committees which have been established within the division for the following broad purposes:

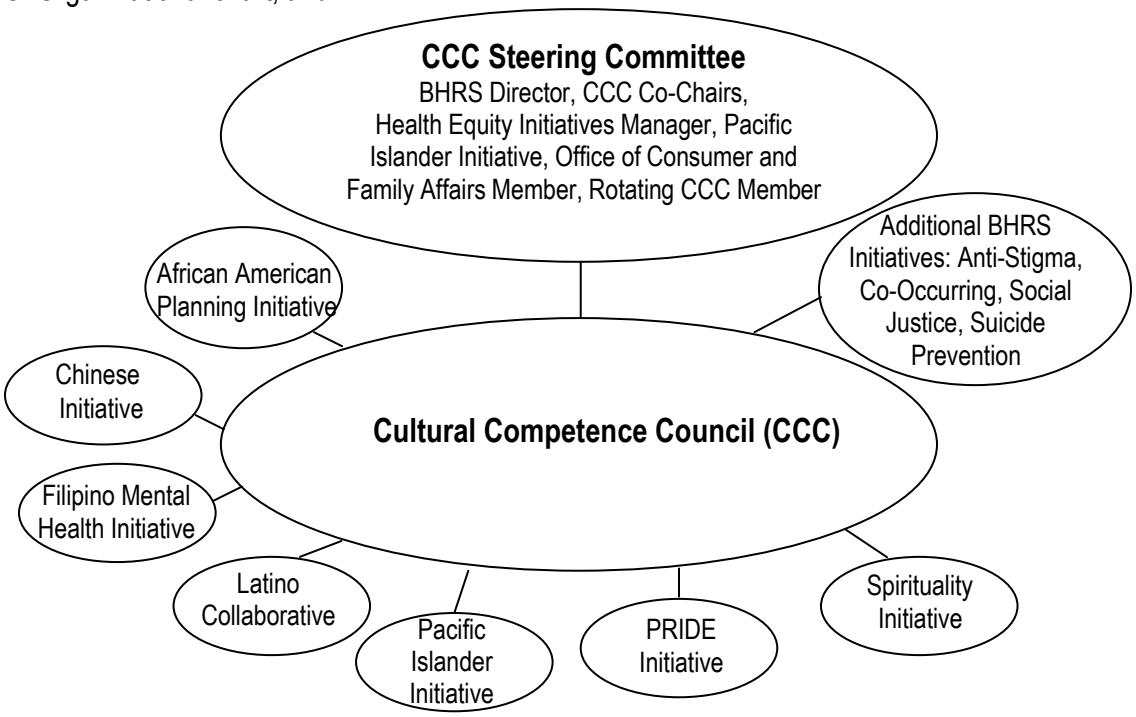
- To promote excellence and efficiency in client care.
- To facilitate continuity of care between all public and contract providers.
- To promote creative and timely problem solving by seeking input from the broadest range of county and contract staff.
- To enhance diversity in staff and respect for diversity in service.
- To promote meaningful staff development opportunities.

The following committees are the primary advisory committees within the division:

- Child/Youth System Care Advisory (CYSOC)

- Consumer Issues
- **Cultural Competence**
- Human Subjects Review/Research
- Outpatient/Case Management
- Psychiatric Utilization Management
- Residential
- Safety/Risk Management
- Managed Care Committees
- Student/Trainee Program Development
- Youth Unit Chiefs
- Adult Unit Chiefs
- Child and Youth Standing
- Youth to Adult (YTAC)
- Evidence-Based Practices
- Staff Training Committee

C. Organizational chart; and



There is a large overlap of membership between the CCC, CCC Steering Committee, Health Equity Initiatives and additional BHRS Initiatives. We are exploring ways to create efficiency and effectiveness in coordination of efforts.

D. Committee membership roster listing member affiliation if any.

Membership in the CCC is by open invitation (i.e. ongoing recruitment). A challenge is to diversify membership and include more consumers/clients and family members as well as members from other regions of the County (e.g, Coastside, North County, etc.). We may consider rotating the

meeting location on a more frequent basis.

Below are the core members that attend on a regular basis:
Claudia Saggese, BHRS Office of Consumer and Family Affairs
Ellie Dwyer, BHRS Central County
Gloria Gutierrez, BHRS Central County
Abbigail Endres, Caminar, CCC Co-Chair
Jei Africa, BHRS Office of Diversity and Equity (Health Equity Initiatives Manager)
Joe Balabis, Health Policy and Planning
Kristin Dempsey, BHRS Workforce Development Director
Leafa Taumoepeau, BHRS Office of Diversity and Equity (Pacific Islander Initiative)
Michelle Alvarez-Campos, BHRS Youth Services Center
Mary Taylor Fullerton, BHRS Co-Occurring Program Specialist
Pam Ward, BHRS Office of Consumer and Family Affairs
Regina Moreno, BHRS Youth Services Center, CCC Co-Chair
Sonia Velasquez, BHRS Interface
Yadhira Christensen, AOD

Below are members who have attended on an occasional basis:
Crispin Delgado, Health Policy and Planning
Celia Moreno, BHRS Medical Director
Doug Fong, BHRS TAY
Carlos Morales, BHRS Entry to Care Initiative
Elida Oettel, Human Services Agency Family Resource Center
Hedwig DeOcampo, Pre to Three
Teresa Hurtado, Senior Peer Counseling, Family Services Agency
Huong Nguyen, Youth and Family Enrichment Services
Jeannine Mealey, BHRS Quality Improvement
Janeen Smith, Pyramid Alternatives
John Yap, Youth and Family Enrichment Services
Katya Henriquez, Pyramid Alternatives
Linford Gayle, BHRS Office of Consumer and Family Affairs
Louise Rogers, BHRS Director
Isabel Hernandez, Pre to Three
Maria Lorente-Foresti, BHRS Central County
Scott Peyton, BHRS Youth Services Center
Patricia Sanchez, Consumer
Pernille Gutschick, Adult Resource Management
Sara Mitchell, YFES
Tania Chan, BHRS Central County
Travis Sweeney, AOD
Yolanda Booker, BHRS Older Adult (OASIS)
Zach Comtois, Adult Resource Management

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

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

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

The CCC Steering Committee reviews services/programs/cultural competence plans with respect to cultural competence issues at the County on a monthly basis through the Health Equity Initiatives Manager. Please refer to the CCC Minutes for FY 2009-2010 (Appendix D, pp. 3-37).

At the half day annual CCC Strategic Planning meeting on April 16, 2010, the CCC received updates from the Health Equity Initiatives about their respective activities, challenges and successes over the last year and goals for FY 2009-2010. The MHSA Coordinator and the Workforce Development Director gave updates regarding MHSA planning components and the recently approved MHSA WET Plan. Please refer to the Strategic Planning Meeting Minutes (Appendix D, pp. 23-32)

In addition, information and feedback is sent on a regular basis through email especially when there is no CCC meeting in the immediate future. Co-chairs are responsible for distributing information to the members regularly and efficiently.

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

The Quality Improvement Committee (QIC) facilitates the overarching goals of the transformation process and oversees system improvement activities through a high level of participation by representative members. They meet every other month on the second Wednesday for two hours. The QIC Work Plan includes Cultural Competence Goals, Interventions and Measurements. The Health Equity Initiatives Manager provides informal reports to the QIC on a regular basis about ongoing projects. Please refer to QIC Meeting Agendas and Minutes for FY 2009-2010 (Appendix D, pp. 38-63) as well as the QI Work Plan (Appendix D, pp. 64-78).

In the past, the QI Manager participated both in the CCC and in the CCC Steering Committee, but has not been able to because of shifts in position. However, in the last few months, a QI supervisor has been attending the CCC. In the future, we may consider an ongoing CCC member attend the QIC meeting. The former QI Director was a member of the CCC Steering Committee, and we may consider inviting the current QI Director to join the CCC Steering Committee.

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

CCC members participate in the Quality Improvement Committee; participated in the Cultural Competence and Mental Health Summit XVI planning committees, eClinical Care planning and rollout, and MHSA planning. On an as needed basis, the CCC invites staff to learn, dialogue and

give recommendations about certain activities and training needs such as health equity issues, poverty, immigration, and grievances. The members of the CCC are often called individually as well to participate or provide feedback or support about a programmatic or clinical issue.

Recently, the QI Supervisor attended the CCC meeting in June 2010 to discuss the Assessment and Treatment Planning online training being developed and to solicit input into aspects of the training related to culture. This is an ongoing project and the June meeting was devoted to that training. In addition, the CCC invited Nancy Arvold, MFT, to provide a half day White Privilege and Cross Cultural Communication training in late June 2010 as a pilot to a much larger conversation on power and privilege. The CCC is helping shape what this training will look like for a much broader audience.

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

The BHRS Director is a member of the CCC Steering Committee. Also, the Health Equity Initiatives Manager, a member of the CCC Steering Committee, is part of the BHRS Management Team, and attends all Adult/Youth/Joint policy and Leadership meetings.

5. and 6. Participates in and reviews county MHSA planning and stakeholder process;

The BHRS Director, a member of the CCC Steering Committee, participates in and reviews the county MHSA planning/stakeholder process. In addition, the MHSA Coordinator updates the CCC and attended the half day CCC Strategic Planning Meeting. The Workforce Development Director, a member of the CCC, co-coordinated the WET planning process with the MHSA Coordinator. BHRS typically releases MHSA plans for a 30-day public comment period.

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

The BHRS Director, a member of the CCC Steering Committee, participates in and reviews County plans for all MHSA components. The MHSA Coordinator provides MHSA updates to the CCC and has attended the annual CCC strategic planning day. The Workforce Development Director is a CCC member and regularly attends the monthly meeting. Information is shared through various means, and feedback is always welcomed.

Two members of the CCC in collaboration with Robert Willams, PhD, of San Francisco State University Counseling Department, presented a proposal to the Youth Management team in early June 2010 regarding development of an Integrative Multicultural Family Therapy Model and exploring funding through the Innovative Programs component of the MHSA. A follow-up discussion at the Youth Management has been scheduled for September 2010.

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

The CCC has a strong relationship with the Office and Consumer Affairs (OCFA). Three (of four) OFCA staff members are CCC members and they report on ongoing efforts of the OCFA. They act

as liaisons and often engage the CCC on discussions regarding consumer/client related issues and programs. Another OCFA staff member who identifies as a consumer Co-Chairs the Spirituality Initiative. The CCC is addressing ongoing recruitment of consumers/clients and family members.

The Health Equity Initiatives Manager (HEIM) has attended and facilitated Wellness Recovery Action Planning (WRAP) meetings. There are exploratory discussions regarding how to bring cultural competence to WRAP. Our HEIM is scheduled to participate in the January 2011 WRAP Facilitator's Training. Initial conversations about how to have dialogue on cultural competence with Voices of Recovery has also begun.

9. Participates in revised CCPR (2010) development.

The CCC Steering Committee and CCC have participated in the cultural competence planning and have reviewed drafts of the CCPR, authored by the Health Equity Initiatives Manager. There have been many discussions and updates about the CCPR during the CCC meetings to present data and ideas to committee members. Please refer to CCC Minutes (Appendix D, pp. 3-37).

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

Annual Report of the Cultural Competence Committee's activities including:
April 16, 2010, Strategic Planning Meeting and FY 2009-2010 Meeting Minutes (Appendix D, pp. 3-37).

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

1. Detailed discussion of the goals and objectives of the committee;
   a. Were the goals and objectives met?
      If yes, explain why the county considers them successful.

The CCC does not formally prepare a cultural competence plan but Initiative leaders report accomplishments through numerous venues such as Wellness *Matters*, management meetings such as BHRS Leadership (August 5, 2009) and Joint Policy. At the annual CCC Strategic Planning Meeting (see Appendix D, pp. 23-32), there are Initiative updates and recognition of accomplishments as well as small group discussions. At the April 2009 strategic planning meeting, there were discussions around common themes/threads in our work across the Initiatives. The goals for the next year included:

- Continue to improve communication, possibly use the CCC website as a communication tool.
- On a quarterly basis, have at least one Initiative participate in the CCC in order to report on their ongoing work.
- Continue to host a Strategic Planning Event annually.

