

Santa Barbara County Department of Alcohol, Drug
and Mental Health Services

2010 Cultural Competence Plan



Santa Barbara County
Department of Alcohol, Drug and Mental Health Services
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COVER SHEET

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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Executive Summary

The Santa Barbara County Department of Alcohol, Drug and Mental Health Services (ADMHS) is committed to involving consumers, family members and individuals from diverse ethnic and cultural groups in developing, implementing and monitoring programs and services. Stakeholders are involved in forums for diverse communities include the Consumer and Family Member Advisory Committee, the Latino Advisory Committee, Consumer and Family Member Subcommittee of Quality Assurance, the Mental Health Commission, Peer Recovery Learning Centers and human resources panels.

An analysis of the population of Santa Barbara County identified the threshold language as Spanish. The department's commitment to providing culturally competent services is embedded through a wide range of policies and procedures, including telephone access, human resources training and recruitment, bilingual allowances, cultural competence training, interpretation, signage and other areas documented in the plan.

A key strategy to advance ADMHS' commitment to providing culturally competent services are a series of trainings that will focus on ethnically and culturally diverse communities, including: Oaxaqueno, Native American, LGBTQ, African American, Filipino, Latino and the military. Another major strategy for hiring and maintaining a diverse workforce is the requirement for at least 40% of ADMHS and contractor staff to be bilingual/bicultural (Spanish).

Through the Community Services and Supports (CSS), Workforce Education and Training (WET), and the Prevention and Early Intervention (PEI) components, the Mental Health Services Act (MHSA) supports a number of targeted initiatives for outreach, education, linkage and assistance to underserved ethnic and cultural populations. Under the new Cultural Competence Plan, this success will be maximized as the MHSA Division Chief assumes authority for department-wide cultural competence programs and activities.

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CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

I. Santa Barbara County Mental Health System commitment to cultural competence

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

The Alcohol, Drug, and Mental Health Services Department (ADMHS) is committed to involving consumers and family members (including individuals who reflect the diverse populations in Santa Barbara County) in developing, implementing, and monitoring of ADMHS programs and services. ADMHS ensures participation of consumers and family members who reflect cultural diversity on panels, committees, and in stakeholder groups, whose work impacts current and future programs and services.

Consumers and family members participate in hiring panels for ADMHS staff members who have a direct impact on clients. To increase the involvement and comfort level of consumers and family members participating in the hiring panels, the Human Resource Department provides an information session/briefing prior to the interviews.

Consumer and family members are represented on the Quality Assurance Committee, the Mental Health Commission, the Consumer and Family Member Advisory Committee (CFMAC). In fact, for CFMAC, eleven positions are designated for consumers and eleven for family members, with a commitment to include Spanish speaking communities. Seven of the members of the CFMAC are bilingual/bicultural. Transportation, stipends, and simultaneous interpretation are provided.

The Mental Health Commission currently has two members, including the Chair of the Commission, who are bilingual and bicultural. The Latino Advisory Committee (LAC) was established five years ago in an effort to ensure that all MHS programs fulfilled the requirement of serving the unserved and underserved communities. The LAC focuses on services for Latinos and Spanish speakers. Members of the LAC include ADMHS clinicians and non-clinician staff, members of the legal system, social services, and other community-minded organizations. Approximately fifteen members regularly attend the monthly meetings held in a central location. The meetings are usually conducted in Spanish to increase the participation of monolingual Spanish speaking consumers and family members.

The Latino Advisory Committee (LAC) is one example of ADMHS' dedication to serving the county's diverse community. ADMHS expanded its policy (initially for MHS programs only) requiring 40% of all CBO and ADMHS staff be bilingual/bicultural. Currently, thirty-six percent of MHS staff members are bilingual/bicultural. The compliance of this requirement is and will continue to be monitored on a quarterly basis. The results are included on the "scorecard", a quarterly report which details contractual

performance of the Community Based Organizations (Exhibit # 1).

Areas reviewed in the scorecard include:

- Financial Information – quarterly targets, fiscal performance, Medi-cal rate adjustments, etc
- Staffing and Caseload Compliance – staffing mix, caseloads, bi-lingual/bi-cultural requirements, productivity, training compliance, etc
- Program Evaluation – Medi-cal documentation compliance and disallowances, program outcome data, grievances and complaints
- Program Feedback – strengths, weaknesses, areas for improvement, challenges in narrative format from County staff and Contractor staff
- The scorecards are reviewed by the Executive Team. In addition, face-to-face meetings are held with Contractors, with at least one face-to-face meeting per year with each contractor

In addition to the current reporting requirements, ADMHS' guidelines will be enhanced to require that all County and CBO programs report:

- number of bilingual/bicultural staff, by position
- number and ethnicity of clients served
- client's preferred language
- language in which the service was provided
- when interpretation services were provided, and who provided them, such as another clinician, a non-clinician staff person, or the language line, etc.

All requests for Spanish interpretation at public meetings such as the Mental Health Commission, the Consumer Family Advisory Committee Meeting, and all stakeholder meetings will be accommodated with advance notice.

ADMHS is committed to providing culturally competent services. Trainings will focus on the disabled, elderly, Oaxaqueno, Native American, LGBTQ, African American, and military communities. Through the recently approved Prevention and Early Intervention Community Health Education Project (CHEP), new initiatives will be made to teach community members from diverse cultures about accessing social services, learning to advocate for systemic change and advocacy for consumers, family members, and underserved groups.

Mission Statement:

The Mission of Alcohol, Drug & Mental Health Services is to promote the prevention of and recovery from addiction and mental illness among individuals, families and communities by providing effective leadership and delivering state-of-the-art, culturally competent services.

Core Values:

Alcohol, Drug and Mental Health Services decisions and service delivery reflect the following core values:

- Quality services for persons of all ages with addiction and/or mental illness
- Integrity in individual and organizational actions
- Dignity, respect, and compassion for all persons
- Active involvement of clients and families in treatment, recovery, and policy development
- Diversity throughout the organization and cultural competency in service delivery
- A model of care that is clearly defined and promotes recovery
- Emphasis on prevention and treatment
- Integration among clinical/fiscal operations, Alcohol/Drug/Mental Health and Community Based Organizations
- Parity across regions of the county
- Teamwork among ADMHS employees in an atmosphere that is fun, creative, and optimistic
- Collaboration with Community Based Organizations, County partners, and other community agencies
- Continuous learning and improvement in service delivery and administration
- Wellness modeled for clients at all levels, i.e. staff who regularly arrive at the workplace healthy, energetic and resilient
- Safety for everyone through appropriate trainings, promotion of safety practices and well-maintained facilities

Service Philosophy

The Department is oriented toward supporting and promoting recovery for clients and problem solving for communities. It is the Department's role to help individuals identify what brings purpose, meaning, and quality into their lives, and to identify personal goals for living, learning, working, and social relationships.

ADMHS is invested in building upon the assets available within communities to support the well-being of individuals and families, including address environmental conditions that exacerbate individual, family, and neighborhood mental health, alcohol and other drug related problems. As clients of ADMHS recover, their identity as a service recipient becomes less central, and they become more engaged in community life in a positive role (i.e. volunteer, employee, neighbor, artist, author, student, parent, sibling, son/daughter, friend, advocate, member of a faith community, etc).

ADMHS' service system is strengthened by partnerships with community-based organizations, other county and state departments, network providers, and schools and colleges. Many of the clients are served by multiple agencies/departments and it is important that they be well-coordinated and accessible to clients and families.

ADMHS believes that teams are the best way to provide high quality services to persons and communities impacted by mental illness, and/or unsafe alcohol use. The team's primary purpose is to help individuals to reach their personal goals.

Strategic Plan

ADMHS Strategic Goals and Actions for Fiscal Year 10-11

Goal 1: Efficient and Responsive Government: An Efficient, Professionally Managed Government Able to Anticipate and to Effectively Respond to the Needs of the Community.

- Continue to strengthen internal controls and demonstrate ongoing progress in achieving fiscal and quality management goals
- Improve the effectiveness of overall operations through better integration of programmatic, fiscal, contractual and quality management activities
- Guarantee ongoing efforts to improve tracking of the outcome of services
- Develop standard client scheduling and billing procedures

Goal 2: Health and Safety: A Safe and Healthy Community in Which to Live, Work and Visit.

- Receive State Approval for MHSA Innovation programs and funds and implement use of MHSA Innovation resources to improve access to mental health services
- Emphasize staff development in the areas of cultural competence, consumer recovery and best practice approaches to individuals with co-occurring mental health and alcohol/drug conditions

Policies & Procedures

Policy: Upon first accessing services, upon request and annually thereafter, Santa Barbara County Mental Health Plan (MHP) provides beneficiaries with information regarding MHP specialty mental health services including, but not limited to:

- Types of services
- How to access services
- Availability of interpretive services
- List of providers
- Beneficiary rights
- Problem resolution processes
- Advance directives

This information is included in the beneficiary brochure and regional provider list which is made available in English and Spanish. The information is also made available in alternative formats, such as audio tapes, to accommodate individuals with visual impairments and individuals with limited reading proficiency.

The MHP monitors the distribution and availability of these materials through the use of tracking forms that log the date, name of provider/clinic, and materials distributed. Availability of materials in waiting room is also monitored for all ADMHS clinic sites and community based organizations and the provider network.

ADMHS policies and procedures are posted on the Alcohol, Drug, and Mental Health Services website at:

http://www.admhs.org/apps/admhs_main/Problem_Resolution/admhs_compliance_index.asp

1. Cultural Competency Training Policy:

All ADMHS and CBO staff is required to attend 2 cultural competency trainings per year. This information is monitored through the Human Resources data base and reviewed at annual Employee Performance Review's.

| Existing Trainings | | |
|---|--|---|
| Type | Current Process | Recommendations |
| Cultural Competence – Client Culture | Required annually for all staff | <ul style="list-style-type: none"> • Training Day dates are set for each ADMHS Clinic starting March 2010. Trainings include Documentation, Code of Conduct & Compliance Plan, Consumer & Family Culture |
| Code of Conduct & Compliance Plan Training | Required annually for all staff | <ul style="list-style-type: none"> • Training Day dates are set for each ADMHS Clinic starting March Trainings include Documentation, Code of Conduct & Compliance Plan, Consumer & Family Culture |
| HIPAA | Required within 30 days of hire; annual updates In-person on an as-needed basis | Initial: Electronic, coordinated by Quality Assurance Staff through Risk Management. Updates: Integrated with Training Days |
| FSP & LOCRI forms; CALOCUS | In-person on an as-needed basis | ADMHS staff facilitate training |
| 5150 Training | Required for all staff who write 5150's | Facilitated by Urgent Mental Health Care Clinic Manager |
| Other Trainings (need already identified) | | |
| Type | Details | Recommendations |
| Working with Interpreters | Required for direct svc staff who use interpreters | Under development in conjunction with the new CCP. |
| Interpreter Training | Required for all bilingual staff (both MH and ADP) | Under development in conjunction with the new CCP. |
| Cult. Competence Training #2 | Required for all staff annually | Under development in conjunction with the new CCP. |
| Mental Health Laws & Patient Rights | Required by Welfare & Institutions Code re: Patient Rights' Advocates | Work with Patient Rights' Advocates to develop and implement. |
| "Patient Rep" Training | Standardization of procedures | P&P's re: OOC, OHC, UMDAP, SOC, MEDS, and Red Flags to be developed. Train Patient Reps and Clinicians on relevant procedures when finalized. |

2. Network Provider Directory Policy:

Beneficiaries are entitled to a list of Providers that indicates cultural and linguistic services so that beneficiaries have the ability to choose a provider who is culturally sensitive to their needs. In addition, interpretive services, when needed, are provided at no cost.

Policy: The Santa Barbara County Mental Health Plan provides a listing of all individual and group Network Providers and organizational providers, identifying the type of provided services (including cultural and linguistic), at the point of first initiating services and upon request. Beneficiaries can select a provider of choice from the list and that choice will be honored within the appropriate level of care (s 22 & 23).

3. Telephone Access Policy:

Policy: It is the policy of the Mental Health Plan (MHP) to provide a statewide toll-free telephone number with multi-linguistic capabilities, including California Relay as indicated in the Medi-Cal brochure, for Medi-Cal beneficiaries seeking specialty mental health service or for others requesting resource information. Information may include how to access specialty mental health services for routine, urgent, or emergency conditions. In addition, information about the beneficiary problem resolution process can be accessed through this telephone line (Exhibit 37).

4. Policy on Non- English speaking beneficiaries:

The policy states that a beneficiary will be linked to the most appropriate services in their preferred language and individuals or families will not be expected to act as interpreters. Studies have demonstrated that interpretation by family members is ineffective and not culturally competent. (See

5. Policy: To ensure access to care and culturally competent service delivery for non-English speaking beneficiaries, Santa Barbara County Mental Health Plan staff offers a clinician or interpreter who speaks the beneficiary's preferred language whenever there is an indication that English is not the client's (or client's representative) language of choice. Interpreter services can be provided by a client's family member or support person only when this is the preference and choice of the beneficiary, and family member/support persons will not be expected to provide interpretive assistance. Interpreter services are provided at no cost to the beneficiary (Exhibit 9).

6. Policy: The Santa Barbara County Mental Health Plan will distribute beneficiary brochures and information to the community about accessing services. In addition, community agencies that serve individuals in all threshold languages, visual and hearing impaired, homeless populations, and any other agencies that serve hard to reach beneficiaries will be targeted for outreach (Exhibit 32).

7. Policy: To ensure access to care, the Santa Barbara County Mental Health Plan provides appropriate interpretive services and written materials to beneficiaries with special visual, hearing and linguistic needs, and links them to specialty mental health services. In addition, the 24-7 toll free telephone line is accessible to the hearing impaired to access routine and urgent specific mental health services through the California Relay Service (Exhibit 37).

8. Human resources training and recruitment policies

The ADMHS Human Resources Division supports the Department's commitment to delivering culturally competent mental health services. This is evidenced in the new hire training curriculum which includes a section specifically discussing issues regarding sensitivity to diversity. With regards to recruitment policies, and specifically increasing diversity recruitment, the Human Resources Department works with Hire Diversity.com as well as Monster.com diversity recruiting resources. In alignment with MHS principles, Human Resources Division has developed a Recurring Performance Measure that states 40% of all new hires will be bilingual/bicultural Spanish speakers. In addition, the county continues to offer a Bilingual stipend to all Spanish speaking bilingual staff who pass a written and oral examination. Furthermore, ADMHS Human Resources new hire orientation includes a review of the County of Santa Barbara's EEO Anti-Harassment policy which states that discrimination is prohibited based on protected status. All new hires sign off on this policy.

6. Specialty mental health contract requirements

The following are requirements for all ADMHS funded mental health community based organizations (CBOs).

- Contractor shall report on its capacity to provide culturally competent services to culturally diverse clients and their families from the County, including:
 - The number of bilingual and bicultural staff and the number of culturally diverse clients receiving Program services.
 - Efforts aimed at providing culturally competent services such as training provided to staff, changes or adaptations to service protocol, and community education/outreach.
- Contractor shall fill Program service staff positions with staff that reflects the ethnic makeup of Santa Barbara County. At all times, the Contractor shall be staffed with personnel or interpreters who are able to communicate in the client's preferred language.

