# CONTRA COSTA COUNTY
# MENTAL HEALTH SERVICES

# CULTURAL COMPETENCE PLAN

## 2010
**(REVISED)**

## Three Year Plan
## Fiscal Year
## 2010-11, 2011-12, 2012-13

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

CONTRA COSTA
Mental Health Division

## Contra Costa Mental Health
## Cultural Competence Mission and Vision Statement

### Mission Statement

Our mission is to reduce disparities in mental health and health care delivery by creating a workforce that is culturally competent; promotes wellness, recovery and resiliency; and engages in the building and fostering of relationships with individuals and communities of Contra Costa County.

### Vision Statement

All residents of Contra Costa County who seek mental health services will have equal access to those quality health care services that they need. Residents will be cared for, and treated by, a workforce that is broadly diverse and varied by culture and language. We will continuously promote prevention, intervention, healing, and healthy lifestyle choices by removing barriers to culturally appropriate and competent health care. Contra Costa County's health care organization will be known because of the safe and supportive environment it provides for the complete healing of the mind, body, and spirit, and also as an organization that has embraced the tenets of whole-person wellness, recovery and ongoing resiliency.

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# INTRODUCTION

The 2010 Cultural Competence Plan Requirement (CCPR) is a revised version of the original CCPR (2002). The original CCPR addressed only Medi-Cal Specialty Mental Health Services, while the revised CCPR (2010) addresses all mental health services and programs throughout the County Mental Health System. The Contra Costa Mental Health (CCMH) revised Cultural Competence Plan (2010), aims at sustaining, as well as developing, the most culturally and linguistically competent programs and services to meet the needs of the diverse racial, ethnic, and cultural communities in Contra Costa County.

Contra Costa Mental Health is a Division under the Contra Costa Health Services Department (CCHSD). In 2003, in an effort to reduce health and health care disparities, CCHSD adopted the Reducing Health Disparities Initiative (RHDI) plan. This plan is used as a guide by Divisions to implement departmental policies and collect data related to disparities. A report is presented to the CCHSD Director on an annual basis.

As part of the Role of the Divisions in reducing health disparities, CCMH created a cultural competence committee called the Reducing Health Disparities (RHD) workgroup. The RHD workgroup is structured around the guiding principles of the Health Services Department's Reducing Health Disparities Initiative (RHDI). The goal of the workgroup is ensure that all County Mental Health staff provides services with cultural humility that respect the values, belief systems and cultural preferences of our consumers and communities. To accomplish this goal, the RHD guiding principles will be incorporated into the work of CCMH.

Below are some of the guiding principles of the RHDI

- We are committed to eliminating health disparities because our mission is to care for and improve the health of all who live in Contra Costa County with special attention to those who are most vulnerable to health problems. Disparities based on race, ethnicity, language, socioeconomic status or other similar reasons are inconsistent with our mission.
- We recognize that differences in race, ethnicity, age, gender, sexual orientation, language, physical ability, socioeconomic class, education, and many other factors can affect how we relate to patients, clients, customers consumers, communities and each other.
- Our employees participate in training and related activities to increase our knowledge and appreciation of diverse cultures and to become comfortable and effective in a diverse environment
- The RHD structure is designed to ensure RHD efforts are integrated into day-to-day activities of the department and all of its division.
- There is a role for every employee, manager, supervisor and Division Director.

The revised 2010 Cultural Competence Plan serves as a guide in the County's effort in delivering cultural competent services and reducing health and health care disparities. The cultural competence plan addresses different factors in relation to cultural competence, which include assessment of service needs, strategies to reduce disparities, language capacity, race/ethnicity, cultural competent training, and commitment to growing a multicultural workforce.

In addition to existing county mental health programs, the implementation of approved components of the Mental Health Services Act (MHSA), has allowed the county mental health system increase its capacity in community outreach and the delivery of culturally competent services. For example through the Prevention and Early Intervention (PEI) component of MHSA, twenty (20) PEI Providers have been selected and as a collective twenty-three (23) programs are currently being implemented. Since Latinos are the most underrepresented groups in our system of care, of the twenty-three (23) programs, twenty (20) of them are serving the Latino population. Other populations that are being served under the PEI component include Asians, Native Americans, African Americans, Older Adult and LGBTQ consumers.

Also under MHSA is the Workforce Education Training (WET) component. This component has created opportunities for the county mental health system to grow a multicultural workforce. This component has created resources to provide activities such as cultural competent training to county mental health staff, consumers and family members. There are a total of 13 items outlined in the WET Plan that are geared towards the commitment of growing a multicultural workforce, which include hiring and retaining culturally and linguistically competent staff.

Another component of MHSA that has been implemented with efforts geared towards reducing disparities is the Community Services and Support (CSS) Plan. This component is aimed at providing intensive services to a relatively small group of consumers who will be offered Full Service Partnerships. Full Service Partnership combines the notion of fully "wrapping services around" an individual or family with "whatever it takes" to clear the way for each individual to achieve his/her own recovery. CSS strategies are integrated into four service programs and one housing program; strategies are aimed at reducing ethnic disparities across all age groups.

Outcome measures have been created for all strategies in the revised 2010 Cultural Competence Plan. An annual report will be developed to assess the progress of the plan and develop new strategies that appropriately address those areas that need to be revamped in order to reduce identified disparities.

The revised 2010 Cultural Competence Plan is a “working document” and will be revised or adjusted as needed. In order to assure consistency between the goals of the Cultural Competence Plan, and those of the Quality Improvement Program, including those that address State requirements, the Reducing Health Disparities (RHD) Workgroup will participate in the CCMH Quality Improvement Program. This includes having representation on the Quality Management Committee and Quality Improvement Council.

# CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

## I. County Mental Health System Commitment to Cultural Competence

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

Contra Costa Mental Health (CCMH) has policies, along with practices, Mental Health Services Act (MHSA) work plans and committees that incorporate the recognition and value of racial, ethnic, and cultural diversity within the Division's system. The Division has a cultural competence committee called the Reducing Health Disparities Workgroup and also a Consumer workgroup that are involved in different processes of decision making and program planning to make sure that the steps taken in those processes fully incorporate the recognition and value of racial , ethnic, and cultural diversity. Below are excerpts from some of our statements and policies that reflect the awareness, efforts and integration of cultural diversity into the Mental Health System:

***Contra Costa Mental Health's Cultural Competence Mission and Vision Statements***

***Mission:***

***Create a therapeutic milieu that supports the individual's/consumer's culture, values, beliefs, life ways and lifestyles. Educate the workforce to be culturally competent, through a strategic plan which encompasses a set of congruent practice skills, attitudes, policies and structures which come together in a system of agencies and professionals that enables the system to work effectively in cross cultural situations.***

***Vision:***

***All residents of Contra Costa County who seek mental health services will have equal access to those quality health care services that they need. Residents will be cared for, and treated by, a workforce that is broadly diverse and varied by culture and language. We will continuously promote prevention, intervention, healing, and healthy lifestyle choices by removing barriers to culturally appropriate and competent health care. Contra Costa County's health care organization will be known because of the safe and supportive environment it provides for the complete healing of the mind, body, and spirit, and also as an organization that has embraced the tenets of whole-person wellness, recovery and ongoing resiliency.***

***(Excerpt from Policy No. 118: Guidelines for Providing Linguistic Access to Limited English Proficient (LEP) and Deaf/Hearing Impaired Clients in the Mental Health Division)***

***POLICY:***

***Language interpretation and translation services will be available to LEP or deaf/hearing impaired clients by utilizing staff resources inside the county, contracting agency providers, individual providers, or professional interpreters. CCMHP recognizes that culture is a factor that must be weighed in the process of finding a clinician for the client, and in making services accessible to LEP and deaf/hearing impaired clients. CCMHP has a variety of bilingual staff, as well as professional interpreters available (through contractual arrangement). These resources are available at various sites throughout the county and can be utilized, when needed, to assist LEP and/or deaf/hearing impaired clients in receiving culturally competent mental health services. Furthermore, outside***

***contractors, including individual providers, offer much more language capacity than is available with county staff, and this resource should be utilized to remove linguistic barriers to the mental health system***

***(Excerpt from Policy No. 104: Contra Costa Mental Health Cultural Competence Plan)***

***PURPOSE:***

***The Mental Health Cultural Competence Plan serves as a reference document that seeks to embed the principles of cultural/linguistic competencies throughout the Contra Costa Mental Health Plan (CCMHP). The Cultural Competence Plan provides a contextual framework from which the issue of disparities in mental health service accessibility can be addressed. The Cultural Competency Plan will be updated in accordance with the State Department of Mental Health guidelines. Guided by the Recovery Vision and Consumer and Family-driven service values, the plan will reflect the developmental process inherent in improving cultural/linguistic competencies systemically throughout the CCMHP.***

***(Excerpt from Policy No. 119: Guidelines for the distribution of translated materials to consumers in the Mental Health Division)***

***PURPOSE:***

***These guidelines are intended to encourage consistency and common understanding for how and why foreign language materials are distributed in the Contra Costa Mental Health Division. To insure that translated materials are available for non-English speaking clients throughout the system on a consistent basis.***

***(Excerpt from Policy No. 119: Guidelines for the distribution of translated materials to consumers in the Mental Health Division)***

***POLICY***

A. Department wide Goals

To reduce health disparities and health care disparities, all Divisions, employees and managers and supervisors are expected to create and implement strategies to achieve the following goals:

- Improve consumers/clients/patients/customers experience in utilizing CCHS by treating people with respect and responsiveness in a culturally and linguistically appropriate manner.

- Support healthy environments through increased engagement and partnership with communities and public entities that embrace the richness of ideas and build capacity for living well.

- Approach all internal and external customer encounters with cultural humility.
- Develop systems that support and promote access to respectful and responsive service delivery through its recruitment, selection, retention and promotion practices.

***B. Copies of the following documents to ensure the commitment to cultural and linguistic competence Documents will be available on site during compliance review***

{These documents would be available during the compliance review.}

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

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

CCMH has numerous programs that have practices and activities that demonstrate and support community outreach and engagement. The establishments of strong linkages with culturally diverse communities, including faith-based organizations for outreach and team participation, are key elements in our outreach engagement and involvement efforts. The county's partnership with community based organizations has created various avenues' to reach populations with mental health disparities. Below are some of the programs we have that have practices that demonstrate community outreach and engagement:

*Familias Unidas* provides services to children and adults in the East and West regions of the county, respectively. Outreach and engagement activities focus on the Hispanic population. Typically, Familias Unidas targets the hard to reach; uninsured; mono-lingual participants and/or their families. The location in which they provide services fosters the Hispanic cultural making the environment inviting, familiar and comfortable for the participants. The majority of Familias Unidas staff are bi-lingual in Spanish which eliminates the language barrier for the children and their caregivers as well as the adult consumers.

*Community Health for Asian Americans (CHAA)* provides services to children and adults in the East and West regions of the county, respectively. CHAA primarily focuses their outreach efforts towards those who are below 300% of the Federal Poverty Level, who have a serious mental illness and adults who are homeless or at risk for homelessness. Program participants and the community can identify with the primarily Asian staff creating a welcoming and friendly environment for service delivery.
The TAY population is a hard to reach population as they are often transient and service encounters may be brief. The majority of services provided by *Fred Finch* youth center are to African American youth. Linguistic barriers are less of an issue for this program; however, the outreach and engagement to homeless youth is a focus of Fred Finch Youth Center. Outreach is conducted in local shelters for men, women and families; in motels; and on the streets of the Bay Area. Additionally, staff outreach to the County's probation department to solidify the probation department as a referral source for potential program participants.

*Center for Human Development (CHD)* assists African American families in Bay Point, Pittsburg, and surrounding communities with mental health resources provided by African American Health Conductors. CHD also provides activities that include: culturally appropriate education on mental health topics through "Soul to Soul," "Body and Soul," and "Mind, Body, and Soul" support groups and other health education workshops.

*La Clínica de La Raza, Inc* (La Clínica) has implemented Vías de Salud (Pathways to Health) to target Latinos residing in Central and East Contra Costa County. They are screening for behavioral health issues and risk factors, such as symptoms of depression, anxiety, substance abuse, reactions to trauma, domestic violence, sleep difficulties, and pain, and are providing efficient and effective prevention services to a large number of Latinos to reduce stress, reduce isolation, and other factors that contribute to mental illness. By strengthening communication within families, La Clínica increases family connections.

*Mental Health Consumer Concerns*, established in 1976, is a peer led and operated non-profit organization which provides a variety of community-based mental health wellness and peer support services, as well as mandatory patients' rights advocacy services. In 1981, MHCC sought and became the first client group in California to be awarded a Patients' Rights Advocacy contract. MHCC collaborates with the CCMHP and county mental health contract provider organizations to provide many specialized peer services to meet the needs of individuals from all parts of Contra Costa County.

In FY 10/11, CCMH will initiate a contract with *Lao Family and Asian Community Mental Health.* The goal of the organization and the project they would be undertaking is to strengthen communities; improve intra-family communication; and increase access to mental health services in Contra Costa County. These activities will improve the well-being of South and Southeast Asian refugee and immigrant families to prevent and educate the incidence of serious mental illness. Lao Family Community Development will use Strengthening Families Program curriculum to engage the South and Southeast Asian communities, increase family resiliency, reduce stigma of mental illness, and increase awareness of mental health services in West Contra Costa County.

*Rainbow Community Center* provides a community-based social support program designed to decrease isolation, depression and suicidal ideation among members of the Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) community residing in Contra Costa County. Key activities include: a) a series of social support groups that are designed to promote resilience and build a sense of community affiliation in an effort to reduce stigma and isolation; b) social support services expanded to include depression and suicidal assessments among program participants; c) creating an information and referral system that links LGBTQ community members into culturally competent mental health services.

*Native American Health Center* provides a variety of weekly group sessions and quarterly community events, including an elders support group, substance abuse recovery group and Positive Indian Parenting Groups. The Native Wellness Center designed to strengthen family communications, build a strong community, and to help Native Americans navigate the complex human service systems in Contra Costa County. Expected results from these activities include increased culturally relevant mental health services offered to Native American Community in Contra Costa County

Solicitation of Diverse Input in Planning Process

The county solicits diverse input from various cultural groups in mental health planning processes and services development. For example during all MHSA planning processes, beginning with the Community Support and Services (CSS) component of MHSA, extensive outreach was done to gain input from

diverse communities, including those with identified disparities. The following were ways in which efforts were made to get input from diverse communities during the Prevention and Early Intervention (PEI) planning process:

Community Forums: Three community forums were held in the East, West and Central regions of the county, to encourage anyone in the county to join in a group discussion and to contribute to the county's assessment of priorities for PEI.
Focus Groups: Thirty five (35) group discussions were conducted throughout the county. Efforts were made to achieve diversity across groups- Diversity in location, racial/ethnic groups, providers/consumers/family members/community members, and identified populations with disparities.
Survey: A brief survey was developed to learn more from individuals about their priorities for community needs, target populations and types of interventions.
Additionally, 46 Stakeholder Workgroup Members were selected from among 59 applicants to form two diverse planning bodies. Stakeholder Workgroups included representation from:

- Underserved Communities: Asian/PI, African American, Latino, Native American, LGBTQ
- Consumers and Family Members/Loved ones
- Providers of Mental health services
- Faith Community
- Drug and Alcohol Services
- Educators and Education Representatives

While focus groups were held in English and Spanish (the County's threshold language), survey input also came from those whose primary languages included Spanish, Chinese, Filipino and others.; Providers of services to monolingual community members speaking a language other than Spanish were encouraged to administer the survey orally to their constituents.

***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.***

CCMH has different programs, workgroups, committees that fosters and builds relationships with racial/ethnic and linguistically diverse clients, family members, community organizations, and mental health boards, in the mental health system's planning process for services. The following are some of the planning programs, workgroups and committees in the county mental health system, with participants and representatives from various diverse groups:

Office for Consumer Empowerment
The Office for Consumer Empowerment (OCE) is a peer implemented branch of the Administration of the CCMH and is responsible for representing the consumer perspective in all planning and policy development, as well as promoting and facilitating the involvement of consumers in CCMHP processes. The OCE provides outreach and engagement to persons with lived mental health experience to facilitate recovery and wellness education through presentations and individual peer support in diverse areas of the community.

MHSA Consolidated Planning Advisory Workgroup (CPAW)

The Mission and Purpose of the MHSA Consolidated Planning Advisory Workgroup (CPAW) is to assist Contra Costa Mental Health (CCMH) with integrated planning, as well as to increase the transparency of CCMH-MHSA efforts. CCMH seeks to both build on the current experience and expertise plus gain new perspectives through increased cultural and ethnic diversity. Representation includes all three regions of the County, as well as representation from all 4 of the age groups that planning processes have been built upon (0-18, 18-25, 25-60, 60+). CPAW is comprised of consumers, family members, community members and representatives from community based organizations.

Data Committee

The Data Committee is a permanent sub-committee of the Consolidated Planning Advisory Workgroup (CPAW). The charge of the Data Committee is to review the fiscal and outcome reports (FSP baseline, post enrollment; FSP housing; supportive housing; MHSA expenditure summary) and report back on implications or issues regarding this data. The Data Committee also is charged with recommending future markers or indicators needed for MHSA evaluation (such as the FSP survey), and recommending ways that reports can become more user friendly. This committee is comprised of Mental Health Administration Staff, representatives from community based organizations, family members and consumers.

Aging and Older Adult Committee

The Aging and Older Adult Committee is a sub-committee of the CPAW. The group is charged with focusing on the Mental Health needs, health and well being of the aging and older adult population in Contra Costa County. The group works to assure that the Mental Health services provided in the county are medically and culturally competent and accessible to the older adult population. This sub-committee is comprised of Mental Health Administration Staff, representatives from community based organizations, family members and consumers.

Family Services Advocate

This workgroup helps families work successfully with their loved one's mental health professional and helps in offering services such as education on mental illness, community resources/NAMI, placement assistance, referrals for behavioral health/psychiatric services etc.

Mental Health Commission

The Contra Costa County Mental Health Commission has a dual mission: First, To influence the County's Mental Health System to ensure the delivery of quality services which are effective, efficient, culturally relevant and responsive to the needs and desires of the clients it serves with dignity and respect; and Second, To be the advocate with the Board of Supervisors, the Mental Health Division, and the community on behalf of all Contra Costa County residents who are in need of mental health services.

Reducing Health Disparities (RHD) Workgroup

The goal of the RHD workgroup is to create and implement strategies to achieve specific goals. Some of these goals include: (i) Support healthy environments through increased engagement and partnership with communities and public entities that embrace the richness of ideas and build capacity for living well; (ii) Improve consumers experience in utilizing Contra Costa Health Services by treating people with respect and responsiveness in a culturally and linguistically appropriate manner. The workgroup consists of mental health staff, individuals from various cultural backgrounds, consumers and family members.

Housing

The housing committee works to develop partnerships, see opportunities for advocacy, and be innovative and progressive thinkers. The committee informs and disseminates information on mental health housing for consumers and family; they provide direction for and assistance in presenting a "Housing 101"

curriculum and glossary; they provide ongoing input CPAW related to meeting housing needs for Contra Costa County mental health consumers and families. This committee is comprised of Mental Health Administration Staff, representatives from community based organizations, family members and consumers.

Inclusion Initiative

The Contra Costa Health Services Department created a program called the Inclusion initiative. The mission of this initiative is to protect Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex and Two-Spirit (LGBTQQI2-S) consumers and their families from discrimination and mistreatment by providing culturally affirmative and clinically competent environments of care.

Tony Sanders, a program manager with CCMH, is coordinating efforts in integrating the Inclusion Initiative in the county mental health system. The Inclusion Initiative is being incorporated in CCMH by offering Cultural Competence Training- to train MH providers to serve the LGBT population; training in collecting data from the LGBTQQ12-S population; and the creation of a website (EastBayPride.com) which offers information about services and resources available in serving this population.

### *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.*

The county mental health system makes effort in providing skills development and strategies to strengthen those community based organizations that are involved in providing essential mental health services to the public. This is done in various ways, for example:

Trainings

Training Announcement: The county mental health system has created a training calendar for all CBOs to access on-line to view all available trainings offered by the county mental health or other health organizations. Also included in the calendar, are links to register for the trainings, flyer and any other relevant information regarding the training. The training calendar for CBOs has trainings that run through the year and the calendar is continuously updated as more training become available. Since CCMH is approved by various accreditation agencies, we are able to provide Continuing Education Units to CBOs for those trainings that fall within the scope of the accreditation agencies. Because some trainings are time-sensitive in regards to registration deadlines, individual emails are also sent to CBOs to notify them of available trainings and skill development opportunities.

CBO Internship Program

In Fiscal Year 10/11 the county has implemented plans to place interns at various community based organizations across all three regions in Contra Costa County. This new program starts September 2010. These placements will provide support for the CBOs by giving them more staff capacity to meet their goals of providing efficient, essential and culturally competent services. A fraction of the interns will be bi-lingual, most preferably Spanish-speaking (the County's threshold language).

Technical Assistance

Technical Assistance is also available to CBOs. Through assessing the needs of CBOs during meetings, conference calls, or email correspondence, certain topics are addressed on the County website as a

resource for community organizations to access. CBOs are notified of resources that are available to them for the use in providing essential services.