At the April 2010 annual meeting, participants discussed the role of the CCC and how to measure outcomes with respect to cultural competence.

Many CCC goals have been met including:

- Logo, website (www.smhealth.org/bhrs/ode), Mission and Vision.
- Cultural Competence and Mental Health Summit XVI hosted successfully, with over 750 attendees, 36 workshops, two keynote speakers, evening caucuses and entertainment. Follow-up Cultural Competence and Mental Health summit with a small "s" – ongoing series of encore presentations.
- Legitimization Committee successfully addressing issues of operationalizing the CCC, including changing meeting time to allow for workplace acknowledgment of participation, clarifying expectations of membership (basic knowledge, training, advocacy), relationship being established with human resources.
- Annual Strategic Planning Meeting consistently met two years. This planning meeting is aimed at networking, sharing information and resources as well as coordination of plans and efforts.
- Linguistic Access efforts. In partnership with county agencies, community organizations and Gibson and Associates, the Health System completed a county-wide needs assessment of linguistic access to health care services in San Mateo County in 2006. Two CCC members are leading the training "Working Effectively with Interpreters in a Behavioral Health Setting" that will be provided four times in the second half of 2010 starting in June (and additional sessions in 2011). All BHRS staff and contractors are required to attend this training.
- Close coordination with Co-Occurring Disorders (COD)/Conditions efforts, including representation by CCC members on COD committees.
- Presentations regarding CCC Initiatives and Cultural Humility to: BHRS Leadership, Caminar (2009), Contractors' meeting, Youth and Family Enrichment services (YFES) (2009), Crisis Intervention Training (CIT), and the Mental Health Board.
- Anti-Stigma event in October 2009 "In the Shadows: Cultural Perspectives on Living with Addiction and Mental Illness," that served as Behavioral Health and Recovery Services' Kick-off to the Anti-Stigma Project of the MHSA Prevention and Early Intervention Plan.

2. Reviews and makes recommendations to county programs and services;

The CCC reviews all county programs and services and makes policy recommendations through the CCC Steering Committee.

3. Goals of cultural competence plans;

Again, the CCC does not prepare a formal plan. One goal is to prepare and present an annual plan to BHRS Leadership that includes all the Initiatives activities and goals.

4. Human resources report;

Not applicable.

5. County organizational assessment;

An organizational assessment was completed in Spring 2003 for the Cultural Competence Plan

Update FY 2003-2004 that included a self-assessment survey. In partnership with county agencies, community organizations and Gibson and Associates, the Health System completed a county-wide needs assessment of linguistic access to health care services in San Mateo County in 2006.

The MHSA WET Plan contains a more recent Workforce Needs Assessment in the Plan's Exhibit 3. As part of the Workforce Needs Assessment, an employee survey was distributed in November 2008 that asked ethnicity and language proficiency. The Workforce Development Director is a member of the CCC and discussed the WET Plan at the CCC's Annual Strategic Planning Meeting in April.

6. Training plans; and

The CCC consistently addresses cultural competence issues, including consumer and family member representation at every training, with review and oversight by the Workforce Development Education Committee (WDEC) in planning and evaluating trainings. We are exploring this further with members of WDEC. Some CCC members participate in WDEC meetings. A small subcommittee was formed to work on this project with QI.

7. Other county activities, as necessary.

The Quality Improvement Committee meets every other month. They review portions of their Quality Improvement Work Plan at every meeting. Cultural Competence is a section in the QI Work Plan. The QIC is developing an online training focused on culturally competent, client centered assessment and treatment planning to be available in Q2 FY 2010-2011. The QI Supervisor is working with the CCC to share information and solicit input into this training.

Because of BHRS's cultural competence commitment and work, we have been asked to co-lead a countywide cultural competence initiative with a staff member from Health Policy and Planning. Since the initial meeting in 2007, the San Mateo County Board of Supervisors have approved the Countywide Cultural Competence Standards developed by the Committee.

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

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

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

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

Total BHRS staff (411) and contractors.

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

The County Human Resources Department has established an annual target for every employee to receive 20 hours of career-related training per fiscal year. For Supervisors, there is an expectation that eight of the 20 will be focused specifically on topics related to the supervision and management of employees. The Health System identified Cultural and Linguistic Competency Trainings as part of its Cultural & Linguistic Operational Standards. Please refer to San Mateo County Health Department Cultural and Linguistic Standards (Appendix E, pp. 1-3). We have two approaches to get our staff trained: the BHRS Education and Training Plan, part of which is funded by the MHSA WET Plan, and through the BHRS Office of Diversity and Equity's ongoing efforts and activities.

The BHRS Education and Training Plan 2010 Update webcast may viewed at www.smhealth.org/bhrs. Click on the "Training and Education" portal on your left. This will bring you to the training page. The webcast is the second item on the list, San Mateo County Education and Training Plan - 2010 Update. Highlights include a special annual training series focus on treatment of psychosis and treatment of depression in FY 2010-2011. For the last two years, the focus was on the treatment of trauma. Again, the cultural responsiveness component is an expectation for all these training efforts.

In addition, the Office of Diversity and Equity will provide the following trainings:

- CBMCS Multicultural Training Program - will be provided nine times over three years. We are hoping to have at least one Train the Trainer for the CBMCS.
- Working Effectively with Interpreters in a Behavioral Health Setting - will be provided numerous times from 2010-2011 creating a baseline for all staff. All staff will be required to attend one session.
- Interpreter Training – is being planned late 2011 for those who have been trained and used as interpreters.
- Cultural Humility – a workshop/training with Dr. Melanie Tervalon is being planned on understanding the concept of cultural humility in 2011.

- Leadership through the Lens of Culture - An exploratory study is being done to secure funding to create a leadership curriculum using concepts of culture (e.g. communication styles, *platicandos*, etc.)
- Indigenous Healing Series – A series of workshops/training that will present alternative and indigenous healing methods from different communities is being planned within the next two fiscal years to address different healing methods. The Health Equity Initiatives are being tapped to help coordinate these training series.
- Spirituality as a Tool for Wellness and Recovery Series – A series of workshops/training is being planned within the next two fiscal years. This training is being planned in conjunction with the ongoing Spirituality Initiative workgroup.
- A number of small planning groups have been identified to work with emerging communities such as the Arab community and the veterans community. The ODE is taking a lead on these planning meetings.

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

Please refer to the BHRS Training Request Checklist for questions regarding cultural competence. (Appendix E, pp. 4-5).

For continuing medical education trainings, the invitation letter to presenters includes the following: **"Cultural Requirement:** Our patient population is highly diverse in San Mateo County and our audience will greatly appreciate any comments relating your presentation topic to the diverse needs of our population. Also of note, the California Legislature passed Assembly Bill 1195 stating that all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine (http://www.imq.org/imqdoc.cfm/120#ab1195). Thank you in advance for addressing this at some point in your presentation."

Please refer to the Continuing Medical Education (CME) Monitor Summary (Appendix D, p. 6) which includes the following questions:

- Was cultural competence addressed at any point by this CME activity?
- Was linguistic competence addressed at by the CME activity?

II. Annual cultural competence trainings

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

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

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

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

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

We have dramatically increased the breadth and depth of trainings offered since the last Cultural Competence Plan was submitted in 2004.

Please note that Grand Rounds and other Continuing Medical Education trainings attendance is tracked by professional affiliation, not by function. When attendees sign in, they sign in as MDs, RNs, LCSWs, MFTs, PhDs and Other Professionals.

FY 2009-2010 Grand Rounds

Training Event	Description of Training	Hong long and often (hours)	Attendance by Professional Affiliation	Attendance by Professional Affiliation	Date of Training	Name of Presenter
			MDs	NON-MDs		
Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Health & Mental Health Profile Tongan Youth in San Mateo County	1.25	15	25	9/8/09	Edith Cabulsay
	Obsessive Compulsive Disorder	1.25	19	40	9/22/09	Lorin Koran MD
Cultural Formulation	Seeking Safety Panel	1.25	13	17	10/13/09	Kristin Dempsey
Social/Cultural Diversity	Gang Awareness Presentation	1.25	15	42	10/27/09	Tim Gatto
	Obesity: Causes, Barriers Behavioral Management	1.25	15	19	11/10/09	Simone Madden PhD
Cultural Awareness	Strategies for Reducing Weight/Risk of Type Diabetes	1.25	13	14	11/24/09	Richard Hayward PhD
Cultural Sensitivity, Cultural Awareness	HIV Prevalence & Risk Factors In MI Minority	1.25	13	10	12/8/09	John Onate MD

Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Lose 25 Years or 25 Pounds Metabolic Syndrome	1.25	13	10	12/22/09	Marie Soller MD
Multicultural Knowledge	Post Traumatic Stress Disorder in the Neonatal Intensive Care Unit	1.25	15	14	1/12/10	Richard J. Shaw, MD
Multicultural Knowledge, Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Current Issues for the Assessment and Care of Gay, Lesbian, Bisexual and Transgender Clients	1.25	23	33	1/26/10	Robert Cabaj, MD
	Pain Management	1.25	16	10	2/9/10	John Sorrell, PhD
Cultural Formulation, Cultural Sensitivity, Cultural Awareness	PTSD in Southeast Asia	1.25	17	23	2/23/10	Nang Du, MD
	Update on ECT and TMS	1.25	21	18	3/9/10	Brent Solvason, MD
	Personalized, Quantitative, Evidence-Based Treatment for Bipolar Disorders	1.25	17	17	3/23/10	Terence Ketter, MD
Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Transgender Issues	1.25	17	22	4/13/10	Randall D. Ehrbar, PsyD
	Hallucination-Like Experiences in Religious Experiences and Outside: An Anthropological Perspective	1.25	15	19	4/27/10	Tanya Luhrmann, PhD
	PTSD	1.25	17	29	5/11/10	Cheryl Gore-Felton, PhD
Social/Cultural Diversity, Multicultural Knowledge	Delivering Group Intervention for PTSD and Depression in Women with Breast Cancer in Rural Areas	1.25	8	16	5/25/10	Cheryl Kroopman, PhD
Cultural Formulation	Malingered Psychosis	1.25	14	15	6/8/2010	Peter Dell, MD
Cultural formulation, Multicultural Knowledge	A Psychiatric Approach to Working with People with Developmental Disabilities and Mental Illness	1.25			6/22/10	Nebeela Rahman, MD
		Total	296	393		

FY 2009-2010 Continuing Medical Education trainings (not including Grand Rounds) (as of 6/17/10)

	Description of Training	Hong long and often (hours)	Attendance by Professional Affiliation	Attendance by Professional Affiliation	Date of Training	Name of Presenter
Cultural Awareness, Social/Cultural Diversity	Developing Trauma-Informed Policies & Procedures	3.00	0	30	07/21/09	Gabriela Grant
	LOCUS Use and Interpretation	3.00	3	40	07/30/09	Keith Clausen, PhD