- Contractor shall maintain bilingual capacity and provide staff with regular training on cultural competency, sensitivity, and the cultures within the community.
- Contractor shall provide services that consider the ethnic and cultural diversity of clients and families served.
- Contractor shall display Medi-Cal Member Services Brochures in English and Spanish in their offices. In addition, providers shall post grievance and appeal process notices in a visible location in their reception areas along with copies of English and Spanish grievance and appeal forms with Mental Health Plan (MHP) self addressed envelopes to be used to send grievances or appeals to ADMHS Quality Assurance Division.
- Contractor shall be knowledgeable of MHP policies on Beneficiary Rights as outlined in the Medi-Cal Member Services Brochures.
- Contractor shall ensure that direct service staff attend two cultural competency trainings per fiscal year and shall retain evidence of attendance for the purpose of reporting to the Cultural Competency Coordinator.
- Contractor shall establish a process by which Spanish speaking staff members who provide direct services in Spanish or interpretive services are tested for proficiency in speaking, reading, & writing Spanish. Additionally, interpreters and staff who request interpretation services must attend one training per fiscal year on interpretation in the mental health field, the workshop is offered through the county at least one time per year. Contractor shall retain evidence of employees' attendance at these workshops.

Additional program requirements for all MHSA programs:

- Cultural Competence: Providers adopt behaviors, attitudes and policies that enable staff to work effectively in cross-cultural situations.
- Client and Family Driven System of Care. Clients and families of clients identify needs and preferences that result in the most effective services and support.
- Community Collaboration. Individuals, families, agencies, and businesses work together for a shared vision.
- Integrated Service Experiences. Services for clients and families are "seamless," limiting the need for negotiating with multiple agencies and funding sources.
- Focus on Wellness. Through a foundation of recovery and resilience, people diagnosed with a mental illness are able to live, work, learn and participate fully in their communities.
- In addition to the information entered into the County MIS system, Contractor shall track the following, per MHSA requirements:

- Number of clients served in which language (English/Spanish/Other);
- Number of groups offered in which language (English/Spanish/Other).
- Contractor is expected to demonstrate their capacity to provide culturally competent services to culturally diverse clients and their families. Contractor is expected to report the number of bilingual and bicultural staff, as well as the number of culturally diverse clients to whom it provides services. The CBO is also expected to provide evidence of cultural competency by providing a description of the training staff receives, changes/adaptations of their service protocol, and/or other efforts such as community education/outreach aimed at providing culturally competent services. A report shall be submitted during the Medi-Cal site reviews.

7. Other key documents

ADMHS forms in English have been translated into Spanish. This includes Beneficiary Brochure, Complaints, Grievances, & State Fair Hearings, Satisfaction Surveys, Consent forms, HIPAA related forms. In addition, booklets on Patient's Rights and a guide to Medi-Cal services are available in English and Spanish at www.admhs.org.

Community collaboration/input regarding mental health planning and services

The Department works collaboratively with the Mental Health Commission, Quality Improvement Committee, Consumer Family Advisory Committee, and the Latino Advisory Committee. The committees make recommendations regarding policies and delivery of services. The committees are composed of culturally, ethnically, and linguistically diverse members who are beneficiaries, family members, ADMHS Staff and professionals who work outside of the County Mental Health System. In addition, ADMHS provides training opportunities for and with community organizations to enhance skills and knowledge of the committee members.

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

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

The only threshold language other than English in Santa Barbara County is Spanish. However, community members from different racial, ethnic, cultural and linguistic groups were invited to participate in the Mental Health Services Act Planning meetings,

with an emphasis on Latino communities.

Increasing Outreach and Engagement of Members of Latino Communities

- All MHSA-funded programs, whether staffed by ADMHS or by contracted community-based organizations, are required to maintain a staff that is 40% bilingual bicultural. This requirement was created to expand the availability of culturally competent services for Spanish-speaking and Latino clients throughout Santa Barbara County.
- Stakeholder announcements inviting community members to participate in MHSA stakeholder planning meetings are routinely translated into Spanish.
- In fiscal year 2009, the Department purchased two interpretation devices allowing for simultaneous interpretation. Interpretation is routinely made available at all stakeholder meetings conducted by the Department. The equipment is also made available to other Santa Barbara County Departments as well as community-based organizations (CBOs) that provide mental health services and education to different ethnic groups.
- ADMHS staff members are routinely made available to provide simultaneous interpretation upon request at any ADMHS-sponsored community meeting such as the Mental Health Commission, the Consumer and Family Member Advisory Committee meetings and other events. ADMHS staff are available to translate for events sponsored by CBOs that provide mental health services or for advocacy groups.
- Spanish-speaking community members and other diverse groups were an integral part of the development of the peer-run Recovery Learning Centers (RLC) in the three major regions of the County. To maximize the involvement and representation from the Spanish Speaking Latino community, materials used during the planning meetings were provided in Spanish. Simultaneous interpretation was available as needed.
- Focus groups were conducted with different ethnic and/or unserved communities for the preparation of the MHSA Prevention and Early Intervention (PEI) Plan. Focus groups included Spanish speaking transition-age youth (TAY), Latino (monolingual Spanish speakers), Native American, Oaxaqueno, and Lesbian, Gay, Transgender, and Questioning (LGBTQ) individuals.
- Spanish-speaking ADMHS staff participate at health fairs and are available to answer questions and provide Spanish literature identifying different mental health conditions and where or how to access information and services.
- The recently approved PEI plan includes a specific “promotoras” or community health educator program designated for the Latino, Oaxacan, Native American

and LGBT communities. In addition, a new PEI program strengthens preventive mental health services in community medical clinics countywide. It is designed to increase access to underserved communities by offering services in convenient, non-stigmatizing locations, and to Spanish speaking and other ethnic and /or unserved and underserved groups.

- Currently two members of the Mental Health Commission are Latinos and advocate for greater access for Latinos and Spanish-speaking individuals and culturally competent services.
- The Latino Advisory Committee (LAC) membership includes Latino mental health providers, consumers, and family members, who are dedicated to expanding and enhancing services to the Latino/Spanish-speaking community members. The LAC meets monthly.
- MHS administrative staff initiated the development of several Spanish Speaking Consumer and Family Support Groups throughout Santa Barbara County. Participants named the group “El Nuevo Amanecer / New Dawn.” Two monthly groups currently meet in Santa Barbara and Santa Maria. Both groups are currently supported by MHS staff. The members are regularly invited to attend planning meetings, to join committees, and were specifically involved in the Mental Health Services Act planning and implementation meetings for the WET, PEI, CIT, and CSS funding streams. Eight of the members participated in the ten-day consumer and family training for peer support services in July 2010.

Recent Trainings

- Working with the Oaxacan Community: All ADMHS staff and dozens of community-based organizations were invited to participate in a free all-day training educating mental health and public health providers about the Oaxaqueno community.
- Crisis Intervention Training (CIT): The 32 hour training is provided annually to approximately 35 law enforcement officers county-wide. The training focuses on general mental health issues, crisis response skills, a panel of consumers and family members and cultural competence awareness.
- “Healing the Wounded Spirit”: Training about Native American Culture and mental health needs, drew a diverse group of more than 200 attendees, many of whom came from the mental health sector and social service sectors.
- WET funds were designated for the Consumer and Family Member Peer Training Program. A ten day peer training which took place July 12, 2010 to July 23, 2010. The training consisted of building entry level workforce knowledge to enhance client/family member ability to enter or re-enter the workforce. Thirty-five clients attended the training and graduated. This included 13 bilingual/bicultural Spanish speakers. The training is designed

to enhance ADMHS' ability to meet the client and family needs of Santa Barbara County's population. A bilingual Spanish speaker translator was provided for bilingual/monolingual trainees. Where possible, the training materials and announcements were provided in Spanish.

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.

Engagement & Support

ADMHS is committed to better engaging and serving unserved and underserved communities. Spanish is the second threshold language of Santa Barbara County. As a result, ADMHS has incorporated ethnic specific groups in order to better serve the Latino and Spanish-speaking community.

- In Southern Santa Barbara County, El Nuevo Amanecer is a Latino/Spanish support group for consumers and family members struggling with mental illness and/or alcohol and drug use. The support group meets twice a month. The group also has active members who provide advocacy and outreach to and for the Spanish-speaking community.
- Santa Maria based Latino Spanish support group offers consumers and family members a forum to discuss their struggles while building community and decreasing the stigma associated with mental illness. The group meets on a monthly basis and is held in a community setting. The group has spearheaded advocacy activities to draw awareness to the needs of monolingual Spanish speaking community members.
- Consumers and family members who participate in El Nuevo Amanecer, the support group for Spanish speakers, are regularly invited to participate in MHSA planning and implementation meetings for WET, PEI, and CSS programs.
- Peer-Run Recovery Learning Centers (RLCs) were designed with approximately one-third of the attendees representing the Latino/Spanish-speaking community. During the development of the charter and program planning process, documents were translated into Spanish and simultaneous interpretation in English/Spanish was provided.
- The Latino Advisory Committee (LAC) includes staff from the Alcohol, Drug, and Mental Health Services Department, CBOs and representatives which include members from the judicial and social service sectors. The Director of ADMHS is

highly supportive of the Committee and supports the attendance of ADMHS managers and line staff participating in the monthly meetings.

- Underserved groups were asked to be involved in the program planning and design process for MHSA PEI projects. Focus groups and/or key informant interviews were conducted with the following groups: Transition=Age Latino Youth, the Oaxaqueno Community, Native American community, Lesbian, Gay, Bisexual, Transgender, and Questioning, Latinos/Spanish speakers.
- Members of the Consumer and Family Member Advisory Committee (CFMAC) are consumers and family members who provide input on the development, implementation, and review of ADMHS programs. Spanish interpretation services are always available for the monthly meetings. Currently seven of the 18 voting members are Latinos. All members are eligible to receive a stipend and mileage reimbursement for their attendance
- Key MHSA planning documents and feedback forms are translated into Spanish and posted to the ADMHS web site. All documents in English or Spanish are made available via US Postal Service at no charge upon request.
- Thirty-five clients attended the Peer Training program and graduated. Thirteen attendees were bilingual/bicultural Spanish speakers. For monolingual speakers, interpretation services were provided. Where possible the training materials and announcements were provided in Spanish.
- The involvement of the underserved communities was critical in the development of two key aspects of the PEI Plan. The Promotora program and the Community Health Clinics programs were created to respond to the feedback from the Spanish speaking/Latino, Oaxaqueno, LGBTQ, Native American, and TAY communities. The Promotora program is providing liaisons dedicated to helping underserved individuals gain access to services and knowledge about mental health conditions. The Community Health Clinics have Spanish-speaking representatives dedicated to helping Spanish-speaking individuals access affordable mental health services in a neighborhood setting in both North and South Santa Barbara County.

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.

- All ADMHS contracted providers and ADMHS staff are invited to all cultural competence trainings offered by ADMHS. During the time of July 2009-2010 ADMHS trained 214 ADMHS and contracted Community Based Organizations in cultural competence. All CBO and ADMHS staff members are encouraged to attend the trainings at no charge. CEUs are generally made available to attendees. All contractors and ADMHS staff members are required to participate

in at least two cultural competence trainings per year.

- Oaxaqueno training – Staff from ADMHS, contracted CBOs and partner county agencies, consumers and family members were invited to attend a four-hour training about the Oaxaqueno community. Two-hundred and twelve persons attended the training.
- Client culture trainings are offered to all ADMHS staff and CBO's throughout Santa Barbara County. The training includes consumer and family Latino perspectives. Discussions include trauma, access to services, diagnosis/labeling/stigma, societal, familial, and personal challenges, cultural significance and perspectives on mental illness, medication and hospitalization.
- Crisis Intervention Training provided to approximately 35 law enforcement officers included cultural perspectives and family/consumer perspectives of mental health.
- ADMHS' MHSAs programs currently require 40% staff be bilingual/bicultural in order to enhance services to the bilingual/bicultural communities.
- Prevention and Early Intervention funds will be used to provide culturally and linguistically based support to assist individuals and family members in accessing preventive mental health and social service assistance. The Promotora (peer support) positions will be based in local agencies that have a presence in the designated cultural community. The PEI funded positions include two Spanish speaking Latinos, one member of the LGTBQ community, one member of the Native American community and one member of the Oaxaqueno community.
- The Recovery Learning Center Charters require contractors to include monolingual and bilingual consumers and family members as advisory boards members. CBO's are required to provide services and groups in Spanish. Unlike the traditional consumer and family member advocacy efforts, the Latino consumer and family members advocated for planning sessions and charters that reflected the familial cultural values which call for consumers and family members both be included in all aspects of the RLC planning and service provision components.
- From July 2009 to July 2010 over 200 CBO and ADMHS staff attended the following trainings: Consumer and Family Culture, Oaxaqueno Culture, and Native American culture.

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

- The need to enhance the cultural competence of all ADMHS staff and contract staff is essential to improve the services that ADMHS provides through the

mental health system.

- It is important that the time and location of meetings be selected to maximize the involvement of unserved and underserved community members. For example, some underserved individuals hold multiple jobs and have family commitments and are unlikely to attend meetings held during weekday business hours. An effort will be made to hold meetings and groups at times that will increase the involvement by ethnic communities.
- ADMHS has instituted enhanced reporting and monitoring requirements of bilingual/bicultural staffing levels as an effort to increase outcomes.
- Ensuring direct participation of underserved groups in the planning and monitoring of programs has resulted in changes of key and foundational structures including the integration of cultural and linguistic priorities. For example, the Recovery Learning Center steering committee meetings are required to provide Spanish language interpretation and Latino representation from both consumers and family members.
- ADMHS will establish a system that identifies in which language the services were provided and by whom. This information will provide a benchmark for ADMHS to in order to measure the need for increased capacity.
- Historically, ADMHS has under budgeted for the translation of department documents. There has been a notable increase in translation and interpretation requests due to increased Spanish speaking consumer and family member involvement through MHSA program implementation. The Department's goal is to provide resources that not only translate documents into Spanish but certify that the documents are translated to at least a 6th grade level. This increased need in translation and interpretation services will be considered in the planning for the next budget year and addressed in the Cultural Competency Committee.

E. Identify county technical assistance needs.

To gather the additional information, ADMHS will need to upgrade the technological capacities of the documentation system. The data collection will include the requirement to identify the language in which a service was provided; and if interpretation services were provided by another clinician, a staff person, or a telephone interpretation service.

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

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.

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 designee is Refugio “Cuco” Rodriguez-Rodriguez. Mr. Rodriguez is the ADMHS Mental Health Services Act Division Chief. He has extensive experience in the areas of cultural competency and issues related to diversity and cross-cultural communication.

Mr. Rodriguez is bilingual and bicultural and has worked in community based settings and has been responsible for the development of programs and services to ethnic communities. Furthermore, he also led the effort to engage underserved communities for the local MHSA process. Mr. Rodriguez has been an active community leader for many years and has served on numerous statewide MHSA committees related to ethnic disparities, cultural competency, and stigma discrimination. He has also presented at multiple national and statewide conferences on topics including outreach to Latino communities, cultural competency, improving services to marginalized Latino youth, and engaging Latino communities in mental health services. Mr. Rodriguez is well qualified for this position and will provide the leadership necessary to accomplish Santa Barbara County’s Cultural Competency Plan.