PEI/CSS Monthly Roundtable

This is a countywide community forum where CCMH contract providers come together and make presentations outlining the work of their organization under their MHSA contracts. This forum is utilized as a learning collaborative for CBOs. It's an opportunity for CBOs to share lessons learned, create network between each other and share technical assistance needs in which CCMH would address to meet those needs.

Other

As an attempt to capture CBOs training and skill development needs, a training survey is being created for administration to all contract providers. The survey is broken down into different sections that comprise of job classification, type of training and an optional demographic section. The survey will be used to assess the needs of community based organizations and tailor those needs towards offering needed and competent trainings. The survey would be created and distributed by August 2010.

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

Through the County's continuous effort in community outreach and engagement, the county has built strong relationships with different community organizations, cultural groups and individuals in all three regions of Contra Costa County. These relationships have helped the County's program planning process and implementation because these subject matter experts are involved in different planning committees. Because of lessons learned from past processes, they are effective in supporting and directing the county towards creating effective and cultural competent programs.

The County has also learned that by holding community forums and roundtable discussions, an avenue is created to share information and build more partnership with members of the community. For example, as a community outreach and engagement strategy, the CCMH PEI staff have organized roundtable meetings on all three regions of the county. In this community meetings, which is opened to the public, some of the County's contract providers come together to share information with the public on the services they offer. Through this same channel of communication, the county uses this opportunity to relay important messages on program planning and implementation and also creating a platform for community members to speak and voice their needs.

Rather than creating new meetings requiring effort and time exhaustion, the County has learned that it is important to involve existing community groups in program planning because it makes the planning process more successful , and by continuous building and sustaining of community groups, there has always been an increase in the diversity of the group population.

### *E. Identify county technical assistance needs.*

- How to truly develop and then mentor cultural brokers.

- Facilitation of skills when working with different cultural groups all assembled in one setting. Learning how to be sensitive to emerging cultural issues, need to be included in any curriculum developed for staff doing outreach and engagement in the community.

**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 Ethnic Services Coordinator for the Contra Costa County Mental Health Division is Imo Momoh, MPA. Imo assumed this role in April 2010, after the position was vacated by the previous ESM, Vidya Iyengar, LMFT. Prior to assuming this role, Imo was heavily involved in the ethnic services and cultural competence efforts in CCMH since 2006. He was also co-chair of the Reducing Health Disparities (RHD) Workgroup and oversaw much of the county's efforts in the integration of cultural competence in program planning and service delivery.

Imo was welcomed and introduced to members of the Bay Area Regional ESM Committee on May 27, 2010. Imo is also currently serving as co-chair of that committee. He was appointed to this position on July 6, 2010.

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

Key responsibilities of the ESM include:

- Providing leadership in the area of cultural competency. The ESM is required to be knowledgeable in cultural competence principles and also demonstrate the ability to work effectively with culturally diverse staff and communities within the county.

- Chairing the cultural competence committee. The cultural competence committee in the Contra Costa County Mental Health Division is called the Reducing Health Disparities (RHD) Workgroup. The ESM is responsible for making sure the efforts of the workgroup reflect the activities outlined in the workgroup's work plan.

- Coordination of key individuals regarding the infusion of cultural competence into each respective area of service planning and delivery. This includes the ESM participating or having a RHD member participate in all planning committees.

- Promotes language access and identification of resources along with appropriate and competent behavioral health interpreters and translators. The ESM provides leadership to address the biases, prejudices, stereotypes and related "isms".

- Ensures that staff including contractors and all other system partners are culturally competent in their practices in the county mental health system.

- Is responsible for providing guidance towards achieving and maintaining cultural competence in Policies and Procedures; and service delivery.

- Provides consultation and technical assistance to staff members and community stakeholders in the area of cultural competence and assist in the development and dissemination of culturally and linguistically appropriate literature and educational materials.

- Serves as a bridge between cultural communities, families and youth providers, community agencies and other stakeholders. They develop connections and formal/informal agreements with racial, ethnic, cultural and other diverse groups in the community.

- Advocates on behalf of cultural communities within the system of care and partner agencies.

- Assists in the coordination of trainings. This position further assists in the development of a training plan and training performance standards to enhance the ability of staff to provide culturally appropriate services.

- Participates in the resource mapping process, to identify key stakeholder groups for representation on committees. This includes ethnic, racial, and cultural groups.

## IV. Identify budget resources targeted for culturally competent activities

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

For evidence of budget dedicated to cultural competence, please see Appendix C.

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

*For interpretation and translation services*, the county mental health system uses International Effectiveness Center and Windrix, as for providing interpretation services for consumers. The County spends about $220,000 annually for Translation services provided by IEC and spends about $165,000 annually, for services provided by Windrix. The County is also currently piloting the use of Video Conferencing to provide interpretation services. The services video conferencing interpretation service is provided by the Health Care Interpreter Network (HCIN).

The Mental Health Division has contracts with *Community Health for Asian Americans* totaling $1,992,729 to provide culturally competent mental health services to Asian American adults and children and their families. The Division has contracts with *Desarrollo Familiar*, Inc. totaling $1,473,897 to provide culturally competent mental health services to Spanish-speaking adults and children and their families in West Contra Costa County.

The *Y Team Collaborative* is made up of four contractors: Community Health for Asian Americans, West Contra Costa Youth Services Bureau, Bay Area Community Resources, and YMCA of the East Bay. Their Contract amounts total about $1,327,793 annually. These contractors provide services to various cultural groups including Asian Americans, African American, Hispanics, high risk youths etc.

Also through the *Prevention and Early Intervention component of MHSA*, there are numerous programs that are provide outreach to racial and ethnic county identified target populations. Below are brief descriptions of some of the programs, their budget allocations for FY 09/10, and each program's target population:

| | |
|---|---|
| Native American Health Center:<br>• Native American Wellness Center | The Native Wellness Center is designed to build a strong community, strengthen family communications, and help Native Americans |

| | |
|---|---|
| $213,422 | navigate the complex human service systems in Contra Costa County. |
| Rainbow Community Center<br>• LGBT Community Mobilization & Social Support Project<br><br>$ 138,955 | **Lesbian, Gay, Bisexual, Transgender, Queer and Questioning**. RCC provides a community-based social support program designed to decrease isolation, depression and suicidal ideation among members of the(LGBTQ) community |
| YMCA of the East Bay:<br>• One Family at a Time<br><br>$ 178,125 | YMCA serves primarily **African American and Latino families** in an area of high poverty and violence to improve access to health and mental health care. |
| La Clinica De La Raza<br>• Vias de Salud (Pathways to Health); and<br>• Familias Fuertes (Strong Families)<br><br>$ 256,750 | La Clinica has implemented 2 programs serving the **Latino Community** one is an assessment screening tool to identify social isolation ,depression, substance abuse and domestic violence and to provide immediate intervention and group follow up for those identified. They are also providing parenting classes to support families. |
| Jewish Family & Children's Services of the East Bay<br><br>$159,699 | JFCS provides mental health education and navigation to the immigrant communities including, **Latino, Afghan, Bosnian, Iranian, and Russian Communities**. They are also training county and community agencies on how better to work with immigrants from these cultures. |
| Center for Human Development<br>• African American Health Conductors; and<br>• Senior Peer Outreach Program<br><br>$144,000 | CHD has 2 separate programs:<br>Mental Health Education and Navigation to the **African American** Community in their <u>African American Health Conductors Program.</u><br>The Youth Senior Peer Counseling Program pairs **Youth and Seniors** to decrease senior isolation and provide youth growth and training opportunities. |

The County mental health system has a Policy and Procedure (P&P) that promotes the participation of consumers and family members in program planning and implementation committees. Consumers and family members are provided per-diems to participate and provide relevant input to the committees. Below is an excerpt from the policy:

**(Excerpt from Policy # 144 - Consumer Family Member Stakeholder Per Diems for Participation in MHSA Planning & Implementation)**

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***I. POLICY:***

***It is the policy of Contra Costa Mental Health to reimburse consumer(s), family member(s) and stakeholders through a per diem payment for their participation in Mental Health Services Act planning and implementation.***

*……*

***I. Policy for Awarding Per Diems***

1. ***No payments in cash for services may be made by County staff.***
2. ***Per Diems may include gift cards and/or payments by check (by MHCC) to the individual.***

3. *No per diem will be available if a consumer or family member participates in an activity and their participation is considered part of paid work time, either through the County or another employer.*
4. *The value of the Per Diem will depend of the time spent by the consumer/ family member/ stakeholder in providing services and is determined as follows:*

    i. *Meetings, Workgroups, Interview Panels*
        a. *0 – 4 hours: $15 (Per Diem or gift card)*
        b. *5 – 8 or more hours: $25*

    ii. *Childcare: up to $7.50 per hour for the same amount of time as the time claimed for the designated activity;*
    iii. *Trainings: Approved actual travel costs, including registration fees (as defined under Contra Costa Administrative Bulletin # 111.7.*

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# 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).***

*Table 2.1: Total Population of Contra Costa County*[i]

| Gender | Population | Percent |
|---|---|---|
| **Male** | 507,955 | 49% |
| **Female** | 534,522 | 51% |
| | | |
| | | |
| **Ethnicity** | **Population** | **Percent** |
| **White** | 506,949 | 48.63% |
| **Hispanic** | 252,553 | 24.23% |
| **Asian** | 139,659 | 13.40% |
| **Pacific Islander** | 4,417 | 0.42% |
| **African American/Black** | 96,803 | 9.29% |
| **American Indian** | 4,478 | 0.43% |
| **Multi Race** | 37,619 | 3.61% |
| **Total Population** | **1,042,478** | **100%** |

*Total Population by Age Group*

| Age Group | Population | Percent |
|---|---|---|
| **Youth Total Population (0-17)** | 263,156 | 25% |
| **Adult Total Population (18+)** | 779,321 | 75% |
| **Total Population** | **1,042,478** | **100%** |

*Youth Population (0-17)*

| Age | Population | Percent |
|---|---|---|
| **(00-05)** | 79,664 | 30% |
| **(06-11)** | 87,150 | 33% |
| **(12-17)** | 96,342 | 37% |
| | | |
| **Gender** | **Population** | **Percent** |
| **Male** | 134,987 | 51% |
| **Female** | 128,169 | 49% |
| | | |
| **Ethnicity** | **Population** | **Percent** |
| **White** | 101,187 | 38.45% |
| **Hispanic** | 84,879 | 32.25% |
| **Asian** | 29,945 | 11.38% |
| **Pacific Islander** | 1,232 | 0.47% |
| **Black** | 26,871 | 10.21% |
| **American Indian** | 769 | 0.29% |
| **Multi Race** | 18,273 | 6.94% |
| | | |
| **Youth Total Pop.** | **263,156** | **100%** |

***Adult Population (18+)***

| Age (18+) | Population | Percent |
|---|---|---|
| **18-20** | 43,119 | 5% |
| **21-24** | 45,323 | 6% |
| **25-34** | 122,239 | 16% |
| **35-44** | 176,941 | 22% |
| **45-54** | 164,376 | 21% |
| **55-64** | 112,555 | 14% |
| **65+** | 122,589 | 16% |
| **Total** | 787142 | 100% |
| | | |
| **Gender** | **Population** | **Percent** |
| **Male** | 372,968 | 48% |
| **Female** | 406,353 | 52% |
| | | |
| **Ethnicity** | **Population** | **Percent** |
| **White** | 405,762 | 52.07% |
| **Hispanic** | 167,674 | 21.52% |
| **Asian** | 109,714 | 14.08% |
| **Pacific Islander** | 3,185 | 0.41% |
| **Black** | 69,932 | 8.97% |
| **American Indian** | 3,709 | 0.48% |
| **Multi Race** | 19,346 | 2.48% |
| | | |
| **Adult Total Pop.** | **779,321** | **100%** |

***Data Source: State of California, Department of Finance,*** **E-3 Race / Ethnic Population Estimates with Age and Sex Detail, 2008**

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

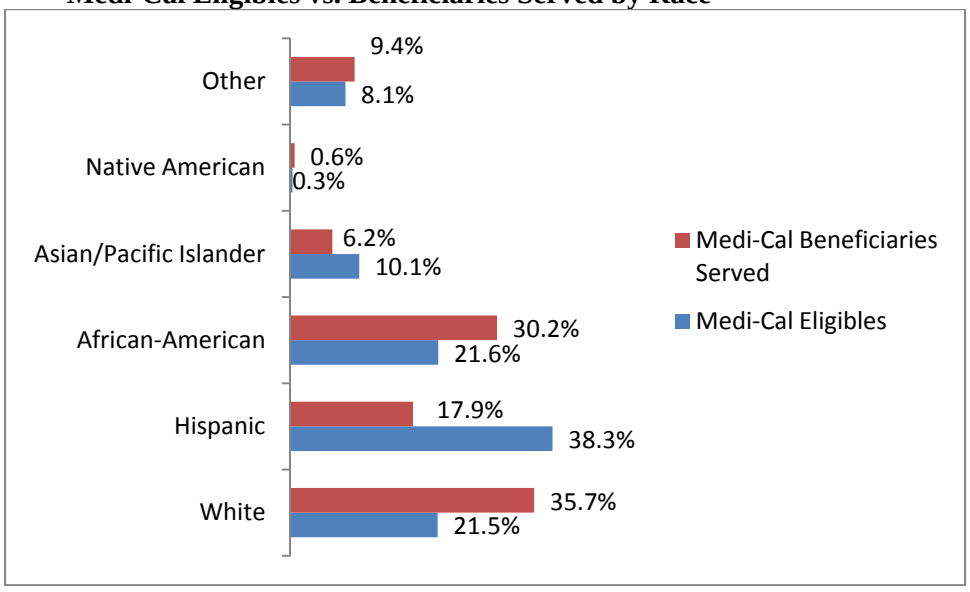
***A. Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender (other social/cultural groups may be addressed as data is available and collected locally).***

***<u>Table 2.2</u>: Penetration Rates of Medi-Cal Eligibles and Beneficiaries***

| | | | | Penetration Rate | |
|---|---|---|---|---|---|
| | County Pop | Medi-Cal Eligibles | Medi-Cal Beneficiaries Served | Penetration Rate | Statewide Penetration Rate |
| **Race/Ethnicity** | | | | | |
| White | 48.63% | 21.54% | 35.65% | 13.68% | 11.72% |
| Hispanic | 24.23% | 38.34% | 17.94% | 3.87% | 3.41% |
| African-American | 9.29% | 21.64% | 30.23% | 11.55% | 10.10% |
| Asian/Pacific Islander | 13.8% | 10.08% | 6.15% | 5.04% | 4.39% |
| Native American | 0.43% | 0.33% | 0.64% | 15.87% | 10.69% |
| Other | 3.61% | 8.07% | 9.40% | 9.63% | 8.96% |
| **Total** | 100% | 100% | 100% | | |
| | | | | | |
| **Age** | | | | | |
| 0-5 | | 18.09% | 4.43% | 2.02% | 1.40% |
| 6-17 | | 26.13% | 33.00% | 10.44% | 7.81% |
| 18-59 | | 39.77% | 55.66% | 11.57% | 8.56% |
| 60+ | | 16.01% | 6.91% | 3.57% | 3.40% |
| | | | | | |
| **Gender** | | | | | |
| Female | 51% | 57.91% | 55.97% | 7.99% | 5.65% |
| Male | 49% | 42.09% | 44.03% | 8.65% | 6.90% |

***Data Sources: DMH Approved Claims and MMEF Data CY 08 (CAEQRO Data) – See APPENDIX B***

**Medi-Cal Eligibles vs. Beneficiaries Served by Race**



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

County and Medi-Cal Population

In reference to the table above, there are vast differences between the county population and the Medi-Cal population, except in the case of Asian and Pacific Islanders, who appear to be fairly represented in the in the Medi-Cal population, when compared to the general population. African Americans (21.6%) and Hispanics (38.3%) are over-represented in the Medi-Cal population when compared to the county general population (9.29% and 24.23% respectively); while the White group is vastly underrepresented in the Medi-Cal population (21.5%) when compared to the county general population (48.6%).

Medi-Cal Eligibles to Beneficiaries Served

The Hispanic and Asian/Pacific Islander group are the most underrepresented groups of beneficiaries served when compared to the Medi-Cal eligibles. The Hispanic group comprises of 38.3% of Medi-Cal Eligibles, yet only 17.9% of the beneficiaries served in the county mental health system are Latinos. The second underserved group is the Asian/Pacific Islander group. They represent 10 % of the eligibles while they comprise only of 6.2% of beneficiaries served.

African Americans and Whites are over-represented in the mental health system of care. The African American group represents 21.6% of Medi-Cal Eligibles and represent about 30% of beneficiaries served; Whites represent almost 22% of the eligibles and about 36% of the population of beneficiaries served.

Penetration Rates

The penetration rate is calculated by dividing the unduplicated beneficiaries served by the monthly eligible count. In Contra Costa County the penetration rate for each ethnic group is slightly higher than the state average for each of those groups. For instance, in the county mental health system, the penetration rate for *African Americans* was 11.6%, whereas the statewide average penetration rate was only 10.1% for that group. The penetration rate for *Native Americans* was substantially higher in the county mental health system when compared to the statewide average. In the county mental health system, this group had a penetration rate of about 16%, and had a statewide average penetration rate of only 10.7%. *Whites*, with a penetration rate of 13.7%, had the second highest penetration rate in the county mental health system.

Comparing Latino to White Population (Medi-Cal Eligibles Served)

It is evident that Latinos have an extremely low penetration rate as beneficiaries of mental health services. According to the APS data, the average number of eligibles per month of Latinos in Contra Costa County in CY 08 was 48,171; of this population 1,863 received mental health services. This makes the penetration rate for the Hispanic group 3.9%. The average number of eligibles per month for the white ethnic group was 27,064; 3,703 of this group received mental health services. This makes the penetration rate for the white group 13.7%.

*In comparing the Latino to White population*, if Latinos and White had the same penetration rate of 13.7%, a total of 6,589 Latinos would have received services in CY 08, rather than the actual 1,863 Latinos who received services; an increase of over 250%. Strategies and objectives to address this disparity are outlined in Criterion 3.

## AGE

**Table 2.3: Medi-Cal Beneficiaries by Age**

| | County Population | Medi-Cal Population | Medi-Cal Beneficiaries Served |
|---|---|---|---|
| Youth Population (0-17) | 25% | 44.2% | 37.4% |
| Adult Population (18+) | 75% | 55.8% | 62.7% |

***Data Sources: DMH Approved Claims and MMEF Data CY 08 (CAEQRO Data) – See APPENDIX B***

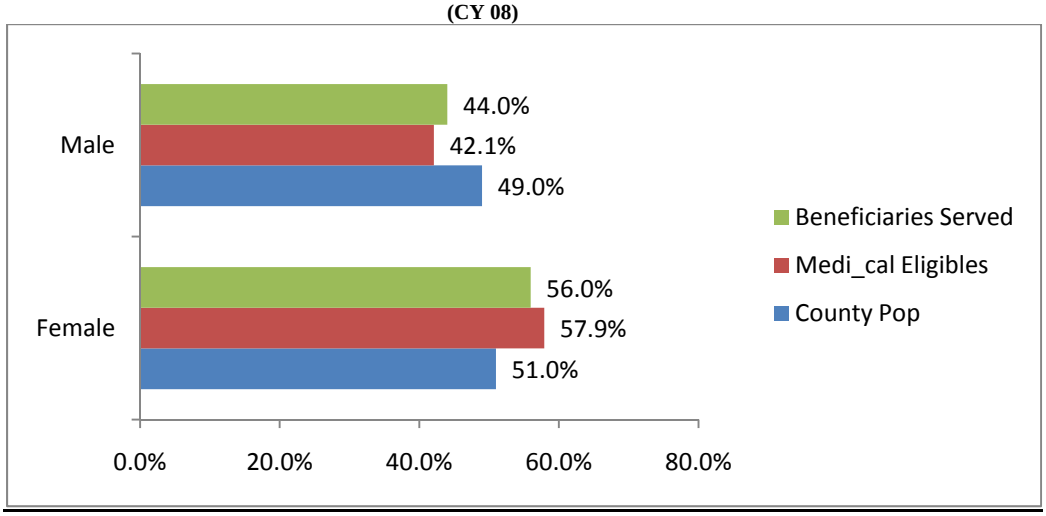
Age Analysis

Although youth population (0-17) comprise of 25% of the general population in Contra Costa County, they account for 44.2% of the Medi-Cal population. They also represent 37.4% of beneficiaries served. Based on the above data, it is evident that there is an overrepresentation in the Medi-Cal population for youths when compared to that of the general population in Contra Costa County. But an underrepresentation of beneficiaries served when compared to the Medi-Cal population.

The Adult population (18+) comprises of 75% of the general population in Contra Costa County, but represents only 55.8% of the Medi-Cal population. However, the adult population represents approximately 62.7% of beneficiaries served. This analysis depicts that there is an underrepresentation of adults (18+) in the Medi-Cal population when compared to adults in the general population. Also, there is an overrepresentation of adults in beneficiaries served when compared to adults in the Medi-Cal population.

## GENDER

**Comparison of County Pop., Medi-Cal Eligibles, & Beneficiaries Served by Gender**
**(CY 08)**




Gender Analysis

There was a higher representation of females in the Medi-Cal population when compared to the county general population. Females represent approximately 58% in the Medi-Cal population but only 51% of the county general population. The female population of beneficiaries served (56%) was slightly lower when compared to the female population of Medi-Cal eligibles (58%). Contra Costa County had a higher penetration rate when compared to the statewide penetration rate for both males and females.