	CA/LOCUS Use and Interpretation	3.00	0	0	07/30/09	Keith Clausen, PhD
	Nurturing Parent Programs (3-Day Training Aug 3-5)	21.00	0	8	08/03/09	Valerie Gemanis
	Supervising Update	6.00	0	55	08/06/09	
Cultural Formulation, Multicultural Knowledge, Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	CBMCS Multicultural Training Program (4 day training)	32.00	0	23	8/11/09, 8/13/09, 9/1/09, 9/3/09	Jei Africa, PsyD
	Change Agent Quarterly Meeting	3.00	0	46	08/14/09	Cline/Minkoff
Cultural Awareness, Social/Cultural Diversity	Developing Trauma-Informed Policies & Procedures - Implementation and Troubleshooting	3.00	2	21	08/20/09	Gabriela Grant
Cultural Formulation, Social/Cultural Diversity	Looking through a Different Lens: Filipino Experience	6.00	3	83	08/28/09	Jei Africa, PsyD
	AOD Narcotic Replacement Therapy Policy	1.00	0	18	09/23/09	Brian Greenberg
Social/Cultural Diversity	BHRS/GGRC Monthly Youth Case Conference - Co-Occurring Series	1.25 monthly			9/24/2009, 10/22/09/, 12/03/09, 1/28/10	Luna Calderon
	Principles & Techniques of Motivational Interviewing	6.00	6	61	09/30/09	Kristin Dempsey
	Psychopharm, Co-Occurring D/O Stimulant-Subst	7.00	0	73	10/07/09	Carl Dawson, MS
Multicultural Knowledge, Social/Cultural Diversity	Suicide in the AOD Client Populations Improving Skills	1.50	0	18	10/08/09	Celia Moreno, MD
	Prevention Management of Assaultive Behavior	6.00	0	43	10/08/09	Ian Brennan
	Understand Changes MediCal & ACCESS Processs	2.00	0	26	10/09/09	Keith Clausen, PhD
	Eating Disorders Consultation Group	5.50	pending	pending	10/23/09	Robin Apple, PhD
	Touchpoints Training	18.00	0	18	10/26/09	Kissandra Rivera
	Drug Medi-Cal Orientation	7.00	0	15	10/27/09	James Cortese
	Honoring Your Consumer's WRAP: components and purpose of the WRAP plan	3.00	0	33	11/2/2009, 11/6/09	Debra Brasher
	Principles & Techniques of Motivational Interviewing	3.00	4	42	12/08/09	Kristin Dempsey
Multicultural Knowledge, Cultural Sensitivity, Cultural Awareness	Starting the Conversation & Making the Connection: Addressing Suicide in our Community	3.00	3	130	01/20/10	Kristin Dempsey
	Handling Prescription Drugs in Residential Settings	1.50	0	28	01/20/10	Brian Greenberg

Multicultural Knowledge	Gambling as an Escape	3.00	1	44	01/27/10	Gabriela Grant
Multicultural Knowledge	Engaging Fathers: A Broad Spectrum Look at the "Why" and the "How"	4.00	1	8	01/29/10	Carol Cowan
Cultural Formulation, Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Looking through a Different Lens: Cultural Considerations when Working with Filipinos	6.00	1	60	03/10/10	Jei Africa, PsyD
	Principles & Techniques of Motivational Interviewing	6.00	1	8	03/19/10	Kristin Dempsey
Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	San Mateo County Pacific Islander Initiative: Working Beyond Silos to Improve Cultural…	1.50	0	22	03/25/10	Leafa Taumoepeau et al.
Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Building Collaborations among Community Members to Address Needs of Filipinos	1.50	0	20	03/25/10	Karla Talkoff
Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	Confronting Cultural Disparities among African American Males and Identify……	1.50	0	17	03/25/10	Kenneth Stephenson
Social/Cultural Diversity	Transformative Life Skills for Mental Health Professionals	6.00	0	36	03/30/10	Bidyut Bose/Luna Calderon
Cultural Formulation, Multicultural Knowledge, Cultural Sensitivity, Cultural Awareness, Social/Cultural Diversity	CBMCS Multicultural Training Program (4 day training)	32.00	0	24	4/6/10, 4/8/10, 4/20/10, 4/22/10	Jei Africa, PsyD, Nelson Jim, Katya Henriquez
	Medication Used in Substance Abuse Recovery and Prescription Drub Abuse	7.00	0	38	05/18/10	Carl Dawson, MS
	Law and Ethics: Clinicians Compliance with Current Standards	6.00	4	95	06/10/10	Daniel Taube
Training staff in the use of mental health interpreters, Training in the Use of Interpreters in the Mental Health Setting	Working Effectively with Interpreters in a Behavioral Health Setting	4.00 in June 2010; also in Aug., Oct. and Dec. 2010	0	20	06/17/10	Jei Africa, Joe Balabis and Alejandra Sosa Siroka
		Total	29	1,203		

In addition to the training, there is a Spanish-speaking Providers Consultation Group that meets monthly for one hour for case presentations and discussions affecting consumers/clients, youth and families. This consultation group started prior to 2000 and is facilitated by a Supervisor and a Psychiatrist. The case consultations are presented in Spanish. A provider who does not speak Spanish and would like case

consultation may schedule a time in advance to present a case in English. Please see flyer (Appendix E, p. 7).

Other consultations have also been scheduled among staff and Initiative members when there are complex cases, for example, transgender youth case consultation by PRIDE Initiative members on. Coordination is done by the requesting clinician to Health Equity Initiatives members.

In our North County clinic, a Filipino Case Consultation was also started a year ago by a Filipino resident (psychiatrist) in an effort to provide support in to clinicians (and other providers) working with Filipinos. Consultation is on a case-by-case basis and is requested to the Unit Chief.

There is also a Complex Case Conference held weekly for 90 minutes where staff can bring their most challenging cases. It has generally involved complicated families. Both adult and youth teams are present as well as contractors. Attendees learn from each other important skills in assessment, collaborative interventions, strengths-based practice and partnering. Please see flyer (Appendix E, p. 8).

III. Relevance and effectiveness of all cultural competence trainings

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

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

In 2007-2008, BHRS performed a comprehensive Staff Training Survey that informed the BHRS Education and Training Plan, including the WET Plan. The results of this survey is also being used as a guide for the ODE's training efforts. We also identify training needs to increase knowledge and skills through various means: data collected from our system, Quality Improvement Committee, consumers/clients and family members, and through the Cultural Competence Council and the Health Equity Initiatives. For FY 2008-2011, a focus on Trainings in Foundational Knowledge which include Cultural Competence has been identified.

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

We began implementing the practice of providing pre/post tests in 2009 and have not yet standardized the practice for all trainings. Through numerous dialogues with the WET Director and members of the CCC, we started implementing pre/post tests as a tool to evaluate the effectiveness of training. Since this is still in infancy stage, we decided that the trainings hosted by the BHRS Office of Diversity and Equity include pre/post tests, including CBMCS Multicultural Training Program and Working Effectively with Interpreters in a Behavioral Health Setting. In addition, CAADAC/CAADE providers must complete a Post Test Evaluation after a training to receive CAADAC/CAADE credit for attending a course. The Health Equity Initiatives Manager presented this idea to Joint Policy to start the dialogue and discuss potential barriers and challenges. Presentations to Youth and Adult Policy have also occurred. Next steps would be to present to Leadership the recommendation that all trainings will begin to require attendees to complete a pre and post test. A significant culture change will have to occur for staff to embrace the necessity of measuring

the effectiveness of our training. Since this is a new practice, we remind staff of the rationale and the goal we hope to achieve at every training.

3. Summary report of evaluations; and

Please refer to our template Course Evaluation (Appendix E, p. 9) that may be modified for a specific training. We provide a summary to the Continuing Medical Education reviewer and send presenters a thank you letter with an evaluation summary to provide them with feedback that might be relevant to their presentation.

Examples in Exhibit E include evaluation summaries for:

- 2nd Annual Trauma Conference "Practice is Progress: Expanding Skills in Trauma Work" (Appendix E, pp. 10-12).
- Working Effectively with Interpreters in a Behavioral Health Setting (Appendix E, pp. 13-14).

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

BHRS is currently considering methods and practicing various techniques to obtain training follow-up from all the training sessions provided. Currently, there have been conversations within the ODE to send our follow-up questions 30-90 days from a training asking staff how they are using the training, what was the most useful, and where they need additional assessment. Initially, we started to do this for the CBMCS Multicultural Training. We sent a follow-up online survey via email asking attendees what they have done to promote and integrate cultural competence training (CBMCS) in their agencies and teams. Please refer to the survey responses (Appendix E, pp. 15-20). In the future, we will require trainings, as appropriate, to follow-up in this manner as well.

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

Training supervisors to be able to assess and recognize skills associated with the training for trainees they supervise is one way to ensure the trainee is utilizing the skills learned. For example, Motivational Interviewing has been provided to at least 500 staff members and partner agencies. Small group consultation and skills practice have been integrated throughout the County to develop and strengthen these skills. The Workforce Development Director provided a Motivational Interviewing for Supervisors training (Exhibit E, pp. 20-25). This is to ensure that those clinicians trained in the skill are practicing the newly learned skills and that the program is supporting the use of these new skills. This provides for follow-up of training skills taught on an ongoing basis in the clinical setting.

There currently is consideration regarding the development of a training for trainers program, that would include training about cultural humility, among other identified core competencies. The trainers would receive standardized training, would receive on-going training, and will assist in the assessment of outcomes of training among staff they trained.

Another tool being explored assessment of a supervisor's inclusion of key diversity criteria in supervision. This tool developed by Stanislaus County asks the supervisees to rate their experience and observations of

their supervisors. We presented this idea to Leadership and the CCC in our July 2010 Joint Policy meeting (Agenda and handouts in Appendix E, pp. 26-30). More discussion and dialogue is currently occurring to assess the challenges and barriers that might potentially come up because of this tool.

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

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

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

Note: The following explanation is offered to assist counties in understanding the issue to be addressed here. Cultural competence incorporates a set of values, experiences, and skills that direct service providers are expected to attain to provide appropriate and effective specialty mental health services to clients in a culturally competent manner. Training efforts should be concentrated in providing direct service providers with cultural competence skills and an understanding of how the consumer, their mental illness, their experience with the mental health system, and the stigma of mental illness, has impacted the consumer. Clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with a mental illness, the mental health system, and their own ethnic culture. These personal experiences and beliefs can be used to empower clients to become involved in self-help programs, peer advocacy and support, education, collaboration and partnership in system change, alternative mental health services, and in seeking employment in the mental health system.

In all training, attempts are made to have consumer or family presentations on a salient aspect of the training issue. We need to embed this in every training opportunity. For instance, at the supervisors update, a consumer spoke powerfully regarding what clinical skills were the most effective in her recovery, and encouraged supervisors to promote these skills among their staff members. A Consumer and Family Academy is being planned by the Lived Experience Work Group of the Workforce Education and Development Committee. The proposal is to train people with lived experience to be trainers, starting with a culturally diverse group of 10 consumer/clients and family members with experience in the youth and

adult systems. They would be paid approximately $35/hour. This training will either take place in late October 2010 or spring 2011. In addition, Lived Experience Work Group members do outreach at schools, the intern orientation, and at the upcoming Bay Area conference on Consumer and Family employment on October 20th.

Please refer to the BHRS Training Request Check List for questions regarding the consumer/client and family member perspective (Appendix E, pp. 4-5).

We encourage providers to host trainings on cultural competence and also provide technical assistance as needed. For example, with funding through a BHRS Mental Health Services Act Training Grant, Women's Recovery Association staff members across all departments shared a half-day offsite training workshop in March 2010 facilitated by nationally-acclaimed diversity trainer Lee Mun Wah, founder of StirFry Seminars and Consulting and author of *The Art of Mindful Facilitation.* Lee Mun Wah led a customized workshop that focused on how cultural competency requires not only an awareness of cultural differences, but also cross-cultural communications skills, community development expertise, and an awareness of social issues and contexts.

The ODE has also encouraged partner agencies to establish opportunities where cultural competence can be addressed. We continue to provide technical assistance to agencies whom we work with (e.g. Caminar, Edgewood, Pyramid Alternatives) to make this an ongoing priority in their agency. We have provided training and consultation, facilitated dialogues and brainstormed ideas. These agencies have also been encouraged to attend all of our meetings and participate and partner with us in all our health equity work.

BHRS has partnered with NAMI San Mateo County to provide the 10-week NAMI Provider Education Program since 2008. This Program focuses on the bio-psycho-social model of collaborative treatment - the lived experience of people and families struggling with mental illness. We are starting the 5th NAMI Provider Education Program in September 2010 at the Silicon Valley Community Foundation. BHRS staff provide resources such as speakers for presentations, continuing education credits, and outreach.

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

As noted in Criterion 5, IV. A. above, attempts are made to have family member presentations included in trainings. Please refer to the BHRS Training Request Checklist for questions regarding the consumer/client and family member perspective (Appendix E, pp. 4-5).

The Days of Partnering noted in Criterion 1, II. C. trains providers to help clients and their families navigate multiple agency services.

BHRS hosted "Asking the Psychiatrist" for parents in Spanish on September 9th 5:30 – 6:45 p.m. (flyer in English and Spanish in Appendix E, pp. 31-32).