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

The Cultural Competency Officer will plan, implement, monitor, and evaluate the ADMHS’ cultural and linguistics healthcare and outreach services and programs. Mr. Rodriguez’s duties will include:

- Develop and manage the implementation of the Cultural Competency Plan, including a training and education program.
- Facilitate and coordinate the development and on-going management of the cultural competence committee.
- Develop programs to assess the cultural competency of staff and to develop a minimum core curriculum standard for annual diversity trainings, and provide ongoing monitoring, including Latino culture, client culture, other culturally diverse populations.
- Identify the behavioral health care needs of ethnically and culturally diverse populations as they impact county systems of care; make recommendations to management, coordinate and promote quality and equitable care.
- Maintain and ongoing relationship with community organizations, planning agencies, and the community at large.
- Visit and assess ADMHS contract agency facilities; make recommendations about facility changes and location in accordance with the needs of diverse population.
- Plan, organize, provide and document access outreach to gathering places of underserved cultural populations.

- Develop, manage, and document process for monitoring access responsiveness and provide corrective feedback regarding all under-served cultural populations.
- Develop, implement, and monitor program budgets.
- Develop and implement translation and interpretation services.
- Gather data and make recommendations to incorporate into work plan goals for penetration and retention rates of threshold language and other culturally diverse populations.
- Update the Cultural Competency Plan annually.
- Other duties to ensure services in the mental health system of care are culturally and ethnically competent.

IV. Identify budget resources targeted for culturally competent activities

A. Evidence of a budget dedicated to cultural competence activities

The calculation for this component was derived by adding multiple components of MHSA as well as core budget line items. In particular, the most significant contributions can be found in the CSS MHSA component. These contributions include funding in personnel that is directly connected to improving cultural competency issues and establishes a standard for a minimum requirement of bilingual and bicultural staff. This amount is included in the total calculation. The department currently allocates approximately \$4,094,000 towards cultural competency activities. A significant contribution comes from the MHSA funding allocation. These costs include the expenditures related to the requirement that 40% of all direct service staff in MHSA programs must be bilingual (Spanish/English) and bicultural. In addition, MHSA has also designated funding for consumer and family support activities, funding for cultural competency trainings for all staff, and funding to support the Cultural Competency position.

Although the budget allocated is considerable, it is important to recognize the significance of the department's commitment. Furthermore, the ADMHS strategy to address the issue of disparities, particularly with the Latino community, was to develop the staffing capacity to provide services that were linguistically and culturally appropriate. Consequently, ADMHS instituted the bilingual bicultural percentage requirement for all MHSA funded programs. It is believed that once the staffing capacity has been established, the populations with the threshold language will be served and increase the cultural competency capacity.

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;

The department currently allocates approximately \$40,000 for direct interpreter services for the "language line".

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

As stated in the previous section, the Department believes that the standard established requiring all MHSA program to have a minimum 40 % of bilingual bicultural staff in programs is directly related to the reduction of racial, ethnic, cultural, and linguistic mental health disparities. Consequently, the department currently allocates approximately \$4,094,000 towards these activities. ADMHS also considers this budgetary allocation in terms of developing strategies to develop culturally appropriate mental Health Services.

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

Although the total allocation of \$4,094,00 can be considered funding for strategies that directly or indirectly assist in providing outreach to racial and ethnic communities, the Department does have other clearly identified components within the PEI MSHA strategies that speak directly to outreach. Those programs can be found with in the PEI components and are the following:

The PEI Promotoras Component directly targets ethnic and other unserved communities throughout Santa Barbara County. This component is currently funded at an amount of \$390,000 towards the execution of these efforts. The Integrated Primary Care and Mental Health program of the PEI Component also focuses on addressing the issue of disparities amongst ethnic and other unserved communities. The allocation for this component is \$500,000 per year.

4. Culturally appropriate mental health services; and

As stated above, ADMHS has dedicated PEI funds towards providing culturally appropriate mental health services.

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

At this time ADMHS does not have specific incentives itemized for these items. However, ADMHS believes that some of these issues are addressed through existing budget allocations. Furthermore, the two PEI components identified previously Promotoras and Primary Care and Mental Health Integration, are being administered by non-traditional providers. When ADMHS sought out providers for these components, providers with strong community connections who may not be part of the Department's traditional network were sought. With the exception of one provider, all of these agencies are new partners.

Bilingual allowance is one of the main incentives that ADMHS provide to its staff members toward meeting the threshold language needs of the community. Bilingual allowance is \$57.69 biweekly for SEIU Local 620 staff and \$25.38 biweekly for Psychiatrists and Managers. An employee, whose duty assignments require regular and frequent use of bilingual language skills in English and either Spanish or Hmong or any other language shall be designated to receive a bilingual allowance.

CRITERION 2: UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

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

Selected Data for Santa Barbara County, California (U.S. Census Bureau)

Please note: The U.S. Census does not recognize "Hispanic/Latino" as an ethnicity or race. "Hispanic/Latinos" may be of any race. Consequently, the sum of "Persons of Hispanic or Latino origin" and all the recognized racial designations does not add up precisely to 100%. This is because a small number of "Hispanics/Latinos" who did not designate themselves as "White" may be double counted in a racial designation such as "Black persons", "Persons Reporting Two or More Races," etc.

| | Santa Barbara County | California |
|--|----------------------|------------|
| Footnotes | | |
| (a) Includes persons reporting only one race. | | |
| (b) Hispanics may be of any race, so also are included in applicable race categories. | | |
| Population, 2009 estimate | 407,057 | 36,961,664 |
| Population, percent change, April 1, 2000 to July 1, 2009 | 1.9% | 9.1% |
| Population estimates base (April 1) 2000 | 399,356 | 33,871,648 |
| Persons under 5 years old, percent, 2008 | 7.4% | 7.4% |
| Persons under 18 years old, percent, 2008 | 23.6% | 25.5% |
| Persons 65 years old and over, percent, 2008 | 13.0% | 11.2% |
| Female persons, percent, 2008 | 49.5% | 50.0% |
| Black persons, percent, 2008 (a) | 2.4% | 6.7% |
| American Indian and Alaska Native persons, percent, 2008 (a) | 1.7% | 1.2% |
| Asian persons, percent, 2008 (a) | 4.5% | 12.5% |
| Native Hawaiian and Other Pacific Islander, percent, 2008 (a) | 0.2% | 0.4% |
| Persons reporting two or more races, percent, 2008 | 2.5% | 2.6% |
| Persons of Hispanic or Latino origin, percent, 2008 (b) | 39.5% | 36.6% |
| White persons not Hispanic, percent, 2008 | 51.8% | 42.3% |
| Living in same house in 1995 and 2000, pct 5 yrs old & over | 48.3% | 50.2% |
| Foreign born persons, percent, 2000 | 21.2% | 26.2% |

| | | |
|--|----------|------------|
| Language other than English spoken at home, pct age 5+, 2000 | 32.8% | 39.5% |
| High school graduates, percent of persons age 25+, 2000 | 79.2% | 76.8% |
| Bachelor's degree or higher, pct of persons age 25+, 2000 | 29.4% | 26.6% |
| Persons with a disability, age 5+, 2000 | 64,541 | 5,923,361 |
| Households, 2000 | 136,622 | 11,502,870 |
| Persons per household, 2000 | 2.80 | 2.87 |
| Median household income, 2008 | \$60,645 | \$61,017 |
| Per capita money income, 1999 | \$23,059 | \$22,711 |
| Persons below poverty level, percent, 2008 | 12.7% | 13.3% |

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

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

The data that appear on the next page were published in the CAEQRO report for the Santa Barbara County Mental Health Plan for FY 2009-10 (December 2-3, 2009).

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

According to the analysis published by CAEQRO for Santa Barbara County FY 2009-10, the disparity in penetration rates for Hispanics compared to non-Hispanic Whites continued to improve in CY 2008, primarily as a result of a continuing decrease in the White penetration rate. For the first time in the four years displayed (CY 2005-2008), the Santa Barbara County Mental Health Plan shows parity in approved claims between Hispanic and White beneficiaries. This change is partially due to an increase in average claims to Hispanic beneficiaries and a greater decrease in average claims to White beneficiaries.

CAEQRO Figure 17 – Examination of Disparities – Hispanic versus White

| | Number of Beneficiaries Served & Penetration Rate per Year | | | | Approved Claims per Beneficiary Served per Year | | Ratio of Hispanic versus White for | |
|-----------------------|--|-------|----------|--------|---|---------|------------------------------------|-----------------------|
| | Hispanic | | White | | Hispanic | White | PR Ratio | Approved Claims Ratio |
| | # Served | PR % | # Served | PR % | | | | |
| Statewide CY08 | 128,391 | 3.41% | 165,436 | 11.72% | \$4,448 | \$4,621 | .29 | .96 |
| MHP CY08 | 1,599 | 4.31% | 2,633 | 8.66% | \$6,724 | \$6,654 | .50 | 1.01 |
| MHP CY07 | 2,064 | 4.49% | 2,442 | 12.05% | \$6,427 | \$8,206 | .37 | .78 |
| MHP CY06 | 2,124 | 4.23% | 2,497 | 17.33% | \$5,986 | \$8,533 | .24 | .70 |
| MHP CY05 | 2,058 | 4.19% | 2,464 | 16.66% | \$5,524 | \$7,838 | .25 | .70 |

CAEQRO also found that the Santa Barbara County Mental Health Plan continued to show a disparity very similar to the statewide averages in penetration and approved claims ratios for females compared to males in CY 2008.

CAEQRO Figure 18 – Examination of Disparities – Female versus Male

| | Number of Beneficiaries Served & Penetration Rate per Year | | | | Approved Claims per Beneficiary Served per Year | | Ratio of Female versus Male for | |
|-----------------------|--|-------|----------|-------|---|---------|---------------------------------|-----------------------|
| | Female | | Male | | Female | Male | PR Ratio | Approved Claims Ratio |
| | # Served | PR % | # Served | PR % | | | | |
| Statewide CY08 | 223,739 | 5.65% | 208,410 | 6.90% | \$4,032 | \$5,238 | .82 | .77 |
| MHP CY08 | 2,629 | 6.27% | 2,377 | 7.39% | \$6,060 | \$7,718 | .85 | .79 |
| MHP CY07 | 2,806 | 6.81% | 2,542 | 8.06% | \$6,997 | \$8,733 | .84 | .80 |
| MHP CY06 | 2,805 | 6.95% | 2,597 | 8.51% | \$6,925 | \$8,406 | .82 | .82 |
| MHP CY05 | 2,768 | 6.94% | 2,510 | 8.33% | \$6,443 | \$7,470 | .83 | .86 |

Medi-Cal Approved Claims Data for SANTA BARBARA County MHP Calendar Year 08
 From the CAEQRO Report, December 2-3, 2009)

| Medi-Cal Approved Claims Data for SANTA BARBARA County MHP Calendar Year 08 | SANTA BARBARA | | | | | MEDIUM | | STATEWIDE | |
|---|---|---|-----------------|------------------|---|------------------|---|------------------|---|
| | Average Number of Eligibles per Month (4) | Number of Beneficiaries Served per Year | Approved Claims | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year | Penetration Rate | Approved Claims per Beneficiary Served per Year |
| TOTAL | 74,073 | 5,006 | \$34,276,938 | 6.76% | \$6,847 | 6.09% | \$4,895 | 6.19% | \$4,614 |
| AGE GROUP | | | | | | | | | |
| 0-5 | 16,997 | 437 | \$1,815,077 | 2.57% | \$4,153 | 1.48% | \$3,638 | 1.40% | \$3,778 |
| 6-17 | 19,876 | 1,469 | \$13,026,231 | 7.39% | \$8,867 | 7.52% | \$5,895 | 7.81% | \$6,088 |
| 18-59 | 29,169 | 2,733 | \$17,003,652 | 9.37% | \$6,222 | 8.23% | \$4,519 | 8.56% | \$3,947 |
| 60+ | 8,032 | 367 | \$2,431,977 | 4.57% | \$6,627 | 3.56% | \$3,905 | 3.40% | \$2,937 |
| GENDER | | | | | | | | | |
| Female | 41,921 | 2,629 | \$15,931,269 | 6.27% | \$6,060 | 5.61% | \$4,242 | 5.65% | \$4,032 |
| Male | 32,152 | 2,377 | \$18,345,669 | 7.39% | \$7,718 | 6.70% | \$5,604 | 6.90% | \$5,238 |
| RACE/ETHNICITY | | | | | | | | | |
| White | 30,390 | 2,633 | \$17,519,323 | 8.66% | \$6,654 | 10.41% | \$5,087 | 11.72% | \$4,621 |
| Hispanic | 37,085 | 1,599 | \$10,751,120 | 4.31% | \$6,724 | 3.22% | \$4,648 | 3.41% | \$4,448 |
| African-American | 1,888 | 292 | \$1,974,676 | 15.47% | \$6,763 | 8.84% | \$4,393 | 10.10% | \$5,026 |

| | | | | | | | | | | | |
|---------------------------|-------|-----|-------------|--------|---------|--|--------|---------|--|--------|---------|
| Asian/Pacific Islander | 1,686 | 96 | \$670,253 | 5.69% | \$6,982 | | 4.48% | \$3,350 | | 4.39% | \$3,329 |
| Native American | 285 | 50 | \$351,951 | 17.54% | \$7,039 | | 11.23% | \$5,014 | | 10.69% | \$4,994 |
| Other | 2,742 | 336 | \$3,009,614 | 12.25% | \$8,957 | | 10.37% | \$6,368 | | 8.96% | \$5,491 |

| ADMHS Medi-Cal Beneficiaries by Language, Calendar Year 2008 3,793 Unduplicated Medi-Cal Beneficiaries (Source: ADMHS) | | |
|---|----------------------------------|------------|
| Language | Number of Medi-Cal Beneficiaries | Percentage |
| Arabic | 1 | 0 |
| Cantonese and other Chinese | 71 | 2 |
| English | 3,218 | 85 |
| Farsi | 1 | 0 |
| Japanese | 2 | 0 |
| Other Non-English | 2 | 0 |
| Other Sign Language | 1 | 0 |
| Samoan | 1 | 0 |
| Spanish | 258 | 7 |
| Tagalog | 3 | 0 |
| Thai | 8 | 0 |
| Unknown/Not Reported | 224 | 6 |
| Vietnamese | 3 | 0 |
| Total | 3,793 | 100 |

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

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

In CY 2009 ADMHS served:

- Race/Ethnicity: 52% whites, 21% Hispanics, 4% African Americans, 1% Native Americans (17% had no information/missing information).
- Language: Seventy-seven percent of ADMHS clients were identified as having English as their preferred language, and 3% identified Spanish as their preferred language (17% were missing information). (Source: ADMHS)
- Age: Five percent of 0-15 year olds were served. Eighty-five percent were 16-59 year olds, and 9% were over 60 years old (1% had no information/missing information).
- Gender: Forty-eight percent of females were served and 50% males (2% had missing information).