## LANGUAGE

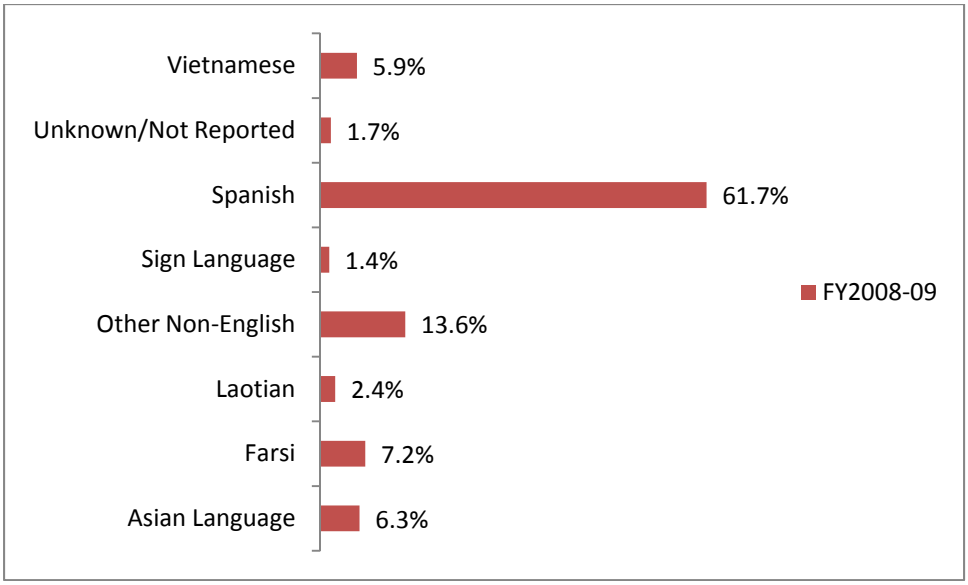
**Table 2.4: Preferred Language of Clients (2005-2009)[ii]**

| Language Name | FY2005_06 | FY2006_07 | FY2007_08 | FY2008_09 | % of FY 08-09 |
|---|---|---|---|---|---|
| Asian Language | 52 | 51 | 59 | 123 | 0.7% |
| English | 14181 | 13133 | 13805 | 15599 | 89.0% |
| Farsi | 93 | 98 | 117 | 138 | 0.8% |
| Laotian | 41 | 33 | 30 | 47 | 0.3% |
| Other Non-English | 246 | 261 | 265 | 267 | 1.5% |
| Sign Language | 20 | 19 | 23 | 27 | 0.2% |
| Spanish | 852 | 863 | 951 | 1184 | 6.8% |
| Unknown/Not Reported | 15 | 14 | 18 | 34 | 0.2% |
| Vietnamese | 66 | 43 | 49 | 114 | 0.7% |
| **Grand Total** | **15566** | **14515** | **15317** | **17533** | **100.0%** |

| Language | FY2005_06 | FY2006_07 | FY2007_08 | FY2008_09 | % Change |
|---|---|---|---|---|---|
| **Spanish** | 852 | 863 | 951 | 1184 | 51.6% |
| | | | | | |
| **TOTAL (CCMHP)** | **15566** | **14515** | **15317** | **17533** | **15.4%** |

***Data Source: CCMH Billing and Information System- Insys***

**Client Utilization**
**Non-English Languages (FY 08-09)**



Language Analysis

In Contra Costa Mental Health, in FY 08-09, *89% of clients indicated English* as their preferred language, while *almost 7% picked Spanish as their preferred language*. Other non-English languages including Asian language, Farsi, Laotian and Sign language, make up the remaining 4% of preferred languages selected by clients. When compared to the Medi-Cal beneficiaries by primary language, it is clear that the penetration rate of Spanish-speaking clients in CCMH is low. However, in an effort to continually increase the penetration rate, between FY 04-05 and FY 08-09, there was a 51.6% increase of Spanish speaking clients[iii].

The general population data for Contra Costa County indicates the county is comprised primarily of English (74%) and Spanish speaking people (26%)[iv]. The Medi-Cal beneficiaries by primary language data depict a different picture. Only 60% of this population is English speaking, and about 30% are Spanish speaking. Spanish is identified as a threshold language in Contra Costa County[v].

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

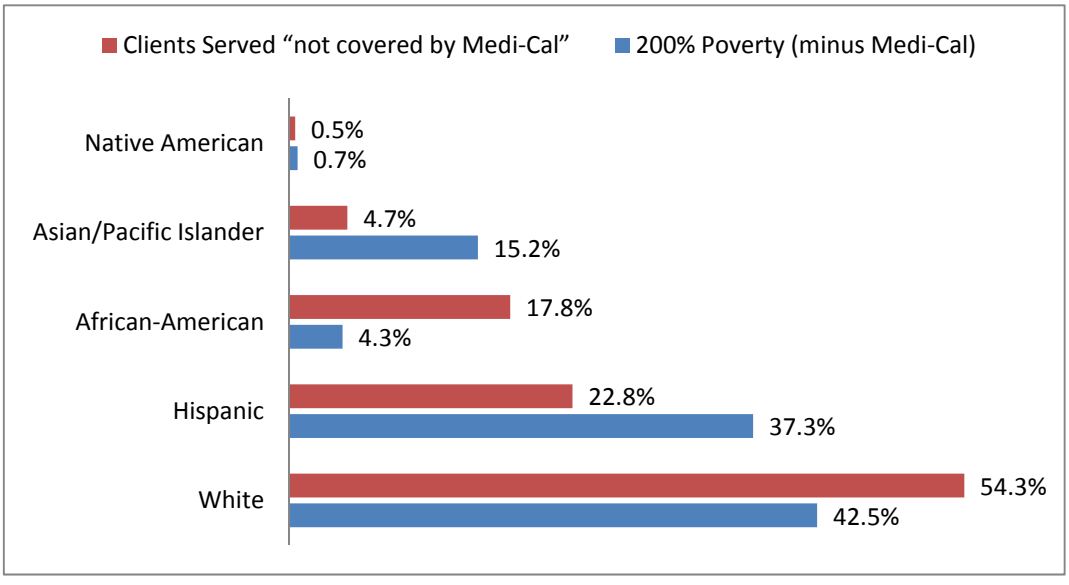
***A. Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender (other social /cultural groups may be addressed as data is available and collected locally).***

**Table 2.5: Summary of 200% FPL and Client Utilization by Race, Age and Gender [vi]**

| Race/Ethnicity | 200% Poverty (minus Medi-Cal) | Clients Served "not covered by Medi-Cal" |
|---|---|---|
| White | 42.47% | 54.3% |
| Hispanic | 37.32% | 22.8% |
| African-American | 4.31% | 17.8% |
| Asian/Pacific Islander | 15.20% | 4.7% |
| Native American | 0.70% | 0.5% |
| | | |
| Age | | |
| 0-17 | 10.28% | 27.7% |
| 18+ | 89.72% | 72.3% |
| | | |
| Gender | | |
| Female | 46.71% | 42.5% |
| Male | 53.29% | 57.5% |

***Data Source:*** http://www.dmh.ca.gov/News/Reports_and_Data/default.asp

**200% Poverty Population vs. Client Utilization**



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

In the above table, the population of clients served, not covered by Medi-Cal, appears to have an over-representation of African Americans and an underrepresentation of Hispanics when compared to the 200% poverty population.

African Americans represent about 4.3% of the 200% poverty population, whereas they represent almost 18% of clients served.

Hispanics, on the other hand represent about 37% of the 200% poverty population, and yet they only represent about 23% of the clients served. Asians and Pacific Islanders are also underrepresented. This group comprises of 15.2% of the 200% poverty population and represents only about 5% of the clients served.

In the *age section*, there is an over-representation of clients served in the 0-17 age group and an underrepresentation in the 18+ age group.

In the gender section, females are slightly underrepresented in the clients served population when compared to the 200% poverty level population. However, males are overrepresented in the client served population (57.5%) when compared to the 200% poverty level (53.3%).

It is has already been stated previously, in comparing penetration rates with other ethnic groups, that there is an underrepresentation of clients served in the Hispanic and Asian/Pacific Islander groups. This is also true when these groups of clients served are compared to other populations like the general and the 200% poverty population.

Language data isn't available for the 200% poverty level. However when we analyze the preferred language data of clients served (uninsured) in CCMH, it shows that 88.3% picked English as their preferred language; 9.6% picked Spanish; and other languages including Vietnamese, Laotian, Asian Language, represent the remaining 2% of the client preferred language population.

## 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).***

**Table 2.6: Population Assessment by Age and Race[vii]**

| Children and Youth (Ages 0-18) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Fully Served | | Underserved or Inappropriately Served | | Total Served | | County Poverty Population | | County Population | |
| | Male | Female | Male | Female | # | % | # | % | # | % |
| TOTAL | 619 | 425 | 2477 | 1700 | 5221 | 100% | 63187 | 100 % | 262706 | 100% |

| RACE/ETHNICITY | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| African American | 209 | 143 | 834 | 573 | 1759 | 33.7% | 14791 | 23.4 % | 29601 | 11.3% |
| Asian Pacific Islander | 24 | 17 | 97 | 67 | 205 | 3.9% | 5493 | 8.7% | 29832 | 11.4% |
| Latino | 131 | 90 | 525 | 360 | 1106 | 21.2% | 25082 | 39.7 % | 72809 | 27.7% |
| Native American | 4 | 3 | 18 | 12 | 37 | 0.7% | 201 | 0.3% | 1816 | 0.7% |
| White | 226 | 155 | 904 | 620 | 1905 | 36.5% | 14224 | 22.5 % | 115321 | 43.9% |
| Other | 25 | 17 | 99 | 68 | 209 | 4.0% | 3397 | 5.4% | 13327 | 5.1% |

| **TAY/Adults (Ages 18-59)** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Fully Served** | | **Underserved or Inappropriately Served** | | **Total Served** | | **County Poverty Population** | | **County Population** | |
| | **Male** | **Female** | **Male** | **Female** | **#** | **%** | **#** | **%** | **#** | **%** |
| **TOTAL** | **957** | **894** | **5420** | **5064** | **12334** | **100 %** | **89808** | **100 %** | **598758** | **100%** |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 216 | 202 | 1223 | 1143 | 2784 | 22.6 % | 14576 | 16.2 % | 54940 | 9.2% |
| Asian Pacific Islander | 46 | 43 | 259 | 242 | 590 | 4.8% | 9288 | 10.3 % | 83754 | 14.0% |
| Latino | 137 | 128 | 779 | 728 | 1773 | 14.4 % | 25417 | 28.3 % | 126373 | 21.1% |
| Native American | 7 | 6 | 38 | 35 | 86 | 0.7% | 453 | 0.5% | 4485 | 0.7% |
| White | 492 | 460 | 2788 | 2605 | 6344 | 51.4 % | 36176 | 40.3 % | 316507 | 52.9% |
| Other | 59 | 55 | 333 | 311 | 757 | 6.1% | 3898 | 4.3% | 12699 | 2.1% |

| **Older Adults (Ages 60+)** | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Fully Served** | | **Underserved or Inappropriately Served** | | **Total Served** | | **County Poverty Population** | | **County Population** | |
| | **Male** | **Female** | **Male** | **Female** | **#** | **%** | **#** | **%** | **#** | **%** |
| **TOTAL** | **45** | **77** | **253** | **436** | **811** | **100%** | **31554** | **100 %** | **157202** | **100%** |
| RACE/ETHNICITY | | | | | | | | | | |
| African American | 7 | 12 | 40 | 69 | 129 | 15.9% | 5121 | 16.2 % | 11461 | 7.3% |
| Asian Pacific Islander | 4 | 8 | 25 | 43 | 79 | 9.7% | 3263 | 10.3 % | 18127 | 11.5% |
| Latino | 5 | 9 | 29 | 50 | 92 | 11.3% | 8930 | 28.3 % | 13321 | 8.5% |
| Native American | 0 | 1 | 2 | 3 | 6 | 0.7 | 159 | 0.5% | 860 | 0.5% |
| White | 24 | 42 | 138 | 238 | 443 | 54.6% | 12711 | 4.3% | 111548 | 71.0% |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Other | 3 | 6 | 19 | 33 | 62 | 7.6% | 1370 | 4.3% | 1885 | 1.2% |

***Data Source*: Contra Costa County MHSA Community Services and Supports Final Three-Year Plan**

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

There are ethnic disparities in all age groups. Latinos are consistently the most significantly underserved population across all age groups. Asians/Pacific Islanders are the second most under represented group. For example, in the TAY group, Latinos represent 28% of the county poverty population and yet only 14.4% of clients served. The same representation can been seen when looking at the Older Adult group, Latinos in that group represent about 28% of the poverty population and yet they only represent 11% of clients served.

Examining the Asian/Pacific Islander group in the children and youth age group, it shows that this ethnic group represents almost 9% of the county poverty population and yet only it represent less than half of the clients served (4%) of clients served .

African Americans are overrepresented in the TAY group when comparing the percentage of client served to the poverty and county population. In this age group, African Americans represent over 22% of the clients served while they only comprise of 16.2% and about 9% of the poverty and county population, respectively. Whites are grossly overrepresented in the Older Adults age group when comparing the number of clients served to the county poverty population. While this group comprises of 4.3% of the county poverty population, it represents over 54% of the clients served.

## 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?***

Contra Costa Mental Health chose the following six PEI priority populations outlined by DMH:

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

Stakeholder Planners established priorities for Target Populations and Community Needs as required by DMH. Additionally, they prioritized strategies for addressing priority population and needs. Priorities were categorized into four overlapping/interacting domains: These four Initiatives include: Fostering Resilience in Children and Families; Youth/Youth Adults; Communities; and Older Adults. After categorizing these initiatives, nine projects were formed which can be seen in the table below. The table contents the project name, target populations and the names of the agencies that are being contracted with through the PEI programs to meet the needs.

**Table 2.7: PEI Project Contractors**

***Target Population**: **(1)** Underserved Cultural Populations **(2)** Individuals Experiencing Onset of Serious Psychiatric Illness **(3)** Children/youth in Stressed Families **(4)** Trauma-exposed **(5)** Children/Youth at Risk of School Failure **(6)** Children/Youth at Risk or Experiencing Juvenile Justice Involvement*

| Project and Agency | Target Population |
|---|---|
| **Project 1: Building Connections in Underserved Cultural Communities** | 1 |
| Native American Health Center; Rainbow Community Center; YMCA: BBK Collaborative; La Clinica de La Raza; Jewish Family and Children's Services; Center for Human Development; | |
| | |
| **Project 2: Coping with Trauma Related to Community Violence** | 4 |
| RYSE Center | |
| | |
| **Project 3: Stigma Reduction and Awareness Education** | 1,2,3,4,5,6 |
| Contra Costa Mental Health – Office for Consumer Empowerment | |
| | |
| **Project 4: Suicide Prevention** | 1,2,3,4,5,6 |
| Contra Costa Crisis Center | |
| | |
| **Project 5: Supporting Older Adults** | 1,2,4 |
| Lifelong Medical Care; Center for Human Development | |
| | |
| **Project 6: Parenting Education and Support** | 1,2,3,4,5,6 |
| Child Abuse Prevention Council (CAPC); La Clinica de La Raza; Family Stress Center; Latina Center; Contra Costa Interfaith Housing; | |
| | |
| **Project 7: Families Experiencing the Juvenile Justice System** | 1,3,4,5,6 |
| West Contra Costa Youth Services Bureau (WCCYSB); Family Institute of Pinole (FIP); | |
| | |
| **Project 8: Families Experiencing Mental Illness** | 2,4 |
| Contra Costa Clubhouse; | |
| | |
| **Project 9: Youth Development** | 1,2,3,4,5,6 |
| People Who Care (PWC); STAND; RYSE Center; El Cerrito High School (ECHS); Martinez Unified School District (MUSD) | |

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

In selecting the PEI priority populations, CCMH created two stakeholder workgroups, broken down into two sub-groups focusing on age groups 0-25 and 26+ years of age. The workgroup used data collected during the Community Program Planning Process (CPPP), as well as their own knowledge and experience to rank priority populations and priority strategies for PEI efforts in Contra Costa County. The stakeholder workgroups were diverse and included consumers, their families, mental health providers, educators, law enforcement representatives and other organizations. Data that was used by the stakeholders in their decision-making came from a range of sources including:

a) "Quick Scan" of existing data available in the county.
b) Focus groups in the community
c) Community forums
d) Survey

Additionally, some data collected from the original CSS process was used for this process. Below are brief descriptions of some of the major ways data was collected during the planning process.

**Community Forums**: Three community forums were held in three regions of the county to encourage anyone in the county to join in a group discussion and to contribute to our assessment of priorities for PEI. Forums were held in Bay Point, Martinez and San Pablo. Translators for Spanish and Vietnamese were available at forums.

**Outreach:** Outreach for Community Forums was conducted via "blast fax" to over 400 non-profits and county departments using an extensive list managed by the Department of Health Services. Additionally, a press release was sent to local media including the Contra Costa Times and its affiliates.

**Focus Groups**: Thirty five group discussions, ranging in size from 3-27 people were conducted throughout the county. The majority of discussions were among groups that already exist in the county and were willing to invite CCMH to a regularly scheduled meeting. Effort was made to achieve diversity across groups-diversity in location, racial/ethnic groups, providers/consumers/family members/community members, and service or target population focus. One focus group was conducted in Spanish.

**Survey**: A brief survey was developed to learn more from individuals about their priorities for community needs, target populations, and types of interventions. The survey was available on-line at www.cchealth.org and in hard copy. It was available in Spanish and English. Availability of the survey was publicized to over 400 non-profits and county departments using an extensive list managed by the Department of Health Services.

**Stakeholder Workgroup:** Members were selected from among 59 applicants to form two diverse planning bodies-one for the 0-25 age group and the other for ages 26+. The task of each group was to establish priorities for community needs, target populations and priority strategies.
Stakeholder Workgroup Members included:

- Underserved Communities: Asian/PI, African American, Latino, Native American, LGBTQ
- Education: Special Education Districts, Schools, school-based health centers and students
- Consumers and families/loved ones
- Providers of Mental Health services
- Health care: Primary care, school-based health centers
- Social Services
- Law Enforcement
- Faith Community
- Drug and Alcohol Services
- Contra Costa County Mental Health Commission

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

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

**The county shall include the following in the CCPR:**

- Medi-Cal population
- Community Services Support (CSS) population: Full Service Partnership population
- Workforce, Education, and Training (WET) population: Targets to grow a multicultural workforce
- Prevention and Early Intervention (PEI) priority populations: These populations are county identified from the six PEI priority populations

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

## *Target Populations with Disparities*

| Population | Target Population with Disparities |
|---|---|
| **Medi-Cal** | • Latinos<br>• Asian/Pacific Islanders<br>(Medi-Cal Eligibles) |
| **CSS** | In All Four Age Groupings<br>• Latinos<br>• Asian/Pacific Islanders<br>• Individuals who are homeless or at serious risk of homelessness<br>• Individuals at 200% of poverty level or below |
| **WET**<br>**(Workforce Shortage Areas)** | Hispanic, Asian/Pacific Islanders and Native Americans staff. (Low total staff FTE: Client Ratio)<br><br>Language Proficiencies:<br><br>Staff proficient in Spanish Language,<br>Staff proficient in the Asian Languages |
| **PEI**<br>*1. Underserved Cultural Populations*<br>*2. Children/Youth at Risk of School Failure*<br>3. *Children/Youth at Risk of Experiencing Juvenile Justice Involvement.*<br>4. *Children/youth in stressed families* | • Latinos<br>• African Americans<br>• Asians/Pacific Islanders<br>• Native Americans<br>• Lesbian/Gay/Bisexual/Transgender/Questioning |

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).**

The process of data collection and the data collected as described in *Criterion 2 Section V* was used in identifying the target populations with disparities. In the stakeholder's goal of identifying the target populations with disparities, the county used information collected that reflected disparities either in race/ethnicity, gender, age or language. Part of the process involved comparing different populations (e.g. Medi-Cal Eligibles vs. Clients Served) to see what disparities exists within and between these populations. The Stakeholder Workgroup broken down into two-sub workgroups focusing on 0-25 and 26+ years of age, used all of the data collected as well as their own experience to identify target populations with disparities as well as to create strategies in reducing the identified disparities. The rationale behind the process was for the county to be able to strategize and prioritize strategies in creating programs that would function as an entity towards reducing the identified disparities within the target populations.