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

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

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-Ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	43	0	3							
Case Manager/Service Coordinator.....	14	0	4							
Employment Services Staff.....	0	0	0							
Housing Services Staff.....	0	0	0							
Consumer Support Staff	25	0	2							
Family Member Support Staff	8	0	2							
Benefits/Eligibility Specialist.....	0	0	0							
Other *Unlicensed* MH Direct Service Staff.....	42	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	**132**	**0**	**11**	**34**	**23**	**19**	**2**	**0**	**17**	**116**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	8	0	1							
Case Manager/Service Coordinator.....	42	0	2							
Employment Services Staff.....	50	0	2							
Housing Services Staff.....	3	0	0							
Consumer Support Staff	17	0	2							
Family Member Support Staff	4	0	2							
Benefits/Eligibility Specialist.....	4	0	0							
Other *Unlicensed* MH Direct Service Staff.....	43	0	4	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	**171**	**0**	**13**	**63**	**26**	**28**	**25**	**1**	**18**	**161**
Total, A (County & All Other):	**303**	**0**	**24**	**97**	**49**	**47**	**27**	**1**	**35**	**277**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT By Occupational Category - page 2

Major Group and Positions	Estimated # FTE authorized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Caucasian	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	19	0	2							
Psychiatrist, child/adolescent	9	1	2							
Psychiatrist, geriatric	1	1	0							
Psychiatric or Family Nurse Practitioner	1	1	2							
Clinical Nurse Specialist	14	1	1							
Licensed Psychiatric Technician	0	0	0							
Licensed Clinical Psychologist	4	0	0							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW) [2]	55	0	6							
MSW, registered intern (or waivered) [3]	0	0	0							
Marriage and Family Therapist (MFT) [3]	70	0	8							
MFT registered intern (or waivered) [4]	0	0	0							
Other *Licensed* MH Staff (direct service)	1	0	0							
				(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, B (County)	**174**	**4**	**21**	**67**	**42**	**8**	**19**	**0**	**22**	**158**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	1	0	0							
Psychiatrist, child/adolescent	5	1	1							
Psychiatrist, geriatric	0	0	0							
Psychiatric or Family Nurse Practitioner	1	1	2							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	0	0	0							
Licensed Clinical Psychologist	18	0	4							
Psychologist, registered intern (or waivered)	3	0	0							
Licensed Clinical Social Worker (LCSW)	10	0	1							
MSW, registered intern (or waivered)	7	0	1							
Marriage and Family Therapist (MFT)	15	0	1							
MFT registered intern (or waivered)	10	0	1							
Other *Licensed* MH Staff (direct service)	0	0	0	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, B (All Other)	**70**	**2**	**11**	**42**	**5**	**0**	**11**	**0**	**1**	**59**
Total, B (County & All Other):	**244**	**6**	**32**	**109**	**47**	**8**	**30**	**0**	**23**	**217**

[2, 2, 3, 4]: We should note that, in our direct experience, MSWs and MFTs with language capacity such as Spanish, Chinese or Tagalog are very hard to find and hard to fill.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	2	0	0							
Registered Nurse	0	0	0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	7	0	1							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0							
				(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	**9**	**0**	**1**	**4**	**0**	**1**	**1**	**0**	**1**	**7**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	1	0	0							
Registered Nurse	0	0	0							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	0	0	0							
Occupational Therapist	0	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	3	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0	0	0							
				(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	**4**	**0**	**0**	**0**	**0**	**1**	**2**	**0**	**0**	**3**
Total, C (County & All Other):	**13**	**0**	**1**	**4**	**0**	**2**	**3**	**0**	**1**	**10**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor	7	0	1							
Supervising psychiatrist (or other physician)	6	0	1							
Licensed supervising clinician	31	0	4							
Other managers and supervisors	27	0	2							
				(Managerial and Supervisory; Sub-Totals Only) ⬇						
Sub-total, D (County)	**71**	**0**	**8**	**43**	**10**	**3**	**9**	**0**	**2**	**67**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	8	0	0							
Supervising psychiatrist (or other physician)	0	0	0							
Licensed supervising clinician	15	0	1							
Other managers and supervisors	37	0	3							
				(Managerial and Supervisory; Sub-Totals and Total Only) ⬇						
Sub-total, D (All Other)	**60**	**0**	**4**	**37**	**0**	**5**	**4**	**0**	**11**	**57**
Total, D (County & All Other):	**131**	**0**	**10**	**80**	**10**	**8**	**13**	**0**	**13**	**124**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	25	0	1							
Education, training, research	54	0	4							
Clerical, secretary, administrative assistants	4	0	0							
Other support staff (non-direct services)	5	0	1							
				(Support Staff; Sub-Totals Only) ⬇						
Sub-total, E (County)	**88**	**0**	**6**	**23**	**30**	**3**	**22**	**0**	**6**	**84**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	1	0	0							
Education, training, research	0	0	0							
Clerical, secretary, administrative assistants	38	0	2							
Other support staff (non-direct services)	5	0	0							
				(Support Staff; Sub-Totals and Total Only) ⬇						
Sub-total, E (All Other)	**43**	**0**	**2**	**8**	**10**	**5**	**9**	**0**	**9**	**41**
Total, E (County & All Other):	**131**	**0**	**8**	**31**	**40**	**8**	**31**	**0**	**15**	**125**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE
(A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-Ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E) .....**	**474**	**4**	**45**	**171**	**105**	**34**	**53**	**0**	**48**	**411**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E).....**	**348**	**2**	**30**	**150**	**41**	**39**	**51**	**1**	**39**	**322**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**822**	**6**	**75**	**321**	**146**	**73**	**104**	**1**	**87**	**733**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/Latino/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			4,532	4,277	1,329	1,023 (includes all Asian)	57	1,462 (includes 818 "unknown")	12,680

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. Unlicensed Mental Health Direct Service Staff:			
Consumer Support Staff.....	42	0	4
Family Member Support Staff.....	12	0	4
Other *Unlicensed* MH Direct Service Staff	17	0	0
Sub-Total, A:	**71**	**0**	**0**
B. Licensed Mental Health Staff (direct service)	**0**	**0**	**0**
C. Other Health Care Staff (direct service).....	**0**	**0**	**0**
D. Managerial and Supervisory.....	**2**	**0**	**0**
E. Support Staff (non-direct services).....	**15**	**0**	**0**
GRAND TOTAL (A+B+C+D+E)	**17**	**0**	**0**

III. Language Proficiency

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish	Direct Service Staff 238 Others 96	Direct Service Staff 227 Others 187	Direct Service Staff 465 Others 283
2. Tagalog	Direct Service Staff 14 Others 22	Direct Service Staff 39 Others 62	Direct Service Staff 53 Others 84
3. Mandarin	Direct Service Staff 17 Others 3	Direct Service Staff 48 Others 8	Direct Service Staff 65 Others 11
4.	Direct Service Staff Others	Direct Service Staff Others	Direct Service Staff Others
5.	Direct Service Staff Others	Direct Service Staff Others	Direct Service Staff Others

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

IV. REMARKS: Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

A. Shortages by occupational category: The County has long understood the occupational shortages; however, both the Education and Training and the Workforce Development planning processes helped hone this understanding. Among those positions identified through the planning process as hard to fill are child psychiatrists and child psychologists, nurses and psychiatric nurse practitioners. In addition, in all occupations, as the comparison between staff and consumer ethnicity describes below, there is a critical need to diversify the workforce across all occupational categories.

The present plan includes one action designed to sustain a two-year effort to address the absence of sufficient child psychiatrists. Child Psychiatrists have long been a difficult position to fill in San Mateo County -and in most counties. To address this challenge, the Child Psychiatry Fellowship was initiated in 2007-08 and 08-09 utilizing MHSA WET funding advanced to counties early implementers of the MHSA. It will be sustained in 2009-10 with MHSA WET funds. The Child Psychiatry Fellowship responds to a critical, historically hard to fill position within the San Mateo County BHRS system. The Fellowship is a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. It is also designed to provide education to a new generation of psychiatrists about recovery-based, strength-based service delivery.

Other workforce shortages were identified in the planning processes, including early childhood treatment staff -particularly men, bilingual peer and family partners and bilingual outreach staff; African American treatment staff across positions.

One of the most challenging barriers to sustaining a workforce fully responsive to consumer and family needs is the high cost of living in San Mateo County. With the cost of living driven by one of the highest housing costs in the country, recruitment of all personnel becomes challenging, particularly individuals of color, interns, and the hard-to-fill positions mentioned above.

Another factor must be considered when assessing workforce shortages: County analysis of population and prevalence data revealed that the County is significantly under-serving the Hispanic/Latino and Asian populations and over-serving both the white and African American populations; that said, over-serving the African American population does not necessarily mean that we are serving this group in a culturally competent fashion. If the Hispanic/Latino and Asian populations were fully served, an additional 400 Hispanic/Latino and 500 Asian consumers would receive services. The County has been making inroads in serving these populations more effectively, particularly the Hispanic/Latino community, as the number of Hispanic/Latinos served has risen from 3,000 to 4,000 in the last two years. To fully serve these individuals would require an increase in staffing with an emphasis upon recruiting to improve the diversity of the existing workforce to better reflect the population served. See the discussion that follows for more on workforce race/ethnicity comparability.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services: As the tables in Exhibit 3 illustrate, there is a significant difference in the composition of the workforce and the consumers that this workforce serves, with a significant over-

representation of White and Asian staff and a significant under-representation of both Hispanic/Latino and African American staff, particularly Hispanic/Latino staff. The table below excerpts Exhibit 3 data to allow for easier comparison. Clearly the most significant gap in workforce cultural composition is in relation to Hispanic/Latinos, a gap that is more noteworthy and critical as the County is more successful in engaging a larger proportion of the Hispanic/Latino population into treatment. The present proposal aims, among other things, to develop a systematic approach to introducing communities of color to the behavioral health profession and facilitating access to training and education that would enable more individuals of color to consider a behavioral health career in San Mateo County.

MH Prevalence data for San Mateo (2000 Census)[4]			
4,707	8,357	804	2,873
26.55%	47.14%	4.54%	16.21%

C. Positions designated for individuals with consumer and/or family member experience: San Mateo County has long been committed to consumer involvement in system planning and operation, and has a number of initiatives that have facilitated recruitment and placement of a significant number of consumers and family members in positions within the behavioral health system. The push now is to move beyond hiring consumers as peer partners and family members as family partners and to build career ladders that enable experienced consumers and family members to assume positions not explicitly designated for consumers and family members. The County has developed a highly collaborative relationship with the College of San Mateo, Vocational Rehabilitation Services (VRS) and community-based organizations to develop career paths for consumers and family members. Funding from the MHSA Community Services and Supports Plan created peer operated centers

Comparison Consumer vs. Staff Ethnicity						
White	Hispanic	AA	API	NA	Mixed	Total
Client Ethnicity						
4532	4277	1329	1023	57	1462	12,680
35.74%	33.73%	10.48%	8.07%	0.45%	11.53%	100%
Staff Ethnicity (All positions)						
321	146	73	104	1	87	733
43.79%	19.92%	9.96%	14.19%	0.14%	11.87%	

[4] This analysis of un-served populations uses the State DMH website data regarding prevalence projections as factored by 200% of poverty, adjusted by San Mateo County's self-sufficiency adjustment factor for one adult with two children, which is 1.9476. As acknowledged in DMH Letter No: 05-02, 200% of poverty is not an adequate predictor of need in counties where there is a higher cost of self-sufficiency.

that employ consumers as peer partners. VRS has developed part-time positions for consumers in a variety of business roles outside of behavioral services, e.g. janitorial, food service and medical records technicians. While these non-behavioral health care positions are not included in the totals above, they represent a significant advance for consumers, enabling them to move from positions within behavioral health care to other positions, greatly expanding career alternatives.

D. Language proficiency: The staff survey conducted for this process generated a surprising result with over 330 staff indicating proficiency in Spanish. This represents almost 50% of the entire workforce. It is believed that this is a significant over-statement of Spanish-speaking capacity as focus groups, staff planning meetings, and other input processes have consistently indicated that there is a significant need for more Spanish speakers in all positions, but particularly in peer and family roles and treatment positions. The extent to which the Hispanic/Latino community is under-served is, no doubt, in part is a result of the lack of sufficient Spanish speaking staff. Focus groups participants also identified the need for more bilingual staff in Chinese, Tagalog, Samoan and Tongan languages.