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

- Race/Ethnicity: Thirty percent of whites were identified as living 200% below the poverty level, although ADMHS serves 52% whites. ADMHS served 21%

- Hispanics, while 61% were identified as living 200% below the poverty level.
- Language: Sixteen percent of individuals who speak English at home were identified as living 200% below the poverty level, while almost 87% of those who spoke Spanish at home live 200% below the poverty level. Seventy-seven percent of the services delivered by ADMHS were to individuals who were identified as having English as their preferred language. Only 3% of clients were identified with Spanish as their preferred language. (Source: ADMHS)
 - Age: For 0-17 year olds, 32% were identified as living below the poverty line, individuals 0-15 received 5% of the services. Fifty-seven percent of people 18-59 were identified as living 200% below the poverty level. Eighty-five percent of the population served was between the ages of 16-59. Eleven percent of the 60+ population was identified as living 200% below the poverty level, the 60+ population made up 9% of the individuals receiving mental health services in Santa Barbara County.
 - Gender: There is not a large discrepancy between 48% of females being served versus 50% males.

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

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

About Santa Barbara County

According to the 2000 Census, the total population of Santa Barbara County is approximately 400,000. Major population centers are the Santa Maria Valley, Lompoc Valley, and South Coast. Half of the County population lives in the North and Central regions of the County, which is geographically separated from the South Coast by the Santa Ynez Mountains.

The North County comprises 30% of the County population, including the cities of Santa Maria (population 88,800) and Guadalupe (pop. 6,300). Twenty percent of the county population resides in the Central County including the cities of Lompoc (pop. 42,300), Buellton (pop. 4,600), and Solvang (pop. 5,400). South County makes up 50% of the county population, including the cities of Santa Barbara (pop. 91,000), Goleta (pop. 29,200), and Carpinteria (pop. 14,300). The remainder of the population lives in the vast unincorporated areas of the county.

Estimates of Unserved Populations by Age Group

A number of populations within Santa Barbara County are unserved. These groups

include the uninsured; a portion of the severely mentally ill/seriously emotionally disturbed 200% of poverty population; geographically isolated regions of the county; homeless; Native Americans; and the lesbian, gay, bisexual and transgender (LGBT) community. As MHSA planning and implementation processes unfold; ADMHS may identify additional unserved populations.

In Santa Barbara County, 13% of all residents are uninsured; the statewide average is 14%. Children 0-15 years, transition-age youth, adult and older adult uninsured rates are either below or similar to the statewide rates. The most significant finding is that 14% of children (0-15 years) are uninsured, which is 50% higher than statewide (7%). Uninsured children are not likely to receive the medical and mental health care that they need.

There is an ethnic disparity within the uninsured population of Santa Barbara County. Only 8% of the total Caucasian population is uninsured, compared to 25% of the total Latino population. This is consistent with the statewide disparity between Latino and Caucasian uninsured populations (statewide uninsured Caucasian is 8%; statewide uninsured Latino is 26%). This disparity may be partially attributed to economic and social inequities between Latinos and Caucasians.

Further analysis of the uninsured across age groups and ethnicities suggests that with the exception of older adults, there is ethnic disparity between children, transition-age youth and adult Caucasians and Latinos. Older adults may have lower uninsured rates due to access to Medicare. The greatest disparity appears to be in the children and transition-age youth groups. The uninsured rate for Latino transition-age youth (43%) is nearly three times higher than Caucasian transition-age youth (15%). Latino children uninsured rates (24%) are three times that of Caucasian children (7%). Furthermore, Latino adults (34%) are significantly more uninsured than Caucasian adults (12%).

These disparities are alarming and indicate that without insurance of some kind, a large number of Latino transition-age youth, adults, and particularly children may not have access to needed mental health services. With larger populations of Latinos in North County (Santa Maria, Guadalupe, New Cuyama), and higher utilization of services by children in North County, it is likely that many of the Latinos who are uninsured and have a higher need for services. Particularly Latino children and transition-age youth, are under-served. In regions of Santa Barbara County such as Guadalupe, the Latino population is 83% of the community.

Regardless of ethnicity, individuals in Santa Barbara County 60 or older are uninsured at a low rate. Latinos in this age group in Santa Barbara County are uninsured at a rate of one percent, compared to the California rate of 11%.

Severely Mentally Ill/Seriously Emotionally Disturbed

Another unserved population is a significant number of persons with severe mental illness/serious emotional disturbance living at 200% of poverty. The California

Department of Mental Health prevalence estimate of this population for Santa Barbara County is 11,620. In FY 2005 ADMHS served approximately 6,600 clients with severe mental illness/serious emotional disturbance (57% of prevalence estimate), which leaves about 5,000 persons (43%) with a serious mental illness/severe emotional disturbance unserved. Using California Department of Mental Health prevalence estimates of the age group breakdown, it is projected that within the 5,000 unserved, children account for 31% of that population, transition-age youth 26%, adults 34%, and older adults 9%.

Estimates of gender characteristics of the unserved population suggest that there are slightly more male than female children (0-17), but that there is a large disparity in adults (18+), with 63% female and 37% male. A potential unserved population is adult males with severe mental illness/serious emotional disturbance.

With respect to the ethnic representation within age groups, based on California Department of Mental Health estimates, ADMHS projects that the adult (18 +) unserved population is more evenly divided between Latinos (47%) and Caucasians (45%). However, within the child (0-17) severely mentally ill/seriously emotionally disturbed unserved population, 75% are Latino and 19% Caucasian. Again, in Santa Barbara County, it appears that it is Latino children who are at-risk for being uninsured, significantly higher rates of severe mental illness/serious emotional disturbance than Caucasian children, and lower rates of access to services.

Homeless Population

The homeless population in Santa Barbara County includes an unserved group. Due to favorable weather conditions and environment, Santa Barbara County has a large homeless population. Estimates suggest that there are about 6,500 homeless persons in the county. Of these individuals, the Santa Barbara County Public Health Department estimates that 12% of the homeless population is children, 12% transition-age youth, 70% adult, and 6% older adult. Approximately 10% of ADMHS clients are identified as homeless, although, ADMHS believes this to be an under-represented figure. The homeless receiving mental health services from ADMHS were primarily Caucasian (69%), while Latinos accounted for 15% and African-Americans 9% of homeless clients. This is quite dissimilar to national figures, which indicate that 50% of the homeless population in the U.S. is African American, 35% are Caucasian and 12% are Latino.

Geographically, the majority (80%) of homeless clients received services in South County, suggesting the possible need for enhanced services to the homeless in South County, but also increased outreach and access to mental health services for the homeless in Central and North County. Research suggests that approximately 30% of homeless persons have a severe mental illness/serious emotional disturbance or about 2,000 persons (of an estimated 6,500) in Santa Barbara County. Approximately 647 homeless individuals received services from ADMHS (FY 09-10).

Individuals who are Geographically Isolated

Areas of Santa Barbara County, particularly in the north, such as New Cuyama and Guadalupe, are small, but grossly under-served and/or unserved. For example, as mentioned previously, Guadalupe is 83% Latino with a total population of 6,063. In FY 04-05, ADMHS served 187 clients (approximately 3% of the total client population) residing in Guadalupe. Of the 187 clients, 73% were Latino, and a third of the Latino clients served were children.

Another region of concern in the County is the Carpinteria Valley, which is located along the coast 13 miles south of Santa Barbara with a population of 19,108 (Census 2000). Residents of Carpinteria Valley who need mental health services are somewhat geographically isolated in that the nearest County mental health clinic is in Santa Barbara. Due to budget cuts, the Carpinteria clinic closed in 1991 and there has been a lack of community-based organizations and mental health professionals providing services to clients with Medi-Cal. Although 13 miles may not appear to be a challenge to accessing services, traveling that distance when in crisis is a serious barrier and deterrent to seeking services. For clients without personal transportation, the trip can take over an hour on public transportation and often requires transfers that may be difficult for clients with physical and/or emotional problems.

In addition, traveling to Santa Barbara is a barrier to accessing services for Carpinteria children during school hours and after school, particularly when using public transportation. In FY 04-05, ADMHS served 133 residents of Carpinteria Valley, only 2% of the total client population. Latinos comprised 32% of those clients while 59% were Caucasian.

Native Americans

Native Americans are another group that is largely unserved by ADMHS. Very few Native Americans access ADMHS services. Census 2000 indicates that there are approximately 5,000 Native Americans living in Santa Barbara County. Many members of the Santa Ynez Band of Chumash Indians reside in the Central region of the county. In FY 04-05, ADMHS served a total of 95 Native Americans across all age groups. However, ADMHS did not serve any transition-age youth Native Americans. Clearly, Native Americans are an unserved population in the county, and in need of outreach and engagement in culturally-bound services.

Lesbian, Gay, Bisexual and Transgender

ADMHS considers the lesbian, gay, bisexual & transgender (LGBT) community to be essentially unserved by ADMHS. In 2003, there were approximately 4,000 (18 years and over) were self-identified lesbian, gay and bisexual residents living in Santa Barbara County (CHIS, 2003). This represents 1% of the county population. Three-quarters (75%) of the LGBT community were between the ages of 26 and 59, 75% were Caucasian and 25% were Latino, with no evident gender disparity. Unfortunately, no

population data are available on children and youth who might be LGBT in Santa Barbara County.

Currently, ADMHS does not systematically collect sexual orientation data on child and adult clients. Therefore, we are unable to determine the level of service to the LGBT community, which, again, constitutes a disparity. ADMHS recognizes that there are LGBT clients currently receiving services, but due to the stigma of mental illness, addiction and/or being LGBT, clients may not self-identify. ADMHS believes that creating a welcoming environment for LGBT clients is critical and continues to develop a strong relationship with the LGBT community. Representatives from Pacific Pride, that provides services to the HIV/AIDS and LGBT communities, served on the Stakeholder Steering Committee and participated in the MHSA Summit.

Service Utilization by Race/Ethnicity

Chart A: ADMHS Service Utilization by Race/Ethnicity

(Percentages highlighting the most substantial ethnic disparities are shaded.)

| CHILDREN AND YOUTH | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
|-------------------------------|--------------|--------|------------------------|--------|--------------|------|---------------------------|------|-------------------|------|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 69 | 42 | 1,314 | 872 | 2,330 | 100% | 36,819 | 100% | 89,162 | 100% |
| African American | 3 | 4 | 43 | 29 | 79 | 3% | 593 | 2% | 1,497 | 2% |
| Asian Pacific Islander | 0 | 0 | 15 | 5 | 20 | 1% | 656 | 2% | 2,811 | 3% |
| Latino | 19 | 15 | 702 | 386 | 1,122 | 48% | 27,660 | 75% | 47,697 | 53% |
| Native American | 1 | 1 | 18 | 11 | 31 | 1% | 172 | <1% | 754 | 1% |
| White | 42 | 19 | 501 | 413 | 975 | 42% | 6,868 | 19% | 33,406 | 37% |
| Other | 4 | 3 | 35 | 28 | 103 | 4% | 733 | 2% | 2,997 | 3% |

| TRANSITION AGE YOUTH | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
|------------------------|--------------|--------|------------------------|--------|--------------|------|---------------------------|------|-------------------|------|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 21 | 16 | 938 | 819 | 1,794 | 100% | 31,689 | 100% | 71,829 | 100% |
| African American | 5 | 0 | 36 | 33 | 74 | 4% | 491 | 2% | 1,347 | 2% |
| Asian Pacific Islander | 0 | 0 | 13 | 22 | 35 | 2% | 2,064 | 6% | 4,099 | 6% |
| Latino | 4 | 6 | 447 | 347 | 804 | 45% | 14,101 | 44% | 29,459 | 41% |
| Native American | 0 | 0 | 0 | 0 | 0 | 0% | 129 | <1% | 516 | 1% |
| White | 11 | 10 | 420 | 383 | 824 | 46% | 13,845 | 43% | 34,796 | 48% |
| Other | 1 | 0 | 22 | 34 | 57 | 3% | 1,059 | 3% | 1,612 | 2% |
| ADULT | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 153 | 125 | 1,677 | 2,251 | 4,206 | 100% | 44,546 | 100% | 187,507 | 100% |
| African American | 12 | 14 | 94 | 108 | 228 | 5% | 808 | 2% | 4,362 | 2% |
| Asian Pacific Islander | 3 | 0 | 46 | 54 | 103 | 2% | 1,441 | 3% | 9,064 | 5% |
| Latino | 18 | 11 | 364 | 608 | 1,001 | 24% | 27,013 | 60% | 66,506 | 35% |
| Native American | 3 | 5 | 20 | 31 | 59 | 1% | 287 | 1% | 1,473 | 1% |
| White | 115 | 94 | 1,113 | 1,385 | 2,707 | 64% | 14,411 | 32% | 103,680 | 55% |
| Other | 2 | 1 | 40 | 65 | 108 | 3% | 586 | 1% | 2,422 | 1% |
| OLDER ADULT | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 6 | 18 | 138 | 234 | 396 | 100% | 16,223 | 100% | 67,220 | 100% |
| African American | 0 | 1 | 0 | 13 | 14 | 4% | 389 | 2% | 1,082 | 2% |
| Asian Pacific Islander | 0 | 1 | 3 | 8 | 12 | 3% | 597 | 4% | 2,486 | 4% |
| Latino | 1 | 5 | 20 | 35 | 61 | 15% | 4,366 | 27% | 10,010 | 15% |
| Native American | 0 | 0 | 1 | 4 | 5 | 1% | 69 | <1% | 435 | 1% |
| White | 5 | 11 | 103 | 164 | 283 | 71% | 10,528 | 64% | 52,600 | 78% |
| Other | 0 | 0 | 11 | 10 | 21 | 5% | 274 | 2% | 607 | 1% |

*Fully Served adults and older adults defined as clients receiving 24/7 wraparound services (e.g., Supportive Housing Initiative Act, AB2034). Fully Served children defined as clients open to children's clinics and receiving therapeutic behavioral services. Source of data: ADMHS. Fully Served transition-age youth 16-17 were defined using the children's criteria and combined with transition-age youth 18-25. Fully Served transition-age youth 18-25 were defined using the adult/older adult criteria.

*Under-served/Unserved defined as children, transition-age youth, adults and older adults open to the system, but not receiving 24/7 wraparound services or therapeutic behavioral services in conjunction with children's clinic services. Source of data: ADMHS.

*Total Served population data based on 8,726 clients served in FY 04-05. Source of data: ADMHS.

*County 200% of Poverty Population data drawn from U.S. Bureau, Census 2000. Census poverty data age groupings (0-15; 16-24; 25-54; 55+) are inconsistent with MHSA age groupings (0-15; 16-25; 26-59;

60+). Data for transition-age youth and adults may be under-represented and older adults may be over-represented, according to MHSA age groups.

*County Population data is based on projections that are benchmarked to Census 2000: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000-2050. Sacramento, CA, May 2004. Census 2000 reported Santa Barbara County population to be 399,347; Dept. of Finance reported a projected population of 415,718 for FY04-05.

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

Analysis of Ethnic Disparities

Note: the “poverty/population” formula has traditionally been used by the California Department of Mental Health as a method to ensure that financial resources reach those most in need.