Data that was used by the stakeholders in their decision-making came from a range of sources including:

a) "Quick Scan" of existing data available in the county.
b) Focus groups in the community
c) Community forums
d) Survey

## 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).***

| Population | Disparities | Target Population |
|---|---|---|
| **Medi-Cal** | Latinos and Asian/Pacific Islanders have low penetration rates and low access to mental health services.<br><br>The Asians and Pacific Islanders represent 10 % of the Medi-Cal Eligibles while they comprise only about of 6% of beneficiaries served.<br><br>The Hispanic group is grossly underrepresented in beneficiaries served; while this group comprises of 38.3% of Medi-Cal Eligibles, only 17.9% were served in CY08 with a penetration rate of 3.87%, which is very low especially when compared to the penetration rate of the White ethnic group (13.7%). | ▪ Latinos<br>▪ Asian/Pacific Islanders<br>o (Medi-Cal Eligibles) |

| | | |
|---|---|---|
| **CSS** | Latinos are consistently the most significantly underserved population across all age groups.<br><br>For example, in the TAY group, Latinos represent 28% of the county poverty population and yet only 14.4% of clients served. Also in the Older adults group, Latinos in that group represent about 28% of the poverty population and yet they only represent 11% of clients served.<br><br>Asians/Pacific Islanders is the second most underrepresented group. In the children age group, it shows that this ethnic group represents almost 9% of the county poverty population and yet only 4% of the clients served. | <u>In All Four Age Groupings</u><br><br>▪ Latinos,<br>▪ Asian/Pacific Islanders,<br>▪ Individuals who are homeless or at serious risk of homelessness<br>▪ Individuals at 200% of poverty level or below. |
| **WET** | Workforce shortages in positions where candidates proficient in Spanish and Asian Languages are needed.<br><br>Spanish speakers are most in demand. The number of Spanish speaking direct service staff would need to increase by 56% to meet current need.<br><br>The percentage of direct service staff (9%) and managerial/supervisory staff (8%) that are Hispanic/Latino is low relative to that of non-direct support staff (19%) and Hispanic/Latino clients who seek services (17%).<br><br>African American clients represent the second highest racial/ethnic group (26%), yet only 9% of licensed staff and 12% of managerial staff are African American. | Individuals competent in Spanish and Asian Languages and who also meet the needed specialty to feel the position.<br><br>Individuals from the Spanish and Asian ethnic group to fill needed positions, in order to have an organization to reflect the community the county serves.<br><br>Unlicensed Direct Service Staff. |
| **PEI (Priority Population with Disparities)** | | |
| **Underserved Cultural Pop**<br><br>**Children/Youth at Risk of School Failure** | For Southeast Asian Populations, the overall prevalence of mental health disorders is much higher than the general population. Estimates for PTSD and major depression for Mien and Cambodian populations suggest rates ranging from 70% to over 90%.<br><br>40% of Contra Costa children live in immigrant families. Children in Immigrant families are more likely to live in poverty, less | ▪ Latinos<br>▪ African Americans<br>▪ Asians/Pacific Islanders<br>▪ Native Americans<br>▪ LGBTQ |

| | | |
|---|---|---|
| **Children/Youth at Risk of Experiencing Juvenile Justice Involvement**<br><br>**Children/youth in Stressed Families** | likely to attend preschool, less likely to have health insurance, and less likely to be in good health than children in non-immigrant families.<br><br>In 2006, African American children (who account for 11.3% of the 0-17 population), constituted of 48% of all children in out-of-home care. Native American children, comprising less than 1% of the 0-17 population, totaled 1.76% of those in out-of-home care.<br><br>The highest dropout rates are among African Americans, Latinos and Pacific Islanders.<br><br>In 2006, 9.3% of Contra Costa county public high school students dropped out of school. The highest dropout rates are among African Americans, Latinos and Pacific Islanders.<br><br>In 2002 and 2004, there were 2,510 births to teen girls 15-19 years living in Contra Costa County, an average of 837 births.<br><br>African American and Latino youth are more likely to be involved in the juvenile justice system- and in disproportionately higher percentages-than white or other groups.<br><br>African American youths make up 42.3% of the population in Richmond, but account for 70% of arrest and 69% of referrals to probation.<br><br>In 2005, the felony arrest rate among African American youths (50.3/1,000) was 5-10 times higher than every other group.<br><br>15.7% of Contra Costa students were suspended in 2006, higher than the statewide average of 13.9%.<br>In 2003, there were 4,037 domestic violence reports in Contra Costa County. Children were present in 40% of those reports. | |

**III. Identified strategies/objectives/actions/timelines**

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

## Strategies

Strategies for each of these components were designed using the Proposed Guidelines from the California State Department of Mental Health. These strategies were designed to identify priority populations and meet key community needs in Contra Costa County. Strategies in each of the plans are structured into programs, projects and Action Items. Below are programs/plans/action items that encompass the strategies identified to reduce identified disparities.

***PEI Strategies***

The strategies identified for the PEI population are structured around four initiatives: (i) Fostering Resilience in Communities Initiative; (ii) The Fostering Resilience in Older Adults (iii) The Fostering Resilience in Children and Families Initiatives; and (iv)The Fostering Resilience in Youth/Young Adults Initiative. Under each of these initiatives there are a total of nine (9) projects that are geared towards reducing the disparities for the selected populations. Below are the nine projects with their strategy descriptions.

| **Project** |
|---|
| **Project 1: Building Connections in Underserved Cultural Communities** |
| The project is designed to strengthen undeserved cultural communities in ways that are relevant to specific communities to increase wellness and reduce stress and isolation, to decrease the likelihood of needing services of many types, and to help support string families. This is accomplishes through a contracting process that allows members of underserved cultural communities, in conjunction with CCMH, to strengthen communities; strengthen communication; and provide Mental Health Education/System Navigation Support. |
| |
| **Project 2: Coping with Trauma Related to Community Violence** |
| There are two programs within this project: (i) Coping with Community Violence; and (ii) Community Mental Health Liaisons for Trauma. Youths and families of the African American and Latino community that are exposed to trauma are the target groups for this project. The project includes positioning of three mental health liaisons, one in each region of the county to provide immediate direct early intervention; be available in the community and to law enforcement; and identify and offer linkages to other trauma-related resources. |
| |
| **Project 3: Stigma Reduction and Awareness Education** |
| Development of the Stigma reduction and Awareness Campaign includes collaboration with the Mental Health Reducing Health Disparities Workgroup, stakeholders and CCMH staff to sponsor a recovery-based, culturally diverse, conference for local providers, consumers and family members that addresses stigma reduction in the mental health system. |
| |
| **Project 4: Suicide Prevention** |
| This project has three key programs:<br>1) Plan – Development of a Suicide Prevention Task Force that will collaborate and Coordinate with the State Department of Mental Health and regional efforts, and will develop a county-wide Suicide Prevention Plan. |

2) Campaign – Appointment of a Suicide Prevention Campaign county-wide in 2009-2010.
3) Crisis Line Capacity Expansion – through RFP process, a local nationally certified suicide crisis line agency has been selected, and will add multilingual staffing in order strengthen language and cultural capacity for the agency,

**Project 5: Supporting Older Adults**

This project consists of two programs: (i) Expand the Senior Counseling Program- the program is based on the well-known senior peer counseling model from the Center for Healthy Aging in Santa Monica, CA. (ii) Community Based Social Support for Isolated Older Adults – through RFP, CCMH contracts with several community providers for social supports and activities for isolated older adults. The community based organizations demonstrate their access to the target population, along with an understanding of the methods for successful recruitment, transportation, and return participation by seniors in their communities

**Project 6: Parenting Education and Support**

This project is a selective prevention and early intervention project which is designed to educate and support parents and caregivers in high risk families to support the strong development of their children and youth. There are three programs in this project (i) Partnering with Parents Experiencing Challenges (ii) Parenting Education and Support; and (iii) Multi-Family Support Groups.

**Project 7: Families Experiencing the Juvenile Justice System**

This is an early intervention project with two programs to identify youth in the Juvenile justice system and provide family supports that will help the youth to become strong, healthy, law abiding members of their communities. Interacting programs for this project include: (i) Community Supports to Youth on Probation; and (ii) Screening, Early Intervention, and Discharge Support at the Boys Ranch.

**Project 8: Families Experiencing Mental Illness**

This project includes one program with three components: (i) development of out-of-home activities for mental health consumers that would allow respite for family caregivers; (ii) Provision of transportation to consumers from home respite activities in the community, particularly on evening and weekends; (iii) Management of flex funds to provide in-home respite when out-of-home consumer activities are not indicated.

Through an RFP process, more than one community based provider will be selected to develop and provide respite for family caregivers.

**Project 9: Youth Development**

CCMH will select and fund, through an RFP process, youth service entities to implement and carry out youth development projects that are relevant to their target population. Youth Development projects are defined as strength-based efforts that build youths' assets and foster resiliency. Projects that have shown promise of effectiveness, especially in underserved cultural communities where efforts are less likely to have been evaluated are considered under this project.

***CSS Strategies***

Below are projects with strategies in the CSS plan for reducing the disparities identified. These strategies are integrated into four service programs and one housing program, and since cultural competence and the goal of reducing disparities is a priority for CCMH, each work plan of every service program is structured around these efforts.

| **Work Plan 1: Children's FSP (Project ACCST (Active Community Services & Supports Teams):** |
|---|
| The Families Forward project advances the goals of MHSA through supports and services to improve resilience for children with emphasis on access, consumer/family involvement, a personalized/age specific support plan for each child/family, strong cultural and linguistic competence, strong community partnerships, and peer led services. This is accomplished through 24 hour/7 day a week service teams in the east and far east region of Contra Costa County. These interagency, interdisciplinary, ethnically diverse community response teams will provide crisis stabilization; short-term case planning and problem resolution; family resource development; community linkages and advocacy; educational linkages and advocacy; and long term case management.<br><br>Strategies: Cultural and gender-sensitive outreach; Services located in racial/ethnic communities with linkages to full range of supports; Transportation; Services and supports provided at school, in the community and at home. |
| **Work Plan 2: TAY FSP – TAY Program** |
| The goal of the TAY Program for transition aged youth (between 16 and 25) is to create a positive youth development environment in which transition aged youth with psychiatric disabilities (SED or SMI) can take personal responsibility and make good choices about their lives when provided with housing, services and supports that they need. In reference to the previously identified disparity that African American and Latino youth are more likely to be involved in the juvenile justice system- and in disproportionately higher percentages-than white or other groups, this program aims to prevent admission to jail, institutionalization and unnecessary lives of poverty. This is done by supporting consumers to address mental and physical health issues, substance abuse, housing instability and critical social, education and vocational needs. This housing-first approach has been instituted through a partnership-based framework that builds upon successful, pre-established networks with homeless, housing, social service, health and behavioral health care providers in the region.<br><br>Keys to the cultural competency of the TAY Program are the embedding of its outreach/personal service coordinators in community-based agencies serving ethnic populations that are often not reached by county systems. Because Latinos and Asians/Pacific Islanders are the most significantly underserved populations, CCMH will focus its efforts in these areas and with these language capacities. |
| **Work Plan 3: Adult FSP – Bridges to Home Project** |
| The Adult FSP project serves adults, ages 26-59, living within the western region of Contra Costa County. The goal of the Project is to support individuals to address, reduce and/or resolve the psychological issues and sociological conditions that are often linked to homelessness; and to attain hope, self-sufficiency, wellness, and a life of quality in the community. Consumers' stated needs and goals will define the services and supports that are provided, allowing for the development of participants' self-direction and personal responsibility. The FSP assists persons with psychiatric disabilities to move from the street, homeless encampments, and situations that put them at serious risk of homelessness into permanent housing with full access to both clinical and consumer-driven supports. Culturally specific outreach efforts engage the target population. |

| **Work Plan 4: Older Adult System Development** |
| --- |
| There are currently no specialized geriatric mental health services in Contra Costa County. The Older Adult Program advances the goals of MHSA by establishing an integrated service delivery structure that does not currently exist for seniors. Services are consumer friendly, culturally competent and client-driven. Culturally competent outreach helps to identify and engage consumers. Co-located and integrated medical/mental health services reduce barriers to care. The Core Structure allows for expansion for more comprehensive services and increased service volume in the future. Service is targeted to seniors who are Medi-Cal recipients of with incomes at 300% of federal poverty level or below. |
| **Work Plan 5 – Housing Program** |
| Housing available in this program support Full Service Partners (FSP's) in Programs #1, 2, and 3. (Children/Families; TAY's; Adults). They are homeless (adults) or imminently homeless (Children/TAY) and otherwise eligible for FSP programs 1, 2, and 3. The CCMH housing program consists of several housing specific elements. The services and supports that will wrap around these housing elements include: (i) New Facilities; (ii) Housing "vouchers" through master leases; (iii) Development of new housing options for all groups in the future. |
| **Work Plan 6: System Development Strategies** |
| A series of ongoing activities were identified as priorities for development of systems outside of Full Service Partnerships. The most significant of these is the Older Adult Program, which is described as Work Plan 4. The additional systems development pieces do not constitute stand-alone programs but rather, are a series of strategies for overall systems development. These include:<br><br>Strategy 1: Enhancement to the Office for Consumer Empowerment<br>Strategy 2: Planning for Future Systems Development<br>Strategy 3: Peer Benefits Advocates<br>Strategy 4: Expansion of Family Partner Program<br>Strategy 5: Wellness Services<br>Strategy 6: Transformation Training |

**Workforce Education and Training (WET) Strategies**

There are 13 action items included in the WET plan that are structured around reducing the identified disparities above. These action items below are the 13 action items and their objectives:

| Workforce Staffing Support |
|---|
| **Action Item 1: Workforce Education & Training Coordination**<br>• Ensure that family members; consumers; and underserved and underrepresented communities are included as both trainers and participants<br>• Hire a Consumer Employment Coordinator through CCMH's Office for Consumer Empowerment to partner with Adult and Children's Family Services to guide CCMH in the efforts of this plan.<br>• Supporting a peer-training program that prepares consumers and family members to enter workforce.<br>• Provide ongoing trainings to existing staff on Recovery culture incorporating Recovery principles in all trainings offered by CCMH |
| Training and Technical Assistance |
| **Action Item 2: Staff Development Training Initiative**<br>• Offer Spanish language training to staff to increase language capacity and cultural competency.<br>• Offer core/foundational training that include cultural competency, recovery, interpreter training etc.<br>• Conference: Recovery in Diverse Communities<br>• Recruiting and developing internal Subject Matter Experts (staff, community leaders, consumers) to offer technical assistance on best practices |
| **Action 3:Mental Health Training for Law Enforcement**<br>• Increase cultural awareness of law enforcement towards issues specific to mental health consumers.<br>• Include consumers and family members as guest speakers/trainers during instruction.<br>• Collaborate with Law Enforcement agencies to offer CIT training to Law Enforcement and mental health staff. |
| Mental Health Career Pathways Programs |
| **Action Item 4:** Consumer Employment Strategies (SPIRIT Program Expansion & Enhancement)<br>For 12 years, CCMH has offered consumer training programs, now formalized as the Service Provider Individualized Recovery Intensive Program (SPIRIT). AS a career pathway, many of its graduates have gone to securing full-and –part-time employment with CCMH and other agencies. Based in its success the following activities are planned:<br>• Work with Contra Costa College staff and faculty to formalize the SPIRIT course in College's academic catalog by academic year 2009-2010.<br>• Collaborate with contract agencies in Contra Costa County to develop them as potential internship and job placement sites for SPIRIT graduates.<br>• Offer "soft skills" training for potential consumer employees, including interviewing, resume development and basic-on-the job etiquette.<br>• Create a SPIRIT alumni network for graduates to offer continuing support, mentorship and resource sharing. |
| **Action Item 5: Family Member Employment Strategies**<br>• Increase the number if Adult Family Partners to work with families in the Adult and Older Adult system.<br>• Provide staff development trainings for family partner staff/volunteers annually.<br>• Explore and adapt the development of a formalized training curriculum for employment in the |

public mental health system.

**Action Item 6: Developing Mental Health Concentration in High School Health Academies**

- Develop a curriculum for a mental health concentration in existing High School Health Academy.
- Develop a Stipend program for high school students enrolled in this program.
- Partner with schools in unserved and underserved communities in the area of outreach and recruitment strategies.
- Support the development of this activity through recruiting staff as guest speakers and eventually offering a limited internship appropriate for high school students enrolled in Health Academies to expose them to careers in the public health system.

**Action Item 7: Community College Partnerships: Psychosocial Rehabilitation Certificate (PSR)**

County and community-based organizations recognize the need for well trained staff that may not have the resources to complete a bachelors or graduate degree but have the skills and desire to complete a formal training program. Consumers and family members also have this need. As a result of this need, CCMH is working with faculty to implement the Psychosocial Rehabilitation Certificate program using the curriculum developed by the California Association of Social Rehabilitation Agencies (CASRA).

- Complete PSR certificate consultation and coursework recommendations by August 2009.
- Track enrollment and completions in the initial PSR program at Contra Costa College.
- Train CCMH staff in the PSR certificate program.

**Action Item 8: Psychiatric Technician Program**

- Explore ways to incorporate and develop psychiatric technicians in the workplace.
- Explore existing and potential Psychiatric Technician Programs in Contra Costa and surrounding areas.

Residency and Internship Programs

**Action Item 9: Expanding Graduate Level Internship Opportunities**

- Place graduate level interns and trainees in the Adult and Older Adult system in the next 18 months. Emphasize recruitment of bilingual and bicultural individuals with consumer/family member experience.
- Expand internship program to provide stipends for interns placed at CBOs.
- John F. Kennedy University has a Counseling Psychology program focused on Latino/Hispanics for MFT licensure. CCMH has trained and hired JFKU graduate and plans to expand internship opportunities for this program.
- Hire interns as Student workers starting Fall 2008

**Action Item 10: Psychiatry Workforce Development**

Contra Costa County has experienced a particular shortage with regards to psychiatrists and it isn't uncommon with many County mental health systems. The Division also needs to increase the language and cultural capacity; and ethnic diversity of its psychiatrists. In an effort to do that, the county plans to:

- Develop an affiliation with UC Davis and UCSF to explore developing a psychiatric residency and/or fellowship program for CCMH. Promote the development of culturally relevant, recovery-oriented curriculum and experience to include both county and CBO systems of care
- Explore the training and professional development needs of psychiatrists in Contra Costa County.
- Provide training and supervision for psychiatrists and other medical staff that addresses cultural competence and the needs of consumers and family
- Develop a team of psychiatrists as Subject Matter Experts with specialization community psychiatry (dealing with different cultures)

**Action Item 11: Nursing Workforce Development**

- Work with Samuel Merritt College and UCSF School of Nursing to provide outreach and recruit student to the Nursing Internship Program with an emphasis on recruiting multicultural and multilingual students.

| |
|---|
| • Formalize the internship program for Psychiatric Nurses and RNs.<br>• Explore the training and professional development needs of nursing staff in the system. |
| **Action Item 12: Scholarship Program for Bachelor Level Degree**<br>• Support development of a future workforce with an increased proportion of multicultural consumers and family members employed within the public mental health system in Contra Costa County.<br>• "Growing our Own", this activity supports staff being able to obtain a degree while employed and would be tied to the employee's commitment to remain in CCMH for an agreed period of time.<br>• Increase workforce diversity and language capacity by offering a higher differential pay for bilingual individuals. |
| Financial Incentive Programs |
| **Action Item 13:Scholarship for Masters' Level Degrees**<br>The workforce Needs Assessment documented the need for a dramatic increase in MSWs throughout CCMH. Educational financing assistance will provide opportunities for current County mental health staff to obtain an MSW while employed. This strategy, which will tied to the employee's commitment to remain with Contra Costa County Mental Health for an agreed period of time, ensures advanced level of competencies and possible promotion for known workers. During their engagement in educational programs, a portion of the participants' tuition may also be paid with WE&T funds. |

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

II. Medi-Cal population

The county targeted goal is to bring all underserved groups to the current average penetration rate of 8.27 percent. This means the penetration rates for the two underrepresented groups, Hispanic and Asian/Pacific Islander, will need to increase by 4.4% and 3.3% respectively, to meet the current average penetration rate. We plan on meeting these goals with our county-run services and MHSA programs, which has created a lot of avenues of community outreach and a broader range of providing community mental health services.

III. 200% of poverty population

Similar to the Medi-Cal population of clients served, there is an underrepresentation of Hispanics and Asian/Pacific Islanders. Strategies to increase the penetration rate of these underserved groups would include partnering with community organizations and also providing services in areas where these groups are prevalent. For example two providers have been selected through an RFP process, to provide services to the Asian/Pacific Islander Immigrant Communities of Contra Costa County. These contracts have not yet been awarded but are being recommended to the Board of Supervisors for approval. We also currently have contractors providing services to the Hispanic population. One of these contractors is La Clinica de la Raza. They implemented two programs serving the Latino Community**;** one is an assessment screening tool to identify social isolation, depression, substance abuse and domestic violence and to provide immediate intervention and group follow up for those identified. They are also providing parenting classes to support families.

IV. MHSA/CSS population

The goal here is to reduce the ethnic disparities that are evident in all age groups. Efforts to meet this goal will include the work plan strategies identified in the CSS plan. Strategies to reduce identified disparities include cultural and gender-sensitive outreach; services located in racial/ethnic communities with

linkages to full range of supports; transportation; services and supports provided at school, in the community and at home. In another example of key strategies, keys to the cultural competency of the TAY Program are the embedding of its outreach/personal service coordinators in community-based agencies serving ethnic populations that are often not reached by county systems. Because Latinos and Asians/Pacific Islanders are the most significantly underserved populations, CCMH will focus its efforts in these areas and with these language capacities.

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

The strategies identified for the PEI population are structured around four initiatives: (i) Fostering Resilience in Communities Initiative; (ii) The Fostering Resilience in Older Adults (iii) The Fostering Resilience in Children and Families Initiatives; and (iv)The Fostering Resilience in Youth/Young Adults Initiative. Under each of these initiatives there are a total of nine (9) projects that are geared towards reducing the disparities for the selected populations. These projects are outlined above in Section III (A).