E. Other, miscellaneous: N/A.

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

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.

County analysis of population and prevalence data revealed that the County is significantly under-serving the Hispanic/Latino and Asian populations and over-serving both the White/Caucasian and African American populations; however, over-serving the African American population does not necessarily mean that we are serving this group in a culturally competent fashion.

There is a significant difference in the composition of the workforce and the consumers that this workforce serves, with a significant over-representation of White/Caucasian and Asian staff and a significant under-representation of both Hispanic/Latino and African American staff, particularly Hispanic/Latino staff.

For the Medi-Cal population, Hispanic/Latinos and Asian and Pacific Islanders ethnicities have low penetration rates while White/Caucasians and African Americans have high penetration rates. In terms of language, Asian and Spanish languages are underserved across age ranges and regions. The lowest penetration rates are for youth age five and younger and older adults age 66 and older.

For the above 200% of poverty population, we are underserving Asian, White, and multi-ethnic youth; youth under age five; as well as Asian and White adults, and older adults age 65 and older.

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.

San Mateo County's WET Plan was approved in March 2010. There were no cultural consultant technical assistance recommendations reported to the County. Please refer to the public comment received for the WET Plan (Exhibit F, pp. 1-13).

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

At the time of this submission, we have not yet fully implemented our WET Plan, which was approved in March 2010. We have very specific "targets" in terms of objectives for growing a multicultural workforce specifically stated in our WET plan. These objectives are in the Plan, specifically Action 12: Increase diversity of staff to better reflect diversity of client population (p. 49 of WET Plan) and Action 13: Retain diverse staff (p. 50 of WET Plan).

Although the WET Plan was just approved, we have been working on some of these objectives. Examples include:

- A significant priority of the San Mateo BHRS WET plan is to increase the diversity of the behavioral health care workforce in the county. In addition to identifying recruitment and

retention strategies to engage diverse workers, it is recognized that the division needs to develop interest in the field early in the careers of youth. In September 2010, BHRS will release the **High School Mental Health Career Pathways Project Request for Proposals** which will initiate the establishment of a specifically behavioral-health oriented career pathway for high school age students. The pathways project is intended for high school juniors and seniors who are interested in psychology, and will involve both behavioral health curriculum in the classroom, as well as experiential opportunities in clinics and agencies. Such programs have been successful in attracting diverse youth throughout the state. It is the intention of BHRS to find ways to find methods to track the youth completing the program to determine if diversity is being created through the pathways curriculum.

- Members of the Health Equity Initiatives have all participated in **recruitment efforts at internships fairs**. Staffs from these Initiatives represent BHRS at fairs which seek to attract counseling and social work interns and trainees to open training positions in the fall. Many Initiatives are working on brochures they can use to distribute at these fairs to attract diverse students. It is understood that when students from diverse programs see diverse BHRS personnel, they are more interested in seeking information about internship positions. This is a critical career pathway link as many new hires among clinical staff occur from the current pool of graduating interns and trainees. Please refer to the Office of Diversity and Equity brochure (Appendix F, pp. 14-15).
- **Cultural Competence Stipend** for interns and trainees representing underserved communities attracts diverse staff. Initially intended for masters level counseling and social work students, the stipend is currently available to the Health Equity Initiatives Intern, those obtaining a certificate in Alcohol and Other Drug services counseling, as well as nursing students. The stipend application is continually revised and improved so the staff reviewing applications is able to best determine diversity and appropriateness for the award. Please refer to the Cultural Competence Stipend Application Form as well as draft changes to the form being considered (Appendix F, pp.16-18). There are 20 annual multicultural stipends (increased from 10), and we have trained approximately 40 stipended interns FY 2006-2010.
- **Mentorship Program** The Work Force Development Committee and Latino Collaborative are currently developing a pilot mentorship program. The intention of mentorship is to help build diversity in the public mental health system by providing additional support and guidance to employees who are culturally diverse, new to the work world, and/or have lived experience in behavioral health. Based on research, as well as from the experiences of current staff, it is understood that mentorship provides a critical support for new hires and employees seeking to advance or change their careers.

In addition, when the initial CSS Plan was approved in 2006, the County applied for advance WET funding for positions that grow a multicultural workforce. Those positions included:

- WET/Workforce Development Director.
- San Mateo County - Stanford University Child and Adolescent Psychiatry Fellowship. The rationale for this position is to provide emphasis on clinical training and research experience in community child and adolescent psychiatry. There is tremendous need for child and adolescent psychiatrists with expertise in community child and adolescent

psychiatry, including best practices in public sector care and culturally informed approaches. This fellowship position addresses this need.
- Community Workers.

At a 2009 Leadership Breakfast, we reviewed data that compared each clinic's workforce to their clients served by race/ethnicity/language and age (youth, adult, older adult). More specifically, we looked at ethnic and language percentages for clinicians, interns and administrative staff at the specific clinics, compared to the clients served. Although it is difficult to make clear determinations from this data (often the samples were small), it allowed departments to see how well the various staffing groups reflected the ethnicity and language of the clients. The goal was for this data to provide a starting place for discussion by each clinic site about appropriate goals and processes for future hiring decisions. There will follow-up on these discussions in FY 2010-2011, asking for ideas for proceeding in hiring practices – at this point primarily with interns, based on the data, as well as reflection upon it. Please refer to June 2010 Flow Report Summary for each of our clinics that includes information on open cases, admits per month, staff professional license by percentage, shared cases, added staff by year and discharges (Appendix F, pp. 19-20).

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

San Mateo County's WET Plan was approved in March 2010. The major issue is prioritizing all the objectives, given increasing limited time of workforce. Also, in the time it took to plan and submit the WET planned approved, the priorities of the staff have changed. This is due to increasingly limited budgets, as well as the addition of new technologies. For instance, Dialectical Behavior Therapy (DBT) is highly effective approach, but it needs a lot of staff training time to be implemented in a high fidelity model.

We are actually in the process of determining what else might not work in our new culture. We do not know all this yet, as we are still assessing which practices are most appropriate in which locations. We have done a considerable amount of work putting a variety of training out into the community. Even with DBT, we are still doing the training, but we are finding ways to adapt it so it works given our staffing. So, in short, the other things we need to cut or reshape are to be determined and in process. For instance, we are looking at a culturally competent Functional Family Therapy model, and we are still determining where Pro-Social Skills might be best implemented.

F. Identify county technical assistance needs.

Assistance with strategies and coordinated efforts across the Division to hire and retain diverse staff, including youth and consumers/family members. We also need assistance with shifting the balance between what our multicultural workforce needs are now and what is our vision for the future.

Criterion 7
County Mental Health System
Language Capacity

I. Increase bilingual workforce capacity

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.

Please refer to Action #12 of the WET Plan (p. 49 of the WET Plan): Increase diversity of staff to better reflect diversity of client population.

Action #12 Description: A concentrated effort needs to be made to create a workforce that is more reflective of the communities served, and that has the skills and knowledge needed to best provide services to these individuals. Traditional efforts to attract diverse workers into mental health jobs have had limited success, and it has become clear by discussions with relevant stakeholder groups, that strategies can be employed to increase interest in these positions.

Objectives	Actions (description)	Planned Actions (dates)
▪ Utilizing existing cultural initiatives and outreach collaboratives to deliver information regarding potential career opportunities.	▪ Health Equity Initiative members attend college outreach fairs. Initiative members to provide education as guest speakers in High School Health Academy.	▪ Fall/Winter intern/trainee fairs held in Dec/Jan/Feb ▪ 2011/12 Academic School year to start
▪ Developing appropriate recruiting materials relevant to specific populations.	▪ Initiatives are in the process of developing brochures describing their initiatives. Can also be used for job recruitment. Can edit materials for specifically workforce recruitment.	▪ Current/ongoing
▪ Utilizing media outlets that target specific populations	▪ Some Initiatives are engaging in culture-specific media – e.g. Chinese radio show.	▪ Additional media outlets to be targeted.
▪ Ensuring diverse hiring and promotion panels (for	▪ Diverse hiring panels already a priority which	

both recruitment and retention).	Human Resources follows up on. HR is involved with BHRS WET plan, and WET Director can speak directly with recruiter to ensure diverse panels are employed when hiring.	
▪ Participating in community events, e.g. health fairs, county fairs, ethnic events, to promote BHRS career opportunities. ▪ Contacting and engaging with culture-specific organizations such as the Historically Black Organizations or HBOs regarding career opportunities. ▪ Outreaching to college fraternities and sororities with diverse memberships. ▪ Targeting schools that have a high concentration of students of color for outreach and recruitment. ▪ Creating structures/processes to oversee implementation of recruiting efforts.	▪ Participation in community events ongoing. Some FY 2009-2010 examples: Pride March, Gay Prom, East Palo Alto Community Forums, Latino Family Night, African American Summit. ▪ High School Mental Health Career Pathways Project RFP (released Sept. 2010)	▪ Contacting culture-specific organizations, outreach to colleges and diverse schools – strategies to be determined.

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.

Please refer to the (WET Plan) Workforce Needs Assessment (pp. 22-29 of the WET Plan).

3. Total annual dedicated resources for interpreter services.

For FY 2008-2009 and FY 2009-2010, the contract for interpreter and translation services was $158,000. The contract was amended in April 2010 from $133,000, with and additional $25,000 budgeted to BHRS. The total spent in FY 2008-2009 was $66,935.94 and in FY 2009-2010 was $90,184.49.

The San Mateo County Health System has a three year contract (FY 2010-2013) with Avid Translation for $450,000 for interpretation services. The Health System contracted with viaLangauage to provide translation services for FY 2010-2013. Of the $450,000 contract with Avid Translation, $320,000 or 71% is budgeted for BHRS. Of the $150,000 contract with viaLanguage, $40,000 or $27% is budgeted for BHRS.

Starting in 2008, the Health System started implementing efforts to address linguistic access in the County; creating a whole system of providing support to LEP clients and their families. In October 2008, a Language Assistance Services intranet website http://intranet.co.sanmateo.ca.us/health/la was launched to provide Health System staff access to all policies, standards and resources related to linguistic access in one centralized location.

Staff may call the Language Assistance Line (650-573-3660) for over-the-phone interpretation services or to request in-person interpreters, including American Sign Language interpreters, and/or document translation. All staff members have received training and a wallet sized “pink card” for information about how to access over-the-phone interpreters. Please see the pink card (Exhibit G, p.1). Requests for telephone interpretation are minimal, only one or two per quarter.

Requests for in-person interpreters have been increasing in the past few years. In FY 2009-2010, there were 333 requests for interpreter services and 16 requests for document translation across the Health System. Please see the number of interpretation requests by language (Exhibit G, p. 2).

In our efforts to provide linguistically appropriate services at meetings and community events, we also use our in-house interpretation equipment to provide simultaneous interpretation. Our records indicate that since March 2010, this equipment is reserved between one and four times per month.

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

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

1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. **Note:** The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

The Behavioral Health and Recovery Services ACCESS Team operates Monday-Friday 8:00 am – 5:00 pm for assessments, information and referrals based on individual needs. ACCESS has

English and Spanish language capacity. We are also currently working on expanding ACCESS, making our entry to care more welcoming to both mental health and AOD clients.
Phone: 800.686.0101
TDD: 800.943.2833.

Outside of regular business hours, callers may leave a message and their calls are returned the next business day. Callers may also dial 3 or stay on the line to speak to a live person; these call are routed to Psychiatric Emergency Services (PES).

Health System staff may access 24-hour phone interpretation by calling 650-573-3660 where they will be connected to an over-the-phone interpreter through AT&T.

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

BHRS protocol and providers prefer in-person interpretation, which is available during business hours Monday-Friday 8:00 am – 5:00 p.m. and on a case by case basis after hours.

