An original, three copies, and a compact disc of this report (saved in PDF [preferred] or Microsoft Word 1997-2003 format) due July 28, 2010 to:

Department of Mental Health
Office of Multicultural Services
1600 9th Street, Room 153
Sacramento, California 95814

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Name of County Mental Health Director: Michael Kennedy, MFT
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CHECKLIST OF THE
2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

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CRITERION 1
COUNTY MENTAL HEALTH SYSTEM
COMMITMENT TO CULTURAL COMPETENCE

Rationale: An organizational and service provider assessment is necessary to determine the readiness of the service delivery system to meet the cultural and linguistic needs of the target population. Individuals from racial, ethnic, cultural, and linguistically diverse backgrounds frequently require different and individual Mental Health Service System responses.

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

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.

1. Sonoma County has several policies, procedures and practices that reflect our recognition and value of racial, ethnic and cultural diversity within our Mental Health System.
   
   - We have a policy regarding use of interpreters (MH Policy IV.E.3) (see Criterion 8.IV)
   
   - We have a policy regarding linking clients to culturally-appropriate services (MH Policy IV.E.3) (See Criterion 8.IV)
   
   - We established goals for hiring Spanish-speaking staff in certain job classes, including specific clinical job class, to ensure hiring of ethnically/linguistically appropriate clinicians. We have exceeded those goals in the past year. We have hired or transferred a total of 4.55 bi-Lingual staff in the past year and a half.

2. We have had, and continue to have, monthly trainings for all staff, which include trainings on specific ethnic issues, and this year we trained all staff on general self-awareness related to ethnicity, class, religious and other issues that we all face as humans. Furthermore, we expect all general clinical trainings to include discussion of how cultural/ethnic issues play into the training topic. (see section Criterion 5)
California Department of Mental Health Cultural Competence Plan Requirements

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

The CCPR shall be completed by the County Mental Health Department. The county will hold contractors accountable for reporting the information to be inserted into the CCPR.

The county shall include the following in the CCPR:

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

1. The Sonoma County Department of Health Services Mental Health Division (MHD) Mental Health Board (MHB) meets monthly to advocate and promote recovery for those with mental illness by identifying culturally relevant needs, monitoring cost-effective strategies, and making recommendations to the County Board of Supervisors. The MHB members are made up of consumers, their family members and loved ones, members of underrepresented cultural communities including veterans, members of the LGBTQQI community and others that make up the diversity of Sonoma County. The MHB travels to different regions in Sonoma County in order to outreach to historically isolated communities and to seek alternative input into the mental health system. The MHB is open to the public for anyone to attend and make comment. The MHB is also responsible for holding public hearings to allow the public to respond to MHD’s published plans.

2. Previous planning for Mental Health Services Act initiatives have included robust community involvement with special attention to ethnic and cultural communities who have experience disparities and have not historically had access to mental health services.

All of the MHSA planning efforts had common elements:

All planning processes employed 5 Guiding Principles:

- Inclusive and representative
- Transparent and easy for all participants to understand
- Collaborative and in partnership with consumers of mental health services, their family members and loved ones and the community
- Broad participation from diverse groups in Sonoma County
- Culturally competent

These guiding principles were realized in the following ways:

In order to ensure full participation, each MHSA initiative required MHB to hold trainings for stakeholders that included understanding Mental Health Services Act in its entirety and each component specifically, Sonoma County planning process, evidence based, promising and best practice models. MHD staff also participated in training to understand how to facilitate a community planning process.

To account for both community member difficulties of participation and desire to participate, each planning process allowed stakeholders meaningful participation no matter how much or little as their time allowed. Community members were welcomed to
participate at any point in the planning process. All planning meetings allowed for translation services, and meetings were held at varying times throughout the community to ensure access and participation. To augment information and discussion at planning meetings, and to ensure input from a variety of community members, alternative methods were used to increase participation including surveys, focus groups with special populations, and work groups were also held. A partial list of participants includes:

- Unaffiliated community members
- Consumers of mental health services both unaffiliated and from local consumer operated programs - (Interlink Self Help Center, Wellness and Advocacy Center, The Empowerment Center)
- Family members and loved ones with mental illness - (National Alliance on Mental Illness, Buckelew Programs)
- Advocacy organizations - (Disability Rights CA (formerly Protection and Advocacy), Advocates for Empowerment, Redwood Community Health Coalition, NAACP, Mental Health Coalition),
- Community based mental health treatment organizations - (Victor Treatment Center – Willow Creek, Community Support Network, Buckelew Programs, Petaluma Peoples Services Program),
- Homeless services - (The Living Room, Mary Isaak Center, Catholic Charities, Petaluma Kitchen)
- Senior Program - (Human Services Department - Adult and Aging, Jewish Family and Children Services – Seniors at Home)
- Schools, colleges, and universities - (Sonoma County Office of Education, Sonoma County Special Education Local Plan, Santa Rosa Junior College, Sonoma State University, University of San Francisco –Santa Rosa campus)
- Community Health Clinics - (West County Health Services, Indian Health Project, Southwest Community Health Center, Petaluma Health Center, Alliance Medical Clinic, Alexander Valley Regional Medical Center, Sonoma Valley Community Health Clinic)
- Housing Organizations (Community Housing - Sonoma County , Burbank Housing)
- Early childhood programs (Early Learning Institute, First 5 Sonoma County)
- Transitional age youth programs (VOICES, Social Advocates for Youth)
- Faith based organizations (Community Baptist Church, Bridges Center for Better Living)
- Alcohol and other drug programs (Drug Abuse Alternative Program, DHS – Alcohol and Other Drug Services, California Human Development)
- Law enforcement (Sonoma County Probation Department, Sonoma County Sheriff’s Department)
- Community based social services programs (West County Community Services, La Luz, Graton Day Labor Program, California Human Development)

3. MH Division made particular efforts during the Prevention and Early Intervention (PEI) request for proposal process of selecting and funding PEI projects that will effectively address the community mental health needs and populations prioritized during Sonoma County’s DHS MHD PEI community planning process in order to improve access and
reduce disparities through delivery of culturally competent PEI programs accessible to all linguistic, cultural, and ethnic communities and services are offered in a way that accounts for diverse cultural and ethnic experiences and perspectives.

To accomplish this goal, (MHD) convened a PEI Planning Committee to review tasks, discuss timelines, and to make recommendations at every phase of the PEI RFP process. The PEI Planning Committees objectives were to:

I. Develop a communication strategy to ensure access to a diverse pool of applicants to provide PEI services, including grassroots community organizations;
II. Provide training and technical assistance to ensure the submission of proposals that are culturally competent and from a broad range of potential providers, and
III. Make certain the RFP Selection Committee members were chosen from a pool of applicants who were 50% people of color and were both experienced and content knowledgeable

The PEI Planning Committee members were made up of staff from National Association for the Advancement of Colored People – Sonoma County (NAACP), Community Action Partnership (Community Action), First 5 Sonoma County (First 5), and MHD. Harder & Co. Community Research provided support to the PEI Planning Committee by documenting the PEI Planning Committee’s activities, providing information and doing research and drafting documents at the request of the PEI Planning Committee. Harder & Co. was not a decision making partner.

Outcomes from the above objectives included:

Communication:
I. The PEI Planning Committee contacted 318 interested agencies, individuals, and organizations that represented a range of providers and interested individuals. Contacts were made using a variety of methods including post card, phone calls, personal visits, email and web posting.

II. MHD received 42 proposals representing 87 organizations for the 6 PEI strategy areas

Training and Technical Assistance:
I. The PEI Planning Committee recruited 43 community members who are content experts and had unique knowledge in the 6 strategy areas as potential RFP Selection Committee members.

II. The PEI Planning Committee recommended 37 people to serve on the RFP Selection Committee. The PEI Planning Committee reached unanimous agreement on all RFP Selection Committee members. The Directors of Health and Mental Health supported each recommended reviewer. Thirty-three community members who are content experts and have unique knowledge participated as RFP Selection Committee members.

Request for Proposal Selection Committee
I. Selection Committee members filled out a ‘Confidential Data Form’ used to gather
demographic information. The demographics of the RFP Selection Committee were:

<table>
<thead>
<tr>
<th>Primary Ethnic Background**</th>
<th>Age</th>
<th>Gender</th>
<th>Sexual Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American - 2</td>
<td>20 to 29 - 4</td>
<td>Male - 16</td>
<td>Straight - 25</td>
</tr>
<tr>
<td>Asian - 1</td>
<td>30 to 39 - 8</td>
<td>Female - 16</td>
<td>Lesbian - 2</td>
</tr>
<tr>
<td>African American - 8</td>
<td>40 to 49 - 3</td>
<td>Transgender - 1</td>
<td>Gay - 4</td>
</tr>
<tr>
<td>Latino - 9</td>
<td>50 to 59 - 12</td>
<td></td>
<td>Transgender - 1</td>
</tr>
<tr>
<td>Caucasian - 12</td>
<td>60 to 69 - 5</td>
<td></td>
<td>Bisexual - 1</td>
</tr>
<tr>
<td>Mixed Race - 1</td>
<td>70 to 79 - 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**5 people identified their Secondary Ethnic Background as: Native American = 1; Caucasian = 2; Asian = 2

Five RFP Selection Committee Members identified as consumers of mental health service and 13 identified as a family member of a consumer of mental health services.

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

Community Outreach Practices: many of SCMH outreach and engagement efforts are done through the Community Intervention Program (CIP) and the Community Mental Health Centers (CMHC).

- CIP participates in at least 5 fairs per year targeting the Latino community; assertive engagement during fairs by assessing specific needs, providing self assessments in depression, anxiety and domestic violence; providing information and referrals and individual consultation. Most of the time, two clinicians table at the fairs, both are bilingual/bicultural in Spanish.
- Starting in November 2009, CIP set the goal of completing, at least 5 home visits per month to Latino homes. The goal of these visits is to reduce distrust of government and increase personal relationships.
- CIP staff attends the monthly Latino Service Providers (LSP) meetings and periodically SCMH hosts the meeting The LSP is a group 450 individuals and agencies with a primary interest in serving the Hispanic communities of Sonoma County since 1989.
- CMHC staff regularly attends Concilio, a collaborative meeting in Sonoma Valley to address the concerns of the Latino Community in the Sonoma Valley area
- Latino Mental Health Dialogues: In collaboration with Early Learning Institute and Santa Rosa Community Health Centers, the CIP manager has been conducting the LMHD since October 2007. The LMHD provide a brief presentation on a specific topic, networking and in-depth case support; typically we have between 15-25 attendees. The target audience is Sonoma County home visitors, promotores/as de salud and in general all paraprofessional working with the Latino Community.
- The CIP manager and CIP staff provide presentations to various community agencies staff serving the homeless and the Latino community including Catholic Charities, Elsie Allen HS, Social Services, So Co Library, California Parenting Institute, Sonoma County Human Services Department, Sonoma County Social
Services.

• CIP recently began to providing some outreach services to African-American churches in Santa Rosa. They provided a three-session seminar on Positive Parenting Program. This activity will be conducted a few times a year with different groups of parents. At another church, we are providing some presentations on dealing with the homeless--who come for meals to the church--who suffer from Mental illness.

• Our Laotian staff provides support: interpreting, brief case management, advocacy, crisis intervention to over 60 clients of Laotian and Cambodian origin. Staff provides three ongoing support groups that meet every other month:

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

To assist in the skill development, strengthening community organizations, building capacity and sustainability MHD has engaged Harder and Company Community Research who has partnered with Community Action Partnership – Sonoma County to provide training, technical assistance and evaluation services of Mental Health Service Act initiatives. This strong partnership was formed in recognition of the high priority of MHD placed on not only documenting the impact of MHSA investments, but simultaneously building the capacity of the community mental health service system to meet the goals of system transformation with special attention to increasing accesses and reducing disparities of ethnic and cultural communities.

MHD has been working with Harder and Company as a planning consultant since 2004. They provide expertise in community planning and evaluation with particular attention to outreach to geographically and culturally isolated communities. Community Action Partnership is charged with building community and to advocate for social and economic justice and brings significant expertise in the delivery of capacity building and technical assistance services.

MHD will work closely with its partners to development of:

• A coordinated system of care that is effective, accessible, and responsive to the community, and
• Sustainable organizations to provide that care.