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

### *A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI*

***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.***

The community planning process has resulted in our ability to provide Prevention and Early Intervention Services to many ethnically, culturally and age diverse groups. For providers who are new to our system the transition to providing Prevention and Early Intervention Services has been a growth experience most of which has been positive. The existing system of care which is stressed by diminishing resources and a great demand for services has not yet fully integrated or perhaps accepted these services. We are holding regional round table meetings in order to, share the resources, open the dialogue and work toward integrating and collaborating in the provision of services in our system of care. The contractors have largely been very successful in rolling out the programs and reaching the underserved populations. It has been an easier transition for the providers which are new to our system of care than those who have been Medi-Cal and EPSDT trained. The new model doesn't fit well with the old and changing the framework has been a challenging journey.

In regards to Workforce, Education and Training, we have learned that it is not best to offer trainings without knowing the training needs of your target audience (staff, consumers/family members, contractors). Without the knowledge of the training needs of your target audience, there a high possibility of people not showing up for trainings and in most cases these trainings have to be cancelled. In an effort to eliminate this issue, the County is currently working on a Training Survey that would collect feedback from staff and consumers on their topic of interests in regards to training.

In the WET plan it was stated that we would convene the Training Advisory Workgroup at least three times annually, but because of the increased need for support in rolling out the activities in the WET plan, we created a schedule in which the workgroup meets every month to discuss those activities that need immediate attention.

During the initial implementation efforts of the WET plan, there were a lot of trainings that the County had to offer but in order to provide Continuing Education Units we had to go through the Accrediting Agencies like the Boards of Registered Nurses and Board of Behavioral Sciences. The process of getting

these trainings approved could range from a month and a half to three months. In an effort to save time and provide these trainings in a timely manner, the County applied to various Accrediting agencies and was given approval to provide units. We have in-house specialists that review and approve courses to see if it meets the requirements of offering CEU's. Contra Costa County Mental health has been approved as a Continuing Education (CE) Provider with the following boards: Board of Behavioral Sciences (BBS); Board of Registered Nursing (BRN); and The California Foundation for Advancement of Addiction Professionals (CFAAP).

**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 provides the status of the county's implementation efforts (i.e. timelines, milestones, etc.).***

## Status of Implementation

**Prevention and Early Intervention - Status of Implementation**

Below are updates of the programs currently under the PEI component. On the left column, it has the name of the program and the project in which the project relates to, as described in Section III.

| Name of Program | Population served | Timeline/services reported (FY 09- ) |
|---|---|---|
| Native American Health Center **(Project #1)** | **Native American** Health Center provides weekly group sessions and quarterly community events, including an elders support group, youth group, substance abuse recovery group and Positive Indian Parenting Groups. The Native Wellness Center is designed to build a strong community, strengthen family communications, and help Native Americans navigate the complex human service systems in Contra Costa County. | The contract was let in 09-10 and is serving the Native American Population of Contra Costa County. Outreach efforts have been extensive, including interviews on Native American radio and television booths at public events and cultural competency trainings for public officials and health care staff. A site was secured in Richmond and many community events have been held to engage this community. |
| Rainbow Community Center **(Project #2)** | **Lesbian, Gay, Bisexual, Transgender, Queer and Questioning**. RCC provides a community-based social support program designed to decrease isolation, depression and suicidal ideation among members of the (LGBTQ) community. Targeted groups include LGBT youth and their families, HIV/ Aids, and Seniors. | 320 clients have received outreach services in April<br>135 clients have participated in groups in April<br>136 hours of individual therapy were provided in April<br>375 unduplicated clients have been served year to date |

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| YMCA/Building Blocks for Kids<br>**(Project #1)** | YMCA serves primarily **African American and Latino families** in an area of high poverty and violence to improve access to health and mental health care. They support block by block community organizing and events to improve life skills and promote social change. | 56 clients YTD have received family resource navigation services<br>171 clients YTD have participated in strengthening family communication program<br>1740 clients YTD have participated in the building community component. |
| La Clinica de la Raza<br><br>**(Project #1 and #6)** | La Clinica has implemented 2 programs serving the **Latino Community** one is an assessment screening tool to identify social isolation ,depression, substance abuse and domestic violence and to provide immediate intervention and group follow up for those identified. They are also providing parenting classes to support families. | In the 3rd Quarter 326 client services were provided with an unduplicated count of 190 clients served. |
| Jewish Family and Children's Services<br><br>**(Project #1)** | JFCS provides mental health education and navigation to the immigrant communities including, **Latino, Afghan, Bosnian, Iranian, and Russian Communities**. They are also training county and community agencies on how better to work with immigrants from these cultures. | 48 staff from community agencies YTD have participated in cross cultural training.<br>221 clients YTD have participated in mental health education groups<br>282 clients YTD have received assessment, early intervention and/or mental health system navigation services.<br>383 unduplicated clients YTD |
| Center for Human Development<br><br>**(Project # 1 and #5)** | CHD has 2 separate programs: Mental Health Education and Navigation to the **African American** Community in their <u>African American Health Conductors Program.</u><br>The Youth Senior Peer Counseling Program pairs **Youth and Seniors** to decrease senior isolation and provide youth growth and training opportunities. | Current data not available. |
| RYSE<br><br>**(Project #2 and #9)** | RYSE has implemented 2 programs:<br><u>The Trauma Response and Resiliency System</u> which serves **youth who have been impacted by incidents of violence** through critical incident response and organizing the community to create a plan for multi-level | TRRS efforts have resulted in the formation of a working group including; law enforcement, residents, Youth CBO's, Health Services, EHS and other community agencies.<br>958 youth services have been provided in the Health and Wellness Program YTD |

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| | response.<br>RYSE Health and Wellness Program supports **youth ages 14-21 serving the Multi-Ethnic communities** of the county by providing assessment, health and wellness, arts and culture, education, career counseling and youth leadership and counseling. They have developed a youth oriented online support and information site at RYSEPortal.com, providing on line access to support the values of harm reduction and youth empowerment. | 293 youth services have been provided in academic and career counseling program YTD.<br>889 youth services have been provided in the media arts and culture program YTD.<br>357 client services have been provided in the culture keeper program YTD.<br>306 client services have been provided in the leadership and advocacy program YTD.<br>298 client services have been provided in the academic and career counseling program YTD.<br>3084 youth have accessed the internet site RYSEPortal.com<br>A total of 483 unduplicated clients have been served YTD. |
| Contra Costa Crisis Center<br><br>**(Project #4)** | Contra Costa Crisis has increased their Crisis line capacity to the **Spanish Speaking** by doubling their crisis line accessibility to 80 hours a week. They have increased the number of trained, **multi lingual volunteer staff** from 10 to 20.<br>They conduct ASIST trainings and organize with the county and other community agencies an annual Suicide Prevention Training. County and Contractor are co-leaders in the Suicide Prevention Committee. | Of their 24,487 callers YTD, the Crisis line has served 499 Spanish Speaking Callers. 10 new multi-lingual, multi- cultural volunteer staff have been trained.<br><br>The Suicide Prevention Committee has been formed and is planning county suicide prevention efforts, strategies and has provided 2 ASIST trainings and is co-sponsoring un upcoming day long workshop with a nationally recognized expert. |
| LifeLong Medical Care<br><br>**(Project #5)** | Lifelong Medical Care Provides on-site screening and activity groups to **Multi-ethnic Seniors** living in public housing in order to increase connectedness and self efficacy to isolated seniors. | Current data not available |
| Child Abuse Prevention Council<br><br>**(Project #6)** | CAPC provides evidence based parenting programs to **African American and Spanish Speaking Families** throughout the county. | 35 and parents have participated in parenting classes and 37 children in the children's program to date. |
| Family Stress Center<br><br>**(Project #6)** | Provides evidence based triple P Parenting Seminars to **parents** throughout the county | 64 parenting classes were provided in April.<br>215 parents participated in seminars YTD.<br>307 unduplicated parents have been served YTD |

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| Latina Center<br><br>**(Project #6)** | The Latina Center conducts culturally and linguistically appropriate parent education to the **Latino Community.** They conduct outreach and engagement activities to this community. They have trained Parent Advocates and Parent Partners to provide mental health information and navigation. | 289 parenting classes were provided in April<br>304 clients participated in parenting classes YTD<br>458 clients participated in family activities/cultural events in April<br>871 YTD.<br>1695 Unduplicated clients have received services year to date. |
| Contra Costa Interfaith Housing<br><br>**(Project #6)** | Contra Costa Interfaith Housing provides permanent housing and on-site support services to **27 formerly homeless families**. These include parenting classes, educational evaluation and support, pre-school classes, family groups, sobriety groups and domestic violence groups. | 547 hours of service provided to families in April<br>63 clients served in April |
| West Contra Costa Youth Services Bureau<br>**(Project #7)** | WCCYSB provides support to **youth, siblings and families of multicultural youthful offenders** who are reentering their communities from the Orin Allen Youth Rehabilitation Facility. These include intensive group support, vocational training and support and recreational activities. | 36 groups/72 hours provided to multi-cultural youth YTD<br>141 Sibling Prevention and Early Intervention Services YTD<br>15 groups/30 hours Family Empowerment Support YTD<br>131 hours of Wraparound meetings reported for April |
| Family Institute of Richmond<br><br>**(Project #7)** | Family Institute of Richmond provides Brief Strategic Family therapy to **multi cultural youth who are involved with the juvenile justice system** in primarily East and Central County. | Current data not available. |
| Contra Costa Clubhouses<br><br>**(Project #8)** | The Clubhouses provide peer based programming for adults in recovery from psychiatric disorders. Services funded through PEI include on site recreational, life skills and family respite services for members. | 123 client services and 204 hours of service in the Multimedia Program.<br>52 client services and 179 hours of service have been provided in the expressive arts program.<br>66 clients have received 102 hours of service in the healthy living program.<br>150 TGIF services and 357 hours of service in the TGIF Socials.<br>60 people have participated in 408 hours of Tuesday Program.<br>17 clients have received in home outreach services.<br>108 clients have received meals<br>37 clients have utilized the ride program. |

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| | | 118 unduplicated clients have been served year to date. |
| People Who Care<br><br>**(Project #9)** | People Who Care provides after school vocational training and employment opportunities for **at risk multi-cultural youth.** | 39 Youth YTD have received job training<br>23 youth YTD have participated in anger management groups<br>67 youth YTD have done community service.<br>83 unduplicated clients have been served year to date |
| STAND!<br>**(Project #9)** | Stand! provides primary prevention activities for **multi cultural teens** to educate them regarding teen dating violence. They also provide secondary prevention support groups for teens who are at risk or have experienced teen dating violence. | 4375 youth have participated in the Expect Respect Program to date. |
| El Cerrito High School James Moorehouse Project<br>**(Project #9)** | Contractor provides on-campus programming for **Multi- Cultural Youth**, in areas including, substance abuse, anger and violence, conflict mediation, health education, teen pregnancy and parenting support, bereavement, and counseling. | Data not available. |
| Martinez Unified School District, New Leaf Program<br>**(Project #9)** | Career Academies are provided for **multi cultural high school students**<br>Which, include career testing, preparation, and internships to result in a high school diploma and skills transferable into sustainable living. | Data not available. |
| Asian Pacific Islander Services<br>**(Project #1)** | 2 providers have been selected through and RFP process, to provide services to the **Asian/Pacific Islander Immigrant Communities** of Contra Costa County. | These contracts have not yet been awarded but are being recommended to the Board of Supervisors for approval. |
| Community Mental Health Liaisons for Trauma<br>**(Project #2)** | This planned and approved program would provide for regional liaisons to **respond to critical incidents** and work with other key agencies to create a trauma response system. | These county positions have not These positions have not yet been filled. |
| Office of Consumer Empowerment<br>**(Project #3)** | Provides **stigma reduction and awareness education**, through anti-stigma training, Speakers | The anti-stigma trainings have been conducted.<br>The Speakers Bureau has begun |

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| | Bureau and the Wellness and Recovery Task Force. | training for the Speakers and a Recovery Conference is being planned for the fall. |
| Senior Peer Counseling | Is expanding their language capacity to include **Spanish and Asian Language** Speaking Staff which provide health education and navigation services, | The new Asian Senior Peer Counseling staff has just been hired and the search for a Spanish Speaking staff is in process. |
| Partnering with Parents Experiencing Challenges **(Project #6)** | This county run program will target **support for families with a child (of any age) with serious emotional disturbance** by providing assessment, support and linkages to community resources. | The county has not yet been able to fill these positions. |
| Early Intervention Program | This county run program will utilize Mental Health Liaisons to support youth as they transition out of custody. | The East and West County Liaisons have been hired and a Mental Health clinician is now working full time at Oren Allen Youth Rehabilitation Facility. |

**WET Updates - Status of Implementation**

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| **Action Item 1**: Workforce Education & Training Coordination | The Workforce Training Advisory Group plays an integral part in supporting the activities of the Workforce Education and Training plan. The group, which began with 18 members who represent county administration, clinical and non-clinical staff, met twice during the fiscal year.<br><br>A total of 23 trainings were conducted during the fiscal year. Family members, consumers, and underserved/underrepresented communities were included as trainers and participants. Consumers who participated as trainers were central to the SPIRIT program curriculum. SPIRIT is a consumer-lead course that includes guest lecturers who are consumers.<br><br>In FY 08-09, 21 students participated in Contra Costa's intern program and worked in a variety of placements, such as Chris Adams center, County Children and Adult clinics and Contra Costa Regional Medical Center. |
| **Action Item 2:** Staff Development Training Initiative | During FY 08-09, there were over 20 staff development training opportunities, including *Law, Ethics and Confidentiality in Behavioral Health, Addressing Inequities in Health,* and *Youth Suicide and Self-Harm.*<br><br>Included in the training list for FY 08-09 are trainings which include CCMH staff as "subject matter experts". During FY 08-09, CCMH staff conducted 16 these training sessions, covering topics such as *Documentation, Partnership Plan, CALOCUS,* and *Subpoena training* for various audiences.<br><br>During FY 08-09, CCMH staff participated in an online meeting with Essential Leaning to view a demonstration of their product and invited a number of staff members to pilot the online *Law and Ethics* course. After a successful meeting CCMH will purchase an online learning product in spring 2010 as a resource for improved workforce training.<br><br>Finally, during fall 2008 the planning process for the "Recovery in Diverse Communities Conference" was initiated. The Recovery Planning Group was created in October 2008 and includes 19 members who represent Contra Costa Mental Health Administration, community stakeholders, as well as consumers and met three times during FY 08-09. Plans are being made to provide the training by FY 09-10. |
| **Action 3:** Mental Health Training for Law Enforcement | Two Crisis Intervention Trainings (CIT) were offered to law enforcement and mental health staff during FY 08-09. Consistent with the philosophy of MHSA, consumers and family members were included as guest speakers for the training. Consumers were invited to share their past experience involving law enforcement, suggest methods to communicate more effectively with consumers and their families and provide insight related to promoting an integrated service experience with law enforcement. In order to support Contra Costa's diverse mental health consumer population, cultural issues were addressed throughout the trainings. |
| **Action Item 4**: Consumer Employment | CCMH, in conjunction with Contra Costa College in West County, offered the Service Provider Individualized Recovery Intensive Training (SPIRIT) Program during the 2008 spring semester. SPIRIT is a 14-week consumer training |

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| Strategies (SPIRIT Program Expansion & Enhancement) | program followed by a supervised internship. D<br><br>During FY 08-09, negotiations between CCMH and CCC College were initiated to include the SPIRIT program in the college catalog and in that same year the program became part of the school's catalog.<br><br>During the 08-09 school year, the SPIRIT program experienced a successful term with 35 students enrolled and 32 students completing their internships at various agencies such as Contra Costa Mental Health and with contract agencies such as Anka, Rubicon, and Crestwood.<br><br>To provide ongoing support and resource sharing, the SPIRIT club was created as a network for students after graduation. The club has 76 SPIRIT graduate contacts, from which about a fourth participate in club-sponsored events. The SPIRIT course and alumni network continues to be a valuable piece to the mental health recovery for consumers in Contra Costa demonstrated by the success and growth of the program. |
| **Action Item 5**: Family Member Employment Strategies | During FY 08-09, creating a training program for family member employment in the public mental health system was initiated by CCMH staff. CCMH explored integrating existing curriculum and collaborating with subject matter experts to guide the structure of a family member training program for employment. In efforts to formalize the family support worker position, CCMH staff recommended updates to the duties and responsibilities to the family support worker position. To support the engagement of consumers and family members as employees, a number of staff development trainings were offered to family partner staff/volunteers. As outlined in the WET plan, trainings in 2008 covered topics such as *Documentation, VanDenBerg High Fidelity Wraparound, Strengths, Needs, Culture Discovery (Part I): What is Culture,* and *Strengths, Needs, Culture Discovery (Part II): Changing Deficit-Focused Dialogue to Strengths*. |
| **Action Item 6**: Developing Mental Health Concentration in High School Health Academies | In May 2010, a group of individuals were identified as Subject Matter Experts (SME) in the development of a High School Mental Health Curriculum. These individuals include Mental Health Clinical Staff and High School Educators (Principal and Instructor). The Training Advisory Workgroup has delegated some of its members to recruit more SME in the development of this curriculum, and also look for High school academies that are interested in developing a mental health concentration within their existing programs. The workgroup, of Subject Matter Experts, plan to start meeting in July 2010. CCMH plans to have a curriculum developed by January 2011. |
| **Action Item 7**: Community College Partnerships: Psychosocial Rehabilitation Certificate (PSR) | Building on the partnership with Contra Costa College, CCMH worked to implement the Psychosocial Rehabilitation Certificate Program during FY 08-09. The PSR program has been developed and classes expected to begin fall 2010. Additionally during FY 08-09, the PSR Advisory Group met to assist with the promotion and recruitment for the PSR program. Twenty four individuals representing consumers, family members, community-based providers, CCMH, as well as the Department of Rehabilitation and Contra Costa College were included in the Advisory Group. |

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| **Action Item 8**: Psychiatric Technician Program | The Training Advisory Workgroup is currently holding discussions on how to effectively implement this action item. The CCMH Medical Director will oversee the planning and implementation of this action item. Contact has already been made with University of California, San Francisco, to explore developing a Psychiatric residency and/or Fellowship program for CCMH. The goal here is also to promote the development of culturally relevant, recovery-oriented curriculum and experience to include both County and CBO systems of care. CCMH plans to begin implementation of this item by fall 2010. |
| **Action Item 9**: Expanding Graduate Level Internship Opportunities | Providing graduate level internship opportunities is imperative for supporting the success of the county's mental health workforce. In FY 08-09, 21 interns participated in the Mental Health Internship program, of which fourteen provided outpatient services in our clinics. Seven interns provided services in other settings, such as hospitals, where they were part of treatment teams.<br><br>The placement of interns in both clinics and hospitals has enhanced care for mental health consumers in Contra Costa County. Specifically, the services that were provided by those working in our outpatient mental health clinics include 1,825 distinct services to 135 unduplicated consumers. Because the services provided in settings such as the hospital are not provided by individuals, but by the treatment team, the numbers of services and the unduplicated client count for services specifically provided by the interns working in these settings are unavailable. |
| **Action Item 10**: Psychiatry Workforce Development | To help alleviate the shortage of needed staff in psychiatry, such as psychiatrists, nurses, and licensed technicians, Contra Costa is working to expand the professional shortage designation areas to include more of the county. This state designation allows for incoming psychiatric staff to be eligible for various state loan forgiveness programs, thereby making Contra Costa a more attractive option for employment for new graduates. Contra Costa currently has two professional shortage area designations granted by the state (Central Richmond and North Antioch); additional areas are currently being examined in order to expand the geographic areas eligible for loan forgiveness. The outcome of the designation process will complement our work to enhance the psychiatric workforce in the county.<br><br>Preliminary discussion around developing the Psychiatry Workforce in Contra Costa County was initiated during FY 08-09. The two main ideas developed during these discussions included creating a Contra Costa College-based Community Psychiatry Fellowship in association with UCD or UCSF and creating a Community Psychiatry elective for psychiatry residence in either UCD or UCSF. Future work to develop the County's workforce plan includes getting buy-in from CCMH administrative staff and affiliated Universities and developing a curriculum. |
| **Action Item 11**: Nursing Workforce Development | During FY 08-09, CCMH had an executed contract affiliation agreement between the Regents of the University of California, San Francisco, School of Nursing for clinical placement of Psychiatric, Mental Health, Nurse Practitioners, Post Masters, graduate students, into our clinical internship program. |