A video-based interpreter system is available at San Mateo Medical Center (SMMC) and all medical center clinics. At sites where SMMC and BHRS are co-located (at the Medical Center and North County clinic), BHRS staff have access to video language conferencing through the Health Care Interpreting Network (HCIN), but currently it is not being used. There has not been any information about how to access HCIN by non-SMMC staff. This seems to be an option that staff have not yet considered.

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

New phones at ACCESS have been recently installed that allow for calling a third party, e.g. phone interpretation services. In the past, ACCESS staff needed to obtain the caller's phone number and telephone them back after connecting with the language line. The new phone lines can be monitored which will be used for training and Quality Improvement purposes. Monitored calls can be used to train new staff and interns as well as assist staff with high risk consumers or challenging callers. The quality improvement aspect of monitoring calls is to coach staff on improving customer service.

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.

The Working Effectively with Interpreters in a Behavioral Health Setting training includes training for staff about how to access the language line. The first series of trainings will be offered in June, August, October and December 2010. The goal is to train all BHRS staff and contract providers to be able to feel confident enough to use these available resources to help their clients.

Training needs for ACCESS staff also includes the process of identifying the language needs of a caller.

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

Between April and July 2009, several hundred desktop and wall signs indicating a "Right to Interpretation" were distributed to locations where the public access services, San Mateo County Health System offices and locations where clients are served. Front-line staff were instructed on how to utilize Language Assistance Services for walk-in clients requiring assistance and given information on accessing the intranet resource site. Please refer to the flyer (Appendix G, p. 3): "You have the right to an interpreter at no cost to you. Ask an employee. (translated into Spanish, Tagalog, Russian, Chinese (traditional and simplified), Tongan, Samoan, Hindi, Vietnamese, Farsi, Japanese, and also provides information about American Sign Language (dial 711 for California Relay Service)."

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

This BHRS Profile of Bilingual Pay Employees was prepared in September 2008 and does not include the San Mateo Medical Center:

Admin/Accounting: Administrative Secretary II & III and Medical Office Specialist	9
Clinical/Direct Staff: Adult Psychiatrist, Case Management/Assessment Specialist, Child Psychiatrist, Community Mental Health Nurse, Marriage and Family Therapist I & II, Mental Health Counselor I & II, Psychiatric Social Worker I & II and Supervising Mental Health Clinician.	88
Intake/Admission Staff: Patient Services Assistant II and Patient Services Supervisor.	9
Other: Community Worker I & II, Human Services Analyst II and Mental Health Program Specialist.	16
**N/A: data indicates classification not identified	4

Total	126

The Health System contracts with Avid Technologies FY 2010-2013 to provide interpreter services. In addition, as noted in Criterion 1 Section IV., B., 5., BHRS provides a salary differential for bilingual, bicultural staff as well as contracted network private providers. Please refer to Mental Health Policy No.: MH 01-08 (January 2002), Subject: Bilingual Salary Differential – Spanish and Tagalog Speaking Staff (Appendix A, pp. 122-124). Private providers are reimbursed at rates between 9.7%-10.3% higher for providing bilingual services (e.g. individual therapy reimbursed at $96 per hour for bilingual services compared to $88 per hour for non bilingual services). Please also refer to Beneficiary Provider List and their language capacity (Appendix H, pp. 6-32).

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

Common views around interpreter use are that it takes too long, rapport cannot be established or is lost with a client, it is expensive, it is disruptive, the provider is proficient enough in the language (e.g. Spanish), and the quality of care is affected. Through our Working Effectively with Interpreters in a Behavioral Health setting, we are creating a culture shift of feeling that interpreters are crucial in providing client care. Myths, ethics and role expectations are discussed in this training to provide the provider a clearer understanding of the benefits of working with interpreters especially from LEP clients.

Please refer to the Linguistic Access Policy Year One Update (Appendix G, pp. 18-23) progress made on recommendations regarding linguistic access to services to Limited English Proficient populations.

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

Providing training across BHRS and contract providers is a challenge especially when the training is not perceived as directly related to client (clinical) care. Staff tends to prioritize clinical activities, which are billable, over administrative activities. (This was very apparent when presentations were being done to inform staff and contractor's (leadership) about the interpreter training requirement.) Taking time for a training, even if provided at no cost, is expensive in terms of billable time.

Historical challenges for ACCESS is assisting callers that speak non-threshold languages. The staff needs to first identify the language spoken by the caller and either find a staff member to telephone the caller back or connect to the language line. If you ask a person to call back, they most likely would not and a "window of opportunity" is lost. The new phones now enable ACCESS staff to connect directly with the language line.

For non-threshold languages, the process is used infrequently and ACCESS staff do not have much experience assisting and referring people who call especially for people who are Medi-Cal beneficiaries but do not meet the severe mental illness (SMI) criteria. ACCESS training needs

include increased knowledge to refer people to services and resources and create a "warm hand-off."

For Initial Contact Information calls, there have been long delays as BHRS transitions from VAX to AVATAR. This causes delays in getting pertinent information about the clients in the system and work flow will improve become more efficient as staff become more accustomed to AVATAR.

After business hours, it is rare that a caller leaves a message in a language other than English or Spanish. Again, a window of opportunity may be lost.

E. Identify county technical assistance needs.

Equipment challenges include the lack of video conferencing capability. As noted in Criterion 7, Section II., A., 2. above, BHRS staff have access to the HCIN in sites where BHRS and SMMC co-locate.

It would be helpful to evaluate interpretation services on the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey.

For non-threshold languages, it would be helpful to create work flow chart so that ACCESS staff can provide information, including referral, as effectively as possible. This process is used infrequently at this time.

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.

This information is posted in all San Mateo County Health System offices and locations where clients are served. Please refer to the flyer (Appendix G, p. 3):
"You have the right to an interpreter at no cost to you. Ask an employee. (translated into Spanish, Tagalog, Russian, Chinese (traditional and simplified), Tongan, Samoan, Hindi, Vietnamese, Farsi, Japanese, and also provides information about American Sign Language (dial 711 for California Relay Service).
NOTE TO EMPLOYEES: For more information on Language Assistance Services or for copies of this poster, contact (650) 573-3660 and Press 0 (zero) to speak with a representative. You may also visit the intranet site at http://intranet.co.sanmateo.ca.us/health/LA/"

In addition, the San Mateo County Health Department provides the *Quick Reference Guide to Interpretation & Translation Services*, a reference guide for staff (and has been distributed to all Health System programs) (Appendix G, pp. 4-7). This includes the Language Assistance Line phone number, and how to access American Sign Language (ASL) interpreters, in-person

language interpreters, document/text translation, over-the-phone interpreters, "Please hold" instructions (in Spanish, Tagalog, Cantonese and Mandarin).

Please visit the Language Assistance Services intranet site for additional resources...

- Complete procedures for working with interpreters and /or translating documents
- Frequently Asked Questions
- Helpful tips for over-the-phone interpretations
- "Please Hold" instructions in additional languages
- Linguistic Access Initiative information

...at http://intranet.co.sanmateo.ca.us/health/LA.

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

This information is included in a client's clinical records/charts. Please refer to the Outpatient Progress Note – Language and Other Information (Appendix G, p. 8).

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

Whenever possible, the Mental Health Plan seeks to provide services in the language of choice of all consumers. Please refer to the Beneficiary Provider List and the languages spoken by respective providers: Afrikaans, Arabic, Armenian, Cantonese, Farsi, French, Fujianese, German, Hindi, Indonesian, Italian, Japanese, Korean, Malay, Malayalam (India), Maltese, Mandarin, Portuguese, Punjabi, Russian, Spanish, Tagalog, Toisanese, Ukrainian, Urdu, Vietnamese. In addition, one provider uses "SEE" (Signing Exact English) for deaf children. Please refer to list of contract providers that are linguistically proficient in threshold and non-threshold languages (Appendix H, pp. 6-32).

Provider agencies typically submit their agency's language capacity in their proposals but we have not captured this in our contract agreements. At a recent contractors meeting, this topic was discussed and it seems that each agency keeps a listing of their language capacity (for licensing), but they are not required to submit this information. For the CSS Full Service Partnerships, the two contract agencies report language capacity for those programs on a quarterly basis for our internal MHSA report. For FY 2010-2011, we can begin to establish contract requirements related to language capacity.

Please also refer to Mental Health Policy No.: MH 99-09, Subject: Private Provider Contracts - Language Capabilities (Appendix G, p. 9).

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

The Health System contracts with Avid Translation to provide interpretation services for FY 2010-2013. Avid Translation screens interpreters on basic language knowledge/skills; cultural awareness/sensitivity; public health, medical, and mental health terminology; interpreting skills;

sight translation and written translation. Their interpreters are required to have 20 hours of training in interpreting and a required practicum and 10 hours of Continuing Education is required per year.

Sixty percent of Avid's spoken language interpreters are certified by State of California (CHIA) and 32% are certified by the American Translators Association and 8% by the Federal Court. Eighty percent of Avid's American Sign Language interpreters are certified by the Registry of Interpreters for the Deaf and 20% are certified by National Association of the Deaf.

Please refer to Avid Translation's Proposal to Provide Language Translation and Interpretation Assistance Services of February 8, 2010 and information provided regarding Quality Assurance (Appendix G, pp. 10-11).

Exhibit A of our the Health System's contract with Avid Translation includes "Services will be provided by certified and qualified interpreter/translators who are experienced in providing services to low-income, culturally diverse communities. Interpreters shall participate in at least eight (8) hours training per year on providing culturally appropriate services."

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

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.

Please refer to BHRS Policy 99-01, Subject: Services to Clients in Primary or Preferred Languages (Appendix G, pp. 12-15).

As noted in Criterion 1, Section IV., B., 1, the Health System contracted with Avid Translation for interpretation services and viaLanguage for translation services for FY 2010-2013. Of the $450,000 contract with Avid Translation, $320,000 or 71% is budgeted for BHRS. Of the $150,000 contract with viaLanguage, $40,000 or $27% is budgeted for BHRS.

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.

Please refer to BHRS Policy 99-01, Subject: Services to Clients in Primary or Preferred Languages (Appendix G, pp. 12-15).

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.

Please refer to Health System Policy A-26, No Use of Minors & Careful Use of Family for Interpretation Policy (Appendix G, pp. 16-17).

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;

The Guide to Medi-Cal Mental Health Services is available in English, Spanish and Tagalog. Upon request to the MHP ACCESS line, the materials can be provided electronically, in large print, or by audiotape.

The Office of Consumer and Family Affairs (OCFA) produces a brochure that provides information about the OCFA, Consumer Rights and Additional Resources (Appendix A, pp. 75-76).

2. General correspondence;

3. Beneficiary problem, resolution, grievance, and fair hearing materials;

Please refer to *Guide to Medi-Cal Mental Health Services regarding the Appeals, State Fair Hearing and Grievance processes* (pp. 40-55).

Please refer to Mental Health Policy No.: MH 03-03, SUBJECT: Consumer Problem Resolution Process.

Please refer to The Office of Consumer and Family Affairs Consumer Rights and Problem Resolution Brochure: For Mental Health and Alcohol and Other Drug Services (available in English, Spanish and Tagalog).

4. Beneficiary satisfaction surveys;

A Consumer Perception Survey is available from Research and Evaluation (English, Spanish).

5. Informed Consent for Medication form;

Please refer to Verification of Consent to Medication (English, Spanish, Tagalog).

6. Confidentiality and Release of Information form;

Please refer to:
1) Authorization for the Verbal Release of Protected Health Information to Family, Friends, or Individuals Providing Social Support (English, Spanish, Tagalog)

2) Authorization for Use or Disclosure of Protected Health Information (English, Spanish and Tagalog).

7. Service orientation for clients;

The Welcome Packet (for Adults, Children/Youth and eventually Transition Age Youth) currently given to clients is being updated. A hard copy is available from the Manager for Health Insurance Outreach and Coordination.

Please refer to the Guide to Medi-Cal Mental Health Services (available in English, Spanish and Tagalog).

8. Mental health education materials,

The Office of Consumer and Family Affairs Family Information/Emergency Brochure produces *"I think my Child has an Emotional, Mental Health or Substance Abuse Problem...What Do I Do? Where to Find Help in San Mateo County"* (available in English, Spanish, Simplified Chinese, Traditional Chinese, Tongan, and Samoan).