These activities create a unique opportunity for MHD to reduce stigma and reach underserved populations, such as Latino, African American, Native American, and LGBTQ communities. They will also allow MHD to expand the capacities of organizations serving people of color and other at risk populations by providing technical assistance, training to enhance cultural competency and expand linkages with existing and newly established programs by:

1) System Coordination - Convening and working closely with an Integrated Core Lead Group and Evaluation Advisory Committee comprised of community members (parents, teachers, peer educators, and medical professionals) to assist in project evaluation and selection of best practices models and for training providers of mental health services.

2) Risk Identification Training – Training identified ‘gatekeepers’ in best practice models (identified by the Integrated Core Lead Group) to increase awareness and early detection of mental health issues in the populations they serve.

3) Screening – Assess the needs of organizations and assist them in obtaining the tools and
California Department of Mental Health Cultural Competence Plan Requirements

<table>
<thead>
<tr>
<th>4) Evaluation Toolkit– Development of a ‘toolkit’ for organization to develop and implement their own customized evaluations plans, including support and training to use the toolkit.</th>
</tr>
</thead>
</table>

In addition to the above skill-development at the organizational level, the Community Intervention Program provides skill-development at the program and individual level as noted below:

CIP provides periodic training and presentations at various community agencies serving:
- **Ongoing bimonthly Latino MH dialogues:** These dialogues are meant for home visitors, promotores y promotoras de salud and anyone working with the Latino population. Our main goal is to provide support, resources and skills to paraprofessionals so that they can include a mental health conversation in their dialogue with their Latino clients. These dialogues are facilitated by Early Learning Institute, Santa Rosa Community Health Centers and Sonoma County Mental Health.
- **CIP psychiatrists provide in-service and consultation at the FQHCs and the Drug and Alcohol Alternatives Services, the largest provider of substance abuse services in the county.**
- **CIP manager provided three presentations regarding mental health issues in 2010 to Catholic Charities Staff who works predominantly with the under-served homeless population and the Latino community**
- **Two presentations to California Parenting Institute bilingual/bicultural staff on working with Latino couples**
- **Three presentations to Social Services staff provided by CIP staff in dealing with Mentally Ill clients**
- **On-going consultation with staff at Homeless agencies on how to deal with residents who suffer from mental illness**
- **Several consultations with Santa Rosa Main Library in dealing with mentally ill patrons**
- **Bi-monthly meeting with Santa Rosa Police Department**
- **Monthly meeting with Petaluma Police Department**
- **Monthly support to the two leaders of Nuestra Voz**

D. **Share lessons learned on efforts made on the items A, B, and C above.**
- **As we’ve become available to the community our fears that we would be inundated with clients didn’t materialize**
- **Building collaborative relationships with agencies, facilitated providing accurate information, improves our knowledge of community agencies and our ability to get services for our clients**
- **We are learning about unmet community needs**
- **We serve clients better by meeting them where they are; it’s working well serving Latino clients at the FQHC’s**
- **Home visits to Latino families to build trust and familiarity; generated referrals**
from within relatives and friends

- MHSA philosophy and flexibility has improved services to the Latino community
- Have been able to correct misinformation re: county services, provide accurate information,

E. Identify county technical assistance needs.

- None at this time. Our Community Research and Planning contractor (Harder & Co.) provides some technical training and assistance to new community organizations regarding data gathering and report writing.
III. Each county has a designated Cultural Competence/Ethnic Services Manager (CC/ESM) person responsible for cultural competence

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

The county shall include the following in the CCPR:

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

- Mario Guerrero, MFT, is the Program Manager who leads Sonoma County’s Cultural Responsiveness Committee. He is also the lead manager of the Community Intervention Program, the MHSA program that provides the majority of outreach activities to under-served and hard-to-reach populations in Sonoma County. He has been a manager for SCMH for 7 years, the CIP manager for 4 years, and the CRC committee chair for the past two years.

  He does have direct access to the Mental Health Director and meets periodically with him.

  In order to make changes in policy and practice, it has been effective to use the Quality Improvement Steering Committee (QIS) to bring recommendations, questions and problems up through the various levels in the organization.

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

Sonoma County does not have a written description of these responsibilities.

- Mr. Guerrero is the program manager of the CIP.
  - Provides direction for the team members
  - Provides outreach and consultation to organizations, programs and individuals as noted earlier in II.C.

- Mr. Guerrero chairs the Cultural Responsiveness Committee
  - Develops and leads cultural responsiveness activities and campaigns
  - Develops and implements agenda items.
  - Helps develop cultural competence training activities.
  - Helps develop the Cultural Competence Plan

- Mr. Guerrero is a member of the QIS committee
  - Brings issues from CRC to QIS for discussion and resolution of issues.

- Mr. Guerrero is a member of the training committee
  - Ensures that cultural competence issues are addressed at all appropriate trainings.
  - Helps develop the training program.
IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

A. Evidence of a budget dedicated to cultural competence activities.
   - There is no specific cultural competence line item in the Sonoma County budget. However,
     - CIP budget is approximately $1,300,000
     - PEI total budget is approximately $1,000,000

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;
   - We have contracts with specific interpreters and translation services:
     - Language People, for phone and in-person interpretation, and document translation.
     - Communiqué, for hearing-impaired interpretation
     - Individual contracts for Cambodian, Laotian, and Spanish interpretation.

2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
   - As part of the PEI planning process, six projects were funded for a total of $559,821 specific to reducing disparities. These include:
     - Action Network - $85,151
     - Alexander Valley Health Center - $46,000
     - Community Baptist Church - $180,287
     - Positive Images (Gay/Lesbian)- $77,172
     - Sonoma County Indian Health Project - $76,500
     - West County Comm. Health Services/Latino Providers - $94,711

3. Outreach to racial and ethnic county-identified target populations;
   - As noted above – Community Baptist Church is a primarily African-American Church. Positive Images works with Gay/Lesbian/Bi-sexual/Transgender youth and adults. Sonoma County Indian Health Project serves all Native American nations in the county.
   - Community Intervention program (CIP) is specifically devoted to providing outreach to homeless, under-served and hard-to-reach populations. It has a major focus on outreach to the Latino population.

4. Culturally appropriate mental health services; and
   - CIP is comprised of Latino, Caucasian and Laotian staff, specifically to provide culturally appropriate outreach and mental health services.

5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.
   - The Mental Health Plan pays an additional premium for network providers who provide bi-lingual services to Spanish-speaking individuals.
CRITERION 2
COUNTY MENTAL HEALTH SYSTEM
UPDATED ASSESSMENT OF SERVICE NEEDS

Rationale: A population assessment is necessary to identify the cultural and linguistic needs of the target population and is critical in designing, and planning for, the provision of appropriate and effective mental health services.

Note: All counties may access 2007 200% of poverty data at the DMH website on the following page: http://www.dmh.ca.gov/News/Reports_and_Data/default.asp within the link titled “Severe Mental Illness (SMI) Prevalence Rates”.

Counties shall utilize the most current data offered by DMH. Only small counties, as defined by California Code of Regulations 3200.260, may request Medi-Cal utilization data from DMH by submitting the appropriate form to DMH, no later than five calendar months before plan submissions are due. To complete the Data Request Form, counties must contact the Office of Multicultural Services at 916-651-9524 to have a DMH staff person assist in the completion of the proper form. Eligible counties may be provided data within thirty calendar days from the data request deadline; however, all requests are first-come first-serve and provided according to DMH staff availability and resources.

I. General Population

The county shall include the following in the CCPR:

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

Per the US Census Bureau projections, in 2009, Sonoma County had an estimated population of approximately 464,326 people, broken down as follows:

<table>
<thead>
<tr>
<th>By Gender:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>231,613 male</td>
<td>(49.6%)</td>
</tr>
<tr>
<td>237,993 female</td>
<td>(50.4%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>By Race/Ethnicity:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian:</td>
<td>(67.7%)</td>
</tr>
<tr>
<td>African-American:</td>
<td>(1.8%)</td>
</tr>
<tr>
<td>American Indian/Alaska Native:</td>
<td>(1.6%)</td>
</tr>
<tr>
<td>Asian:</td>
<td>(4.0%)</td>
</tr>
<tr>
<td>Native Hawaiian/Other Pacific Islander:</td>
<td>(0.3%)</td>
</tr>
<tr>
<td>Two or more races:</td>
<td>(2.9%)</td>
</tr>
<tr>
<td>Latino (any race):</td>
<td>(23.6%)</td>
</tr>
</tbody>
</table>

By Age:
- Under 5 years: (6.1%)
- 18 years and over: (77.6%)
- 65 years and over: (13.0%)
II. Medi-Cal population service needs (Use current CAEQRO data if available.)

The county shall include the following in the CCPR:

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

Sonoma County’s breakdown of services provided by populations for fy08-09 and fy09-10 is:

<table>
<thead>
<tr>
<th>For Fiscal Year 08-09 and FY09-10</th>
<th>All Served Unduplicated</th>
<th>Caucasian</th>
<th>Hispanic / Latino</th>
<th>African American</th>
<th>Native American</th>
<th>Asian / Pacific Islander</th>
<th>Mixed Ethnicity / Other non-white / Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sonoma County General Population (2009 estimate)</td>
<td>472,107</td>
<td>67.70%</td>
<td>23.60%</td>
<td>1.80%</td>
<td>1.60%</td>
<td>4.30%</td>
<td>2.90%</td>
</tr>
<tr>
<td>Populations served by SCMH services: FY08-09</td>
<td>4925</td>
<td>74.21%</td>
<td>9.26%</td>
<td>5.24%</td>
<td>1.99%</td>
<td>2.46%</td>
<td>6.74%</td>
</tr>
<tr>
<td>Populations served by SCMH services: FY09-10</td>
<td>5134</td>
<td>75.15%</td>
<td>9.08%</td>
<td>5.06%</td>
<td>1.85%</td>
<td>2.45%</td>
<td>2.75%</td>
</tr>
</tbody>
</table>

| Percent by Gender FY 08-09 | Female | 47.22% | 2314 | 47.62% | 38.14% | 38.76% | 52% | 44.63% | 44.88% |
| Male | 52.78% | 2586 | 52.19% | 61.86% | 61.24% | 48% | 55.93% | 50.30% |

| Percent Served by Age FY08-09 | Age Totals | % | 0-5 | 0.85% | 0.44% | 2.71% | 1.02% | 19.39 | 0.83% | 3.31% |
| | 6-12 | 11.35% | 559 | 9.95% | 12.06% | 17.05% | % | 42.86 | 8.26% | 20.18% |
| | 13-18 | 21.97% | 1082 | 18.88% | 29.61% | 30.26% | % | 35.71 | 23.14% | 32.23% |
| | 19-59 | 56.93% | 2804 | 60.33% | 55.04% | 44.19% | % | 60.33% | 37.05% |
| | 60+ | 8.67% | 427 | 10.00% | 2.85% | 5.43% | 1.02% | 7.44% | 7.23% |
### Penetration Rates FY09-10 All Clients

<table>
<thead>
<tr>
<th>For Fiscal Year 09-10</th>
<th>All Served</th>
<th>Caucasian</th>
<th>Latino</th>
<th>African American</th>
<th>Native American</th>
<th>Asian/Pacific Islander</th>
<th>Mixed Ethnic/Other non-white</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percent by Gender</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>45.92%</td>
<td>2349</td>
<td>54.60%</td>
<td>46.35%</td>
<td>39.23%</td>
<td>58%</td>
<td>47.62%</td>
</tr>
<tr>
<td>Male</td>
<td>54.08%</td>
<td>2766</td>
<td>45.40%</td>
<td>53.65%</td>
<td>60.77%</td>
<td>42%</td>
<td>52.38%</td>
</tr>
</tbody>
</table>

### Percent Served by Age

<table>
<thead>
<tr>
<th>Age Totals</th>
<th>%</th>
<th>5134</th>
<th>3858</th>
<th>466</th>
<th>260</th>
<th>95</th>
<th>126</th>
<th>329</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>1.05%</td>
<td>54</td>
<td>0.96%</td>
<td>1.29%</td>
<td>1.15%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>2.43%</td>
</tr>
<tr>
<td>6-12</td>
<td>12.52%</td>
<td>643</td>
<td>11.64%</td>
<td>11.80%</td>
<td>16.92%</td>
<td>17.89%</td>
<td>11.11%</td>
<td>20.06%</td>
</tr>
<tr>
<td>13-18</td>
<td>21.74%</td>
<td>1116</td>
<td>18.46%</td>
<td>28.54%</td>
<td>35.38%</td>
<td>45.26%</td>
<td>18.25%</td>
<td>34.65%</td>
</tr>
<tr>
<td>19-59</td>
<td>56.14%</td>
<td>2882</td>
<td>59.18%</td>
<td>56.45%</td>
<td>40.77%</td>
<td>33.68%</td>
<td>63.49%</td>
<td>35.87%</td>
</tr>
<tr>
<td>60+</td>
<td>8.55%</td>
<td>439</td>
<td>9.77%</td>
<td>2.58%</td>
<td>5.77%</td>
<td>3.16%</td>
<td>7.14%</td>
<td>7.14%</td>
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### Penetration Rates Medi-Cal Only FY09-10

<table>
<thead>
<tr>
<th>Percent by Gender</th>
<th>Percent of Gender Served by Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>47.55%</td>
</tr>
<tr>
<td>Male</td>
<td>52.45%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percent Served by Age</th>
<th>Percent of Ethnicities Served by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Totals</td>
<td>%</td>
</tr>
<tr>
<td>0-5</td>
<td>2.50%</td>
</tr>
<tr>
<td>6-12</td>
<td>17.88%</td>
</tr>
<tr>
<td>13-18</td>
<td>22.25%</td>
</tr>
<tr>
<td>19-59</td>
<td>49.18%</td>
</tr>
<tr>
<td>60+</td>
<td>8.20%</td>
</tr>
</tbody>
</table>
This last graph and chart shows the combined efforts of direct services provided by Mental Health and unique outreach contacts by CIP together. As can be seen, we have increased our total “penetration rate” to Latino’s in fy09-10.