Latino/Hispanic Community

Research conducted in 2005 as part of the MHSA Community Services and Supports (CSS) planning process determined that Latinos were at risk for lack of access to services, particularly Latino adults. ADMHS was found to serve significantly more Caucasian adults than Latino adults in terms of their respective prevalence in the county 200% of poverty population. Latinos made up 24% of ADMHS adult clients, but 60% of the County 200% of poverty population. Caucasian adults were only 32% of the County 200% of poverty population, but made up 64% of all adults served.

Asian/Pacific Islander Community

Disparity was found across all age groups for the Asian Pacific Islander population. This suggests that ADMHS is not reaching or delivering services at a rate commensurate with their occurrence among people living at 200% of poverty in Santa Barbara County.

Native Americans

Native Americans are another group largely underserved by ADMHS. Very few Native Americans access ADMHS services. Census 2000 indicates that there are approximately 5,000 Native Americans living in Santa Barbara County. Many members of the Santa Ynez Band of Chumash Indians reside in the Central region of the county. In FY 04-05, ADMHS served a total of 95 Native Americans across all age groups. However, ADMHS did not serve any Native American transition-age youth. Native Americans are an unserved population in the County in need of outreach and engagement in culturally-bound services.

Children and Youth

A significant ethnic disparity exists between Latino children and youth served by ADMHS compared to Latino children and youth in the county 200% of poverty

population. Nearly half (48%) of children and youth served by ADMHS are Latino, while 75% of the county 200% of poverty population is Latino. In contrast, 42% of the children and youth served by ADMHS were Caucasian, even though they constitute only 19% of the Santa Barbara County's children and youth living at 200% of poverty.

Of the total child and youth population served, it appears that only 3% of Latino children and youth were fully served, and 6% of Caucasian children and youth are fully served. Within the fully served children and youth population, 31% of were Latino; however, 55% of all fully served children and youth were Caucasian. This finding reflects a disparity between Latino and Caucasian children living at 200% of poverty who are fully served by ADMHS. Ninety-seven percent (97%) of the Latino children and youth served were under/unserved compared to 94% Caucasian, suggesting no ethnic disparity.

Transition-Age Youth

When comparing percentage of the poverty population to the percentage served by ADMHS, no ethnic disparities emerged for the Latino transition-age youth population. Fully served Latino transition-age youth represented 1% of the transition-age youth population by ADMHS, in contrast to 3% for Caucasians.

Analysis of underserved/unserved transition-age youth indicates that there was no significant difference between Latino and Caucasian transition-age youth individuals. Very few youth served in this age group were African American or Asian. There were no fully served or under/unserved transition-age youth Native American individuals.

Adults

As in the other three age groups, Latinos are an underserved group. Latinos make up 24% of ADMHS adult clients, but 60% of the county 200% of poverty population. Caucasian adults are 32% of county 200% of poverty population but 64% of all ADMHS adults served.

There was no significant disparity between Latino and Caucasian individuals who were under/unserved; however, ADMHS serves significantly more Caucasian adults than Latino adults compared to their prevalence in the county 200% of the poverty population.

Among all adult clients served by ADMHS, the ethnic distribution of fully served clients was 11% of African Americans were fully served, 3% Latino, 8% Caucasian, 3% Asian and 14% Native American. Within the fully served population, 10% were Latino and 75% Caucasian. Clearly, there is a significant disparity. It is also interesting that in the context of the total ADMHS client population, a higher proportion of African Americans and Native Americans were fully served than Caucasians and Latinos, particularly considering that African Americans and Native Americans constitute relatively small proportions of the ADMHS client and severely mentally ill/seriously emotionally disturbed 200% of poverty populations.

Older Adults

The overall ethnic disparity is less dramatic in the older adult population than other age groups, yet still significant when comparing Latinos and Caucasians. Latino older adults made up 27% of the county 200% of poverty population, but only 15% of those served by ADMHS. Caucasians comprised 64% of people living in poverty in Santa Barbara County, but constituted 71% of the older adults served.

Ten percent (10%) of the total Latino older adult population are fully served, but the percent is lower for Caucasians, 5.6%. Twenty-five percent (25%) of all fully served older adults are Latino; 67% are Caucasian. No Native Americans older adults were fully served.

There were no significant disparities between under/unserved Latino and Caucasian older adults in the context of the total older adult population served. However, within the under/unserved populations, 15% were Latino and 72% Caucasian, which highlights an ethnic disparity. All older adult Native Americans are under/unserved (1% of the under/unserved)

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

- 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

The PEI planning process resulted in stakeholders identifying all six populations as priorities:

1. Trauma Exposed Individuals
2. Individuals Experiencing Onset of Serious Psychiatric Illness
3. Children and Youth in Stressed Families
4. Children and Youth at Risk for School Failure
5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
6. 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).

Research conducted during both the CSS and PEI planning processes identified disparities within target populations. For example, a major disparity regarding access to

services between Caucasians and Latinos 0-17. Consequently, a number of the PEI projects and strategies were formulated to reach underserved segments of the Latino community.

- Mental health programs were strengthened in community health clinics, settings that reduce stigma and geographical barriers for access by Latinos countywide;
- New TAY mental health teams for detection and early intervention will focus on underserved youth in both north and south County;
- Early childhood mental health programs will target underserved Latino children countywide;
- A school-based program in South County will provide prevention and early intervention services to children and youth who have been underserved;
- Community health educators from Latino communities will provide outreach, education and linkages to underserved members of the Latino community.

The community health education component of PEI will also target additional underserved cultural groups, including Latinos, Native Americans, Oaxacans and LGBT.

The PEI planning process was conducted in five phases in order to identify the target populations.

Phase One: Research Conducted by the University of California, Santa Barbara (UCSB). To obtain a solid research foundation from which to build the PEI planning process, a team of researchers with the UCSB Gevirtz Graduate School of Education compiled comprehensive information regarding mental health risk factors and prevalence (including national, state and local data). The data were then presented at all PEI planning meetings.

Phase Two: Regional Stakeholder Forums. In March 2009, three community forums, one in each of the County's major population centers (Santa Maria, Lompoc and Santa Barbara), offered stakeholders:

- Background about MHSA and PEI guidelines
- Summary of the research findings by UCSB
- Participation in one of four workgroups based on the four age groups (children, TAY, Adults and Older Adults) that prioritized community mental health needs and priority populations

Two means of informing stakeholders about the PEI Community Forums were used. First, ADMHS announced the forums at a number of major stakeholder groups, including the CFMAC, the Latino Advisory Committee (LAC), the Santa Barbara County Mental Health Commission (MHC) and Latino consumer and family member support groups in North and South County. Second, to ensure widespread coverage, emails were sent to 275 individuals or representatives of various organizations throughout the County reflecting the following key PEI constituencies and all age groups:

- Alcohol and Drug Treatment
- Community Centers
- Individuals with a serious mental illness
- Education
- Employment
- Faith-Based
- Family Members of individuals with a serious mental illness
- Homeless Activists
- Law Enforcement
- Mental Health
- Physical Health
- Social Services
- Underserved Communities

Phase Three: Focus Groups and Key Informant Interviews - The third phase of the stakeholder planning process was designed to ensure diversity and representation of underserved and unserved communities with an emphasis on individuals and groups who were unlikely to participate in regional meetings and other conventional stakeholder forums. Consisting of 38 individuals, the focus groups and key informant interviews addressed the concerns of the following under-represented groups:

- Transition-age youth;
- Native Americans;
- Latino/Spanish-speaking individuals;
- Members of the Oaxacan community;
- Members of the LGBT community;
- Victims of Crime.

Phase Four: During the three regional stakeholder forums, attendees discussed and ranked PEI priority populations and community mental health needs. An online survey solicited further stakeholder input, including suggested programs and interventions. The survey was based on the priorities, recommendations and information gathered from the interviews, focus groups and regional forums. Approximately 700 stakeholders were invited to complete the survey, which was also available in hard copy and in Spanish upon request. Hard copies of the survey and postage-paid return envelopes were distributed at a meeting of the countywide CFMAC. 138 responses were received.

Phase Five: After synthesizing the multiple and diverse sources of stakeholder input previously described, a draft plan was developed and feedback was solicited and integrated into the final approved plan.

CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES

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

A. List identified target populations, with disparities, within each of the above selected populations.

Medi-Cal:

| Medi-Cal Approved Claims Data for SANTA BARBARA County MHP Calendar Year 08 | | SANTA BARBARA | | | |
|---|---|---|-----------------|------------------|---|
| | Average Number of Eligibles per Month (4) | Number of Beneficiaries Served per Year | Approved Claims | Penetration Rate | Approved Claims per Beneficiary Served per Year |
| TOTAL | | | | | |
| | 74,073 | 5,006 | \$34,276,938 | 6.76% | \$6,847 |
| AGE GROUP | | | | | |
| 0-5 | 16,997 | 437 | \$1,815,077 | 2.57% | \$4,153 |
| 6-17 | 19,876 | 1,469 | \$13,026,231 | 7.39% | \$8,867 |
| 18-59 | 29,169 | 2,733 | \$17,003,652 | 9.37% | \$6,222 |
| 60+ | 8,032 | 367 | \$2,431,977 | 4.57% | \$6,627 |
| GENDER | | | | | |
| Female | 41,921 | 2,629 | \$15,931,269 | 6.27% | \$6,060 |
| Male | 32,152 | 2,377 | \$18,345,669 | 7.39% | \$7,718 |
| RACE/ETHNICITY | | | | | |
| White | 30,390 | 2,633 | \$17,519,323 | 8.66% | \$6,654 |
| Hispanic | 37,085 | 1,599 | \$10,751,120 | 4.31% | \$6,724 |
| African-American | 1,888 | 292 | \$1,974,676 | 15.47% | \$6,763 |
| Asian/Pacific Islander | 1,686 | 96 | \$670,253 | 5.69% | \$6,982 |
| Native American | 285 | 50 | \$351,951 | 17.54% | \$7,039 |
| Other | 2,742 | 336 | \$3,009,614 | 12.25% | \$8,957 |
| | | | | | |

Community Services and Support

| CHILDREN AND YOUTH | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
|------------------------|--------------|--------|------------------------|--------|--------------|------|---------------------------|------|-------------------|------|
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 69 | 42 | 1,314 | 872 | 2,330 | 100% | 36,819 | 100% | 89,162 | 100% |
| African American | 3 | 4 | 43 | 29 | 79 | 3% | 593 | 2% | 1,497 | 2% |
| Asian Pacific Islander | 0 | 0 | 15 | 5 | 20 | 1% | 656 | 2% | 2,811 | 3% |
| Latino | 19 | 15 | 702 | 386 | 1,122 | 48% | 27,660 | 75% | 47,697 | 53% |
| Native American | 1 | 1 | 18 | 11 | 31 | 1% | 172 | <1% | 754 | 1% |
| White | 42 | 19 | 501 | 413 | 975 | 42% | 6,868 | 19% | 33,406 | 37% |
| Other | 4 | 3 | 35 | 28 | 103 | 4% | 733 | 2% | 2,997 | 3% |
| TRANSITION AGE YOUTH | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 21 | 16 | 938 | 819 | 1,794 | 100 | 31,689 | 100 | 71,829 | 100 |
| African American | 5 | 0 | 36 | 33 | 74 | 4 | 491 | 2 | 1,347 | 2 |
| Asian Pacific Islander | 0 | 0 | 13 | 22 | 35 | 2 | 2,064 | 6 | 4,099 | 6 |
| Latino | 4 | 6 | 447 | 347 | 804 | 45 | 14,101 | 44 | 29,459 | 41 |
| Native American | 0 | 0 | 0 | 0 | 0 | 0 | 129 | <1 | 516 | |
| White | 11 | 10 | 420 | 383 | 824 | 46 | 13,845 | 43 | 34,796 | 48 |
| Other | 1 | 0 | 22 | 34 | 57 | 3 | 1,059 | 3 | 1,612 | 2 |
| ADULT | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 153 | 125 | 1,677 | 2,251 | 4,206 | 100 | 44,546 | 100 | 187,507 | 100 |
| African American | 12 | 14 | 94 | 108 | 228 | 5 | 808 | 2 | 4,362 | 2 |
| Asian Pacific Islander | 3 | 0 | 46 | 54 | 103 | 2 | 1,441 | 3 | 9,064 | 5 |
| Latino | 18 | 11 | 364 | 608 | 1,001 | 24 | 27,013 | 60 | 66,506 | 35 |
| Native American | 3 | 5 | 20 | 31 | 59 | 1 | 287 | 1 | 1,473 | 1 |
| White | 115 | 94 | 1,113 | 1,385 | 2,707 | 64 | 14,411 | 32 | 103,680 | 55 |
| Other | 2 | 1 | 40 | 65 | 108 | 3 | 586 | 1 | 2,422 | 1 |
| | | | | | | | | | | |
| OLDER ADULT | Fully Served | | Under-served/ Unserved | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | Number | % | Number | % | Number | % |
| TOTAL | 6 | 18 | 138 | 234 | 396 | 100 | 16,223 | 100 | 67,220 | 100 |
| African American | 0 | 1 | 0 | 13 | 14 | 4 | 389 | 2 | 1,082 | 2 |
| Asian Pacific Islander | 0 | 1 | 3 | 8 | 12 | 3 | 597 | 4 | 2,486 | 4 |
| Latino | 1 | 5 | 20 | 35 | 61 | 15 | 4,366 | 27 | 10,010 | 15 |
| Native American | 0 | 0 | 1 | 4 | 5 | 1 | 69 | <1 | 435 | 1 |
| White | 5 | 11 | 103 | 164 | 283 | 71 | 10,528 | 64 | 52,600 | 78 |
| Other | 0 | 0 | 11 | 10 | 21 | 5 | 274 | 2 | 607 | 1 |

Workforce Education and Training

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

Race/Ethnicity

| | White/ Caucasian | Hispanic/ Latino | African- American/ Black | Asian/Pacific Islander | Native American | Multi Race or Other | Total |
|--|---------------------|---------------------|--------------------------------|---------------------------|--------------------|------------------------------|-------|
| Public MH Population | 4259 | 6428 | 179 | 435 | 74 | 245 | 11620 |
| Workforce | 479 | 390 | 52 | 40 | 4 | 26 | 991 |
| % of Mental Health Pop by Ethnicity | 36.65% | 55.32% | 1.54% | 3.74% | .64% | 2.11% | 100% |
| % of Workforce by Ethnicity | 48.34% | 39.35% | 5.25% | 4.04% | .4% | 2.62% | 100% |

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).

PEI stakeholder forums were held in each major population center in Santa Barbara County (Santa Maria, Lompoc and Santa Barbara). Stakeholders were briefed on MHSA guidelines and research conducted by the University of California, Santa Barbara. Stakeholders broke into workgroups by age of the target populations (children, TAY, adults and older adults). After a discussion they were asked to prioritize priority populations. A series of focus groups were also held targeting specific populations (Latino, TAY, LGBTQ, etc.) known from past planning processes (CSS, WET) to be under-represented in conventional stakeholder processes such as community forums.