Please refer to Pacific Islander brochures: Depression; Domestic Violence; and Stress.

9. Evidence of appropriately distributed and utilized translated materials.

Please refer to Mental Health Policy No.: MH 05-01, Subject: Translation of Written Materials.
Written Materials
For the purposes of this policy, written materials requiring translation include, but are not limited to:

- Client authorization letters, and other letters involving Notices of Action (NOA's).
- Mental Health Plan (MHP) informing materials, including client grievance and appeal brochures; Advance Directive Information; Notice of Privacy.
- All forms requiring client signature such as consents, authorizations, acknowledgements, insurance agreements, clinical contracts, treatment plans, etc.
- Letters concerning financial obligations, changes in financial policy, etc.
- Client educational material, including medication education/information sheets.

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

This information is included in client records/charts. Sample charts are available during the Compliance Review.

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 Perception Surveys are performed twice a year, in May and November. The Survey is translated in Spanish. A summary report is prepared in English.

D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing) **and**
E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

The San Mateo County Health System contracts with viaLanguage and Avid Translation for FY 2010-2013 to provide translation and interpretation services. viaLanguage's internal quality assurance mechanism requires them to do a back translation as well as check for 6th grade literary level. After the translations are received from viaLanguage, BHRS asks consumers/clients and family members to review the documents for cultural and linguistic (and context) accuracy as well as appropriate reading levels.

Please refer to information regarding Cultural Competency and Quality Assurance in viaLanguage's Proposal for Language Translation & Interpretation Assistance Services of February 8, 2010.

In the AGREEMENT BETWEEN THE COUNTY OF SAN MATEO and viaLanguage, Inc., please refer to Exhibit A, paragraphs C. and F. below:

C. Translations shall be completed at a 6th grade reading level, and in a manner that is culturally appropriate assuming Contractor receives English source files between 4th and 8th grade literacy.

F. Services will be provided by certified and qualified translators who are experienced in providing services to low-income, culturally diverse communities. Translators shall participate in at least eight (8) hours training per year on providing culturally appropriate services.

In the AGREEMENT BETWEEN THE COUNTY OF SAN MATEO and Avid Translation, please refer to Exhibit A, paragraph C. below:

C. Provide translation of documents and other text communications. Priority languages or translation of documents are Spanish, Chinese, Tagalog, Tongan, and Russian. With sufficient notice, Contractor shall accommodate requests for other languages as available. Translations shall be completed at a 6th grade reading level, and in a manner that is culturally appropriate.

Criterion 8
County Mental Health System
Adaptation of Services

I. Client driven/operated recovery and wellness programs

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

The commitment to supporting client-driven/operated recovery and wellness programs has been a priority for BHRS.

The Office of Consumer and Family Affairs (OCFA) provides a way for San Mateo County Behavior Health and Recovery Services clients/consumers and their family members to participate and have a voice in the creation and review of policies and service. The OCFA facilitates access to the grievance and problem resolution process, and is dedicated to training, supporting and educating the Behavioral Health System about consumer and family culture.

- Supports consumers and their family members in resolving problems with BHRS services.
- Ensures the active participation of consumers and family members in the design, monitoring and evaluation of public behavioral health services in San Mateo County.
- Provides information, education and support in understanding the system and accessing mental health services, including local community-based organizations dedicated to helping consumers and their families.
- Addresses the concerns of consumers and their family members regarding the mental health system.
- Receives suggestions for improving care for mental health consumers.

Through various programmatic and funding support, we also have established a few consumer-run programs throughout San Mateo County. Descriptions of these programs are as follows:

Heart and Soul, Inc. – This information is from the Heart and Soul website: We are currently defining our position as the premier consumer-run mental health services agency in San Mateo County. We are in our fourth year of providing a number of exemplary programs to consumers. Our centers are strategically located throughout the county. We encourage those caring and dedicated clinicians, case managers and others working in the mental health field to look into our programs. We offer many opportunities for their clients to socialize and expand their horizons.
Locations:
Central County Behavioral Health and Recovery Services Clinic
North County Behavioral Health and Recovery Services Clinic
The Source 500 A 2nd Ave. San Mateo
Coastside Center

Stamp Out Stigma (SOS), a program of Heart and Soul Inc., is a consumer driven advocacy and educational outreach program designed to make positive changes in the public perception of mental illness and inform the community about the personal, social, economic and political challenges faced by people living with mental illness.

SOS presentations consist of 4-6 panelists who share personal experiences of living with mental illness, relating their own experiences of stigma and how they have worked to change the negative societal perceptions. Presentations are interactive, and the audience is encouraged to ask questions.

Other SOS Services include:
Consultation - SOS presenters are experts in helping other client advocacy groups start up their own anti-stigma campaign. SOS has developed a comprehensive toolkit called, "Train the Trainer," that groups can use to provide instruction and inspiration.
Training - SOS provides training and consultation to employers in defining "reasonable accommodations" under the Americans with Disabilities Act of 1990 for persons with mental illness in the workplace.

In nearly 1,700 presentations, SOS has reached diverse audiences throughout the San Francisco Bay Area, including: civic clubs, housing coalitions, mental health boards, police and fire departments, county boards of supervisors, television and radio talk shows, schools of medicine and nursing, crisis-suicide prevention centers, physicians and hospital administrators, graduate schools in psychopathology and social work, universities, colleges, high schools and middle schools.

SOS has been asked to present workshops at national and international conventions, including a conference sponsored by the FBI to develop a training manual for 14,000 law enforcement agencies whose staff has regular interaction with people with psychiatric disabilities. SOS is also a regular presenter at our annual BHRS intern orientation.

Voices of Recovery of San Mateo County
Voices of Recovery (VOR) is for people seeking and maintaining long-term recovery from their own addictions, and long-term recovery from being affected by other people's addictions. VOR is meant to be geographically convenient, culturally diverse and warmly welcoming to all people seeking recovery.

Voices of Recovery will coordinate efforts already established and connect with:
1) Alcohol and drug treatment providers.
2) Other recovery groups (12-Step and non-12-Step).
3) Faith-based organizations.
4) Alcohol and other drug studies students.
5) Organizations providing treatment, information and support for co-occurring/complex disorders and more as we discover them.

Individuals and organizations are invited to join and partner with Voices of Recovery as it grows. Volunteers are encouraged to contribute their voice, energy, ideas and expertise as we develop programs, partnerships and infrastructure.

Vision: Voices of Recovery honors and embraces all unique strengths and challenges along the journey of recovery.
Mission: Voices of Recovery supports lifestyles free from addiction and creates opportunities for advocacy, wellness, and services for ongoing recovery.

Community Recovery Coalition - This is an association of mental health providers, consumers, family members, community-based organizations, mental health service contractors, community colleges and

other county agencies. Its mission is to promote understanding, support and empowerment of persons with psychiatric disabilities to develop and attain personal, wellness and recovery, educational and vocational goals.

NAMI San Mateo County – NAMI San Mateo County (*National Alliance on Mental Illness*) was established in 1974 as Parents of Adult Schizophrenics and later became The Alliance for the Mentally Ill of San Mateo County. It is now one of over 1,000 grassroots affiliates of NAMI National, The Nation's Voice on Mental Illness, covering 50 states. The following information is from NAMI San Mateo County's website: We are a non-profit 501(c)(3) exempt organization governed by a dedicated volunteer Board of Directors comprised of family members who have a loved one with a mental illness. We operate and budget independently of NAMI National.

Our Mission: NAMI San Mateo County is dedicated to improving the quality of life for people with a mental illness and their families through support, education and advocacy.

Our free services and programs include:

- Maintaining an office in Belmont staffed Monday through Friday from 10:00 a.m. to 2:00 p.m. by volunteers answering phone questions and providing information on resources for anyone seeking help.
- Maintaining an office lending library of books and tapes about mental illness.
- Monthly family support group meetings held throughout the County at six locations.
- Ten monthly educational meetings for members and the public.
- Publishing ten monthly newsletters per year.
- Offering twelve week NAMI Family-to-Family classes to help family members understand the clinical treatment of mental illness and learn coping skills four to six times per year from East Palo Alto to Daly City.
- NAMI Provider Education Program.
- NAMI Peer-to-Peer classes by and for consumers of mental health services.
- Providing speakers to other organizations (churches, schools, educational classes, etc.) and
- Advocating for persons with a major mental illness and their families on a county, state, and national level.

Funding for NAMI-SMC comes from membership contributions (approximately 250 paid members), donations, and special events.

The Barbara A. Mouton Multicultural Wellness Center (The Mouton Center) is a new mental health facility and programmatic initiative resource for East Palo Alto (EPA) residents. Opened in June of 2009, The Mouton Center is a place where consumers of mental health services and their family members can go to receive support, information, and be in community with each other. Please see the Mouton Center's June 2010 program calendar (Appendix H, pp.1-4).

BHRS contracts with One East Palo Alto (OEPA) acts as lead agency for The Mouton Center, implementing all aspects of its development and operation. The Mouton Center and OEPA are supported by collaborative mental health initiatives currently with organizational partners including BHRS, the East Palo Alto Mental Health Advisory Group and the East Palo Alto Partnership for Mental Health Outreach.

Featured Activities: Arts & Crafts, Arts in Culture, Board Games, Card Games, Cooking with Culture, Dominos, Family Nights, Folk Medicine & Cultural/Spiritual Healing Health, Exercise & Nutrition, Indoor Recreation, Information Workshops, Movie Sessions, Resource Services, Support Groups, Young Adult Social Activities.

OEPA's current operational strategy to Build Youth and Family Resilience through its Mega-network Continuum of Care Development is partly actualized through The Mouton Center's partnership with San Mateo County. The collaboration of BHRS and The Mouton Center's fellowship, camaraderie, folk medicine and cultural/spiritual healing align with its Mega-network Continuum of Care model.

What makes The Mouton Center so unique is its emphasis on offering a multicultural environment and program reflective of the characteristics of EPA's major ethnic groups to adults 18 years and older and their family members. Also, in keeping with self-help center practices, The Mouton Center is consumer-led, with staff having lived experience as consumers of mental health services and/or or their family members.

Wellness Recovery Action Plan (WRAP) Group – One of BHRS' Strategic Initiatives System of Care Enhancements and Supports Towards Wellness and Recovery strategies is "Recognize recovery is a lifelong process: Individualized planning (WRAP) for supports, self-help and resources that build a life worth living in the community."

Examples of WRAP workshops include:

- The BHRS Office of Consumer and Family Affairs, in collaboration with Inspired at Work, held Wellness Recovery Action Plans for Families workshops beginning in March 2010 for family members to develop their own WRAP.
- Voices of Recovery hosted a WRAP group in March-May 2010.
- Coastside WRAP graduates were pictured in the June 2010 *Wellness Matters*.

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

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

Examples include the Barbara A. Mouton Center (please refer to June 2010 program schedule in English and Spanish in Appendix H, pp. 1-4); Pacific Islander Parenting Project (Appendix A, pp. 82-83); Chinese (Mandarin and Cantonese) Family Support Group started in August 2008, Spanish-Speaking Family Support Group, and Filipino Family Alliance for Mental Health (see list of Support Meetings in NAMI San Mateo June/July 2010 Newsletter in Appendix H, p. 5).

BHRS also provides funding for following peer-led LGBTQQI groups and activities:

- LGBTQQI Group for Ages 16-25 every Monday at 4:00 p.m. at Edgewood Turning Point Drop-In Center
- LGBTQ Adult Support Group 1st and 3rd Tuesday of the month at 5:30 p.m. at Heart and Soul in downtown San Mateo.

- Family Service Agency LGBT Senior Peer Counseling - Confidential, personal and supportive counseling to LGBT people facing the challenges and concerns of growing older. Services available to San Mateo County residents 55 and older. Services also available in Mandarin, Spanish and Tagalog.

Edgewood's San Bruno Youth Drop-In Center provides essential services to an underserved population, the Drop-In Center is a voluntary, peer-driven program that provides interpersonal, educational, vocational and recreational opportunities for San Mateo County youth ages 15-25 to expand the skills necessary for a successful transition into adulthood.