<table>
<thead>
<tr>
<th>FY</th>
<th>Total Clients open in POCO</th>
<th>Total # Latino open in POCO</th>
<th>POCO Latino %</th>
<th>Total # of Clients served in FQHCs</th>
<th>Total # of Latinos receiving MH service in FQHCs</th>
<th>Total # of clients seen by CIP</th>
<th>Total # of Latinos served by CIP</th>
<th>Total # of Latino served</th>
<th>Total # served, POCO + FQHCs + CIP</th>
<th>% Served</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY06-07</td>
<td>5309</td>
<td>608</td>
<td>11.45%</td>
<td>218</td>
<td>39</td>
<td>653</td>
<td>79</td>
<td>726</td>
<td>6180</td>
<td>11.75%</td>
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<tr>
<td>FY07-08</td>
<td>5091</td>
<td>496</td>
<td>9.74%</td>
<td>257</td>
<td>81</td>
<td>1413</td>
<td>160</td>
<td>737</td>
<td>6761</td>
<td>10.90%</td>
</tr>
<tr>
<td>FY08-09</td>
<td>4925</td>
<td>456</td>
<td>9.26%</td>
<td>324</td>
<td>89</td>
<td>1675</td>
<td>205</td>
<td>750</td>
<td>6924</td>
<td>10.83%</td>
</tr>
<tr>
<td>FY09-10</td>
<td>5134</td>
<td>466</td>
<td>9.08%</td>
<td>432</td>
<td>142</td>
<td>1936</td>
<td>337</td>
<td>945</td>
<td>7502</td>
<td>12.60%</td>
</tr>
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</table>

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

- Latino penetration and retention remain the lowest of all ethnic groups. This continues the trend in previous years. However, some of the disparity is due to the fact that many Latinos use the existing Federally Qualified Health Clinics (FQHCs) and other health clinics for their services.
- We have increased our total number of unique contacts to the Latino population in the county as can be seen from the last graph above.
- However, even with this increased visibility and outreach efforts, we only 12.60% of our total population served is Latino.
- Males of all ethnicities (except Caucasians and Native Americans) are seen more often than females. This is probably due to referrals from schools and other contacts with authorities. It is very likely to be due to perception of men in these populations.

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.
III. 200% of Poverty (minus Medi-Cal) population and service needs

The county shall include the following in the CCPR:

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

- This information is not available in our data system. It has not been a State or Federal mandate or expectation before. However, based on DMH summary data from 2007:

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Total Population (HH, Inst. &amp; Group)</th>
<th>Household Population</th>
<th>Households &lt;200% poverty</th>
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</thead>
<tbody>
<tr>
<td>All ages</td>
<td>22025 464435 4.74</td>
<td>20931 452696 4.62</td>
<td>8679 102651 8.45</td>
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</table>

<table>
<thead>
<tr>
<th>Youth age 0-17</th>
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</thead>
<tbody>
<tr>
<td>Cases</td>
</tr>
<tr>
<td>Youth total</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>3793 53423 7.10</td>
<td>3688 52694 7.00</td>
<td>1217 13866 8.77</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Female</td>
<td>3557 50510 7.04</td>
<td>3522 50229 7.01</td>
<td>1224 14167 8.64</td>
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</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. White-NH</td>
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<td>3742 56225 6.65</td>
<td>783 8967 8.73</td>
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<td>2. African Am-NH</td>
<td>131 1669 7.82</td>
<td>121 1594 7.60</td>
<td>62 682 9.04</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. Asian-NH</td>
<td>274 3917 7.00</td>
<td>272 3899 6.98</td>
<td>93 1080 8.60</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Pacific I-NH</td>
<td>16 224 7.26</td>
<td>16 224 7.26</td>
<td>6 66 8.83</td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5. Native-NH</td>
<td>64 877 7.30</td>
<td>62 867 7.18</td>
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</tr>
<tr>
<td>6. Other-NH</td>
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<td>0 0.00 0.00</td>
<td>0 0.00 0.00</td>
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</tr>
<tr>
<td>7. Multi-NH</td>
<td>270 3806 7.09</td>
<td>265 3782 7.01</td>
<td>75 849 8.83</td>
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<tr>
<td>8. Hispanic</td>
<td>2811 36879 7.62</td>
<td>2732 36332 7.52</td>
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<table>
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<th>Poverty level</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Below 100%</td>
<td>997 9972 10.00</td>
<td>991 9911 10.00</td>
<td>991 9911 10.00</td>
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<tr>
<td>2. 100%-199%</td>
<td>1452 18151 8.00</td>
<td>1450 18121 8.00</td>
<td>1450 18121 8.00</td>
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<td></td>
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</tr>
<tr>
<td>3. 200%-299%</td>
<td>1401 20021 7.00</td>
<td>1401 20021 7.00</td>
<td>0 0.00 0.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. 300%+ pov</td>
<td>3178 52961 6.00</td>
<td>3178 52961 6.00</td>
<td>0 0.00 0.00</td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5. Undefined</td>
<td>321 2827 11.37</td>
<td>191 1908 10.00</td>
<td>0 0.00 0.00</td>
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</table>
### California Department of Mental Health Cultural Competence Plan Requirements

<table>
<thead>
<tr>
<th>Residence</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
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<td>7211</td>
<td>102923</td>
<td>7.01</td>
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<tr>
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#### Adults age 18 and older

<table>
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<tr>
<th>Age</th>
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<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>18-20</td>
<td>426</td>
<td>20259</td>
<td>2.10</td>
<td>326</td>
<td>17592</td>
<td>1.85</td>
<td>184</td>
<td>5630</td>
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<td>21-24</td>
<td>1190</td>
<td>26486</td>
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<td>1131</td>
<td>25634</td>
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<td>10509</td>
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<table>
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<tr>
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<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
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</tr>
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<tbody>
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<td>3941</td>
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<table>
<thead>
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<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
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<tbody>
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<td>2716</td>
<td>3.59</td>
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<td>722</td>
<td>2.06</td>
<td>15</td>
<td>717</td>
<td>2.04</td>
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<td>150</td>
<td>4.49</td>
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<td>0.00</td>
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<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
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<tbody>
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<td>Married</td>
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<tr>
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<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
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<table>
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<tr>
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<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
<th>Cases</th>
<th>Pop</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.Below 100%</td>
<td>2941</td>
<td>28476</td>
<td>10.33</td>
<td>2701</td>
<td>26238</td>
<td>10.30</td>
<td>2701</td>
<td>26238</td>
<td>10.30</td>
</tr>
<tr>
<td>2.100%-199%</td>
<td>3664</td>
<td>50296</td>
<td>7.29</td>
<td>3536</td>
<td>48380</td>
<td>7.31</td>
<td>3536</td>
<td>48380</td>
<td>7.31</td>
</tr>
<tr>
<td>3.200%-299%</td>
<td>2233</td>
<td>51605</td>
<td>4.33</td>
<td>2208</td>
<td>50954</td>
<td>4.33</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
</tr>
</tbody>
</table>
B. Provide an analysis of disparities as identified in the above summary.

- Ranking the highest to lowest rates of estimated mental illness among various racial groups is as follows:
  - All ages: 8.45% are estimated to have serious mental health issues.
    - Youth ages 0-17 all ages: 8.71%
      - Native Americans: 9.13%
      - African-American: 9.04%
      - Pacific Islanders: 9.83%
      - Caucasian: 8.73%
      - Hispanic/Latino: 8.68%
      - Asians: 8.60%
    - Adults ages 18 and older: All ages: 8.36%
      - Native Americans: 11.71%
      - African-Americans: 9.56%
      - Pacific Islanders: 8.83%
      - Caucasian: 8.73%
      - Latino: 8.68%
      - Asians: 8.60%

  - As can be seen from the above rankings, Native American and African-American youth and adults both have the highest estimated rates of mental illness of all distinct ethnic groups.

Note: Objectives for these defined disparities will be identified in Criterion 3, Section III.
IV. MHSA Community Services and Supports (CSS) population assessment and service needs

The county shall include the following in the CCPR:

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

- The following information comes from the CSS Plan:

<table>
<thead>
<tr>
<th>Children and Youth (0-18)</th>
<th>Fully Served</th>
<th>Underserved/ Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population, 2000 (&lt;200%)*</th>
<th>County Population, 2003†</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>Total</td>
<td>M</td>
<td>F</td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>545</td>
<td>407</td>
<td>952</td>
<td>382</td>
<td>285</td>
</tr>
<tr>
<td>African American</td>
<td>22</td>
<td>28</td>
<td>50</td>
<td>18</td>
<td>22</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>8</td>
<td>5</td>
<td>13</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Latino</td>
<td>78</td>
<td>74</td>
<td>152</td>
<td>77</td>
<td>74</td>
</tr>
<tr>
<td>Native American</td>
<td>12</td>
<td>7</td>
<td>19</td>
<td>16</td>
<td>10</td>
</tr>
<tr>
<td>White</td>
<td>409</td>
<td>280</td>
<td>689</td>
<td>251</td>
<td>172</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>13</td>
<td>29</td>
<td>8</td>
<td>6</td>
</tr>
</tbody>
</table>

* Percent column shows percent of population under 200% of poverty level within each racial/ethnic population.

Source: Census 2000


<table>
<thead>
<tr>
<th>Transition Age Youth &amp; Adults (19-59)</th>
<th>Fully Served</th>
<th>Underserved/ Inappropriately Served</th>
<th>Total Served</th>
<th>County Poverty Population, 2000 (&lt;200%)*</th>
<th>County Population, 2003†</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>Total</td>
<td>M</td>
<td>F</td>
<td>Total</td>
</tr>
<tr>
<td>Total</td>
<td>138</td>
<td>164</td>
<td>302</td>
<td>1613</td>
<td>1917</td>
</tr>
<tr>
<td>African American</td>
<td>11</td>
<td>8</td>
<td>19</td>
<td>75</td>
<td>54</td>
</tr>
<tr>
<td>Asian Pacific Islander</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>92</td>
<td>46</td>
</tr>
<tr>
<td>Latino</td>
<td>15</td>
<td>28</td>
<td>43</td>
<td>116</td>
<td>217</td>
</tr>
<tr>
<td>Native American</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>24</td>
<td>16</td>
</tr>
<tr>
<td>White</td>
<td>95</td>
<td>117</td>
<td>212</td>
<td>1226</td>
<td>1510</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>77</td>
<td>77</td>
</tr>
</tbody>
</table>
B. Provide an analysis of disparities as identified in the above summary.

Fully served consumers are identified as those who accessed integrated, wraparound services. Underserved are all other Sonoma County Mental Health consumers who did not receive fully integrated, wraparound services. Unserved are individuals living with SMI or SED who did not receive mental health services. Existing fully served clients include:

- **Children and Youth**: These include children and transition age youth in Intensive Enrollee Based, Resource Team, Residential Treatment Programs and contractors (SAY, Lifeworks, CARE, Petaluma People Services).
- **Adults**: AB2034 (Project Hope) programs, Long-term care, Conditional Release, and those who received services through the Adult Resource Team.
- **Older Adults**: Services from the Older Adult Team

**Children (Ages 0-18)**

Children constituted a quarter of Sonoma County’s population in 2003. Approximately one in five lived under 200% of the poverty level, and the majority of children were White. Although Latinos represent 18.8% of the County’s population, 28.0% of children ages 0-18 and 29.4% of children ages 0-15 were Latino. Compared to those served by MHD, only 17.8% of children served were Latino. African American children were overrepresented in the service group; they constituted 1.6% of the children population, and 5.2% of children served.