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| | In February 2009, Pittsburg Mental Health Center was designated as UCSF's first student clinical rotation, which ended 11/24/2009. The creation of clinical placement protocols was developed with input from Program Managers, Psychiatrist and Nursing staff. During their placements, students participated in CCMH internship orientation program and required HIPPA, EMTALA, and CPI trainings. Following the students' rotation, verbal feedback obtained from UCSF interns, instructors, and a CCMH psychiatrist regarding student clinical rotation has been outstanding, as clinical objectives have been met and placements have been excellent. CCMH has a longstanding contract affiliation agreement with Samuel Merritt College; however, during 2008-2009, we did not receive nursing placement request from their university. Outreach and recruitment efforts at Samuel Merritt College and UCSF University, will continue for subsequent years targeting individuals with multicultural backgrounds. |
| **Action Item 12**: Scholarship Program for Bachelor Level Degree | In June 2010, CCMH began the program development for the Scholarship and Loan Repayment program for county staff that are currently or planning to pursue a Bachelors Level degree or Masters Level degree. The program is designed to pick a total of 10 individuals (5 for the Bachelors Level Degree; and 5 for the Masters level Degree), who would be awarded funds to pay back their student loans. Interested applicants are required to submit specific documents in order to be considered for the program. Mental health staff awarded under this program must complete a minimum two-year service obligation and maintain either full-time or part-time practice.<br><br>CCMH plans to pick the awardees by December 2010. A panel will be selected by the Training Advisory Workgroup, to review all applications and make a recommendation to the Mental Health Director for review and final approval.<br><br>The most qualified applicants will be employed in hard-to-fill or hard-to-retain position in Contra Costa Mental Health Division. Priority consideration will be given to applicants best suited to meet the cultural and linguistic needs and demands of mental health consumers. Priority consideration will be given to those applicants whose background and commitment indicates the likelihood of long-term employment in the public mental health system even after the service obligation has ended. |
| **Action Item 13**: Scholarship for Masters' Level Degrees | This action item is part of the program development and implementation of Action Item #12. The Bachelors and Masters Level Loan Repayment and Scholarship Program is being developed in a manner in which they would be implemented with exactly the same time-frame. Five individuals would be selected under the Masters Level Scholarship program and be awarded funds to pay back their student loans. This item has the same review and selection process as Action #12. |

**CSS Updates- Status of Implementation**

| WORK PLANS #1-3: FULL SERVICE PARTNERSHIP PROGRAMS | |
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| **Program** | **Status of Implementation** |
| **WORK PLAN #1**<br><br>Children's Full Service Partnership Program | Since implementation in 2007, a total of 181 children, youth and families have received services from the Families Forward Program. At the end of fiscal year 2009-2010, there were 69 children, youth and families receiving services.<br><br>Families Forward continues their outreach and engagement efforts to increase enrollment.<br><br>Increasing efforts have been directed toward introducing resiliency measurement tools as well as needs and strengths assessments. Available wraparound services are intended to adhere to the evidence-based wraparound model; therefore, the Wraparound Fidelity Index tool is being implemented to determine how accurately the services adhere to the wraparound model. |
| **WORK PLAN #2**<br><br>TAY Full Service Partnership Program | Since implementation in 2006, a total of 139 transition age youth have received services from Fred Finch Youth Center. At the end of fiscal year 2009-2010, there were 63 Full Service Partners receiving services.<br><br>Fred Finch continues to build relationships with other community organizations to increase the number of referrals.<br><br>To ensure that Full Service Partners are receiving the appropriate level of care, the Levels of Care Utilization System measurement tool is being implemented during FY 10-11. The data collected with this tool will help guide the intensity of services the FSP is receiving and services can be adjusted accordingly. |
| **WORK PLAN #3**<br><br>Adult Full Service Partnership Program | Since implementation in 2006, 241 adults have received services from the Adult Full Service Partnership Program. Currently, there are 179 adults who are active Full Service Partners.<br><br>To ensure that Full Service Partners are receiving the appropriate level of care, the Levels of Care Utilization System measurement tool is being implemented during FY 10-11. The data collected with this tool will help guide the intensity of services the FSP is receiving and services can be adjusted accordingly. |
| **Program** | **Status of Implementation** |
| **WORK PLAN #4**<br><br>Older Adult Systems Development | Since program implementation in 2008, the older adult program has provided services to 195 older adults. At the end of fiscal year 2009-2010 there were 35 people enrolled in the IMPACT program and 77 people enrolled in Intensive Care Management.<br><br>The IMPACT program continues to be challenged when attempting to integrate mental health with primary health. Referrals from primary care are limited and buy-in from line staff is difficult. Persistent efforts to build this relationship continue as do supplementary efforts to increase enrollment. |
| **Program/Agency** | **Status of Implementation** |
| **WORK PLAN #5**<br><br>Housing Program | At the end of quarter 3 of fiscal year 2009-2010, there were 146 people in housing: 111 Adults; 31 TAY; and 4 Children and Families. |

| Program/Agency | Status of Implementation |
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| **STRATEGY #1:** Enhancements to the Office for Consumer Empowerment | In 2005, when this initial 3-year plan was written, the Office for Consumer Empowerment offered the SPIRIT training program; Tender Loving Care (TLC) program; and WRAP planning guidance and support. Additionally, the Consumer Involvement Steering Committee made sure that the consumer perspective is meaningfully included in the planning, implementation and evaluation of all MHSA components. The following activities are currently being implemented in the Office of Consumer Empowerment (OCE): SPIRIT Program and Graduation Ceremony; Circle of Hope Volunteer Program; Speaker's Bureau; Wellness & Recovery Task Force; Leadership Academy; Alumni SPIRIT Club – Networking and Training; Recovery Trainings for Clients, County Staff and Contract Providers; Representation on County Planning Committees; Interagency Collaborations - Support Groups, SPIRIT courses and Internships; Wellness Television - DVD Recovery Training Collaboration with Putnam Clubhouse and County Staff; On-the-job training, ongoing support and monthly meetings with Contra Costa Mental Health Community Support Workers (CSW); Participation in Cal-Mend Project – Integration of Mental Health and Physical Health at a County Clinic; Ongoing advocacy and resource referral for Contra Costa Mental Health Clients; and Recovery curriculum development. |
| **STRATEGY #2:** Planning for Future Systems Development | Planning is on-going {No activity to report}. |
| **STRATEGY #3:** Peer Benefits Advocates | Currently, there is one peer benefits advocate who is located in Central County. The Peer Benefit Advocate assists consumers with medication refill, payment and pharmacy-related issues. Additionally, the Peer Benefit Advocate speaks with consumers who call the Access line who are encountering challenges in obtaining insurance benefits. |
| **STRATEGY #4** Expansion of Family Partner Program | Currently, there are 10 family partners. Seven of the 10 are bilingual in Spanish. Each parent partners carries a caseload of 18 to 25 consumers with 8 to 10 consumers receiving wraparound services.<br><br>There are 9 wraparound facilitators; 2 of the 9 are bilingual in Spanish.<br><br>At the end of fiscal year 2009-2010, there were 124 consumers receiving wraparound services. Since expansion of the Family Partner Program in 2006, a total of 334 consumers have received wraparound services (this numbers includes the 124 that are active). Available wraparound services are intended to adhere to the evidence-based wraparound model; therefore, the Wraparound Fidelity Index tool is being implemented to determine how accurately the services adhere to the wraparound model. |
| **STRATEGY #5** Wellness Services | There are currently 2 wellness nurses providing services in the Central and East regions of the County. During FY 2009-2010, the Wellness nurses provided outreach and engagement-related services to 3,642 people. Additionally, 1,555 services and activities were provided to clients in the Intensive Care Management Program.<br><br>Wellness services provided by each of the nurses are being tracked using the Wellness Program Data Collection Form. This form collects the following |

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| | information:<br>• Home visits/in-home evaluations<br>• Facilitation of clinic-based "Healthy Mental Health Lifestyles" Group<br>• Linkage to Medical Care, Pharmacy, laboratory Services and support groups<br>• Educational and support services provided to clients at community center and elsewhere.<br>• Consultations with staff on behalf of clients (e.g. with case managers, board & care staff, etc.)<br>• Wellness-related special projects |
| **STRATEGY #6** Transformation Training | No activity to report. |
| **WELLNESS AND RECOVERY CENTERS (MHCC)** | |
| **Program/Agency** | **Status of Implementation** |
| Mental Health Consumer Concerns (MHCC) | MHCC provides services at three Wellness and Recovery Centers (WRC) located in Concord, Antioch and Richmond. Furthermore, MHCC provides services to Full Service Partners who participate in the Bridges to Home Program.<br><br>Outreach and engagement activities are done in board and cares; hospitals and various community locations.<br><br>In addition, MHCC operates an extensive Patients Rights Program that supports consumers receiving services in the public mental health system. |

***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.***

The county will use various mechanisms to measure and monitor the effect of identified strategies to reduce disparities. For all strategies identified the county has developed outcome statements; measures of success; and tools to measure success, for each item/agency/work plan. For example the PEI component would use different measurement and evaluation tools based on the program outcomes that are being measured. Measurement tools have been identified for each contract services that are being provided. The measurement and evaluation tools under PEI include: Tracking logs, Oral surveys, PEI questionnaire, referral log, Patient Health Questionnaire (PHQ-9), Parent/caregiver information form etc.
Measurement and evaluation tools under WET include: Personnel reports; intern lists; awardees list with demographic details; training list; personnel records; sign-in sheets; pre-post tests etc.
Measurement and evaluation tools under CSS include: Partnership Assessment Form (PAF); Quarterly Assessment Form (3M); Key Event Tracking Form (KET); Wraparound Fidelity Index (WFI); Child and Adolescent Needs and Strengths (CANS); Child and Adolescent Level of Care Utilization System (CALOCUS); Patient Health Questionnaire (PHQ-9); Consumer Satisfaction Surveys etc.

Collection of data and analysis of all strategies will be done monthly and reports will be created quarterly for each identified strategies. Based on the results of each measurement of success, efforts will continue to be made in meeting or maintaining set goals and objectives

***C. Identify county technical assistance needs.***

Technical assistance from DMH on the following items would be very beneficial to CCMH:

- PEI: provide clear guidelines requirements in regards to PEI reporting. It would be very helpful if the guidelines describe what data to report, and the timeline for reporting that data.
- WET: assistance in the development of programs such as the Loan repayment program and development of a MH curriculum/concentration in High School academies
- CSS: guidance on Exhibit 6 Quarterly Reporting. There isn't much information on the website for people who are new to reporting the required information. A short instruction/informational document posted on the website with contact information for additional support would be helpful.

# 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 or other similar group***

The Mental Health Division has a Cultural Competence Committee called the Reducing Health Disparities Workgroup. The Workgroup meets every third Tuesday of the month. The workgroup has representation from different specialties which include: Consumers and family members, members of community based organizations, Children and Adult Mental health staff.

The RHD workgroup is structured around the guiding principles of the Health Services Department's Reducing Health Disparities Initiative (RHDI). The goal of the workgroup is ensure that all Mental Health county staff provides services that respect the values, belief systems and cultural preferences with cultural humility to our consumers and communities. To accomplish this goal, the RHD guiding principles will be incorporated into the work of CCMH.

Below are some of the guiding principles of RHD

- We are committed to eliminating health disparities because our mission is to care for and improve the health of all who live in Contra Costa County with special attention to those who are most vulnerable to health problems. Disparities based on race, ethnicity, language, socioeconomic status or other similar reasons are inconsistent with our mission.
- We recognize that differences in race, ethnicity, age, gender, sexual orientation, language, physical ability, socioeconomic class, education, and many other factors can affect how we relate to patients, clients, customers consumers, communities and each other.
- Our employees participate in training and related activities to increase our knowledge and appreciation of diverse cultures and to become comfortable and effective in a diverse environment
- The RHD structure is designed to ensure RHD efforts are integrated into day-to-day activities of the department and all of its division.
- There is a role for every employee, manager, supervisor and Division Director.

The CCMH Reducing Health Disparities workgroup is broken down into seven sub-workgroups in which members of the workgroup are spread across (Table 4.1). These sub-workgroups include: Linguistic Access; Workforce Development, Education and Training; Partnership with Multicultural Communities; Work Environment; Governance, Systems and Policy; Data Collection; and Inclusion Initiative (LGBTQ).

The CCMH Reducing Health Disparities workgroup has a work plan that is broken down into different sections with goals and objectives under each of those sections. This work plan sets measurable goals for the group to accomplish with projected completion dates and benchmarks (Table 4.3). The workgroup also has representation in all boards, committees and decision-making process within the mental health system.

***B. Practices that assure members of the Cultural Competence Committee will be reflective of the community***

The Reducing Health Disparities Workgroup has a document that outlines the areas of recruitment for representation in the workgroup. However, we don't have all positions filled according to our areas of

recruitment and it is an on-going effort by members of the workgroup to continue to recruit members until all those vacancies are filled.

Below is an extract from the document of the RHD workgroup "Areas of Recruitment". Please note that the groups outlined are included but are not limited to the workgroup's area of recruitment.
Contra Costa Mental Health
Reducing Health Disparities Workgroup - Areas of Recruitment

- Consumers and Family Members
- Contractors and Network Providers
- Community Partners/Leaders
- Cultural Groups (Native American; Latinos)
- Health Conductors
- County Mental Health Staff (Line staff, Management) - East, West and Central County

## C. Organizational Chart

**Table 4.1: CCMH - Reducing Health Disparities Sub-Workgroups**

| Linguistic Access | Workforce Development, Education & Training | Partnership with Multicultural Communities | Work Environment | Governance, Systems and Policy | Data Collection | Inclusion Initiative (LGBTQ) |
|---|---|---|---|---|---|---|
| | | | | | | |
| Caroline Sison | Hannah Head | Michaela Mougenkoff | Matthew Luu | Imo Momoh | Caroline Sison | Tony Sanders |
| Hala Fattah | Lynor Jackson-Marks | Corina Hidalgo | Dianna Collier | Susan Medlin | Laura Balon-Keleti | David Woodland |
| Imo Momoh | Mickey Jackson | Katherine Wade | Zabeth Cooper | | | |
| | | Tony Lopez | | | | |
| | | Sandra Lopez | | | | |
| | | Elvira Sarlis | | | | |
| | | David Carrillo | | | | |
| | | Raihana Fakhry | | | | |
| | | Nayyirah Sahib | | | | |

**RHD Advisory Group:**
Stacey Tupper, Steve Hahn-Smith, David Cassell, Mariana Moore, Anna Lubarov, Sherry Bradley, Kathryn Wade

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

**Table 4.2: RHD Membership Roster**

| **Reducing Health Disparities Workgroup Members** | |
|---|---|
| Imo Momoh, MPA | *Committee Chair & Ethnic Services & Training Coordinator* |
| Melvora Jackson, MPA | *Committee Vice Chair & Health Conductor/MH Detention Center* |
| Elvira L. Sarlis | *MHSA Support Team Senior Clerk* |
| Caroline Sison, MPH | *Health Services Planner/Evaluator* |
| Hala Fattah, M.D. | *East County Lead Staff Psychiatrist* |
| Mariana Moore | *Contractor Representative/Director, Contractors' Alliance of CC* |
| Michaela Mougenkoff, MFT | *TAY Program Supervisor* |
| Hannah L. Head, MSN, PHN, RN | *Health Conductor/Utilization Review Coordinator* |
| Sandra Lopez | *MH Access Line/ Care Management Unit – Senior Clerk* |
| Nayyirah Sahib | *Consumer Representative/Community Support Worker* |
| Tony Lopez | *Consumer Representative/Community Support Worker* |
| Lynor Jackson Marks, PhD | *Mental Health Clinical Specialist* |
| Dianna L. Collier | *Family Representative/Family Services Coordinator, Children's MH* |
| Matthew Luu, LCSW | *MH Program Supervisor* |
| Laura Balon- Keleti, MPA | *Health Services Planner/Evaluator* |
| Raihana Fakhry | *WET Clerk* |
| Susan Medlin | *Consumer Representative/Coordinator, OCE* |
| David Woodland | *Vocational Services* |
| David Carrillo | *MHSA Project Manager* |
| Zabeth Cooper | *MHSA Clinic Coordinator* |

**Representatives as a collective represent all regions of Contra Costa County.*

**Advisory Group**

| | |
|---|---|
| Stacey Tupper | *MH Project Manager* |
| Steve Hahn- Smith, Ph.D. | *MH Research and Planning Coordinator* |
| David Cassell, LCSW | *MH Quality Improvement Coordinator* |
| Sherry Bradley, MPH | *MHSA Program Manager* |
| Kathryn Wade | *Consumer Representative/Office for Consumer Empowerment* |
| Roya Sakhai. Ph.D. MFT | *Executive Director, Multi- Lingual Counseling* |

**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:***

The Reducing Health Disparities Workgroup is continuously involved in all program review and planning within the Contra Costa Mental Health Division. The workgroup has members in each program planning committee. The goal of the workgroup members serving in these committees is to ensure that cultural competence is integrated in all service and program planning. For example, Policy No. 104 below demonstrates the participation of the RHD workgroup in the activities of the Quality Assurance/Quality Improvement program.

***B. Evidence that the Cultural Competence Committee participates in the above review process:***

In The RHD workplan there are outlined goals for members of the workgroup to participate in all CCMH (including MHSA) program planning and implementation (See Table 4.3 – items 24 and 25).

In addition to the CCMH *Cultural Competence Plan policy (No.104)*, outlines the requirements and involvement of the Reducing Health Disparities Workgroup in the Quality Improvement Program:

***Excerpt from Policy No 104: Contra Costa Mental Health Cultural Competence Plan***

***II. PROCEDURE:***

***The CCMHP's Reducing Health Disparities Work Group reviews, revises and recommends approval of the Cultural Competence Plan to the Mental Health Director as needed, assuring that the Plan meets State requirements, setting a high standard of care for consumers. The CCMHP's Disparities Work Group will also assure the following in regard to the Cultural Competence Plan:***

***A. It is a "working document" and can be revised or adjusted as needed;***
***B. It contains clearly defined targeted goals, and;***
***C. These goals will be reviewed and updated annually, or adjusted as needed.***

***In order to assure consistency between the goals of the Cultural Competence Plan, and those of the Quality Improvement Program, including those that address State requirements, the CCMHP's Reducing Health Disparities Work Group will participate in the CCMHP's Quality Improvement program. This includes having representation on the Quality Management Committee and Quality Improvement Council.***

### *C. Annual Report of the Cultural Competence Committee's Activities*

As previously mentioned the Reducing Health Disparities Workgroup has a work plan that establishes strategies for achieving RHD goals and prioritizes activities based on resources, consumers and community needs. The work plan serves as a monthly, quarterly and an annual report for the group and other relevant entities that are involved in the activities of the group. The work plan is periodically updated to reflect the changes and progress of the goals outlined in the plan.

The work plan consists of the following seven sections:

1. Improve and Monitor Linguistic Access
2. Development of Partnerships within Multicultural Communities
3. Work Environment Enhancement
4. Governance, Systems and Policy Application
5. Data Collection
6. Planning and Implementation of Overall Mental Health Services
7. Implement Cultural Competency in Workforce Development and Training

The Health Services Department Policy #127-A, in which the Mental Health Division adheres to, states the following for the implementation of the plan:

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***Implement the Plan in a manner that:***

1. ***Supports Service Excellence (see Policy 117A) and Reducing Health Disparities principles and results in the development of written behavioral expectations for all CCHS employees, supervisors and managers.***
2. ***Allows for full participation of Divisions, Work Groups and Committees in plan implementation, including development of their own annual work plan.***
3. ***Provides RHD leadership and support to Divisions, Work Group and Committees to successfully incorporate and integrate RHD strategies into daily operations*.**

**(Policy # 127-A, HSD Reducing Health Disparities: Procedure B)**

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Please see the RHD work plan displayed below. It is important to note that is a working document and is therefore subject to change, as goals are accomplished and new plans are established.