Community interest focused on providing prevention and early intervention services for school-age children at risk for failure, children and youth with involvement or at risk of involvement with CWS, young adults in crisis, adults in the criminal justice system, older adults who are isolated and/or experiencing a serious mental health condition and underserved cultural populations of all ages.

The PEI planning process was conducted in five phases in order to identify the target populations.

Phase One: Research Conducted by the University of California, Santa Barbara (UCSB). To obtain a solid research foundation from which to build the PEI planning process, a team of researchers with the UCSB Gevirtz Graduate School of Education compiled comprehensive information regarding mental health risk factors and

prevalence (including national, state and local data). The data was then presented at all PEI planning meetings.

Phase Two: Regional Stakeholder Forums. In March 2009, three community forums, one in each of the County's major population centers (Santa Maria, Lompoc and Santa Barbara), offered stakeholders: a background about MHSA and PEI guidelines; a summary of the research findings by UCSB; participation in one of four workgroups based on the four age groups (children, TAY, Adults and Older Adults) that prioritized community mental health needs and priority populations.

Two means of informing stakeholders about the PEI Community Forums were used. First, ADMHS announced the forums at a number of major stakeholder groups, including the Consumer Family Member Advisory Committee (CFMAC), the Latino Advisory Committee (LAC), the Santa Barbara County Mental Health Commission (MHC) and Latino consumer and family member support groups in North and South County. Second, to ensure widespread coverage, emails were sent to 275 individuals or representatives of various organizations throughout the County reflecting the following key PEI constituencies and all age groups:

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- Community Centers
- Individuals with a serious mental illness
- Education
- Employment
- Faith-Based
- Family Members of individuals with a serious mental illness
- Homeless Activists
- Law Enforcement
- Mental Health
- Physical Health
- Social Services
- Underserved Communities

Phase Three: Focus Groups and Key Informant Interviews - The third phase of the stakeholder planning process was designed to ensure diversity and representation of underserved and unserved communities with an emphasis on individuals and groups who were unlikely to participate in regional meetings and other conventional stakeholder forums. Consisting of 38 individuals, the focus groups and key informant interviews addressed the concerns of the following under-represented groups:

- Transition-age youth;
- Native Americans;
- Latino/Spanish-speaking individuals;
- Members of the Oaxacan community;
- Members of the LGBTQ community;
- Victims of Crime.

Phase Four: During the three regional stakeholder forums, attendees discussed and ranked PEI priority populations and community mental health needs. An online survey solicited further stakeholder input, including suggested programs and interventions. The survey was based on the priorities, recommendations and information gathered from the interviews, focus groups and regional forums. Approximately 700 stakeholders were invited to complete the survey, which was also available in hard copy and in Spanish upon request. Hard copies of the survey and postage-paid return envelopes were distributed at a meeting of the countywide Consumer Family Member Advisory Committee (CFMAC). 138 responses were received.

Phase Five: After synthesizing the multiple and diverse sources of stakeholder input previously described, a draft plan was developed and feedback was solicited and integrated into the final approved plan.

II. Identified disparities (within the target populations)

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

Medi-Cal:

According to the ADMHS - CAEQRO Report, December 2-3, 2009 the following:

- Women have a lower penetration rate than men by 1.12%
- Hispanics have a lower penetration rate than whites by 4.35%
- Hispanics have a lower penetration rate than African-Americans by 11.16%
- 85% of Services are provided in English to Medi-cal beneficiaries while 7% of the services are provided in Spanish. Approximately 36% of Hispanics are estimated to be Spanish only speakers. Approximately 19% of the services should be provided in Spanish if each client were to be provided services in their preferred/required language

CSS:

- 65% of underserved male Latino children was served as opposed to 35% of the underserved female Latino population. This results in a 30% difference between male and female Latino children who received services.
(Source: http://www.admhs.org/apps/admhs_main/MHSA/pdf/MHSA_Data_Packet.pdf, pg 32)
- The homeless population is underserved; children make up approximately 12% of the homeless population.
(Source: http://www.admhs.org/apps/admhs_main/MHSA/pdf/MHSA_Data_Packet.pdf, pg 11)
- 60% of the underserved male children were treated for a serious emotional disturbance and only 40% of the underserved female children were treated for a serious emotional disturbance, although men and woman are approximately 50% of the population.
(Source: http://www.admhs.org/apps/admhs_main/MHSA/pdf/MHSA_Data_Packet.pdf, pg 32)
66% of the underserved white adult male population was provided mental health services and only 33% of the underserved Latino population was provided services. (http://www.admhs.org/apps/admhs_main/MHSA/pdf/MHSA_Data_Packet.pdf, pg 32)

WET:

- Although 55.32% of the mental health population is Hispanic/Latino, only 39.35% of the workforce was Hispanic/Latino. To match the demographics between client and staff, approximately 16% more Hispanics/Latinos would need to be hired.
- Although approximately 48.34% of the workforce is White/Caucasian, only 36.65 % of the mental health clients are White/Caucasian.

PEI:

- The Oaxaqueno community is an invisible community with unmet needs. There are approximately 12,000 indigenous Hispanics in Santa Barbara County, and ADMHS employs one staff person that is trilingual, speaking Mixtec, English, and Spanish. The need for more tri-lingual staff is necessary in order to provide minimal mental health services to the Oaxaqueno community. (Source: Santa Maria Sun, January 18, 2007.)
- The LGBTQ population was not assessed in the CSS plan. Suicide risk for Transition Age Youth and Adults was a key concern for the LGBTQ population, and ADMHS had not previously recognized this group as an underserved group. As a result, the PEI plan has remedied the oversight by designating one community mental health worker be designated specifically to serve the LGBTQ population.

III. Identified strategies/objectives/actions/timelines

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

CSS:

- Use natural healing practices and ceremonies as recognized by enrollees, their families and communities.
- Develop an advisory body consisting primarily of clients and family members to provide advice and feedback on program functioning and development; include representatives from culturally and ethnically diverse and underserved communities.
- Promote community engagement by providing educational forums and developing natural community settings to be welcoming to people in recovery, including outreach to ethnically and culturally diverse communities.
- Provide cultural and gender-sensitive outreach and services at schools, primary care clinics, and community programs in ethnic communities that proactively reach children who may have emotional and/or behavioral disorders and provide easy and immediate access to mental health services when needed.
- Deploy integrated service teams that provide comprehensive mental health, social, cultural, physical health, substance abuse and trauma (including intergenerational trauma) assessments that are strength-based and focused on engagement of the

transition- age youth and provide gender and culture-specific assessments as in the DSM-IV-R cultural formulation.

- Hire staff consistent with racial/ethnic composition of clients and emphasizing cultural competence including bilingual staff.]
- Promote the inclusion of representatives of diverse ethnic and cultural communities in the planning and management of peer-run Recovery Learning Centers in each region of the County.

WET:

The WET plan identifies key strategies which includes the incorporation of cultural competence and language capacity in the workforce.

- Hire a Consumer Empowerment and a Workforce Education and Training (WET) Manager who will provide training, support, and mentoring in both Spanish and English to consumers entering the workforce via internship and other employment
- Develop an Internship Program designed to: 1) afford interested consumers and family members an opportunity to participate in the consumer/family training program; 2) provide supervision and training in Spanish; 3) develop training opportunities for Oaxacan and Native American communities.
- Develop a strategy to increase the workforce by of direct service staff persons who are bilingual/bicultural to serve Spanish speaking communities.
- Increase the capacity of law enforcement to better manage crisis situations with individuals experiencing severe mental illness by providing Crisis Intervention Training which includes components including cultural competence for different ethnic groups as well as the consumer and family culture.

PEI:

- Conduct outreach and education; community engagement, case management and linkages and cultural wellness practices for persons at risk of serious mental illness and their families in the Latino, Oaxacan, LGBT and Native American communities countywide.
- Offer prevention and early intervention services in community health clinics throughout the County that will maximize access for culturally and ethnically underserved communities, including the Latino community, by reducing the barriers of transportation and stigma.
- Provide In-home support, health and development screening, parent education and skills training, infant parent psychotherapy, advocacy, resources and referrals, postpartum support groups and further outreach.
- Focus on providing prevention and early intervention services to children and transition-age youth from underserved cultural and ethnic communities.
- Provide crisis services to school-based support and early detection and intervention teams for TAY. The population served countywide is underserved at risk children and TAY whose ages range from 15-25.

Cultural Competence Implementation Schedule

| 1 st Quarter 2010 July-Aug-Sept | 2 nd Quarter 2010 Oct-Nov-Dec | 3 rd Quarter 2011 Jan-Feb-Mar | 4 th Quarter 2011 April-May-June |
|--|---|---|---|
| <p>Training: Cultural Competence:</p> <ul style="list-style-type: none"> - Native American - Oaxaqueno - Spanish Speakers - Consumers - Family - Language & Culture (Practicing with Palencia) <p>Video Tape Client Experiences</p> <ul style="list-style-type: none"> - Spanish speakers - Parents of young children (Include Consumer Parents) - Oaxaqueno <p>Intake w/Cultural Competence Focus</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - LGBT - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> <p style="text-align: center;">-</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - African American - Asian - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - Native American - Oaxaqueno - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> |
| <p>Orientation</p> <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff <p>Teach "Use of Translators"</p> | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" |
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B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:

II. Medi-Cal population

- Outreach to the Spanish speaking community has been identified as a priority of ADMHS. It has been recognized that more bi-lingual/bi-cultural staff are required in order to engage the Latino/Spanish speaking communities.
- Increase Medi-Cal enrollment to better serve at-risk, indigent individuals.
- The Indigent population is in need of services despite the lack of Medi-cal eligibility, ADMHS has made a commitment to serve the neediest of the indigent population via MHSA programs.

III. 200% of poverty population

- Serve 20% more Latinos in Spanish by July 2015, compared to the July 2009 levels.
- Increase minimum bilingual/bicultural staffing levels to 40% in the entire system of care by 2015
- Require reporting be 100% complete, to include ethnicity and language preferred.
- Review services and programs on a quarterly basis to ensure that they are culturally competent and that the number of bilingual/bicultural staff hired is consistent the projected targets.
- Monitor the number of bilingual/bicultural clients served by bilingual/bicultural staff to ensure appropriate utilization.
- Review services for each age group and assess cultural competence for each program.
- Track ethnicity, language preferred, language

IV. MHSA/CSS population

- Ten programs were developed as a result of the CSS stakeholder process to maximize cost-effectiveness and quality of services; one program was eliminated and two were expanded.
- The LGBTQ, Oaxaqueno and Native American populations were not considerably represented during the CSS planning stages. During the PEI research and planning process, these communities were represented and programs developed to serve them.
- To better serve the Spanish speaking community, ADMHS established a new policy to hire 40% bilingual/bicultural staff in all MHSA programs. The lesson learned is that without the bilingual/bicultural capability, many Latinos will not seek necessary services until an emergency arises.
- ADMHS has established a new policy that will require that 40% of all new staff (county and contract) be bilingual/bicultural by 2015.

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

- All priority populations were identified during the PEI stakeholder process as being important. Populations identified as being unserved and underserved included the Native American, Oaxaqueno and LGBTQ communities.
- The community health educator (Promotora) project will place individuals in the Oaxacan, Latino, LGBT and Native American communities to provide, outreach, support and referrals to programs and services to enhance resiliency, decrease stigma, and connect the identified underserved populations to community services.

- Within each local community clinic mental health representatives will provide the new PEI program that strengthens preventive mental health services in community clinics countywide is designed to increase access to underserved communities by offering services in convenient, non-stigmatizing locations.

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

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.

It is the intention of ADMHS to make the 40% bilingual/bicultural staffing requirement, which is currently in place with all MHSA programs, a requirement for the entire mental health system in Santa Barbara County. Furthermore tracking in which language the service was provided will contribute to a greater understanding of whether the bilingual/bicultural staffing requirements are having the result of providing services in a cultural and linguistically competent manner. The current timeline established for ADMHS and the contracted CBOs to employ 40% of bilingual/bicultural staff is within the next five years. Augment the training plan to include the identified unserved and underserved communities such as the Oaxaquenos, LGBTQ, Disabled, etc... This staffing requirement has implications for all items identified under section B.

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.

Working Well:

ADMHS has made great strides in engaging the Spanish speaking community. Due to ADMHS' commitment to providing interpretation services and to requiring that the Latino perspective be integrated in the planning and monitoring of programs, there has been a dramatic increase of Latino involvement. Two years ago, only one Latino served on the Consumer and Family Advisory committee; now seven Latinos serve. In the MHSA implementation process meetings, Quality Improvement Committee meetings, and the hiring panels at least one position is designated for a Latino Advisory Committee representative. The Recovery Learning Centers (RLC) were designed with a specific focus on the needs of the Latino community. Approximately 50% of the Santa Barbara planning team was Latino and 100% of them used the Spanish interpretation services provided by the department during planning meetings.

Thirteen of the 35 consumers and family members who participated in the WET Peer Training program were Latino. Of this group, one participant also represented the Oaxacan community. Interpretation services were provided during the training to ensure that the monolingual trainees were able to participate.

Lessons Learned:

To provide an adequate level of culturally competent services, increased monitoring of all programs in the mental health system must be instituted. Requiring that all staff members participate in the cultural competence trainings is essential. A review tool to assess cultural competence must be designed and used. The Mental Health Commission, the Consumer and Family Advisory Group and the Latino Advisory Committee should be enlisted in a unified effort to increase and maintain cultural competence. Monitoring and tracking of bilingual and bicultural staffing numbers is necessary to ensure 100% compliance, as well as the number and ethnicities of clients served by the bilingual/bicultural staff members. To address the level of need in the Latino community, greater effort must be made to outreach to those underserved populations; although considerable progress has been made.

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

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.).

200% of poverty population

- Serve 20% more Latinos in Spanish by July 2015, compared to the July 2009 levels.
- Enhance services to Latinos by increasing bilingual/bicultural staffing requirements to 40% throughout the mental health system by July 2015.
- Create measurement tool to assess programs and services' cultural competence by July 2011.
- Establish target that seventy-five percent of clients whose preferred language is not English are served only by bilingual/bicultural staff instead of via interpretation services by July 2015.
- Ensure 100% reporting by ADMHS programs and contract agencies by July 2012.
- Enhance IT capability to track ethnicity, language preferred, language service was provided, if interpretation services were used and if they were by another clinician, non-clinician, friend, or language line. IT capability will be completed by July 2011.
- Analyze and report outcomes with an emphasis on the requirements for the Cultural Competence Plan to the ADMHS Administration, Mental Health Commission, Consumer and Family Advisory Committee, Latino Advisory Committee, and the Cultural Competence Committee on a Quarterly basis beginning in January 2011.

MHSA/CSS population

- Develop a PEI program specifically designed to serve the LGBTQ, Oaxaqueno, and the Native American populations (completed).
- Maintain a 40% bilingual/bicultural ADMHS and contractor staff funded with MHSA by July 2011.

- Obtain a 40% bilingual/bicultural ADMHS and contractor staff throughout entire mental health system by July 2012.

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.