968 of 1,647 of children (58.8%) were in fully served programs FY03-04. Although children with SED had a higher unserved rate compared to adults, those who received MHD services more often received fully integrated services.

**Transition Age Youth and Adults (Ages 19-59)**

The transition age youth and adult population is the largest population in Sonoma County (58.1%). Racial/ethnic patterns for this population reflect that of the general population. Approximately 21.7% of transition age youth and adults reported incomes under 200% of
the poverty level. The 200% poverty rate for Latinos doubled that of Whites, with approximately 41.7% living with low incomes. Overall, a higher proportion of non-white youth and adults reported low incomes compared to Whites.

MHD served 1,152 transition age youth ages 16-24 in FY03-04. Two-thirds (66.7%) of these youth were White, and 19.7% were Latino, which relatively reflect the general demographics of this population. Latino adults ages 25-59, on the other hand, were significantly underrepresented among adults served (7.9% of those served compared to 19.7% of the population). Similar to African American children, African American youth and adults were overrepresented among the served population.

One-quarter (26.1%) of transition age youth and adults served by MHD received fully integrated services. Compared to children and older adults living with SED or SMI, transition age youth and adults living with SMI were more likely to receive services but less likely to be fully served.

Older Adults (Ages 60 and Over)

Older adults represented 17.1% of Sonoma County’s population, the majority of whom (88.8%) were White. Only 5.5% of this population was Latino. Although older adults had a slightly lower income rate compared to other age groups, approximately one third of African American, Latino, and Native American older adults had low incomes.

Overall, older adults had the highest unserved rate (93.6%). Among the 442 served by MHD, over half (55.2%) received full services through the Older Adult Team.

Ethnic Populations

Latino’s are the second largest ethnic group in Sonoma County. While the percentage of consumers receiving MHD services keeps rising, (Latino Access Study 2002, MHD 2003 Update Cultural Competence Plan), the needs analysis demonstrates that Latinos are significantly underserved and unserved. About 90.5% of Latinos living with SED and SMI are unserved. The Latino population is expected to more than double in Sonoma County by the year 2020, and could therefore come to represent one in five county residents. Compared to their representation in the total county population, Latino adults and children are disproportionately living in poverty. Latino adults ages 19-59 represent 18.3% of the county population and 41.5% Latino children represent 28% of the county population, yet 47.1% live under 200% of the federal poverty level.

There is a significant need for bi-lingual Spanish service capacity. Nearly three of four Latino residents speak a language other than English at home. However, English was the primary language for 88.5% of MHD consumers; only 4.4% primarily spoke Spanish. This data could explain the high percentage of Latinos living with SMI in Sonoma County who are unserved. Another factor that may contribute to receiving mental health care is health coverage. According to 2003 CHIS data, 23.9% of Latino respondents living in Sonoma County were uninsured (see table 5). This is compared to only 9.5% of all respondents to the CHIS survey who were uninsured and only 7.3% of White respondents who were uninsured. This disparity further demonstrates the discrepancy between unserved Latinos
living with SED or SMI.

Medi-cal data provides further insight into service access disparities. Latinos represent the largest group of Medi-Cal eligibles (45.6%), and yet Latinos represent the smallest group of eligibles who received mental health services (1.5%).

Pacific Islanders make up only 0.2% of Sonoma County’s population in 2003; four received services in FY03-04. African Americans (39.5%) had the lowest unserved rate by the end of FY03-04, followed by Native Americans (54.1%). These groups make up 1.4% and 1.1% of the county’s population respectively, but represent 4.2% and 1.6% of the county-served population.

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

V. Prevention and Early Intervention (PEI) Plan: The process used to identify the PEI priority populations
The county shall include the following in the CCPR:

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

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

Sonoma County MHD selected the following priority populations across the lifespan:

- Early Childhood Prevention and Early Intervention – Children ages Birth to 5 years:
  - Trauma Exposed Individuals
  - Children/youth in stressed families
  - Children at risk for school failure
  - Children at risk for juvenile justice involvement
  - Underserved cultural populations

- School-based Programs - Children 5 to 18 years
  - Trauma Exposed Individuals
  - Children/youth in stressed families
  - Children at risk for school failure
  - Children at risk for juvenile justice involvement
  - Underserved cultural populations

- Crisis Intervention for Individuals Experiencing First Onset
  - Trauma Exposed Individuals
  - Youth in stressed families
  - Individuals Experiencing Onset of Serious Psychiatric Illness
  - Underserved cultural populations
Reducing Depression and Suicide Among Older Adults
- Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Underserved cultural populations

Reducing Disparities to access to mental health services for ethnic and other cultural minorities
- Trauma Exposed Individuals
- Children/youth in stressed families
- Children at risk for school failure
- Children at risk for juvenile justice involvement
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Underserved cultural populations

System Enhancement
- Trauma Exposed Individuals
- Children/youth in stressed families
- Children at risk for school failure
- Children at risk for juvenile justice involvement
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Underserved cultural populations

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

Each of the proposed PEI projects described in the MHSA PEI Plan is the result of a collaborative planning effort between MHD and stakeholders, including community service providers, medical professionals, consumers, and their family members.

Community work group members prioritized the community mental health needs and populations using local data related in workgroup member’s expertise and extensive content knowledge to gather relevant primary data, secondary data and service recommendations generated through previous Sonoma County planning efforts. Members were asked to share information with other group members to enrich each group’s understanding for the multiple mental health prevention needs of their specific population.

In addition to basic demographics and general mental health data review process explored issues that included: child abuse, foster care, domestic violence, behavioral health, substance use, truancy, academic performance suicide risk, juvenile involvement, depression, health insurance status indicators such as race/ethnicity and language, elder abuse, grief and isolation, language patterns, and poverty demographic indicators. The data the workgroups reviewed and analyzed came from a variety of sources, including:

- US Census Bureau (2002)
- US Department of Health and Human Services, Health Resources and Services Administration (HRSA)
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- CA Institute for Mental Health – The Infant, Pre-school, Family Mental Health Initiative,
- Children Now 2007 California County Data Book
- CA Healthy Kids Survey 2005-2008
- CA Department of Education, Safe & Healthy Kids Program Office
- CA Department of Health Services, Vital Statistics, Death Records 2002-2004
- CA Department of Education Safe & Healthy Kids Program Office
- CA Student Assistance Program Resources Center
- Results of the National College Health Assessment Survey, Santa Rosa Junior College (2007)
- Sonoma County Perinatal Alcohol and Other Drug (AOD) Action Team “Drug Free Babies” Report
- Sonoma County Methamphetamine Profile
- Sonoma County Maternal, Child, and Adolescent Health Five-Year Needs Assessment for 2005-2009
- Children’s Mental Health Partnership’s Perinatal Mood Disorder Strategic Planning Process Summary
- Sonoma County Health Profile
- Planning for Community Based Prevention of Alcohol and Other Drug-Related Problems in Sonoma County Step 1: Assessment. Sonoma Department of Health Services, Prevention and Planning Division (2006)

Furthermore, numerous surveys and focus groups were held to ensure maximum input for a variety of populations.
CRITERION 3
COUNTY MENTAL HEALTH SYSTEM
STRATEGIES AND EFFORTS FOR REDUCING
RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC
MENTAL HEALTH DISPARITIES

Rationale: “Striking disparities in mental health care are found for racial and ethnic populations. Racial and ethnic populations have less access to and availability of mental health services, these communities are less likely to receive needed mental health services, and when they get treatment they often receive poorer quality of mental health care. Although they have similar mental health needs as other populations they continue to experience significant disparities, if these disparities go unchecked they will continue to grow and their needs continue to be unmet...” (U.S. Department of Health and Human Services, Surgeon General Report, 2001).

Note: As counties continue to use this CCPR as a logic model, counties will use their analyses from Criterion 2, to respond to the following:

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

The county shall include the following in the CCPR:

- 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

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

- Medi-Cal: Latino population – based on analysis of county-served clients and based on the number of Medi-Cal beneficiaries. The Latino population is 23% of the county population and 35% of the Medi-Cal population. In FY09-10, approximately 12% of all clients served in some manner were Latino.

- Full Service Partnerships: approximately 5.4% of all clients served in FSPs were Latino. Approximately 0.78% of all clients served were Native American, compared to 1.5% of the county’s Native American population

- WET and PEI – see below

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

   - WET
   Below is a summary of workforce needs assessment including a brief listing of any significant shortfalls or disparities such as, racial/ethnic groups, special populations, and unserved or underserved communities.
   A. Shortages by occupational category:

   * There is a shortage of bilingual/bicultural staff in all occupational categories and at all levels.
* There is a specific need to increase the number of unlicensed direct service staff. Some survey respondents indicated that there are existing teams that are “licensed-heavy,” and that unlicensed staff could carry out many of those tasks, making effective use of resources.

* Positions that were specifically identified as needed by County staff were: For Unlicensed Direct Service Staff, “Client Support Assistant” and “Benefits Counselor”; and for Licensed Direct Service Staff, “Psychiatric Nurse” and “Mental Health Practitioner (advertise position as this, not Psychologist).”

* Positions that were specifically identified as needed by Contractor Agencies were: for Other Health Care Staff, “Other Therapist (physical, arts, and dance); for Managerial and Supervisory, “Agency Mental Health Director.”

* 42 percent of the total current County workforce plans to retire in the next 10 years. Specifically, 44 percent of County direct service staff plan to retire in the next 10 years, posing important shortage challenges.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

* There is a shortage of bilingual/bicultural staff compared to Sonoma County’s client population.

* Shortage: 10.6 percent of the total mental health workforce in Sonoma County is Latino(a)/Hispanic. It is estimated that 22 percent of all Sonoma County residents are Latino(a)/Hispanic (American Community Survey, 2005-2007) and the proportion of Sonoma County Medi-Cal recipients who are Latino(a)/Hispanic is 35%. More importantly, the percentage of Latinos(as)/Hispanics currently receiving mental health services in Sonoma County is 12%, so it is estimated that the proportion planned to be served will be closer to 23% (based on Medi-Cal beneficiaries use of Mental health services at 35%).

* Stakeholders identified that “positions become harder to fill when recruiting for minority staff,” as a survey respondent stated. Another stakeholder added, “We make efforts to recruit from the Hispanic/Latino community. Salaries are often not competitive with government and private sector jobs for those eligible to fill these positions.”

C. Positions designated for individuals with consumer and/or family member experience:

* Stakeholders identified the need to increase the number of positions designated for consumers/family members. A survey respondent indicated, “None of the positions that report to me are designated as family member or consumer positions, nor do the job descriptions state that personal experience is highly desirable. I think this is a significant gap in our staffing patterns.” Another stakeholder stated, “We need to put much more emphasis on recruiting, hiring, and training consumer staff.”
* Focus group participants made recommendations about ways to create pathways for consumers to join the mental health workforce. These include:
  - Increase the number of positions designated for consumers and family members, in all categories, and specifically in direct services;
  - Create part-time positions for consumers and family members, combined with educational/training opportunities;
  - Provide both short-term training and long-term educational opportunities for consumers; and
  - Conduct trainings for supervisors around working with consumer employees.

D. Language proficiency:

* Shortage: It is estimated that 23 percent of all Sonoma County residents over the age of five speak a primary language other than English at home (American Community Survey, 2005-2007). Spanish is a major second language in Sonoma County, given current demographic trends. Therefore, many identified the pressing need to hire staff who are bilingual in Spanish.

* 14 percent of direct service County staff are proficient in Spanish. By comparison, 70 percent of Contract Agencies reported that they have at least one Direct Service Staff proficient in Spanish. Nonetheless, both County and Contract Agencies identify the need to increase linguistic competency by hiring Spanish/English bilingual staff.

* Some stakeholders identified the need to hire bilingual staff who speak other languages as well, including Vietnamese and American Sign Language.

PEI

Each of the proposed PEI projects described in the MHSA PEI Plan is the result of a collaborative planning effort between MHD and stakeholders, including community service providers, medical professionals, consumers, and their family members.