II. Responsiveness of mental health services

A. Documented evidence that the county/contractor has available, as appropriate, alternatives and options that accommodate individual preference, or cultural and linguistic preferences, demonstrated by the provision of culture-specific programs, provided by the county/contractor and/or referral to community-based, culturally-appropriate, non-traditional mental health provider. (Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

BHRS provides the Beneficiary Provider List of Medi-Cal providers for San Mateo's Mental Health Plan as part of the Welcome Packet (available in English and Spanish) to all clients at their Financial Intake and/or first appointment with a clinician. The Beneficiary Provider List includes languages spoken in addition to English (Appendix H, pp. 6-32).

The Alcohol and Other Drug Services (AOD) Directory of Services (Appendix H, pp. 33-52) includes a brief description of each program including language capacity. AOD provides a Women's Services Network brochure (Appendix H, pp. 53-54) that lists six organization providers and their description of services, mission, housing, internal ancillary services, capacity to serve children, childcare, admission/intake process and contact information. The Women's Services Network of San Mateo County recognizes that gender-responsive services are necessary to support women's wellness and recovery and share the common goal of providing holistic services through partnerships to women in our community. The AOD Directory and Women's Services Network brochure are both available at www.smhealth.org/bhrs (click on Alcohol & Other Drug Services).

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.

On the first page of the *Guide to Medi-Cal Mental Health Services*, the following paragraph is included (Appendix H, p. 55):

> How to Get a Provider List:
> You may ask for, and your Mental Health Plan (MHP) should give to you, a directory of people, clinics and hospitals where you can get mental health services in your area. This is called a 'provider list' and contains names, phone numbers and addresses of doctors, therapists, hospitals, and other places where you may be able to get help. You may need

to contact your MHP first, before you go to seek help. Call your MHP's 24-hour, toll-free number above to request a provider list and to ask if you need to contact the MHP before going to a service provider's office, clinic or hospital for help.

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

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

Please refer to the *Guide to Medi-Cal Mental Health Service*s pp. 65-66 regarding "How Do I Get Specialty Mental Health Services?" and "How Do I Find A Provider For The Specialty Mental Health Services I Need?" (Appendix H, pp. 56-57). This Guide is provided to clients at their client orientation meeting.

In the BHRS Office of Consumer and Family Affairs Consumer Rights and Problem Resolution brochure (available in English, Spanish and Tagalog online and in Appendix H, pp. 58-63), there is a list of Consumer Rights including:

- Obtain a list of individual providers, community agencies, and county clinics in your service area, including names, locations, telephone numbers, non-English languages spoken and identification of those not accepting new clients. This list can be obtained by calling the Access Team at 1-800-686-0101.

We perform outreach through community events, often hosted by the Office of Diversity and Equity's Health Equity Initiatives. Please see the FY 2009-2010 Health Equity Initiatives community events listing:

Description of Event	Hong long and often (hours)	Attendance	Date of Event	Name of Host
Sing Tao Chinese Radio - interviews with BHRS clinicians Alice Tong (Cantonese) and Maureen Lin (Mandarin)			7/1/2009 and 8/5/09	Chinese Initiative
Spirituality Initiative Brown Bag	1.50	38	7/30/09	Spirituality Initiative
Parent Night	4.00		9/29/2009; 10/1/09; 10/15/09 10/19/09	Filipino Mental Health Initiative (FMHI)
Fil-Am Festival at Serramonte - FMHI booth		500	10/1/09	Filipino Mental Health Initiative

In the Shadows: Cultural Perspectives on Living with Addiction and Mental Illness			10/24/09	AAPI; Chinese Initiative; FMHI; Latino Collaborative; Pacific Islander Initiative
ALLICE event - informational booth at Colma Community Center			10/28/09	FMHI
Youth Fishbowl: *Don't Hate, Elevate!*	2.50		12/2/09	PRIDE Initiative
African American Planning Initiative Summit: *Celebrating our past and our future*	2.00		2/25/10	AAPI
Youth Fishbowl: *Communicating with Love and Honesty: Tongan Youth Talk to Their Parents*	3.00		3/7/10	Pacific Islander Initiative
LGBTQQI Youth Fishbowl: *Don't Hate Elevate!*	2.50	28	3/23/10	PRIDE Initiative
Latino Family Night	2.00	100	5/7/10	Latino Collaborative
Pacific Islander Parenting Group	Six 3-hour sessions for 18 hours total	16	5/4/10; 5/11/10; 5/18/10; 5/25/10; 6/1/10; 6/8/10 (6/22/10 celebration)	Pacific Islander Initiative
PRIDE Informational and Networking Session	1.50		6/11/10	PRIDE Initiative
San Francisco Pride Parade	5.00	17	6/27/10	PRIDE Initiative

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;

Edgewood Drop-in Center – a voluntary, peer-driven program that provides interpersonal, educational, vocational and recreation opportunities for San Mateo County youth ages 14-25.
931 San Bruno Ave., Ste 1, in San Bruno.

Voices of Recovery - The Drop-In Center is open Tuesdays and Thursdays 4:00-8:00 pm. and is located at 200 Industrial Road in San Carlos.

Heart and Soul - consumer-run mental health services agency with centers in:

- Central County Clinic (Wednesdays and Fridays 10:30 a.m. - 1:30 p.m.)
- North County Clinic (Wednesdays 11:00 a.m. - 2:00 p.m., Fridays 4:00 - 8:30 p.m.)

- The Source located in downtown San Mateo (open Monday, Tuesday, closed Wednesdays, Thursdays and Saturdays for various program hours),
- Coastside (Wednesdays and Fridays 1:00 – 4:00 p.m.)
- Industrial Hotel (Mondays 10:00 a.m.-1 p.m.; Tuesdays and Thursdays 11:00 a.m. – 2:00 p.m.)

Barbara A. Mouton Center – Open Tuesdays through Thursdays 3:00 - 8:00 p.m. and one Saturday each quarter 10:00 a.m. – 5:00 p.m. It is located at 903 Weeks Street, 2nd Floor in East Palo Alto.

Adult Resource Management – Short Term Intensive Case Management as well as Community Program Oversight for San Mateo County Residents meeting system of care eligibility. This team provides case-management services for San Mateo County Residents who are hospitalized in public and private facilities, and for adults who are placed in residential settings and long-term treatment both in and out of county. The team also provides assertive outreach to homeless underserved residents of San Mateo County.

Transportation to clinical appointments and community events may be arranged on a case by case basis through providers.

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); and

Displays in the Central County Clinic lobby create a welcoming environment for clients and their family members. Examples include July 4th, 2009 was celebrated with a cultural display honoring our everyday heroes highlighting American's values. A Lunar New Year display included Chinese decorations. Photos of these displays are included in *Wellness Matters*.

The BHRS contracts with One East Palo Alto to provide Multicultural Center (MCC) Services at the Barbara A. Mouton Multicultural Wellness Center includes language regarding a Multicultural Environment: The contractor will maintain a safe and supportive environment for mentally ill adults and their families who are multiracial, multicultural, and multigenerational. The Multicultural Center environment shall be inviting to African Americans, Latino and Pacific Islanders. The facility should be decorated with multicultural themes reflecting diversity. The MCC will provide information in Spanish, Tongan and other languages.

Please refer to BHRS Policy No.: 10-01, Subject: Providing Services to Persons with Physical Disabilities (Appendix H, pp. 64-65); and BHRS Policy 08-01, Subject: Welcoming Framework, (Appendix H, pp. 66-68).

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.)

Community based settings include Heart and Soul, Voices of Recovery (housed at Youth and Family Enrichment Services), Edgewood Drop-in Center, Barbara A. Mouton Center all discussed in Criterion I, A. above, Ravenswood, and the BHRS Interface Team located in Primary Care.

III. Quality of Care: Contract Providers

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

Our Request for Proposal (RFP) template language asks each prospective provider to provide evidence of the following in their program summary:

Cultural Competence - Describe how your agency/program will ensure cultural competence. This may include culturally relevant program features, staffing objectives that reflect cultural and linguistic diversity and education materials (as applicable) that value the cultural diversity of San Mateo County.

For agency contracts, the following Cultural Competency standards and requirements are included:

1. All program staff shall receive at least one (1) in-service training per year on some aspect of providing culturally and linguistically appropriate services. At least once per year and upon request, Contractor shall provide County with a schedule of in-service training(s) and a list of participants at each such training.
2. Contractor shall use good faith efforts to translate health-related materials in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall provide to County copies of Contractor's health-related materials in English and as translated.
3. Contractor shall use good faith efforts to hire clinical staff members who can communicate with clients in a culturally and linguistically appropriate manner. At least once per year and upon request, Contractor shall submit to County the cultural composition and linguistic fluencies of Contractor's staff.

In addition, when proposals are received in response to an RFP, a review committee comprised of diverse individuals meets and evaluates the proposals. Reviewers specifically rate each proposal by how well they demonstrate and how they will ensure cultural competence within their program(s). The review committee uses a Proposal Rating Sheet that includes Cultural Competency (strengths and weaknesses) as a category along with other categories. Please refer to a sample Proposal Rating Sheet (Appendix A, pp. 24-25). The review committee may also include follow-up verbal questions about cultural competence during an optional interview process such as "What is the cultural composition of your staff?" and "What is the language capacity of your staff?"

IV. Quality Assurance

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

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

BHRS has been involved in a number of Learning Collaboratives offered by CIMH, the most recent one

looking at engagement at our North County clinic. Our team consisted of the Quality Improvement Manager, Health Equity Initiatives Manager, Co-Chair of the Cultural Competence Council with input from numerous staff. Please refer to the Reducing Disparities Learning Collaborative Project Summary (Appendix H, pp. 69-78) San Mateo County, June 8, 2009; the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey; *Databook*.

The BHRS Spirituality Initiative is currently conducting a Client/Consumer and Family Member Survey (Appendix H, pp. 79-80) to better understand the role of spirituality in wellness and recovery. We have received over 450 responses and will be analyzing the results in September 2010.

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

Please refer to the Staff Satisfaction Survey 2009 questions #7, 9 and 16:
- Q7: My supervisor and I frequently discuss cultural competence as a part of the services I deliver.
- Q9: Management actively encourages staff development in the area of cultural competence.
- Q16: BHRS sponsored training increased my competency to work with clients of diverse backgrounds.

Please refer to the Staff Satisfaction Survey 2010 questions #3, 7, 9 and 16:
- Q3: Please indicate if you identify with any of the following cultural heritage groups:
- Q7: My supervisor and I frequently discuss cultural competence as a part of the services I deliver.
- Q9: Management actively encourages staff development in the area of cultural competence.
- Q16: BHRS sponsored training increased my competency to work with clients of diverse backgrounds.

The results of these surveys have been used to inform our system on policy and program decisions that have guided us in the development of new training modules, the inclusion of cultural components in BHRS initiatives, and the need to train supervisors on the active inclusion of cultural discussions with staff who treat a diverse population.

BHRS is actively involved in the recruitment of a diverse staff that can meet the needs of the clients we serve. Results of the data obtained from this survey and of our workforce allow us to identify and recruit staff that will augment our current workforce.

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

The Quality Improvement Committee (QIC) analyzes and discussed grievances at their meeting. Grievances are tracked by how many are received per quarter, by which primary program, and categorized: access to care, change of provider, quality of care, confidentiality, and other (a grievance may include more than one complaint). The number of grievances are also analyzed by percentage of race/ethnicity for clients ages 13-68 and compared to the total number and percentage of clients served by race/ethnicity.

The grievance data is presented at the QIC meeting, which develops policy and training to address needs. Specific concerns are addressed by management as needed. QIC membership includes consumers, family members and staff of BHRS. The Grievance reports provide QIC with an opportunity to identify strengths and areas of improvement in our Grievance Reporting and Resolution process. The results from these reports may influence policy change that is then recommended by QIC. For example, based on the findings of these reports QIC/Office of Consumer and Family Affairs identified the need for a staff/supervisor training on how to assist a client in the filing of a grievance. The presentation was first delivered at the monthly Leadership Forum to introduce/preview the presentation prior to rolling it out to all staff. An all-staff training followed in which each region was trained.