- ADMHS monitors compliance via the Quarterly Reports which are required of all community based organizations.
- The Scorecard review tool will continue to be used to monitor bilingual/bicultural staffing levels reporting and a variety of additional factors helpful in assessing cultural competence and program effectiveness (Exhibit 1).
- Oversight committees, which include the Consumer and Family Member Advisory Board, the Mental Health Commission, and the Quality Improvement Committee, the Latino Advisory Committee, and the Cultural Competency Committee will review all outcome reports which will be reported by ADMHS on a quarterly basis.
- ADMHS expects to have 100% reporting compliance by January 2011 that will include data on ethnicity of clients, served, language of services, etc.

C. Identify county technical assistance needs.

The ADMHS-IT department will need to add components to the reporting software in order to capture the additional information.

**CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE:
INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH
SYSTEM**

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

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

ADMHS is committed to ensuring that all services are provided in a culturally competent and culturally sensitive manner. The Director is committed to engaging all ethnic communities in the Cultural Competence Committee. During November 2010 a group of community leaders and members representing the ethnic makeup of Santa Barbara County will meet to begin the process of designing the framework for the Cultural Competence Committee as required in the Cultural Competence Plan. In order to be culturally appropriate we feel it important that the Committee design the policies, procedures, etc.

- 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. Under development.

C. Organizational chart: To be developed.

D. Committee membership roster listing member affiliation if any: Under development.

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

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

During November 2010 a group of community leaders and members representing the ethnic makeup of Santa Barbara County will meet to begin the process of designing the framework for the Cultural Competence Committee. In order to be culturally appropriate we feel it important that the Committee design the policies, procedures, etc.

- B. Provide evidence that the Cultural Competence Committee participates in the above review process. (See A above.)

- C. Annual Report of the Cultural Competence Committee's activities including:
Not available.

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

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

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

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

ADMHS projects that approximately 500 ADMHS and CBO staff will need to be trained based on 2009 staffing levels.

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

Please see "Three-Year Schedule of Cultural Competence Trainings."

| Three-Year Schedule of Cultural Competence Trainings | | | |
|--|---|---|--|
| Cultural Competence Training Schedule FY 2010-2011 | | | |
| 1st Quarter 2010 July-Aug-Sept | 2nd Quarter 2010 Oct-Nov-Dec | 3rd Quarter 2011 Jan-Feb-Mar | 4th Quarter 2011 April-May-June |
| Training: Cultural Competence: <ul style="list-style-type: none"> - Native American - Oaxaqueno - Spanish Speakers - Consumers - Family - Language & Culture (Practicing with Palencia) Video Tape Client Experiences <ul style="list-style-type: none"> - Spanish speakers - Parents of young children (Include Consumer Parents) - Oaxaqueno Intake w/Cultural Competence Focus | Training Cultural Competence <ul style="list-style-type: none"> - LGBT - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture Provided to ADMHS staff & CBO staff - | Training Cultural Competence <ul style="list-style-type: none"> - African American - Asian - Spanish speakers - Consumers - Family - Language & Culture Provided to ADMHS staff & CBO staff | Training Cultural Competence <ul style="list-style-type: none"> - Native American - Oaxaqueno - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture Provided to ADMHS staff & CBO staff |
| Orientation <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness | Orientation <ul style="list-style-type: none"> - Show Videotapes to each new staff member | Orientation <ul style="list-style-type: none"> - Show Videotapes to each new staff member | Orientation <ul style="list-style-type: none"> - Show Videotapes to each new staff member |

| | | | |
|---|---|---|---|
| <ul style="list-style-type: none"> - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff <p>Teach "Use of Translators"</p> | <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" |
|---|---|---|---|

| Cultural Competence Training Schedule FY 2011-2012 | | | |
|--|---|--|---|
| 1st Quarter 2011 July-Aug-Sept | 2nd Quarter 2011 Oct-Nov-Dec | 3rd Quarter 2012 Jan-Feb-Mar | 4th Quarter 2012 April-May-June |
| <p>Training: Cultural Competence:</p> <ul style="list-style-type: none"> - Native American - Oaxaqueno - Spanish Speakers - Consumers - Family - Language & Culture (Practicing with Palencia) <p>Video Tape Client Experiences</p> <ul style="list-style-type: none"> - Spanish speakers - Parents of young children (Include Consumer Parents) - Oaxaqueno <p>Intake w/Cultural Competence Focus</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - LGBTQ - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> <p>-</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - African American - Asian - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - Native American - Elderly/Disabled - Oaxaqueno - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> |
| <p>Orientation</p> <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff <p>Teach "Use of Translators"</p> | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" |

| Cultural Competence Training Schedule FY 2012-2013 | | | |
|---|--|--|---|
| 1st Quarter 2012 July-Aug-Sept | 2nd Quarter 2012 Oct-Nov-Dec | 3rd Quarter 2013 Jan-Feb-Mar | 4th Quarter 2013 April-May-June |
| <p>Training: Cultural Competence:</p> <ul style="list-style-type: none"> - Native American - Oaxaqueno | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - LGBTQ - Elderly/Disabled | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - African American - Asian | <p>Training Cultural Competence</p> <ul style="list-style-type: none"> - Native American - Oaxaqueno |

| | | | |
|---|---|---|---|
| <ul style="list-style-type: none"> - Spanish Speakers - Consumers - Family - Language & Culture (Practicing with Palencia) <p>Video Tape Client Experiences</p> <ul style="list-style-type: none"> - Spanish speakers - Parents of young children (Include Consumer Parents) - Oaxaqueno <p>Intake w/Cultural Competence Focus</p> | <ul style="list-style-type: none"> - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> <p>-</p> | <ul style="list-style-type: none"> - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> | <ul style="list-style-type: none"> - Elderly/Disabled - Spanish speakers - Consumers - Family - Language & Culture <p>Provided to ADMHS staff & CBO staff</p> |
| <p>Orientation</p> <ul style="list-style-type: none"> - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff <p>Teach "Use of Translators"</p> | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" | <p>Orientation</p> <ul style="list-style-type: none"> - Show Videotapes to each new staff member - Tour facilities and enhance cultural awareness - Test Bilingual/Bicultural Staff - Teach "Use of Translators" |

2. How cultural competence has been embedded into all trainings

All training curricula address cultural competence issues. This includes information and examples regarding consumer and family culture and other cultural groups such as Native American, members of the military, Latino, Oaxaqueno, and LGBTQ. The trainings specifically focus on working with individuals whose native language is not English; this may include Spanish speakers, Mixtec speakers, etc.

II. Annual cultural competence trainings

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

Please see "Cultural Competence Trainings 11-09 to 6-10."

B. Annual cultural competence training 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 (Diversity groups, LGBTQ, SES, Elderly, Disabilities, etc.
6. Mental Health Interpreter Training
7. Training staff in Use of Interpreters in the Mental Health Setting
8. Training in the Use of Interpreters in the Mental Health Setting

Please see "Cultural Competence Trainings 11-09 to 6-10."

| Cultural Competence Trainings 11-09 to 6-10 | | | | | | | |
|--|--|---|---------------------------------------|-------------------------|--------------|-------------------------|--|
| Training Event | Description of Training | How long and often | Attendance by Function | No. of Attendees | Total | Date of Training | Name of Presenter |
| | | | Direct Services | | | | |
| | | | Direct Services Contractors | | | | |
| | | | Administration | | | | |
| | | | Interpreters | | | | |
| 1. Consumer & Family Culture | Consumers/family members share perspectives | 90 min every 2 months starting March 2010 | Admin Direct Serv Contractor | 21 23 2 | 46 | 11/19/09 | Kaufmann Family |
| 2. Consumer & Family Culture | Consumers/family members share perspectives | 90 min every 2 months starting March 2010 | Admin Direct Service Contractor | 1 25 9 | 34 | 3/30/10 | Silvia Perez |
| 3. Consumer & Family Culture | Consumers/family members share perspectives | 90 min every 2 months starting March 2010 | Direct Staff | 16 | 16 | 5/20/10 | Ned Wilson |
| 4. Crisis Intervention Training | How law enforcement can deal effectively with people experiencing mental health crises; included segment on consumer/family perspectives | Once a year; 4 days | Law enforcement professionals | 35 | 35 | 1/26 – 1/29/10 | Maureen Mina, George Kaufmann, Silvia Perez, Tina Wooton |

| | | | | | | | |
|--|--|--------------------|---|-----------------|-----|---------|-------------------------------------|
| 5. Working with the Oaxacan Community | An introduction to Oaxacan Community Culture, Traditions and Needs | One-time training. | ADMHS staff CBO staff partner county agency staff | 21 153 42 | 216 | 7/2/09 | Nayamin Cossio and Bertha Rodriguez |
| 6. Helping our Clients Become Workers – Inside and Out | A recovery-based approach to work. | One-time training | ADMHS staff CBO staff Consumers | 19 36 8 | 63 | 6/10/09 | Dr. Mark Ragins |

| | | | | | | | |
|---|---|---|-------------|---------------------|-----|---------|----------------------------|
| 7. Cultural Diversity: A Primer | Online (E-Learning) This workshop is designed to help all employees look at themselves and to identify attitudes and behaviors that stand in the way of group productivity | Ongoing until all ADMHS staff complete it | ADMHS staff | 261 (as of 5/25/10) | 261 | Ongoing | Network of Care E-Learning |
| 8. Understanding and Valuing Diversity | Online (E-Learning) The training will use mini-lecture, group exercise, dialogue, and discussion to facilitate a new awareness of the fundamental paradox of humanity: everyone is unique while being universally the same. | Ongoing until all ADMHS staff complete it | ADMHS staff | 246 (as of 5/25/10) | 246 | Ongoing | Network of Care E-Learning |
| 9. Immigrant Populations as Victims: Toward a Multicultural Criminal Justice System | Online (E-Learning) This article summarizes a study that investigated whether the diverse cultural makeup of many communities requires the criminal justice | Ongoing until all ADMHS staff complete it | ADMHS | 246 (as of 5/25/10) | 249 | Ongoing | Network of Care E-Learning |

| | | | | | | | |
|---|--|-----------|--|--|-----|---------|------------------------|
| | system to modify its approach. | | | | | | |
| Healing the Wounded Spirit : Working with the Native American Community | What mental health providers should know about Native American healing practices, spiritual perspectives, and historical trauma. | One time. | ADMHS and contract provider staff; community leaders; independent providers. | | 201 | 6/29/10 | Isaac Alvarez Cardenas |

III. Relevance of and effectiveness of all cultural competence trainings

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

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

Cultural competence trainings are an excellent tool for building awareness, which, in turn, is a necessary step in reducing ethnic and cultural disparities. All key players in the public mental health system, including administrators, county and contracted staff, community leaders and clients need to be educated about the needs, beliefs and strengths of culturally and ethnically underserved communities. As awareness is heightened, individuals become more supportive of efforts to increase inclusion. For example:

- The training about the Oaxacan community highlighted how this non-Spanish-speaking group is culturally and linguistically isolated even from the larger Latino community. Language and cultural barriers require unique outreach strategies for the Oaxacan community unprecedented in Santa Barbara County.
- Client and family culture trainings have vividly illustrated the challenges faced by consumers and their families. As clients and family members tell their stories, often with great passion and emotion, this humanizes mental health and makes a positive impact on the mental health and law enforcement professionals who attend the trainings.
- A recent training on the Native American culture illustrated how mental health providers must sometimes look beyond a strict interpretation of standard mental health diagnostic criteria to successfully reach persons with traditional belief systems. Trainings that challenge providers and administrators to remain open-minded help set the stage for a more inclusive system.

No group or profession has a monopoly on the best practices to achieve wellness and recovery. Every underserved cultural and ethnic group has a lot to offer to the wider community and to the system of care. With a robust schedule of cultural competence

trainings addressing the LGBT, Latino and Native American communities, client and family member culture and other issues, ADMHS is committed to continue to build awareness and share ideas across cultures. This will enrich the mental health service delivery system and ensure greater access for underserved individuals.

2. Results of pre/post tests

The MHP is exploring mechanisms to have pre and post testing included in future Cultural Competence training.

3. Summary report of evaluations

The MHP currently collects post-training evaluations. A data base for training evaluations will be created and quarterly summary reports will be developed beginning in January, 2011.

4. Current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings

ADMHS does not currently monitor advancing staff skills and post skills. ADMHS will revise their system to accommodate the recommendations of the Cultural Competence Committee.

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

ADMHS does not currently have a methodology for following up and ensuring that trained staff members are using their acquired skills. ADMHS will revise their system to accommodate the recommendations of the Cultural Competence Committee. =

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

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

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:

Please see "Cultural Competence Trainings 11-09 to 6-10."

ADMHS is committed to incorporating trainings on the culture of consumers, and the culture of family members of consumers, which are called "Consumer and Family Culture" trainings. The first of these trainings was held in November 2009 and included consumers, family members, and a family member of a child consumer. The consumers expressed personal experiences which included hospitalizations, issues with

medications, diagnosis, and labeling. Bilingual, bicultural clients talked about the above issues but also talked about barriers in the system such as culture- specific expressions of distress, the importance of alternate models of treatment, and discrimination. Trainings started on a regular basis as of March 2010 and are now offered every two months. The trainings are designed to educate staff on the personal experiences of consumers and family members, including racial, ethnic, cultural, and linguistic issues. Consumer and family members from a variety of programs and cultural groups are invited to train staff. These trainings are mandatory on an annual basis for all staff, including administrative staff.

CRITERION 6: COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF

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

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.

B. Compare the WET Plan assessment data with the general population, Medi-Cal population, and 200% of poverty data

Workforce Needs Assessment shows the comparability of workforce by race/ethnicity, to target population receiving public mental health services:

| | White/Caucasian | Hispanic/Latino | African-American/Black | Asian/Pacific Islander | Native American | Multirace or other | Total |
|-----------------------------|-----------------|-----------------|------------------------|------------------------|-----------------|--------------------|-------|
| Public MH Population | 4259 | 6428 | 179 | 435 | 74 | 245 | 11620 |
| Workforce | 479 | 390 | 52 | 40 | 4 | 26 | 991 |
| % of MH Pop by Ethnicity | 36.65% | 55.32% | 1.54% | 3.74% | .64% | 2.11% | 100% |
| % of Workforce by Ethnicity | 48.34% | 39.35% | 5.25% | 4.04% | .4% | 2.62% | 100% |

General population, Medi-Cal Population and 200% of poverty data:

| | White/Caucasian | Hispanic/Latino | African-American/Black | Asian/Pacific Islander | Native American | Multi-race or Other | Total |
|--|-----------------|-----------------|------------------------|------------------------|-----------------|---------------------|----------------|
| Santa Barbara County Population** | 212,692 (53%) | 156,499 (39%) | 7,566 (2%) | 17,992 (4%) | 2,229 (1%) | 7,219 (2%) | 404,197 (100%) |
| Public MH Population <200% poverty** | 41,901 (31%) | 81,402 (61%) | 1,921 (1%) | 5,111 (4%) | 748 (1%) | 2,139 (2%) | 133,222 (100%) |
| Santa Barbara County Medi-Cal Eligibles*** | 50,760 (61%) | 27,952 (34%) | 1,902 (2%) | 1,396 (2%) | 367 (<1%) | 987 (1%) | 83,365 (100%) |
| SB County MH Population by Ethnicity (clients served FY 8/09)* | 3,498 (42%) | 3,134 (38%) | 328 (4%) | 78 (1%) | 70 (1%) | 1,081 (13%) | 8,231 (100%) |
| Workforce by Ethnicity* | 479 (48%) | 390 (39%) | 52 (5%) | 40 (4%) | 4 (.4%) | 26 (3%) | 991 (100%) |

*Total may not equal 100% due to rounding.