There was specific Latino consideration in the PEI planning process. The following is taken directly from the PEI Plan:

“Latin representation was present on all levels of the planning process, which included the launch meetings, workgroups, Stakeholder Leadership, and on the Steering Committee.

The Sonoma County MH Division is a core founding member of the Mental Health Coalition’s Latino Engagement Team (LET). SCMHD’s Ethnic Services Coordinator is a key member who participates in all meetings, planning and the actual dialogues which happen every other month. In addition to the dialogue itself, the Team does a planning meeting and a de-briefing meeting. SCMHD provides some clerical support and translation when necessary. Along with a Manager from Southwest Health Clinic, the Ethnic Services Coordinator is in charge of doing the presentation at the dialogue and always provides supervision for specific cases that the participants present. SCMHD’s PEI component will
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continue to support the goals of the Latino Engagement Team.

Lastly, under the PEI Plan, SCMHD will create a Latino Outreach Engagement Committee. This advisory group will be led by the Ethnic Services Coordinator and the Program Manager of Community Mental Health Centers (Mario Guerrero and Susan Castillo) to provide community input on the implementation of all new PEI programs and services.

Community work group members prioritized the community mental health needs and populations using local data related in workgroup member’s expertise and extensive content knowledge to gather relevant primary data, secondary data and service recommendations generated through previous Sonoma County planning efforts. Members were asked to share information with other group members to enrich each group’s understanding for the multiple mental health prevention needs of their specific population.”

In addition to basic demographics and general mental health data review process explored issues that included: child abuse, foster care, domestic violence, behavioral health, substance use, truancy, academic performance suicide risk, juvenile involvement, depression, health insurance status indicators such as race/ethnicity and language, elder abuse, grief and isolation, language patterns, and poverty demographic indicators. The data the workgroups reviewed and analyzed came from a variety of sources, as noted in Criterion II.

Early Childhood Prevention and Early Intervention – Children ages Birth to 5 years:
- Trauma Exposed Individuals
- Children/youth in stressed families
- Children at risk for school failure
- Children at risk for juvenile justice involvement
- Underserved cultural populations

School-based Programs - Children 5 to 18 years
- Trauma Exposed Individuals
- Children/youth in stressed families
- Children at risk for school failure
- Children at risk for juvenile justice involvement
- Underserved cultural populations

Crisis Intervention for Individuals Experiencing First Onset
- Trauma Exposed Individuals
- Youth in stressed families
- Individuals Experiencing Onset of Serious Psychiatric Illness
- Underserved cultural populations

Reducing Depression and Suicide Among Older Adults
- Trauma Exposed Individuals
- Individuals Experiencing Onset of Serious Psychiatric Illness
• Underserved cultural populations

Reducing Disparities to access to mental health services for ethnic and other cultural minorities
  • Trauma Exposed Individuals
  • Children/youth in stressed families
  • Children at risk for school failure
  • Children at risk for juvenile justice involvement
  • Individuals Experiencing Onset of Serious Psychiatric Illness
  • Underserved cultural populations

System Enhancement
  • Trauma Exposed Individuals
  • Children/youth in stressed families
  • Children at risk for school failure
  • Children at risk for juvenile justice involvement
  • Individuals Experiencing Onset of Serious Psychiatric Illness

Underserved cultural populations

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

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

As noted above, the Latino population is the most under-served population in the county.
III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.
   • WET and PEI were recently developed and are being implemented. Strategies are being defined and will be implemented at a later date.

B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:
   II. Medi-Cal population
      • Increase the number of Latino’s served by:
         ○ More clearly identifying target population and Medi-Cal Medical Necessity criteria and training staff on the criteria
      • Twelve of the largest Organizational Providers who provide Medi-Cal services for the county have had their contracts re-structured to provide more discreet information regarding numbers of clients served.

III. 200% of poverty population
   • We will be looking at this issue as Health Care Reform is rolled out.
   • The Sonoma County Department of Health Services is hiring an experienced manager to assist with this for the entire Department.

IV. MHSA/CSS population
   • Managers of the CSS Full Service Partnership teams have been given data regarding the percentages of clients by ethnicity/race. They have been reviewing the data to make recommendations regarding appropriately using and hiring bi-lingual staff, as funds become available.
   • Community Intervention Program has begun providing more outreach to the African-American community.
   • CIP also has also begun meeting with other Latino-focused organizations as those organizations become known to us.

V. PEI priority population(s) selected by the county, from the six PEI priority populations
   • As noted above, each of the areas have been picked due to the issues identified for the populations served.
   • Some contracts have been established to work, for the first time, with some previously unserved populations. The best example is the working with the African American community through the churches and through the NAACP. We have contracted with their Rights of Passage program, to help mentor at-risk African-American youth to help with self-esteem, and to stay out of trouble.
IV. Additional strategies/objectives/actions/timelines and lessons learned

The county shall include the following in the CCPR:

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

1. Share what has been working well and lessons learned through the process of the county’s development of strategies, objectives, actions, and timelines that work to reduce disparities in the county’s identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.
   - Increased collaboration with the community has been well-received by everyone.
   - We have increased collaboration with Sonoma County Indian Health Project, the NAACP, NAMI, and the Latino Health Providers Association.
   - NAMI sponsored its annual county conference on 9/14/10, which focused on educating the community on the mental health issues for specific ethnicities and populations (e.g. Native American, Gay/Lesbian/Bi-Sexual/Transgender, Asian, Veterans, African-American, etc). More than 400 providers, consumers and community members attended.
   - Mario Guerrero, in his position of the MHSA-funded Community Intervention Program, has become a main organizer of the Latino Service Providers.
     - He has been providing training, consultation and education to this association.
   - The County is three years into a five-year collaboration with local law enforcement agencies, to provide Community Intervention Training (CIT) to Sheriff and local police departments. There have been more than 200 sworn officers trained so far.
     - The training has included issues of the nature of mental illness; role-playing how to handle people in crises, and cultural issues/considerations.

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

The county shall include the following in the CCPR:

A. 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.).
   - The objective is to increase Latino penetration by 5%, including outreach activities, by June 30, 2011. Strategies include:
     - Clearly identifying clients in our data system who currently show as “unknown “ ethnicity.
     - Provide increased outreach to Latino communities through CIP.
     - Through PEI contracts, identify previously –unknown individuals who may qualify for services.
     - More accurately capture data regarding our outreach data.
From the WET plan, the objectives include:

- Recruit Latino family members and consumers into the Mental Health field.
- Provide training and support to public mental health staff and Mental Health Board members to increase cultural competence.
- Train bi-lingual/bi-cultural staff interns to provide a variety of peer mentoring and peer counseling services.
- Train bilingual/bicultural interns to outreach to a variety of organizations which provide services to the Latino community to educate groups about public mental health careers.

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.

- FY10-11 will begin the implementation of performance indicators for the 12 largest Medi-Cal contractors that serve Sonoma County. Each is required to provide data on a quarterly basis regarding #s of clients served, and based on contractor-chosen goals. There is a specific manager assigned to each of these contracts to monitor and follow up on the data. The information will be processed; issues identified and addressed through the Quality Improvement committees.
- FY10-11 also begins this same expectations for all contracts awarded through the PEI process.
- From the WET plan: use the Latino Outreach Coordinator to track progress for the WET plan goals.

**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.

- Timely reporting from DMH regarding penetration and retention rates based on ethnicity. We currently rely on CAEQRO reports, which are received yearly. We would like these reports quarterly.
- More access to specific training on developing cultural competence for staff development.
CRITERION 4
COUNTY MENTAL HEALTH SYSTEM
CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE
COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).
   - The Cultural Responsiveness Committee was formally started in August, 2008. It meets monthly. It is comprised of 16 members from various programs and sections of the Mental Health Division. It includes clerical support staff, line staff, managers, and senior management.
   - It is a subcommittee of our Quality Improvement Steering Committee (see org chart in "C").
   - It addresses the cultural competence gaps in the system, and provides suggestions and strategies for addressing them.
   - Develops the training program related to cultural responsiveness.
   - Educates each other and the rest of the staff regarding cultural issues.
   - Reviews policies related to cultural responsiveness, and makes policy recommendations to QIS and QIP.

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;
   - It includes clerical support staff, line staff, managers, and senior management of county-operated programs.
   - Of the 15 members, 7 are Caucasian and 7 are Latino, and one is Afghani.
   - We are in process of evaluating when and how to add community members, contractors, etc.

C. Organizational chart; and
   - The CRC is a subcommittee of the QI Steering Committee (QIS). QIS gives and receives input from the larger Quality Improvement Committee (QIC). In turn, QIS gives and receives input from both the larger QIC and the Quality Improvement Policy Committee (QIP) (see attached QI Program committee below)
The above chart shows where the Cultural Responsiveness Committee resides within the Quality Improvement program.

The following chart shows how QIC and QIS receive and send information and recommendations to QI Policy, in which all Senior Management is present:
Finally, the last graph shows the larger community-involved QI Committee structure:

**QUALITY IMPROVEMENT COMMITTEE AREAS OF RESPONSIBILITY**

- **Q.I. COMMITTEE**
  - Gary Bravo, MD, Chair
  - 21 members

- **Consumer Involvement**
  - Kevin Murphy

- **Family Involvement**
  - Erika Klohe

- **Promote Evidence Based Practices**

- **Client and Program Outcomes**
  - TBD

- **Annual Q.I. Workplan**

- **Performance Improvement Projects**
  - Review Data/Plan Activities

---

D. Committee membership roster listing member affiliation if any.

- Current CRC membership consists of:
  - Susan Castillo, MHSA coordinator
  - Amy Colville, MFT, Intensive Recovery Team (IRT)
  - Rita Cordoba, MFT, Children
  - Ashgar Ehsan, SCSS, FACT
  - Teresa Godino, MFT, Adult Recovery Team (ART)
  - Mario Guerrero, MFT, Program Manager, CIP (Chairperson)
  - Hank Hallowell, PRA
  - Lyle Keller, LCSW, Program Manager, YFS
  - Carlos Hernandez, SCSS, IRT
  - Amy Howard, LCSW, Program Manager, ART
  - Denise Hunt, RN, Senior Manager
  - Martin Marcus, LCSW, QI
  - Raul Matamoros, SCSS, CIP
  - Steven Parsons, LCSW, Program Manager
  - Isabel Palacios, Clerical, Adult Services
II. The Cultural Competence Committee, or other group with responsibility for cultural competence, is integrated within the County Mental Health System.

The county shall include the following in the CCPR:

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

1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;
   - The CRC was instrumental in the development of this Cultural Competence Plan by providing information, guidance, and the actual writing of this plan.

2. Provides reports to Quality Assurance/Quality Improvement Program in the county;
   - As described earlier, the CRC is a subcommittee of QIC, and several members are also part of QIC and other sub-committees of the QI Program.

3. Participates in overall planning and implementation of services at the county;
   - CRC includes 4 managers and 1 senior manager, who are directly responsible for implementing services for county mental health services.
     - One example: CRC analyzed the number of bi-lingual staff by program. It made recommendations to senior management to review how staff are allocated, given budget considerations. As a result, some bi-lingual staff were re-assigned to provide Spanish-speaking resources to different programs.

4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;
   - As described earlier, Mario Guerrero, the Chair of the CRC has direct access to the Mental Health Director. Susan Castillo, as the MHSA lead, has direct access as well.

5. Participates in and reviews county MHSA planning process;
   - Susan Castillo, ASWI, who is a member of the CRC, is the MHSA Lead. She is also a Quality Improvement Coordinator (by job classification), and is involved in many Quality Improvement activities – especially regarding development and implementation of Cultural Competence requirements for the MHSA planning process.

6. Participates in and reviews county MHSA stakeholder process;
   - Susan Castillo developed the planning process to ensure that there was fair representation for all stakeholders, including the issue of representation of different ethnicities and sexual orientation.

7. Participates in and reviews county MHSA plans for all MHSA components;
   - As stated, Susan Castillo coordinates the MHSA plans.

8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
   - As stated, Susan Castillo participated in development of these programs.
   - In addition, she and the Mental Health Director meet monthly with the heads of the three Consumer-run self-help centers funded under MHSA;
     - The Wellness Center – in Santa Rosa
     - Interlink Self-help Center – in Santa Rosa
California Department of Mental Health Cultural Competence Plan Requirements

- The Empowerment Center – in Guerneville

   - Susan Castillo, Mario Guerrero and Marty Marcus wrote this plan. All are members of the Cultural Responsiveness Committee.

B. Provide evidence that the Cultural Competence Committee participates in the above review process.
   - As stated, the staff above are members of the CRC. Information is provided to, and recommendations come from other committee members.