**Table 4.3: Contra Costa Mental Health Reducing Health Disparities 2010 WORKPLAN**

| | *Goal* | *Description* | *Measure* | *Person Responsible* | *Method* | *Completion Date* | *Completion Criteria* |
|---|---|---|---|---|---|---|---|
| **Improve and Monitor Linguistic Access** | | | | | | | |
| 1 | Create Resources for Educating Staff on How to Interact and Use An Interpreter When Delivering Services | Train staff at all MH Division Operated Sites on (a.) how to interact with and (b.)Use an interpreter or translation services | Yes | Imo Momoh | Schedule Trainings for Each Site, Include Information in New Employee Orientation | Annually | Curriculum development and training completed. |
| 2 | Conduct Language Utilization Survey | Estimate current demand for language services, and assess unmet needs on a quarterly basis. | Yes | Dr. Hala Fattah, Caroline Sison | Utilize vendor demands to assess languages used | Quarterly | Analysis of data completed at least quarterly and presented to this committee and Quality Management Committee |
| * 3 | Monitor quality and current use of Language Service Vendors | Quarterly review, present to Quality Management Committee | Yes | Linguistic Access Sub-workgroup members | Create Survey Tool for both Consumers & Professional Staff | Every 6 months | Using an existing tool, assess whether or not the quality of service meets the indicators on tool |
| 4 | Assess bilingual staff resources by region | Complete an assessment of staff's bilingual capacity. | Yes | Linguistic Access Sub-workgroup members | Use P.I.S. Report to Assess Flagged Positions | Every 6 months | Analysis of data completed at least quarterly and presented to this committee and Quality Management Committee |
| 5 | Participate on Health Services Department Linguistic Access Committee | Communicate activities and information between other Divisions and MH Division | No | Imo Momoh, Caroline Sison | Attend HSD-LAC | E/O Month | Regular attendance at HSD-LAC or HSD Workgroup |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6 | Communicate Linguistic Capacity and Access Needs to MH Administration, Program Managers, Supervisors, and line Staff | Using Measured Results (see Items, Above) - Report through Quality Management Committee, Quality Improvement Council, and Regularly in Mental Health Matters Newsletter | Yes | Imo Momoh | Use QIP Data, as above and report to compliance | Quarterly by Month End - March, June, September, December | Using Quality Improvement Project Process, Ongoing measurement of results reported to this Workgroup and Quality Management Committee |
| **HSD RHD INITIATIVES** | | | | | | | |
| HSD 7 | Evaluate Linguistic Competencies of bilingual staff | Use existing vendors to do evaluation of all staff in bilingual positions. | Yes | HSD RHD leadership group | Work collaboratively with HSD | Ongoing | When model is expanded to mental health division |
| **Implement Cultural Competency-Diversity, Workforce Development, Training and Educational Activities** | | | | | | | |
| * 8 | Establish Resource Pool of staff/contractors with expertise in the area of Cultural Competency/Diversity to provide recommendations with Training activities and implementation | | No | WE&T Sub-workgroup, Imo Momoh | Form a core workgroup; invite representation from different programs, including CBOs, consumers. | Completed 2/28/2009 | Established the WE&T advisory workgroup (Part of the MHSA WE&T) |
| 9 | Provide training opportunities that educate staff on Cultural Competency/Diversity | Providing training to establish connection between the values and principles of wellness & recovery, communication guidelines and cultural competency/diversity. | Yes | WE&T advisory workgroup, Imo Momoh, Caroline Sison | Create a log of available trainings and experts from within our staff, including CBOs. Organize trainings that are accessible to staff. | Ongoing | Follow recommendations from Staff training survey |
| 10 | Incorporate topics related to culture, race, ethnicity, language etc. into other trainings offered by the division. | Upon identification of topics, ensure that the material presented is culturally relevant and appropriate. | No | Imo Momoh, WE&T advisory workgroup | | Ongoing | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 11 | Present recommendations developed to attract job applicants from diverse communities | Develop a list of agencies/partners that serve multicultural communities where job listings can be posted | Yes | MH RHD Workforce development and training sub-workgroup | Contact local high schools, community colleges and universities, CBOs etc. | Annually | On-going |
| **HSD RHD INITIATIVES** | | | | | | | |
| A | Establish and Measure the Outcome of Cultural Competency Training | Utilize pre and post-test process for each training to measure the success of the training(s). | Yes | HSD RHD leadership group | | ___ | Pending direction from RHD leadership |
| B | Participate in development of HSD Educational Curriculum on Cultural-Linguistic Competency and Diversity, and Participate in Pilot of Cultural-Linguistic Competency and Diversity Curriculum | Participate in the RHD trainers group | No | Imo Momoh | Attend Mandatory HSD Trainings e.g., communication guidelines, group facilitation in multicultural settings, cultural differences, customer service and cultural competence; and DSM IV TR cultural formulation in assessment of racial/ethnic populations | Ongoing | |
| C | Identify Training Facilitators Within MH Division for Participation in Departmental Training-of-Trainer Model for Curriculum Roll-out | | No | Imo Momoh, WE&T Advisory workgroup | | Ongoing | Trainers Identified |
| **Development of Partnerships within Multicultural Communities** | | | | | | | |
| 12 | Develop, distribute and maintain an inventory of Partnerships and Collaborations within Multicultural Communities | | Yes | Partnership with Multicultural Communities sub-workgroup | Maintain resource list and encourage CBO/ community participation in RHD activities | Ongoing | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 13 | Identify Initiatives Within HSD, Coordinate Efforts and Disseminate Information to MH Division | African American Health Initiative Committee; Promotoras and AA Health Conductors Models; Disportionality of Adjudicated Minors Report Committee, Etc. | No | Imo Momoh | Work Collaboratively with HSD Disparities Initiative Workgroup | Ongoing | Coordinated as Department-wide initiative |
| 14 | Ensure community involvement and partnership | Develop regional collaborations with the community. | Yes | MH- RHD workgroup, RHD leadership group | Participate in health fairs and community activities involving different county divisions in the 3 different regions | Ongoing | |
| 15 | Organize a conference to address mental health stigma in multicultural communities | Collaborate with communities serving multicultural groups and organize a conference for providers on using Recovery principles in practice | Yes | Mary Roy, Susan Medlin, & Partnership with Multicultural Communities sub-workgroup | Organize a planning group and plan for the event | 3/1/2011 | |
| **Work Environment Enhancement** | | | | | | | |
| 16 | Create an Environment that is welcoming to consumers | Bring materials to the clinic that reflects the customers they serve. Improve accessibility to people with disabilities, display signage in languages and format other than English. | No | MH RHD work environment sub-workgroup members, Imo Momoh, Program managers/supervisors Sherry Bradley | Make site visits to get staff feedback on the project. Develop and Distribute signage, décor, posters, pictures, art work, magazines, brochures, information about the services, etc., that are culturally appropriate to the clinics | Ongoing | |
| 17 | Improve information dissemination | Ensure that the informational materials in the clinic are presented in languages of the customers | No | MH RHD work environment sub-workgroup members: Imo Momoh, Sherry Bradley, Program managers/supervisors | Make site visits to get staff feedback on the project. Survey the kinds of informational materials available and arrange for translation or acquire materials in other languages. | Ongoing | Coordinate with Communications Workgroup. |

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|---|---|---|---|---|---|---|---|
| 18 | Implement Service Excellence Principles in the Division | Develop Service Excellence Principles, provide trainings to develop behavior standards within each program/unit | Yes | Imo Momoh, Sherry Bradley | Finalize Service Excellence principles, schedule trainings for Program Managers, compile behavior standards, and develop standard set of behavior expectations for MH Division | 10-Sep | |
| 19 | Recommend RHD and cultural competency policies and procedures for contractors | Assess Policy and Procedure Needs and make recommendations to appropriate committees | Yes | Imo Momoh, Sherry Bradley, Contracts and Grants (C&G), Stacey Tupper, Helen Kearns | a. Explore existing culturally relevant practices and procedures with CBOs b. Develop boiler plate language, C. Make recommendations to insert the language into contracts | Follow guidelines from county counsel and contracts and grants. | Has to follow CC mental health policies and procedures (Ref: Item 24) |
| **Data Collection** | | | | | | | |
| HSD 20 | Workforce Needs Assessment and Gap Analysis | Workforce Needs Assessment and Gap Analysis | Yes | Caroline Sison, Laura Balon-Keleti, CCMH Data Workgroup | In parallel with planning for the MHSA Workforce Education & Training plan, we will collect administrative & survey data on the race, ethnicity, and linguistic competence of the County's MH workforce, including county & contract agency providers, and the MH clients served. | Completed 11/18/08 | A slideshow presentation to Managers and Supervisors at the Nov. 2008 meeting of MHES on results. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MH 21 | Participate in the CCHS RHD Data Workgroup | Attend meetings to provide perspective of MH Division & MH RHD Workgroup members. | No | Caroline Sison, Laura Balon-Keleti, CCMH Data Workgroup | Represent the MH RHD Workgroup as a member of the CCHS RHD Data Workgroup. Provide input on level of specificity and definitions of common variables for adoption and use across divisions. | On-going | Report quarterly to the MH RHD Workgroup on progress made by the CCHS RHD Data Workgroup. |
| 22 | Distribute survey questions to Cultural Competency Survey to Staff | Distribute Cultural Competency survey to County Staff and CBO's | Yes | Caroline Sison, Laura Balon-Keleti, CCMH Data Workgroup | Analyze Survey Data and develop written report | Survey distribution and collection in 09/2010 | Report on cultural competence Staff Survey |
| 22 | Provide input to IT vendor on needed customization of new behavioral health information system. | Define & refine categories of racial/ethnic & linguistic data for greater specificity of data captured. | No | Health Services Planner/Evaluator, CCMH Data Workgroup | Work with vendor to implement the new behavioral health information system and refine the levels of specificity for racial/ethnic and linguistic categories of data based on a standardized CCHS code set. | On-going | A tested and approved interface that allows input of CCHS categories of racial/ethnic and preferred language data. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| HSD *23 | Distribute survey questions to family members pertaining to cultural competency of children's services. | Add cultural competency questions to POQI satisfaction survey and distribute to County clinics and contract providers. | Yes | Caroline Sison, Laura Balon-Keleti, CCMH Data Workgroup | Distribute the POQI survey instrument to the family members at CBO's and County clinics. Collect and analyze survey data. Develop written report and presentation for MH Disparities Workgroup | Survey distribution and collection in 12/2010.<br><br>Data analysis and report preparation in 02/2011. | Report on cultural competence in the delivery of children's services at County clinics and CBO's. |
| **Planning and Implementation of Overall Mental Health Services** | | | | | | | |
| 24 | Participate and review all MHSA program planning and implementation | Provide input and make sure cultural competence is integrated in the planning process. | Yes | Designated members of RHD Workgroup | Help in community outreach and hold focus group during the planning and stakeholder process. Review plan drafts before they are submitted to the State for approval. | On-going | When all plans of MHSA components are approved. |
| 25 | Participate in MH program planning and Implementation | Review all MH program plans and monitor program implementation. | Yes | Designated members of RHD Workgroup | Ensure cultural competence is integrated in all programs, Make sure consumers, family partners and all stakeholders are part of the planning process. | On-going | When program are fully implemented. |
| **Inclusion Initiative (LGBTQQ12-S)** | | | | | | | |
| 26 | Increase System Competency for Working with LGBTQQI2-S Consumers | Provide trainings to increase competency. | Yes | Tony Sanders/Inclusion Initiative Sub-workgroup | By end of year provide at least 3 LGBTQQI2-S cultural competency trainings. | Every 6 months | Trainings to 200-500 providers across all services. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 27 | Increase LGBTQQI2-S Culturally Competent Care Using Realism Data | Have Provider Network intakes respond to set of Realism data questions | Yes | Tony Sanders/Inclusion Initiative Sub-workgroup | Provide 6 or more trainings for Network Providers to learn how to collect Realism data | Every 6 months | By end of year have 95% of submitted Provider Network intakes respond to the set of Realism data questions. |

# CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

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

***A. Contra Costa County shall develop a three year training plan for required cultural competence training that includes the following:***

During the past fiscal year, the County provided a number of trainings related to cultural competence, such as *Mental Health across Cultures; Rethinking Approaches to Reduce Risk and Promote Well-Being for LGBT Youth; Strengths, Needs, Culture Discovery*; and *Tools for Measuring Your Program Success in Reducing Health Disparities*. Contra Costa County Mental Health Division recognizes the importance of training staff to help better serve clients through culturally and appropriate mental health services and in response, have developed a three year training plan to help increase staff's cultural awareness and humility. The process for carrying out the County's CCPR training activities is two-fold: the first year will be devoted to researching and developing available cultural competency trainings that would best fit the needs of staff; once a training curriculum has been selected and vetted by the Training Advisory Workgroup (TAW) and the Quality Improvement Counsel, the training will be required of all staff during the second and third year and continuous efforts will be made to improve the structure and technicalities of the curriculum to ensure the efficacy and efficiency of the trainings.

The County plans to train an approximate total of 1,700 county mental health staff (350 County Staff/ 1,350 from Community-Based organizations/ Network Providers), in the various cultural competency principles outlined in Section B below.[viii]

***Year 1: Training Curriculum Planning***

Contra Costa Mental Health (CCMH) is currently examining several different options for training staff on cultural competence. The four main training curriculum that will be reviewed during the planning stage of year 1 of Contra Costa's Cultural Competency Plan are the (i) *California Brief Multicultural Competency Survey (CBMCS)*; (ii) a training curriculum designed by internal subject matter experts in the County; (iii) an online training program instituted by Contra Costa's Health Services Department; (iv) Essential Learning – CCMH's online learning management system. Additionally, CCMH is also exploring options for interpreter training, specifically *the Mental Health Interpreter Training (MHIT)* Curriculum. CCMH has made cultural competency training a priority by including it as an annual requirement of all staff in its Quality Improvement Plan. As outlined by the CCPR and the Division's Quality Management Plan, once a curriculum is developed, the County's cultural competency training requirement will require everyone to attend a mandatory training session.

CBMCS

The County is exploring the option to use the California Brief Multicultural Competency Scale (CBMCS) and Multicultural Training Program as the main training curriculum for staff. The CBMCS training curriculum consists of four 8-hour training modules; these modules will be spread over the course of the CCPR three year period to a) accommodate the large number of staff who are employed with CCMH and b) ensure that all staff are trained in the core principles of cultural competence, as outlined in this criterion. The modules include *Multicultural Knowledge, Awareness of Cultural Barriers, Sensitivity and Responsiveness to Consumers, and Socio-cultural Diversities*.

The CBMCS also includes a brief self-report multicultural competency assessment that will be administered to staff prior to beginning the training curriculum to assess knowledge gained as a result of completing the program. If adopted, CCMH will offer the CBMCS training modules several times a year to give staff the opportunity to complete the requirements for the year.

Essential Learning

In 2010, Contra Costa acquired Essential Learning, a web-based distance learning vendor, to provide online learning for staff. Essential Learning has an extensive library of behavioral health courses; many of these courses contain cultural competency material relevant to a number of different CCMH positions and, for some classes, offer continuing education credits for staff. Providing the option for distance learning through Essential Learning is beneficial to both staff and administration, as it allows the flexibility to complete trainings at the staff's convenience; the functionality of the learning management system will inform administration on the status of completion, tracking to ensure compliance, and enable the award of continuing education credits. The County also has the option of loading approved internal training curriculum materials to the website, thereby enhancing the course catalogue with internal subject matter expert trainings.

Essential Learning's course listing and descriptions were cross-walked with the CCPR to determine whether the available courses were in-line with DMH's requirements for cultural competence trainings. The County will continue to work with Essential Learning during the planning stage to ensure the training subtopics required in the Plan are addressed by the courses they offer. Additionally, CCMH will work with program managers to identify the most beneficial online courses for their staff to create a more relevant, tailored curriculum and compile a defined list for different job classifications. Staff will be given the choice to select an online course option from a cumulative list of courses that fulfill the cultural competency requirement, as reviewed and approved by MHA. For example, Essential Learning's course, "Mental Health Issues for Gays and Lesbians" would be beneficial for staff members who work in clinics who serve the LGBTQ population, and therefore would be included in the training options for those clinics who have this client focus.

In-House Training Design

A recommendation made by the Training Advisory Workgroup is to use internal staff considered to be Subject Matter Experts (SME) in different areas of cultural competency, to develop a curriculum and provide training to staff. Contra Costa Mental Health staff are aware of the different cultures and client issues they encounter being in the Mental Health System. A number of staff have had prior experience facilitating and delivering trainings in a wide array of subject matters, including cultural competency. During the first year of the plan, the Ethnic Services Coordinator will collaborate and convene a workgroup whose specific charge will be to design and assist in the delivery of the required cultural competency training course. The group composition will be inclusive of different types of service providers and staff to reflect the issues of all clients we serve. The intention is to tap into the resources that exist in the County to gather input from those who are familiar with the county mental health system and the clients in which its serves. The involvement of different staff will foster partnerships, increase staff buy-in, and hopefully encourage enthusiasm of staff to participate in the cultural competence trainings.

The training design will be guided by the *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals* from the California Endowment. The sections, "Recommended Standards for Training Methods and Modalities" and "Standards for Evaluating Cultural Competence Learning" which outlines considerations related to effective cultural competence trainings and evaluations, will provide direction as the work group designs the training curriculum. The training program will cover topics mandated by DMH: *cultural formation, multicultural knowledge, cultural sensitivity, cultural awareness, and social/cultural diversity training*. The staff involved in the designing of the curriculum will ensure planning that is mindful of the different populations we serve with the intention of increasing CCMH staff's cultural humility and cultural awareness.

Online Cultural Competence Training Curriculum under Contra Costa Health Services

Contra Costa Health Services Department (CCHSD), which Mental Health is a division of, is currently exploring different training curriculums to institute across all its divisions. The intention of the Health Services Department is to include cultural competence training as a mandatory requirement of employees. This training will be an addition to other mandated trainings, which include Service Excellence and Sexual Harassment training. One online program, Quality Interactions, is currently being considered by the Department and is piloted across four divisions in CCHSD. The training offers an online format which includes interactive modules that takes the trainee through different case scenarios and is tailored according to job type (non-clinical, clinical staff). This online training will be used as a foundational spring board, as it will be required of all Contra Costa Mental Health, County Hospitals, and County Health Plan staff. If adopted, along with the Health Services Department's online training, Mental Health staff will be required to attend one additional training session from a list of approved courses from MHA; the additional course will be determined by the Training Coordinator, Training Advisory Workgroup, and the Quality Improvement Counsel.

Mental Health Interpreter Training

Training staff on the use of mental health interpreters is covered in a separate training for staff through the use of HCIN interpreter services- since HCIN is utilized by all County clinics, a mandatory introductory training is delivered to all staff. Mental health interpreter training is provided by the contracting companies, and skill is verified by the County as an initial screening process. As a part of the CCPR, CCMH will plan to contract with the National Latino Behavioral Health Association (NLBHA) and the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) to utilize the Mental Health Interpreter Training (MHIT) Curricula to conduct trainings for county mental health interpreters and providers. The 21 hour, 3-day workshop to train interpreters covers a number of topics valuable for training interpreters, such as *Understanding the Role of Culture in Mental Health; Models of Interpreting; and Mental Health Terms, Diagnosis and Services.* Furthermore, the MHIT program also provides training to educate providers in the use of interpreters. Content for this 7-day training covers various topics, which include *Stages of interpreting, Ideas, Concerns and Rationales Beyond the Translation of Words; and Roles of the Interpreter and the Importance of being a Cultural Broker.*

Barriers

When delivering mandatory trainings to a sizable staff, such as Contra Costa's which includes clinicians, direct service staff, managers, administrative/ clerical staff, and non-direct service staff, logistics related to the planning and implementation must be considered. Training sessions must be made accessible by all staff in order to accommodate the different types of jobs that might require staff to be onsite. In attempts to address this barrier, CCMH will plan to offer mandatory cultural competency training during different times of the year, ideally once every quarter.

One overarching issue, no matter which training curriculum is chosen is the cost to the County. Aside from the basic cost of trainings, which include the training materials, trainer fees and venue rental costs, the effect on the productivity of staff must be considered. During the first year of the CCPR planning process, efforts will be made to make the process the least disruptive to staff as possible.

***Year 2 and 3: Institute Cultural Competency Training for all Mental Health Staff***

Once a training curriculum has been chosen and approved by CCMH Quality Improvement Committee, it will be submitted in the County's annual update in 2012. To meet the State's requirement of training all staff, the County plans to institutionalize cultural competence training as a requirement for all current and

incoming staff once the curriculum is complete (by year 2 of the plan). The Mental Health Division anticipates this training requirement to be adopted as County policy for county staff in 2010. Planning for the most appropriate training curriculum for staff will occur during the first year. Subsequent years will serve as training curriculum launch, piloting, and revising the curriculum plan as necessary. Table 5A shows a summary of the training activities that will be accomplished as part of the CCPR and the proposed dates for each.

**Table 5A: Summary of Cultural Competency Plan Timeline for 2011-2013**

| *Activity* | Proposed Schedule |
|---|---|
| Administer Cultural Competency Assessment | Spring 2011 |
| Convene Cultural Competence workgroup<br>Plan training curriculum | Spring 2011 |
| Pilot test<br>Revise as necessary | Fall 2011 |
| Institute training<br>Revise as necessary | 2012 |
| Institute training<br>Revise as necessary | 2013 |

Because of the notable staff size of the Mental Health Division, notices for cultural competency trainings will be publicized through several methods. Currently, the County is able to notify staff of upcoming trainings through an external website that is accessible from any computer; an internal county website; and periodic mass emails to all staff. Training notices will be incorporated into an orientation packet for new staff to ensure compliance within the first weeks of entering the County system.

Compliance Tracking

To ensure compliance, CCMH will track training completions for staff. For in-person trainings, attendance rosters will be documented and tracked by the Research and Evaluation staff. The information will be entered into an existing centralized database where training information, such as evaluations, are currently stored. Mental Health Division's online training host, Essential Learning, is capable of tracking staff training compliance. At the end of the year, records from both in-person and online trainings will be analyzed, comparing the data to personnel records to ensure compliance of all employees.

Ongoing Training Review

In order to provide effective and quality mental health care, trainings courses must address the changing demographics of mental health consumers in the County. To ensure cultural competence is embedded into all trainings, potential training curriculums will be reviewed by the CCMH's Training Advisory and Reducing Health Disparities Workgroups. Both committees, which consists of staff from administration, clinicians, and other providers in the county, provide advice and counsel pertaining to issues around cultural awareness and education.

## II. Annual cultural competence trainings

### *A. Please report on the cultural competency trainings for staff.*

As part of CCMH's commitment to creating a more culturally competent workforce, county mental health staff would be offered a number of cultural competency-related trainings every year. Trainings from fiscal year 2009-2010 are outlined in Appendix D. For each training event, there is a description of the training, frequency, the approximate number of staff attendance, and type of staff that have attended the training sessions. The types of training that are available include face-to-face trainings, online learning and trainings that are provided by staff members who are considered to be Subject Matter Experts (SME) within the county. Some of the training topics include:

- *Cultural Issues in Mental Health Treatment*
- *Health Disparities among Minorities and Others with Psychiatric Disabilities*
- *Rethinking Approaches to Reduce Risk and Promote Well-Being for LGBT Youth*
- *The Needs of Transition Aged Youth*

## III. Relevance and effectiveness of all cultural competence trainings

### *A. Training report on the relevance and effectiveness of all cultural competence training*

The Mental Health Division is committed to improving the delivery of mental health care and eliminating disparities in health outcomes for underrepresented populations. Research suggests implementing training programs, policies, and culturally or linguistically appropriate standards is positively correlated to improved quality of care and improved health outcomes for those populations who experience disparities. The Health Resources and Services Administration (HRSA) strongly advocate for the inclusion of cultural and linguistic competency training and assessment protocols in health care systems[ix]. The County's demographic is constantly changing as the County has experienced a population growth of the Latino, Asian and African American communities in the past years.