**Santa Barbara County Population and Public Mental Health Population provided by CA Department of Mental Health: CPES Estimates of Need for Mental Health Services (2007)

***Santa Barbara County Department of Social Services provided Medi-Cal Eligible data.

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

Not applicable. No technical assistance was used.

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

Limited targets have been developed through the WET Plan to grow a multicultural workforce because the focus was mainly on consumer/family member entry level peer training opportunities, Crisis Intervention Training (CIT) and Registered Nurse (RN) stipends. However, four out of eight consumer/family member peer intern positions are designated as bilingual/bicultural positions for the next two years. See attached for more information on the ADMHS Peer Training and internship opportunities and training program (Exhibits 2 & 3).

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

Rolling out the WET plan is a complex, multidimensional task that focuses on developing an internship program to provide consumers and family members an opportunity to participate in newly developed peer training, to address shortages in the mental health field and to build skills for entry or re-entry into the workforce.

Lessons learned:

- Initially ADMHS reviewed several programs such as SPIRIT, Best Now, Inspire to Work and other Peer Employment Training Programs. The WET Implementation committee consisting of consumers and family member stakeholders, decided to develop the training to fit the Department's mental health system needs. Lesson learned was to look locally for a more suitable program for the community needs.
- Length of time to roll out the WET plan has been problematic particularly because there was a turnover in the Consumer Empowerment Manager position and the position was vacant for a year. At the stakeholder's request, the Department postponed the project until the new Consumer Empowerment Manager was hired. During the replacement process which took a substantial amount of time and the momentum for the WET plan lagged. The lesson learned was to give continual updates on the status to the stakeholders.
- The cultural competency focus of developing materials for the threshold language has led to an increasing need for documents to be translated to Spanish. In the future ADMHS needs to develop a budget for certified translator to meet these needs.

F. Identify county technical assistance needs.
ADMHS is currently assessing the technical assistance needs.

CRITERION 7: COUNTY MENTAL HEALTH SYSTEM LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

- A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity.

The ADMHS Human Resources Division has been involved as a critical participant in the implementation of MHSA programs and is playing a key roll in ensuring the focus of developing a bilingual/bicultural workforce to meet the needs of the target population. Overall, ADMHS has a performance measure that states that the target for each quarter is to hire at least 40% of new hires as bilingual/bicultural Spanish speaking staff, requirement is being met. In addition, 26% of the entire ADMHS staff has bilingual Spanish speaking skills and they are getting paid a differential for using those skills. This is up from 24% in 2008. Bilingual/bicultural staffing for CBOs is also being tracked quarterly on a newly developed contract monitoring system called Scorecards.

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

The WET Internship will provide program intends to hire 4 out of the 8 positions as bilingual/bicultural Spanish speaking Peer Consumer/Family Member positions

- 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.

The CSS programs initially identified targeted positions to be filled with Spanish speakers. Currently, 34% of MHSA/CSS staff consists of bilingual/bicultural staff which demonstrates that ADMHS is currently on track to meet the goal of building bilingual/bicultural staff to 40% of the workforce.

CBO Scorecards will need to be analyzed to determine if they are on track to meet the goal of building bilingual/bicultural staff to 40% of the workforce.

- 3. Total annual dedicated resources for interpreter services.

Currently \$40,000 is dedicated for “language line” interpreter services.

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

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

- 1. A 24-hour phone line with statewide toll-free access that has linguistic capability,

including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

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

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

- ADMHS has policies and procedures in place and implemented for the 24-hour phone line that is available to all individuals and those that require linguistic accommodations. Interpretation equipment is available for meetings and other events as needed. The Quality Assurance Division provides training on language line usage (Exhibit 37).

1. 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.

ADMHS periodically conducts Language Line training for clinical staff members who need to access the line in order to meet the linguistic needs of clients. The training is conducted by Quality Assurance staff (Exhibits 5 & 6).

B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services. Including posting of this right (Exhibit 7).

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

Data show that ADMHS Clinics, Crisis and Recovery Emergency Services (CARES) and Psychiatric Health Facility (PHF) staff are providing services to monolingual clients. Language needs are determined when a client goes through and intake process with ADMHS's ACCESS Team. The ACCESS Team uses a form that collects language need information. Once the client has gone through the Access Line and screened by CARES, clients are referred to programs for services. Information gathered through this intake process is passed on to the clinics so that they can make arrangements for bi-lingual staff and/or interpreter services. Additionally, there is a check-box on the intake form which denotes the primary language and this accompanies the client throughout their treatment. In most cases, when Spanish is determined to be the primary language, a bi-lingual staff member is assigned the case. When needed, the Language Line is utilized to ensure that client language needs are addressed.

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

Providing appropriate accommodation can be highly complex. Santa Barbara County is rich in cultural diversity, and with that richness comes a variety of language needs. The most complicating factor are the various dialects for any given cultural/linguistic preference. The Department has learned that it is not sufficient to simply have bi-lingual capacity in Santa Barbara County's threshold language. ADMHS has had to understand the variety of dialects and attempt to meet the challenge of ensuring interpretation of materials and translation can accommodate those dialects as needed. Additionally, ADMHS has learned that it takes a great deal of human and financial resource to meet the bi-lingual needs of a community such as Santa Barbara County.

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

The primary challenges faced by ADMHS have been in finding alternatives to the language line and in having fully certified interpreter services available due to resource and financial limitations. However, over the past 3 -5 years ADMHS has focused efforts on recruiting and hiring bi-lingual/bi-cultural staff in key positions who can communicate to consumers in their primary language. Additionally, steps have been taken to insure that all clinical staff members remain aware of the availability of the language line as a resource and that they use it whenever necessary. Finally, ADMHS has practices in place to ensure that beneficiary material is consistently available and easily accessed in both English and Spanish at all service sites. Another challenge had been providing interpretation at various stakeholder meetings and processes. MHS funds were utilized to purchase interpretation equipment in order to provide non-intrusive interpretation and improve stakeholder and consumer participation in meetings, trainings and other processes. Increased data collection is necessary in order to gather complete information about the client's ethnicity and preferred language.

E. Identify county technical assistance needs.

At this time, ADMHS is continuing to analyze and identify technical assistance needs and will seek assistance as appropriate when needs are identified.

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

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

Beneficiary Rights and Responsibility material is posted and available in English and Spanish in all ADMHS clinics, provider organizations, and service areas. Additionally,

bulletins regarding the availability of interpreter services and language line are posted in ADMHS clinics and service sites (Exhibit 7).

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

During the intake process, clients are asked to identify their language preference, which is then documented in the client file (Exhibit 12).

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

ADMHS has partially met this criterion by working toward ensuring the appropriate ratio of staff to client needing language accommodations. Presently, 26% of all ADMHS staff members are linguistically proficient in the threshold language. More specifically, 34% of MHS program staff members are linguistically proficient in the threshold language. ADMHS has set a goal of hiring to a 40% linguistically proficient staffing level. Additionally, improvement is needed for contract providers. ADMHS has not set a goal for contract provider staff in terms of linguistic proficiency, but intends to set a threshold for all providers within fiscal year 2010-2011.

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

Spanish Language proficiency testing has been developed by the Latino Advisory Committee and ADMHS Human Resources staff. The exam is administered orally and in writing. There are four parts to the exam:

Part One of the Bilingual Exam is oral and testers are given a scenario in Spanish by the test administrator in which they are to respond to in Spanish.

Part Two is a written exam in Spanish which is fill in the blank with one of a choice of three words.

Part Three is translating Spanish words to English.

Part Four is translating English words to Spanish.

Grading for Part One, oral translation, is either Unsatisfactory (substantial mistakes resulting in ineffective translation), Satisfactory (some mistakes but translation is adequate) or Excellent (demonstrates fluency in Spanish). 70% is a passing grade for Parts Two through Four. The feedback provides the following areas that may need improvement: Fluency, Comprehension, Basic grammar and Pronunciation. If a tester fails they have the option of having another test administrator review their test.

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

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

ADMHS has met this criterion, as the agency has policies and procedures in place regarding offering mental health services and interpretation services as needed. The policies and procedures are fully implemented for individuals that meet the threshold language of the county as well as other languages that are not threshold languages. (Exhibits 9 &13)

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.

This criterion is also met. ADMHS has written policies and procedures for assisting clients that do not meet the language threshold with 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.

ADMHS has policies, procedures and practices in place to comply with items 1 and 2 of Title VI of the Civil Rights Act of 1964 (Exhibit 9). It is the policy of ADMHS that no children shall be used as interpreters unless requested by their legal guardian.

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

A. Culturally and linguistically appropriate written information for threshold languages:

ADMHS has met this criterion by offering standard beneficiary information in English and Spanish. At entry to services and annually, clients are provided with information in English and Spanish regarding availability of interpretive services (Exhibit 7), lists of providers (Exhibits 22&23) , beneficiary rights (Exhibits 11& 20), problem resolution processes, financial responsibilities, consents for release of information, treatment

authorization, discharge criteria, compliance hotline, privacy practices and advance directives (Exhibit 19). Availability of materials in waiting room is also monitored for all ADMHS clinic sites and community based organizations in the provider network. ADMHS monitors the distribution and availability of these materials through the use of tracking forms that log the date, name of provider/clinic, and materials distributed (Exhibit 25).

The MHP maintains a log of distributed materials. Clinics and contracted providers are visited annually at which time the MHP ensures all materials are available and easily accessible. Additionally, the MHP will add a checklist of materials which are required to be displayed and readily available to clients to the Contracted Provider's quarterly reporting requirements. For ADMHS clinics, Office Professional staff are responsible for replenishing materials and completing checklist then submitting to QA quarterly.

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

The ADMHS assessment form includes a section for this documentation (Exhibit 14)

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

The client satisfaction surveys (POQI) conducted by the Department of Mental Health (DMH) are provided in English and Spanish. As summary reports become available ADMHS will analyze the outcomes and make recommended improvements.

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

This criterion has not been met. ADMHS intends to research the best or most efficient method to determine accuracy. Resource availability will determine progress.

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.

This criterion has not been met. ADMHS intends to research the best or most efficient method to determine accuracy. Resource availability will determine progress.

CRITERION 8: ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness program

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

Partners in Hope, is a MHSA CSS program that promotes wellness and recovery through peer support activities in Santa Barbara County. The Partners in Hope Program is a peer-run program providing peer support services to consumers and family members, with the integration of three Peer Recovery Specialists (ADMHS) and three Family Advocates with Transitions Mental Health Association (TMH) and the Mental Health Association (MHA).

Recovery Learning Communities are located in Santa Maria, Lompoc and Santa Barbara are centers where consumers and family members can get information and resources for care and services in Santa Barbara County and learn more about self-help wellness recovery approach to their own treatment.

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.

Partners in Hope has integrated Peer Recovery Specialists and can promote and model recovery from his or her personal experience as well as from training in respected curriculums on best practices for mental health recovery. ADMHS has hired one bi-lingual bi-cultural staff person and has now made it a requirement to have a bi-lingual bi-cultural person in the Santa Maria Peer Specialist position since most of the population in that region is Latino. Peer Recovery Specialists and Family Advocates conduct groups in all three regions of the County. In addition, Partners in Hope has two Peer Recovery Specialists that have AOD experience and conduct groups as well.

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

In the program a Latino Support group, El Nuevo Amanecer provides support and does outreach to the Latino population here in Santa Barbara County and the peer recovery specialist provide groups and activities in Spanish.

II. Responsiveness of mental health services

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

ADMHS offers a variety of referral options to meet the cultural needs of consumers. Referrals are done via the ACCESS Team when appropriate for culturally and linguistically appropriate services (i.e.: Spanish speaking network providers, LGBTQ resources, peer counseling, support groups and various natural and community supports. Clinics and contractors refer or offer culturally sensitive services, as well as research evidenced-based culture-specific programs to ensure availability of the most appropriate services within available resources.

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

ADMHS provides a member services brochures in all service sites and to any individuals seeking service. Contained within that brochure is information regarding all services provided, consumer rights and responsibilities and access information (Exhibit 16).

C. Counties have policies, procedures, and practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

ADMHS maintains 24 hour nationwide Access Line as well as partnerships with CBO's that serve various Medi-Cal Beneficiaries. The MHP maintains a Network of Community Providers available to Beneficiaries and have outreach staff and crisis response staff at CARES and CARES Mobile Crisis. MHP Beneficiary brochures and information including how to access care are distributed via these provider partners (Exhibits 22 & 23).

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.

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

The Santa Barbara's RLC is open from 10:00 am to 4:00 pm Mondays, Wednesdays and Thursdays and 10:00 am to 7:00 pm on Tuesdays. The Santa Maria RLC is open 9:00 am to 5:00 pm Tuesday, Wednesday, Friday, and 11:00 am -5:00 pm on Thursday. Additional activities of the Program are expected to occur outside of the Center hours. In addition, county transportation is provided by the Santa Maria Area Transit for the Santa Maria region, the Metro Transportation Department for the Santa Barbara area and the City of Lompoc Transit for the City of Lompoc, the Vandenberg Community and Vandenberg Air Force base. The Recovery Assistants within the department also provide transportation to clients when necessary.

2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds

The County follows regulations for facilities to be ADA compliant, and contractors are required to do the same. Consumer Art and signs are at the clinics North and South and at the RLC's. In addition, there are magazines and some news documents in Spanish.

3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships

South County (Santa Barbara) is located in a community setting. It is located on a campus that also has Public Health services and Social Services. Veteran's services are located on the campus as well and in addition, the Sheriffs Office and the jail are in the near vicinity. The Santa Barbara Regional Learning Community (MH Wellness Center) is located a few miles away, in the downtown area. The Lompoc Clinic is located more remotely, however the Lompoc Learning Community is located at the Supported Housing program, Home Base on G. The Santa Maria clinic is located on Broadway St. which is centrally located on the main street in Santa Maria. Gatehouse is the Recovery Learning Community in Santa Maria and it is located in a centrally located spot in downtown Santa Maria.

III. Quality of Care: Contract Providers

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

There is language in the standard provider contracts that requires contractors to report the percentage of bi-lingual/bi-cultural staff hired. The Mental Health Services Act programs have a 40% requirement to hire bi-lingual/bi-cultural staff and a required benchmark for all contracts is being considered.

IV. Quality Assurance

- A. List if applicable, any outcome measures, identification, and descriptions of any culturally relevant consumer outcome measures used by the county.
- 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
- C. Grievances and Complaints: Provide a description of how the county mental health process for Medi-Cal and non-Medi-Cal client Grievance and Complaint/Issues Resolution Process data is analyzed and any comparison rates between the general beneficiary population and ethnic beneficiaries.

ADMHS does not conduct these activities at present. The Cultural Competence Committee will incorporate staff satisfaction a key component in the development of the cultural competence plan.