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.
      - If no, what are the next steps?
   2. Reviews and recommendations to county programs and services;
   3. Goals of cultural competence plans;
   4. Human resources report;
   5. County organizational assessment;
   6. Training plans; and
   7. Other county activities, as necessary.

- See below matrix of completed tasks for fy08 -09 and fy09-10. These show the level of discussion and involvement of the CRC in policy recommendation.

### LIST OF COMPLETED TASKS 08-09

<table>
<thead>
<tr>
<th>Task</th>
<th>Comments</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>CCC name</td>
<td>The name of the Cultural Competence Committee was changed to Cultural Responsiveness Committee</td>
<td>3/5/2010</td>
</tr>
<tr>
<td>Insuring that training and lectures address cultural issues</td>
<td>An objective was added to all training goals, A letter was drafted to all presenters and a request to address cultural issues was added</td>
<td>3/5/2010</td>
</tr>
<tr>
<td>In general</td>
<td>We have an open dialogue about issues to do with CCC, strong support from SMT</td>
<td></td>
</tr>
</tbody>
</table>
| CCC | Established the CCC, as part of QIS, July 2008  
Original Members: Marty, Amy, Hank, Susa, Denise, Wendy and Mario. Membership has expanded to include most bilingual bicultural staff: Teresa Godino, Ernie Hernandez, Rosalba Flores, Isabel Palacios, Michael Kozart, and Rita Cordoba.  
Composition of committee was expanded, 6/12/09 | |
| Interpreting: | Training  
Contract Interpreters salary was raised from $13.00 to $17.00  
We’re doing a needs assessment re: interpreting services  
As of Jan. 2010, we have provided 3 training sessions to our bilingual/bicultural clerical staff who interpret. These have continued. Gary to come to the May 2010 training | |
| Translating forms: | We have been translating forms and insuring that they are being used:  
- Med consent – 2/20/09 completed  
PES consent for Tx – 3/10/09 completed  
Request for change of provider  
Right now working on Adult Treatment Plan  
Mental Health Brochure | |
11/21/08, The Cultural Competence Committee reviewed five charts. There were notes in the charts indicating when interpreters were used. If a family member is used as the interpreter, the reason for using a family member must be documented.

Marty to make sure when SCMH programs have compliance reviews that at least one monolingual client’s chart is reviewed.

- Simplified Language People Phone Instructions, 11/19/08
- Use of Interpreters, 12/09/08
- Linking Non-English Speaking Beneficiaries to Services, 12/10/08

Organizational assessment by managers – Contra Costa – done on June 5. Awaiting results.
Indirect assessment – California Brief Multicultural Scale (CBMCS) – Preparing to do this second phase

May 2010 made 4 test calls re: usage of language line

- How are cultural competent services provided by our contract agencies – Denise is f/u

- Diversification of our work force to be more reflective of SC population - strategies
- Designate positions as bilingual
- Having a bilingual staff at all points of entry, PES
- Our environment reflection of the cultures we serve
- Assessing the level of cultural competence in our work force and improving it
- Working on a project to improve our bilingual capacity at PES
- Improving our penetration rates with Latinos – HVs, attendance at Fairs and Conferences
- Funding for training/conferences

**LIST OF COMPLETED TASKS fy09-10**

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</tr>
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</tr>
<tr>
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</tr>
<tr>
<td>• Mental Health Brochure</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Formalized Audits for CC, language issues</strong></th>
</tr>
</thead>
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<tr>
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<th><strong>Updated policies</strong></th>
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<tbody>
<tr>
<td>• Simplified Language People Phone Instructions, 11/19/08</td>
</tr>
<tr>
<td>• Use of Interpreters, revised 6/12/10</td>
</tr>
<tr>
<td>• Linking Non-English Speaking Beneficiaries to Services, revised 6/12/10</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Cultural CC assessment</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizational assessment by managers – Contra Costa – done 2009.</td>
</tr>
<tr>
<td>• Individual assessment – California Brief Multicultural Scale (CBMCS)</td>
</tr>
<tr>
<td>• Clerical/admin support staff assessment done, June 2009</td>
</tr>
<tr>
<td>• Cultural Competence Self-Awareness Training completed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Test calls</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2010 made 4 test calls re: usage of language line</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Other questions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• How are cultural competent services provided by our contract agencies – Denise is f/u</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th><strong>Long term</strong></th>
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<tbody>
<tr>
<td>• Diversification of our work force to be more reflective of SC population - strategies</td>
</tr>
<tr>
<td>• Designate positions as bilingual</td>
</tr>
<tr>
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<tr>
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</tr>
<tr>
<td>• Funding for training/conferences</td>
</tr>
</tbody>
</table>

**Sources of Information:**
Organizational bylaws, meeting minutes, interviews of committee members, and annual reports of Quality Assurance/Quality Improvement Department
Rationale: Staff education and training are crucial to ensuring culturally and linguistically appropriate services. All staff will interact with clients representing different countries or origins, acculturation levels, and social and economic standing. Staff refers not only to personnel employed by the organization but also its subcontracted and affiliated personnel (CLAS, Final Report).

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

The county shall include the following in the CCPR:

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

   1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.
      • Approximately 110 staff are required to have cultural competency training.

   2. Steps the county will take to provide required cultural competence training to 100% of their staff over a three-year period.
      • The Training Committee makes recommendations to the Senior Management through the Quality Improvement Policy committee.
      • There are 12 Staff Development trainings per year (same one given two times each month). QIP makes decisions regarding which ones are mandatory for all staff, or exempts certain employee classes (e.g. clerical) or programs. Specific cultural competence trainings are required of all staff.
         o A database of staff attendance at all trainings is kept
         o Information regarding who did not attend is sent to the program managers
         o All trainings are videotaped and are available on the county intranet for staff to view, for those who could not attend in person.

   3. How cultural competence has been embedded into all trainings.
      • All trainings are required to have at least one specific cultural competence goal. Staff report on their perceptions of how well the presenter(s) achieved that goal on each evaluation.
II. Annual cultural competence trainings

The county shall include the following in the CCPR:

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:*

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How long and often</th>
<th>Attendance by Function</th>
<th>No. of Attendees and Total</th>
<th>Date of Training</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community MH Lecture Series</td>
<td>Client panel discussion of issues related to cultural competence for providers</td>
<td>1.5 hours</td>
<td>*Direct Services</td>
<td>3</td>
<td>7/23/09</td>
<td>Spectrum, Krisitin Brew, MFTI</td>
</tr>
<tr>
<td>Lesbian, Gay, Bi-sexual, Transgender clients</td>
<td></td>
<td></td>
<td>*Admin</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Support staff</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Interpreters</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Community members</td>
<td>35</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Total: 49</td>
<td></td>
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</tr>
<tr>
<td>Training Event</td>
<td>Description of Training</td>
<td>How long and often</td>
<td>Attendance by Function</td>
<td>No. of Attendees and Total</td>
<td>Date of Training</td>
<td>Name of Presenter</td>
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</tr>
<tr>
<td>Community MH Lecture, Iraq and Afghanistan War Veterans</td>
<td>Description of symptoms and issues for those returning from these wars</td>
<td>1.5 hours</td>
<td>*Direct Services</td>
<td>19</td>
<td>3/25/10</td>
<td>Dr. Emily Karem, MD, and one Iraq Vet</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Admin</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Support staff</td>
<td>0</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>*Interpreters</td>
<td>20</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Community members</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Total: 41</td>
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<table>
<thead>
<tr>
<th>Training Event</th>
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<th>How long and often</th>
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<th>No. of Attendees and Total</th>
<th>Date of Training</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Dev. Cultural Self-Awareness</td>
<td>Interactive discussion and self-disclosure regarding different cultural, ethnic and social issues</td>
<td>1.5 hours</td>
<td>*Direct Services</td>
<td>55</td>
<td>4/15/10 and 4/20/10</td>
<td>Susan Castillo, ASW, Mario Guerrero, MFT, et al.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Admin</td>
<td>6</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>*Support staff</td>
<td>11</td>
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<td></td>
<td></td>
<td>*Interpreters</td>
<td>0</td>
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<td>Total: 72</td>
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<tr>
<th>Training Event</th>
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<th>No. of Attendees and Total</th>
<th>Date of Training</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter Trainings</td>
<td>Training, discussion related to providing interpretation for staff</td>
<td>1 hour each time</td>
<td>*Support staff used as interpreters</td>
<td>7</td>
<td>11/18/09</td>
<td>Mario Guerrero, Amy Howard (both were formally trained in 2008)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medical Dir.</td>
<td>6</td>
<td></td>
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<td></td>
<td></td>
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<td>4</td>
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<td>1</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Total: 8 unique stafff</td>
<td></td>
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</tr>
</tbody>
</table>
III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

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

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

   Sonoma County has provided trainings for its staff and community members for more than 15 years. There is a training committee that gets input from staff and community members regarding what issues they want to know about. In addition, QI Policy makes decisions regarding which are priorities and which staff need to attend each training.
   - Family and consumer culture have been long-standing priorities for Sonoma County, as well as required by DMH.
   - Gay/Lesbian issues were requested by staff, as Sonoma County has a large gay/lesbian population.
   - Cultural Self-Awareness came out of our Cultural Responsiveness Committee, which looked at previously-given cultural self-awareness test results from the California Brief Multi-Cultural Competency Scale (CBMCS).
     - As a result of this test, the CRC decided to start off with a general cultural self-awareness training that was interactional in nature.

2. Results of pre/post tests (Counties are encouraged to have a pre/post test for all trainings);
   - All trainings have evaluations. The Cultural Self-Awareness training had a pre and post test self-evaluation as well. 18% of staff who took this training felt that they were more aware of their own cultural issues than prior to taking the training.

3. Summary report of evaluations; and
   - As stated above, all trainings are evaluated based on attendee’s perception of how well the training met its stated objectives. As an example, the summary of the Cultural Self-Awareness training is:

<table>
<thead>
<tr>
<th>Training Met Listed Objectives:</th>
<th>Outstanding</th>
<th>Good</th>
<th>Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Be able to identify belief systems regarding different dimensions of culture</td>
<td>27-36%</td>
<td>40-53%</td>
<td>9-12%</td>
</tr>
<tr>
<td>2. Be able to identify how their belief systems impact their work</td>
<td>28-37%</td>
<td>41-54%</td>
<td>7-9%</td>
</tr>
<tr>
<td>3. Be able to identify how their belief systems may challenge them in their work</td>
<td>25-33%</td>
<td>43-57%</td>
<td>7-9%</td>
</tr>
<tr>
<td>General Overall Rating</td>
<td>27-38%</td>
<td>40-56%</td>
<td>4-6%</td>
</tr>
</tbody>
</table>
4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
   • The training committee and, in this case, the CRC review the data from this training, and are looking at other methods of increasing awareness. Furthermore, we have been providing trainings on different ethnic groups (e.g. Native Americans), and are looking at doing the same thing.
   • Finally, we have reviewed the data from the CBMCS, to determine which areas provide the greatest opportunities for change. Future trainings will be geared to those findings.

5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.
   • We will be re-assessing staff on an annual basis using the CBMCS to determine their perceptions of their changes in cultural competence.
   • Regarding interpreters, we are just developing a rating scale for clinicians to use to rate the interpreters. Feedback based on this will be given to the interpreter.

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

The county shall include the following in the CCPR:

A. Evidence of an annual training on Client Culture that includes a client’s personal experience inclusive of racial, ethnic, cultural, and linguistic communities. Topics for Client Culture training may include the following:
   • Culture-specific expressions of distress (e.g., nervios);
   • Explanatory models and treatment pathways (e.g., indigenous healers);
   • Relationship between client and mental health provider from a cultural perspective;
   • Trauma;
   • Economic impact;
   • Housing;
   • Diagnosis/labeling;
   • Medication;
   • Hospitalization;
   • Societal/familial/personal;
   • Discrimination/stigma;
   • Effects 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.

County Mental Health has had a robust training program for many years. It has included trainings on different ethnicities and cultures (including client culture), and family issues on a regular basis. Below is the training on client and family issues for this year:
### California Department of Mental Health Cultural Competence Plan Requirements

#### 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.

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:

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How long and often</th>
<th>Attendance by Function</th>
<th>No. of Attendees and Total</th>
<th>Date of Training</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Development (2x/month)</td>
<td>Client panel discussion of recovery issues from their perspective</td>
<td>1.5 hours</td>
<td>*Direct Services</td>
<td>54</td>
<td>8/18/09, and 8/20/09</td>
<td>Panel of 6 consumers</td>
</tr>
<tr>
<td>Client Perspective on Mental Health Recovery</td>
<td></td>
<td></td>
<td>*Admin</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Support staff</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Interpreters</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Total: 68</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Training Event:
- Panel discussion of navigating the “system” for families from their perspective

**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.

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:

<table>
<thead>
<tr>
<th>Training Event</th>
<th>Description of Training</th>
<th>How long and often</th>
<th>Attendance by Function</th>
<th>No. of Attendees and Total</th>
<th>Date of Training</th>
<th>Name of Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Dev. Support and Resources for Families of MH Consumers</td>
<td>Panel discussion of navigating the “system” for families from their perspective</td>
<td>1.5 hours</td>
<td>*Direct Services</td>
<td>42</td>
<td>9/15/09, and 9/17/09</td>
<td>NAMI, family members of youth</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Admin</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Support staff</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Interpreters</td>
<td>0</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Total: 48</strong></td>
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</tbody>
</table>
CRITERION 6
COUNTY MENTAL HEALTH SYSTEM
COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE:
HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

The county shall include the following in the CCPR:

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

- Below is an extract of the WET plan, with regard to workforce development needs:

**EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT**

I. By Occupational Category - page 5

<table>
<thead>
<tr>
<th>Major Group and Positions</th>
<th>Estimated # FTE authorized</th>
<th>Position hard to fill?</th>
<th># FTE estimated to meet need in addition to # FTE authorized</th>
<th>Race/ethnicity of FTEs currently in the workforce Col. (11)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>White / Caucasians</td>
</tr>
<tr>
<td>County (employees, independent contractors, volunteers) (A+B+C+D+E).................</td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E).................</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL WORKFORCE (County &amp; All Other) (A+B+C+D+E)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT**

REMARKS: Summary of workforce needs assessment including a brief listing of any significant shortfalls or disparities such as, racial/ethnic groups, special populations, and unserved or underserved communities.

A. Shortages by occupational category:

- There is a shortage of bilingual/bicultural staff in all occupational categories and at all levels.
- There is a specific need to increase the number of unlicensed direct service staff. Some
survey respondents indicated that there are existing teams that are “licensed-heavy,” and that unlicensed staff could carry out many of those tasks, making effective use of resources.

* Positions that were specifically identified as needed by County staff were: For Unlicensed Direct Service Staff, “Client Support Assistant” and “Benefits Counselor”; and for Licensed Direct Service Staff, “Psychiatric Nurse” and “Mental Health Practitioner (advertise position as this, not Psychologist).”

* Positions that were specifically identified as needed by Contractor Agencies were: for Other Health Care Staff, “Other Therapist (physical, arts, and dance); for Managerial and Supervisory, “Agency Mental Health Director.”

* 42 percent of the total current County workforce plans to retire in the next 10 years. Specifically, 44 percent of County direct service staff plan to retire in the next 10 years, posing important shortage challenges.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services:

* There is a shortage of bilingual/bicultural staff compared to Sonoma County’s client population.

* Shortage: 10.6 percent of the total mental health workforce in Sonoma County is Latino(a)/Hispanic. It is estimated that 22 percent of all Sonoma County residents are Latino(a)/Hispanic (American Community Survey, 2005-2007) and the proportion of Sonoma County Medi-Cal recipients who are Latino(a)/Hispanic is 41.76%. More importantly, the percentage of Latinos(as)/Hispanics currently receiving mental health services in Sonoma County is 15.4%, so it is estimated that the proportion planned to be served will be closer to 23% (based on Medi-Cal beneficiaries use of Mental health services at 54.9%).

* Stakeholders identified that “positions become harder to fill when recruiting for minority staff,” as a survey respondent stated. Another stakeholder added, “We make efforts to recruit from the Hispanic/Latino community. Salaries are often not competitive with government and private sector jobs for those eligible to fill these positions.”

C. Positions designated for individuals with consumer and/or family member experience:

* Stakeholders identified the need to increase the number of positions designated for consumers/family members.

* Focus group participants made recommendations about ways to create pathways for consumers to join the mental health workforce. These include:
  - Increase the number of positions designated for consumers and family members, in all categories, and specifically in direct services;
  - Create part-time positions for consumers and family members, combined with educational/training opportunities;
  - Provide both short-term training and long-term educational opportunities for consumers; and
  - Conduct trainings for supervisors around working with consumer employees.

D. Language proficiency:

* Shortage: It is estimated that 23 percent of all Sonoma County residents over the age of five speak a primary language other than English at home (American Community Survey, 2005-2007). Spanish is a major second language in Sonoma County, given current demographic trends. Therefore, many identified the pressing need to hire staff who are bilingual in Spanish.

* 14 percent of direct service County staff are proficient in Spanish. By comparison, 70 percent of Contract Agencies reported that they have at least one Direct Service Staff proficient in Spanish. Nonetheless, both County and Contract Agencies identify the need to increase linguistic competency by hiring Spanish/English bilingual staff.

* Some stakeholders identified the need to hire bilingual staff who speak other languages as well, including Vietnamese and American Sign Language.

B. Compare the WET Plan assessment data with the general population, Medi-cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate
disparities.
- The WET Plan assessment is in agreement with known shortages of Spanish-speaking, bi-cultural providers.
- In addition, the plan calls for increasing the number of mental health consumers in the public mental health system.

C. If applicable, the county shall report in the CCPR, the specific actions taken in response to the cultural consultant technical assistance recommendations as reported to the county during the review of their WET Plan submission to the State.
- Not applicable.

D. Provide a summary of targets reached to grow a multicultural workforce in rolling out county WET planning and implementation efforts.
- There are no targets reached yet, as the WET plan was not funded until the end of June, 2010.

E. Share lessons learned on efforts in rolling out county WET planning and implementation efforts.
- Not applicable – WET is just now starting to be implemented.

F. Identify county technical assistance needs.
-
CRITERION 7
COUNTY MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

Rationale: The diversity of an organization’s staff is necessary, but not a sufficient condition for providing culturally and linguistically appropriate health care services. Although hiring diverse and bilingual individuals from different cultures does not in itself ensure that the staff is culturally competent and sensitive, this practice is a critical component to the delivery of relevant and effective services for all clients. Staff diversity at all levels of an organization can play an important role in considering the needs of clients from various cultural and linguistic backgrounds in the decisions and structures of the organization. (CLAS, Final Report).

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

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

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

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

   - The following workforce language needs assessment is from the WET Plan, which includes contractors as well as county staff:

<table>
<thead>
<tr>
<th>Language, other than English</th>
<th>Number who are proficient</th>
<th>Additional number who need to be proficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Spanish</td>
<td>Direct Service Staff 42</td>
<td>Direct Service Staff 25</td>
</tr>
<tr>
<td></td>
<td>Others 14</td>
<td>Others 4</td>
</tr>
<tr>
<td>2. Vietnamese</td>
<td>Direct Service Staff 0</td>
<td>Direct Service Staff 2</td>
</tr>
<tr>
<td></td>
<td>Others 0</td>
<td>Others 0</td>
</tr>
<tr>
<td>3. Cantonese</td>
<td>Direct Service Staff 1</td>
<td>Direct Service Staff 0</td>
</tr>
<tr>
<td></td>
<td>Others 0</td>
<td>Others 0</td>
</tr>
<tr>
<td>4. Tagalog</td>
<td>Direct Service Staff 4</td>
<td>Direct Service Staff 0</td>
</tr>
<tr>
<td></td>
<td>Others 0</td>
<td>Others 0</td>
</tr>
<tr>
<td>5. Russian</td>
<td>Direct Service Staff 2</td>
<td>Direct Service Staff 0</td>
</tr>
<tr>
<td></td>
<td>Others 0</td>
<td>Others 0</td>
</tr>
<tr>
<td>5. American Sign Language</td>
<td>Direct Service Staff 1</td>
<td>Direct Service Staff 1</td>
</tr>
<tr>
<td></td>
<td>Others 0</td>
<td>Others 0</td>
</tr>
</tbody>
</table>

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.

   - Through concerted efforts to hire bi-lingual staff from MHSA, we have increased our bi-lingual staffing from 14.6 FTE in April, 2009, to 18.15 as of June 30, 2010.
   - This is represents a 19.56% increase in bi-lingual FTE. (one FTE left on 7/1/10)
3. Total annual dedicated resources for interpreter services.
   • Interpretation service contracts are in place as noted:
     o Contract with Language People to provide interpretation, translation and phone-interpretation.
     o Contract with Communiqué to provide interpretation for hearing-impaired
     o Individual contracts with one Khmer (Cambodian)-speaking and one Spanish-speaking interpreter

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

The county shall include the following in the CCPR:

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

   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.

   • We have a 24 hr phone line. We do use the Ca Relay and TDD in PES. We are expanding the TDD phones to all programs.
   • We do use the language lines, but try not to.

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

   • The county is looking into using Voice Over Internet Protocols to “talk” with clients who are hard of hearing using existing computers. This promises to be cheaper and easier than TDD machines.

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

   • Protocol is to use a bi-lingual staff whenever possible to take the call. If the bi-lingual staff is clerical, then the clinician must be part of the conversation.
   • If there is no staff who can speak the language (which is often the case at night in Psychiatric Emergency Services), then the language line is used.

   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 protocol is written, with examples. It has been disseminated to staff, along with the policy regarding use of interpreters.

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

   • All materials that are provided to Spanish-speaking clients are provided in their primary language. Spanish is the only other threshold language in Sonoma County.
C. Evidence that the county/agency accommodate persons who have LEP by using bilingual staff or interpreter services.

- Bi-lingual staff are available in all programs. In addition, we have contracts with interpreter organizations to provide for languages that we do not have the capability to provide. Evidence of bills and chart notes were shown to the DMH Compliance Review team when they last visited Sonoma County.

  1. Share lessons learned around providing accommodation to persons who have LEP and have needed interpreter services or who use bilingual staff.
   - Although we have increased our bi-lingual staffing from 14.6 FTE to 18.15 FTE (a 19.56% increase) in the past eighteen months, we know we do not have enough bi-lingual capability on all teams at all times.
   - We have learned that it is important to schedule interpreters in advance of any sessions, to make certain that they are available.

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

- The language line service is not always the most reliable. Sometimes we get an interpreter immediately, and sometimes it is an issue.
- Staff also need to be refreshed on the use of the language line protocol verbally, even though it is disseminated in writing.
- Mental Health has been challenged to have enough bi-lingual staff for all programs, especially at night at PES.

E. Identify county technical assistance needs.
- None in this area.

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.

- All programs and all organizational provider sites have all the appropriate posters and materials in Spanish. The Quality Improvement Coordinator checks for these as part of each site review, and each utilization review.
- Furthermore, staff and contractors have been informed of the availability of this information on the county website: www.sonoma-county.org/mh/

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

- Protocol is to document in the Telephone Access database evidence that the client either receives services in their preferred language, or that it was offered.
- Protocol in chart notes is to document if an interpreter was used, including whom it
Charts have been checked for this particular issue this past fiscal year. They are checked for this as part of regular utilization reviews as well.

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

- The provider network list shows which providers have which linguistic capabilities.

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

- In order to receive bi-lingual pay in Sonoma County, staff have to pass a county-provided test. There are two levels of proficiency – basic and fluent. Fluent means that one can write in that language as well.
- Clerical staff who are used as interpreters have had several trainings by the Cultural Responsiveness manager and others regarding how to be an interpreter. These trainings have also included translation of some psychiatric terms. Trainings for staff were provided on 11/18/09, 1/27/105/26/10, and 8/25/10. A total of 7 bi-lingual clerical staff received training, and the Medical Director came to one training.

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

The county shall include the following in the CCPR:

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

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.

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

- For A, B, C above, see Policy IV.E.3:
<table>
<thead>
<tr>
<th>APPROVED BY:</th>
<th>REFERENCE/AUTHORITY:</th>
</tr>
</thead>
</table>
| Mental Health Services Director | 1. CCR, Title 9, Chapter 11, Section 1810.410  
2. DMH Information Notice No. 02-03  
3. Title VI, Civil Rights Act of 1964, (42 U.S.C., Section 2000d, 45 C.F.R., part 80) |

**POLICY:**

**I.** The Mental Health Division will make ongoing efforts to inform the public about mental health services offered by the Division and have procedures in place to link non-English speaking beneficiaries to culturally/linguistically competent specialty mental health services.

Beneficiaries will have access to culturally competent/linguistically competent staff or interpreters as appropriate.

A statewide toll-free telephone number will be available 24 hours a day, 7 days a week, with language capability in all languages spoken by beneficiaries of the Mental Health Plan.

Bilingual staff or interpreter services will be available in person or by other means in threshold languages at key points of contact. Language capacity in threshold languages (Spanish) is available during regular operating hours in the Division.

Beneficiaries who do not meet threshold language criteria will be linked to appropriate services. Non-English speaking beneficiaries will be offered interpreter services if no one is available who speaks their primary language.

Key points of contact, such as the Access Team and Psychiatric Emergency Services, will have posted a notice in English and Spanish that limited English proficient (LEP) individuals have a right to free language assistance services.

**II.** It is the policy of the Mental Health Division to use a staff member who speaks the primary language of the person seeking treatment whenever possible. It is expected that programs will assist each other in this regard to provide essential language services whenever possible.

When there is no clinical staff member who can speak the client’s preferred language, it is the policy of the Mental Health Division to use county-certified staff as interpreters to assist clients and staff in providing mental health services for those clients who do not speak English, or have limited English-speaking capability.

Furthermore, it is the policy to not use family members to provide translation for the client, or for the client to translate for the family, unless the client prefers it. Clinical consideration must be given to the appropriateness of the request by the family.

*Family members should never be used when evaluating someone to*
discontinue a 5150 detention, or for evaluation of any high risk situation, including evaluation of suicidal or homicidal ideation.

DEFINITIONS:

1. Key points of contact:
   Common points of access to specialty mental health services from the MHP, including the MHP’s 24-hour toll-free line, beneficiary problem resolution process, county owned or operated or contract hospitals, or any other central access or contact locations established by the MHP.

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

3. Threshold Language:
   A language that has been identified as the primary language, as indicated on the Medi-Cal eligibility Data System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

PURPOSE:

The purpose of this policy is to provide access to appropriate treatment for those clients who cannot speak English sufficiently to meet their mental health needs. Furthermore, this policy is designed to provide staff with appropriate direction on how to access various levels of interpreter services.

PROCEDURE:

I. Telephone Calls
   A. When it has been determined that a caller needs an interpreter, the staff receiving the call should make all efforts to find either a staff member in their program with the necessary language skills, or use the Language People telephone services to speak to the caller (see instructions).

   B. For clients who are hearing-impaired, California Relay services may be used.

II. Face-to-Face interviews
   A. When setting up a face-to-face meeting with a client, it is incumbent upon the staff to ascertain the need for an interpreter, and arrange for one prior to the meeting. This includes clients who are deaf and need sign-language interpretation.

   B. If the staff involved with the client does not speak the preferred language, then the staff member should consult with their program manager regarding the use of another team member who does speak the language to either
provide the service, or to provide translation.

C. Attempts should be made to use clinical staff for clinical services, and clerical staff for administrative activities. This is especially important when providing an initial assessment.

D. If there is no other staff available within that team, then it is permissible to seek help from Division staff from outside of that team.
   1. Staff should inform their Program Manager of their need. The Program Manager may contact another Program Manager within the same section to request the use of that Manager's bi-lingual staff.
   2. The Program Manager making the request should make a determination as to the level of service needed, and should be as specific as possible regarding:
      a) The acuity of the situation (e.g. emergency vs. urgent vs. regular appointment)
      b) The type of service necessary (e.g. clinical or administrative)
      c) The nature of the relationship requested (e.g. one time only vs. ongoing client)
   3. If no bi-lingual staff is available in that Section, then the same request may be made outside of the Section. Care should be taken to not overuse any particular team.

D. If no bi-lingual staff is available, then a contracted interpreter may be called to assist in providing the service. (see attached list of contracted interpreters.)
   • If using a contract interpreter, it is advisable to give them as much notice of the meeting as possible.

E. Guidelines for Use of Interpreters During a Face-to-Face Interview
   • Staff should instruct interpreter as to the nature of the meeting prior to the interview.
   • Staff should instruct where the interpreter should sit (slightly behind and to the side of the client)
   • The interpreter should interpret everything spoken by either party.
   • The interpreter should always ask for clarification from the clinician and the client if something is not clear.
   • The interpreter should clarify if he/she is acting as a cultural broker or advocate
   • The interpreter should ask help from her/his her manager or a clinician if he/she experiences intense emotions or other concerns.

F. A family member should not be allowed to translate for the client, nor
should the client be allowed to translate for or to the family.

- Except at the request of the client,
- and when clinically appropriate.
- **Family members should never be used when evaluating someone to discontinue a 5150 detention, or for evaluation of any high risk situation, including evaluation of suicidal or homicidal ideation.**
- The reasons for using a family member to translate must be documented in the progress note.

G. Documentation of the use of any language other than English must be in the progress note, whether an interpreter is used, or the staff member speaks the language of the client.

- If an interpreter is used, the note should include who provided the interpretation, and what language was spoken.
- If the staff member conducted the session in a different language, the note should reflect what language was spoken.

IV. Translation of Materials
A. **When written material (e.g. forms, brochures) need to be translated into Spanish, either by internal staff or by a translation company, at least two bi-lingual staff must proof-read it to ensure appropriateness of the translation.**

B. Translated material, as with all other written materials, must be approved by the appropriate committee(s) before being distributed.

**FORMS:** None

**ATTACHMENTS:**
1. Language People, Inc. services instructions
2. Communique form
3. List of County-certified Mental Health employees and contracted interpreters
4. Limited English Proficiency Notice

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

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

A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
   1. Member service handbook or brochure;
   2. General correspondence;
   3. Beneficiary problem, resolution, grievance, and fair hearing materials;
   4. Beneficiary satisfaction surveys;
   5. Informed Consent for Medication form;
   6. Confidentiality and Release of Information form;
   7. Service orientation for clients;
   8. Mental health education materials, and
B. Documented evidence in the clinical chart, that clinical findings/reports are communicated in the clients’ preferred language.

As noted previously, all charts indicate that clients were interviewed in their preferred language or that an interpreter was used.

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

- Until May, 2009, the county used the POQI surveys that were translated into Spanish.
- In May of 2009, POQI surveys indicated that 75% of clients who spoke Spanish said that they received information in their primary language.

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

- Translated documents must be proof-read by at least two bi-lingual staff for appropriateness of language.

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.

- Documents are reviewed for appropriate grade reading level.
### CRITERION 8
COUNTY MENTAL HEALTH SYSTEM
ADAPTATION OF SERVICES

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

<table>
<thead>
<tr>
<th>I. Client driven/operated recovery and wellness programs</th>
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</thead>
<tbody>
<tr>
<td>The county shall include the following in the CCPR:</td>
</tr>
<tr>
<td>A. List and describe the county's/agency's client-driven/operated recovery and wellness programs.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The county has three Client-operated recovery and wellness centers:</td>
</tr>
<tr>
<td>o Wellness Center – located in Santa Rosa. Provides programs tailored to individual needs. It was started with MHSA funding. Provides support to return to work, disability rights support, art groups with the goal of selling art, and other wellness programs.</td>
</tr>
<tr>
<td>o Interlink – located in Santa Rosa. Provides drop-in services and some programs tailored to meet the individuals' needs. Has “emotional recovery” support groups. It has been in operation for almost twelve years.</td>
</tr>
<tr>
<td>o Empowerment Center – located in Guerneville. As above. It was created out of the MHSA planning process, at request of consumers, to have client-operated services in other parts of the county, rather than just in central Santa Rosa.</td>
</tr>
<tr>
<td>2. Briefly describe, from the list in ‘A’ above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.</td>
</tr>
<tr>
<td>o None of the above are ethnically, culturally or linguistically specific. All are open to any person who self-defines as a mental health consumer.</td>
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<tr>
<th>II. Responsiveness of mental health services</th>
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<tr>
<td>The county shall include the following in the CCPR:</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>(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).</td>
</tr>
<tr>
<td>• As required by DMH, the MHP provides the Provider Directory to all new clients, which gives information regarding types of services, populations served, and/or</td>
</tr>
</tbody>
</table>
linguistic capabilities.

- As stated earlier, the county contracts with FQHCs and with the Sonoma County Indian Health Project, to provide services for consumers that are not traditional mental health services.
- CIP also works with, and refers clients to a variety of non-profit Latino organizations, including: La Luz, Nuestra Voz, and others.

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.
- The county’s “Guide to Medi-Cal Mental Health Services” provides all of the State-required information.

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.)

- CIP provides multitudes of outreach activities that include: presentations in community forums; staffing tables at health fairs; hosting and training the county’s Latino Health Providers forum; presentations to the local community college; ongoing intensive collaboration and consultation with local Federally Qualified Health Centers; and other community groups. In each of these meetings, CIP describes what services are available in the community, including services that are not provided by, or paid for, County Mental Health.

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;

- In February, 2008, the county restructured how its Access Team (formerly called the "Resource Team"), was relocated to join the main mental health campus on Chanate Road in Santa Rosa. The planning process included discussions regarding accessibility to clients. In addition to its familiarity to all county residents and all community partners by virtue of the main campus having been located here for more than 30 years, it is also on the main bus line.
- The larger county Department of Health Services has long-term plans to move the majority of its services (including Mental Health), to the southern part of Santa Rosa, in the heart of the Latino community. It is specifically being planned to make more services immediately available to the Latino community.
- The county has had local mental health centers in the southern, northern, eastern and western parts of the county for decades, to assure access to services for all county residents.
- The hours of operation are generally 8 AM – 5 PM, Monday through Friday. However, there are five Full Service Partnerships that provide services beyond
those hours, as needed, including weekends.
• As part of the MHSA planning process, it was decided to make outreach activities more accessible. As an example, CIP regularly visit homeless shelters at least once per week in the evenings. They provide staff for health fairs on some weekends as well.
• The MHSA planning process for consumer-operated services reviewed access for consumers, and determined that there should be consumer-run services in other parts of the county, for better access. As a result, an additional center was built in Santa Rosa, and a new one was added in Guerneville (Western Sonoma County).

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
• All county-owned facilities have disable access. Many have upgraded their waiting rooms to be client and culturally-friendly.

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.)
• As part of the MHSA planning process, in order to provide more service to the Latino population, it was decided to co-locate services as much as possible with the FQHCs. We provide some staffing for the FQHCs, and also contract with them to provide appropriate mental health services.
• In addition, we provide staff and funding for services at the Indian Health Project, which provides the majority of its services to the Native American population.

III. Quality Assurance

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

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.

• All trainings are to include objectives related to cultural competence, which are then analyzed.
• Up until last year, the county used the POQI survey information to identify issues of client satisfaction, including issues of access to services/information in the clients’ own language. Action plans were developed based on issues identified.
• The county is currently in process of developing a consumer-driven consumer satisfaction survey, using client focus groups to first determine survey questions that are important to consumers. The first survey should be finished, analyzed, and issues identified by April, 2011.
### California Department of Mental Health Cultural Competence Plan Requirements

#### 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

- The CBMCS survey was given to staff in 2010. Results were tabulated and formed the basis of the all-staff training on Cultural Self-Awareness in April, 2010.
- The Cultural Responsiveness Committee is working on the next training based on the results of the feedback from the last training.

#### A. 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 county Quality Improvement staff receive and handle all grievances. All formal grievances are accepted, regardless of the client’s payer source.
  - A report is generated annually to look at trends. There have been no trends regarding ethnicity, except that we get few grievances, and even fewer from Latino clients.
  - All grievance forms, including requests to change providers, are located at all sites, at all organizational provider sites, and are available on the County Mental Health website.
  - Organizational Providers are reminded yearly of the expectation to provide the forms and inform the clients.
  - County Mental Health clerical staff are reminded regularly of the need to provide the forms and inform the clients.
  - The forms are all available in English and Spanish.
- Complaints may be handled informally at the program level, but the vast majority are logged through the Patients Rights Advocate.
  - These are reviewed monthly and annually in various committees.
- All grievances and complaints are followed-up by the Quality Improvement Staff and/or the Patients Rights Advocate in a timely manner.

#### IV. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

**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.

- All Mental Health contracts include specific language regarding non-discrimination in employment.
- All Mental Health contracts include specific language regarding compliance with all Federal, State and County requirements for providing service – and this includes being able to provide linguistically-competent services.
- PEI contracts were awarded to specific cultural and ethnic groups to provide more services to their communities. These include contracts to Community Baptist Church (African-American), Positive Images (Gay/Lesbian/Bi-Sexual/Transgender), and NAMI.