Key Training Elements Promoting Cultural Competence in Trainings

In response to the constant growth of the County's minority population, CCMH will integrate three key elements in moving in the direction of a more culturally competent workforce in regards to training activities. The first step is to create policies and procedures that convey a consistent message of the importance of cultural competence in the county mental health system. CCMH is creating a training and education policy as well as integrating cultural competence trainings into its quality management plan, requiring all staff to complete the cultural competence training requirement every three years. The selection of cultural competence trainings was a collective effort. The County disseminated a Training Assessment Survey in summer 2010 to gauge the level of interest for different trainings. Once a list of suggested trainings was derived, the selection was vetted by the Training Advisory Workgroup, Reducing Health Disparities Workgroup and the Ethnic Services Coordinator, to ensure the trainings cover the topics mandated by the State.

Another key element in promoting cultural competence in trainings is the creation of an evaluation plan. Evaluative measures, such as periodic review of training pre/post tests and course feedback by CCMH Administration helps to institutionalize practice of cultural awareness and sensitivity and holds employees accountable for measurable behaviors in the workplace. The Research and Evaluation team within CCMH will create evaluation tools for managers and supervisors to use during employee performance reviews, to assess the skills learned from trainings and how the employee utilizes the skills it in the workplace.

Additionally, another key element in promoting cultural competence and also its relevance in trainings is reinforcing staff practice of learned skills from the training opportunities through reward and recognition. This would help strengthen skill retention beyond the classroom setting.

Pre- and Post-Tests

For each training session, CCMH plans to give participants a pre- and post-test to assess their knowledge change due to the training sessions. The Research and Evaluation team will perform analysis and provide recommendations based on the results of pre/post tests. Aggregated results of the training evaluations will include the results of the pre/post test and will include any qualitative information provided. A summary report of the test results will be disseminated to the Quality Management committee, Mental Health managers, Training Advisory Workgroup and the RHD workgroup, to ensure compliance, monitor progress of training activities, and assess the relevance of trainings.

Training Evaluations

CCMH collects evaluations for the trainings offered in the County as part of training protocol. (See Attachment E to view the current format of the evaluation). As part of the County's CCPR, a summary report of the evaluations will be produced for subsequent years. The County also plans to monitor staff skill advancement learned in trainings through a self-assessment via a post training questionnaire. The County plans to integrate a more robust method of ensuring staff retain and practice lessons learned in the trainings. Additionally, CCMH will work in conjunction with program managers to build a comprehensive mechanism for employee evaluation. For example, periodic follow up sessions could be scheduled with managers and staff so that they may create a plan to help monitor progress to integrate the training principles they've learned and how to interweave into practice in day-to-day work.

Annual Report

In efforts to utilize data to gauge cultural competence training plan activities, the Ethnic Services and Training Coordinator will produce an annual report summarizing training activities for the year. The format of the report will include the list of trainings that were delivered during the year, data analysis regarding the attendees (e.g. attendance rates, identification of individuals by work site, etc), a synopsis of the pre/post tests and training course evaluations. This report will be used by Administration to assess the County's attempts to deliver effective and relevant training to staff as well as monitor progress towards meeting the requirements of the CCPR. Results from the pre/post tests as well as information shared at follow-up meetings will be shared with supervisors, possibly integrating the information into performance evaluations to help staff set professional short/long-term goals. One important aspect that has been expressed by administration and echoed by front line staff is the follow up related to the trainings they attend. This will help facilitate the creation of a supportive environment of continuous learning and accountability.

**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- personal experience inclusive of racial, ethnic cultural and linguistic communities.***

CCMH includes training opportunities on Client Culture, which includes content from the personal experience of clients. Within CCMH is the Office for Consumer Empowerment, which provides presentations to network providers and contract providers from the consumer's perspective. OCE also coordinates client sensitivity trainings, led by collaborating agency representatives and SPIRIT students. The trainings include the personal experience and perspectives from the presenter's cultural community. Similar trainings are being planned for a wider audience of staff and will be available during subsequent years.

***B. Training plan also includes for children, adolescents and transition age youth, the parent's and/or caretakers, personal experiences though the following trainings:***

CCMH's training plan includes the personal experiences of children, adolescents, transition age youth, and parent/caretakers, as demonstrated in the training plan. Please see Appendix D for a comprehensive list of the County's trainings.

# 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.**

The extract of the workforce needs assessment submitted to the Department of Mental Health (DMH) for the Workforce Education and Training (WET) component of MHSA is shown in Table 6.1. The assessment is broken down into three different categories which include:

I. Occupational Category

- Unlicensed Mental Health Direct Service Staff
- Licensed Mental Health Staff (Direct Service)
- Other Health Care Staff (Direct Service)
- Managerial and Supervisory
- Support Staff (non-direct service)

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

III. Language Proficiency

The workforce needs assessment was used in the WET plan to create action plans/items that would help meet the workforce needs in the Contra Costa County mental health system. All action items were created around the MHSA WET Proposed Guidelines (DMH Info Notice 07-14).

**Table 6.1: WORKFORCE NEEDS ASSESSMENT**

I. By Occupational Category (page 1of 5)

| Major Group and Positions | Esti-mated # FTE author-ized | Position hard to fill? 1=Yes; 0=No | # FTE estimated to meet need in addition to # FTE authorized | **Race/ethnicity** of FTEs currently in the workforce -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | His-panic/ Latino | African-American/ Black | Asian/ Pacific Islander | Native Ameri-can | Multi Race or Other | # FTE filled **(5)+(6)+(7)+(8)+(9)+(10)** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| **A. *Unlicensed* Mental Health Direct Service Staff:** | | | | | | | | | | |
| ***County (employees, independent contractors, volunteers):*** | | | | | | | | | | |
| Mental Health Rehabilitation Specialist | 8.3 | 0 | 5.0 | | | | | | | |
| Case Manager/Service Coordinator ..... | 32.5 | 0 | 9.5 | | | | | | | |
| Employment Services Staff ..... | 2.0 | 0 | 2.0 | | | | | | | |
| Housing Services Staff ..... | 0.0 | 0 | 0.0 | | | | | | | |
| Consumer Support Staff ..... | 11.5 | 1 | 14.0 | | | | | | | |
| Family Member Support Staff ..... | 10.0 | 1 | 16.0 | | | | | | | |
| Benefits/Eligibility Specialist ..... | 5.3 | 0 | 3.0 | | | | | | | |
| Other *Unlicensed* MH Direct Service Staff ..... | 0.0 | 0 | 0.0 | (*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇ | | | | | | |
| *Sub-total, A (County)* | **69.6** | | **49.5** | **21.3** | **10.5** | **18.3** | **6.0** | **1.0** | **10.5** | **67.6** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers):*** | | | | | | | | | | |
| Mental Health Rehabilitation Specialist | 106.5 | 1 | 5.5 | | | | | | | |
| Case Manager/Service Coordinator ..... | 157.5 | 1 | 5.0 | | | | | | | |
| Employment Services Staff ..... | 18.0 | 0 | 0.0 | | | | | | | |
| Housing Services Staff ..... | 31.0 | 1 | 1.5 | | | | | | | |
| Consumer Support Staff ..... | 119.3 | 1 | 1.0 | | | | | | | |
| Family Member Support Staff ..... | 25.3 | 1 | 3.0 | | | | | | | |
| Benefits/Eligibility Specialist ..... | 1.0 | 0 | 0.0 | | | | | | | |
| Other *Unlicensed* MH Direct Service Staff ..... | 100.0 | 1 | 12.0 | (*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇ | | | | | | |
| *Sub-total, A (All Other)* | **558.6** | | **28.0** | **139.1** | **59.2** | **154.8** | **43.6** | **3.0** | **109.5** | **509.1** |
| **Total, A (County & All Other):** | **628.2** | | **77.5** | **160.4** | **69.7** | **173.1** | **49.6** | **4.0** | **120.0** | **576.7** |

**Table 6.1 (continued): WORKFORCE NEEDS ASSESSMENT**

By Occupational Category (page 2 of 5)

| Major Group and Positions | Esti-mated # FTE author-ized | Position hard to fill? 1=Yes; 0=No | # FTE estimated to meet need in addition to # FTE authorized | **Race/ethnicity** of FTEs currently in the workforce -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | His-panic/ Latino | African-American / Black | Asian/ Pacific Islander | Native Ameri-can | Multi Race or Other | # FTE filled **(5)+(6)+(7)+(8)+(9)+(10)** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| **B. *Licensed* Mental Health Staff (direct service):** | | | | | | | | | | |
| ***County (employees, independent contractors, volunteers):*** | | | | | | | | | | |
| Psychiatrist, general | 26.5 | 1 | 6.0 | | | | | | | |
| Psychiatrist, child/adolescent | 9.8 | 1 | 4.0 | | | | | | | |
| Psychiatrist, geriatric | 3.0 | 1 | 0.0 | | | | | | | |
| Psychiatric or Family Nurse Practitioner | 1.0 | 1 | 3.0 | | | | | | | |
| Clinical Nurse Specialist | 0.0 | 0 | 0.0 | | | | | | | |
| Licensed Psychiatric Technician | 5.5 | 0 | 3.0 | | | | | | | |
| Licensed Clinical Psychologist | 17.0 | 1 | 6.0 | | | | | | | |
| Psychologist, registered intern (or waivered) | 0.0 | 0 | 0.0 | | | | | | | |
| Licensed Clinical Social Worker (LCSW) | 14.8 | 1 | 33.0 | | | | | | | |
| MSW, registered intern (or waivered) | 8.0 | 0 | 0.0 | | | | | | | |
| Marriage and Family Therapist (MFT) | 75.5 | 1 | 9.0 | | | | | | | |
| MFT registered intern (or waivered) | 0.3 | 0 | 0.0 | (*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇ | | | | | | |
| Other *Licensed* MH Staff (direct service) | 0.0 | 0 | 0.0 | | | | | | | |
| *Sub-total, B (County)* | **161.4** | | **64.0** | **94.2** | **13.3** | **14.5** | **12.4** | **0.0** | **16.8** | **151.2** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers):*** | | | | | | | | | | |
| Psychiatrist, general | 10.3 | 1 | 15.9 | | | | | | | |
| Psychiatrist, child/adolescent | 2.7 | 1 | 1.0 | | | | | | | |
| Psychiatrist, geriatric | 0.0 | 0 | 0.0 | | | | | | | |
| Psychiatric or Family Nurse Practitioner | 3.0 | 1 | 0.0 | | | | | | | |
| Clinical Nurse Specialist | 8.8 | 1 | 0.0 | | | | | | | |
| Licensed Psychiatric Technician | 0.0 | 0 | 0.0 | | | | | | | |
| Licensed Clinical Psychologist | 28.5 | 1 | 21.0 | | | | | | | |
| Psychologist, registered intern (or waivered) | 36.9 | 0 | 0.0 | | | | | | | |
| Licensed Clinical Social Worker (LCSW) | 32.3 | 1 | 22.0 | | | | | | | |
| MSW, registered intern (or waivered) | 39.1 | 1 | 6.8 | | | | | | | |
| Marriage and Family Therapist (MFT) | 97.2 | 1 | 100.0 | | | | | | | |
| MFT registered intern (or waivered) | 98.6 | 1 | 5.0 | (*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇ | | | | | | |
| Other *Licensed* MH Staff (direct service) | 32.0 | 0 | 8.0 | | | | | | | |
| *Sub-total, B (All Other)* | **389.3** | | **180.5** | **246.2** | **32.2** | **34.3** | **13.4** | **1.4** | **45.7** | **373.2** |
| **Total, B (County & All Other):** | **550.7** | | **244.5** | **340.4** | **45.5** | **48.8** | **25.8** | **1.4** | **62.5** | **524.4** |

**Table 6.1 (continued): WORKFORCE NEEDS ASSESSMENT**
By Occupational Category (page 3 of 5)

| Major Group and Positions | Esti-mated # FTE author-ized | Position hard to fill? 1=Yes' 0=No | # FTE estimated to meet need in addition to # FTE authorized | **Race/ethnicity** of FTEs currently in the workforce -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | His-panic/ Latino | African-American / Black | Asian/ Pacific Islander | Native Ameri-can | Multi Race or Other | # FTE filled **(5)+(6)+(7)+(8)+(9)+(10** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| **C. Other Health Care Staff (direct service):** | | | | | | | | | | |
| ***County (employees, independent contractors, volunteers):*** | | | | | | | | | | |
| Physician | 0.0 | 0 | 0.0 | | | | | | | |
| Registered Nurse | 16.8 | 1 | 12.0 | | | | | | | |
| Licensed Vocational Nurse | 0.0 | 0 | 0.0 | | | | | | | |
| Physician Assistant | 0.0 | 0 | 0.0 | | | | | | | |
| Occupational Therapist | 0.0 | 0 | 0.0 | | | | | | | |
| Other Therapist (e.g., physical, recreation, art, dance) | 0.0 | 0 | 0.0 | | | | | | | |
| Other Health Care Staff (direct service, to include traditional cultural healers) | 0.0 | 0 | 0.0 | (Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇ | | | | | | |
| *Sub-total, C (County)* | **16.8** | | **12.0** | **10.5** | **1.0** | **0.0** | **2.3** | **0.0** | **3.0** | **16.8** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers):*** | | | | | | | | | | |
| Physician | 4.0 | 1 | 1.0 | | | | | | | |
| Registered Nurse | 5.0 | 1 | 0.0 | | | | | | | |
| Licensed Vocational Nurse | 2.0 | 0 | 0.0 | | | | | | | |
| Physician Assistant | 0.0 | 0 | 0.0 | | | | | | | |
| Occupational Therapist | 1.0 | 0 | 0.0 | | | | | | | |
| Other Therapist (e.g., physical, recreation, art, dance) | 4.0 | 0 | 0.0 | | | | | | | |
| Other Health Care Staff (direct service, to include traditional cultural healers) | 27.0 | 1 | 5.0 | (Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇ | | | | | | |
| *Sub-total, C (All Other)* | **43.0** | | **6.0** | **20.5** | **4.0** | **10.5** | **2.0** | **0.0** | **0.0** | **37.0** |
| **Total, C (County & All Other):** | **59.8** | | **18.0** | **31.0** | **5.0** | **10.5** | **4.3** | **0.0** | **3.0** | **53.8** |

**Table 6.1 (continued): WORKFORCE NEEDS ASSESSMENT**

By Occupational Category (page 4 of 5)

| Major Group and Positions | Esti-mated # FTE author-ized | Position hard to fill? 1=Yes; 0=No | # FTE estimated to meet need in addition to # FTE authorized | **Race/ethnicity** of FTEs currently in the workforce -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | Hispanic/ Latino | African-Ameri-can/ Black | Asian/ Pacific Islander | Native Ameri-can | Multi Race or Other | # FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| **D. Managerial and Supervisory:** | | | | | | | | | | |
| ***County (employees, independent contractors, volunteers):*** | | | | | | | | | | |
| CEO or manager above direct supervisor..... | 4.0 | 0 | 0.0 | | | | | | | |
| Supervising psychiatrist (or other physician) ..... | 0.0 | 0 | 0.0 | | | | | | | |
| Licensed supervising clinician..... | 17.3 | 1 | 3.0 | | | | | | | |
| Other managers and supervisors..... | 11.0 | 0 | 2.0 | | | | | | | |
| | | | | (Managerial and Supervisory; Sub-Totals Only) ↓ | | | | | | |
| *Sub-total, D (County)* | **32.3** | | **5.0** | **22.3** | **3.0** | **2.0** | **1.0** | **0.0** | **4.0** | **32.3** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers):*** | | | | | | | | | | |
| CEO or manager above direct supervisor..... | 60.0 | 1 | 3.5 | | | | | | | |
| Supervising psychiatrist (or other physician) .... | 2.2 | 0 | 1.0 | | | | | | | |
| Licensed supervising clinician..... | 36.6 | 1 | 6.0 | | | | | | | |
| Other managers and supervisors..... | 61.7 | 1 | 3.6 | | | | | | | |
| | | | | (Managerial and Supervisory; Sub-Totals and Total Only) ↓ | | | | | | |
| *Sub-total, D (All Other)* | **160.5** | | **14.1** | **94.1** | **11.0** | **21.0** | **17.7** | **0.0** | **8.0** | **151.8** |
| **Total, D (County & All Other):** | **192.8** | | **19.1** | **116.4** | **14.0** | **23.0** | **18.7** | **0.0** | **12.0** | **184.1** |
| **E. Support Staff (non-direct service):** | | | | | | | | | | |
| ***County (employees, independent contractors, volunteers):*** | | | | | | | | | | |
| Analysts, tech support, quality assurance..... | 9.2 | 0 | 13.0 | | | | | | | |
| Education, training, research ..... | 0.0 | 0 | 2.0 | | | | | | | |
| Clerical, secretary, administrative assistants..... | 56.5 | 0 | 21.0 | | | | | | | |
| Other support staff (non-direct services)..... | 6.3 | 0 | 0.0 | | | | | | | |
| | | | | (Support Staff; Sub-Totals Only) ↓ | | | | | | |
| *Sub-total, E (County)* | **72.0** | | **36.0** | **20.0** | **13.5** | **9.0** | **2.0** | **0.0** | **27.5** | **72.0** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers):*** | | | | | | | | | | |
| Analysts, tech support, quality assurance..... | 47.5 | 1 | 2.5 | | | | | | | |
| Education, training, research ..... | 5.6 | 0 | 2.0 | | | | | | | |
| Clerical, secretary, administrative assistants..... | 46.9 | 0 | 7.8 | | | | | | | |
| Other support staff (non-direct services)..... | 20.7 | 0 | 3.0 | | | | | | | |
| | | | | (Support Staff; Sub-Totals and Total Only) ↓ | | | | | | |
| *Sub-total, E (All Other)* | **120.7** | | **15.3** | **32.9** | **22.2** | **25.2** | **12.8** | **0.0** | **19.7** | **112.7** |
| **Total, E (County & All Other):** | **192.8** | | **51.3** | **52.9** | **35.7** | **34.2** | **14.8** | **0.0** | **47.2** | **184.7** |

**Table 6.1 (continued): WORKFORCE NEEDS ASSESSMENT**

By Occupational Category (page 5 of 5)

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

| Major Group and Positions | Esti-mated # FTE author-ized | Position hard to fill? 1=Yes; 0=No | # FTE estimated to meet need in addition to # FTE authorized | **Race/ethnicity** of FTEs currently in the workforce -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | Hispanic/ Latino | African-American/ Black | Asian/ Pacific Islander | Native American | Multi Race or Other | # FTE filled **(5)+(6)+(7)+(8)+(9)+(10)** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| ***County (employees, independent contractors, volunteers)* (A+B+C+D+E)...** | **352.1** | | **163.5** | **168.3** | **41.3** | **43.8** | **23.7** | **1.0** | **61.8** | **339.9** |
| ***All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E).....*** | **1272.1** | | **243.9** | **532.7** | **128.6** | **245.7** | **89.4** | **4.4** | **182.9** | **1183.6** |
| **GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)** | **1624.2** | | **407.4** | **701.0** | **169.9** | **289.5** | **113.1** | **5.4** | **244.7** | **1523.5** |

**F. TOTAL PUBLIC MENTAL HEALTH POPULATION**

| | | | | **Race/ethnicity** of individuals planned to be served -- Col. (11) | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | White/ Caucasian | Hispanic/ Latino | African-American/ Black | Asian/ Pacific Islander | Native Amery-can | Multi Race or Other | All individuals **(5)+(6)+(7)+(8)+(9)+(10)** |
| (1) | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) | (10) | (11) |
| **F. TOTAL PUBLIC MH POPULATION** | **Leave Col. 2, 3, & 4 blank** | | | **6824** | **2580** | **3871** | **848** | **121** | **827** | **15071** |

**Table 6.2: WORKFORCE NEEDS ASSESSMENT**

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

| Major Group and Positions | Estimated # FTE authorized and to be filled by clients or family members | Position hard to fill with clients or family members? (1=Yes; 0=No) | # additional client or family member FTEs estimated to meet need |
|---|---|---|---|
| (1) | (2) | (3) | (4) |
| **A. *Unlicensed* Mental Health Direct Service Staff:** | | | |
| Consumer Support Staff | 61.8 | 1 | 14.0 |
| Family Member Support Staff | 25.0 | 1 | 23.0 |
| Other *Unlicensed* MH Direct Service Staff | 22.5 | 1 | 0.0 |
| **Sub-Total, A:** | **109.3** | | **37.0** |
| **B. *Licensed* Mental Health Staff (direct service)** | **15.5** | 1 | 0.0 |
| **C. Other Health Care Staff (direct service)** | **4.8** | 1 | 0.0 |
| **D. Managerial and Supervisory** | **35.4** | 1 | 2.1 |
| **E. Support Staff (non-direct services)** | **40.7** | 1 | 1.0 |
| **GRAND TOTAL (A+B+C+D+E)** | **205.6** | | **40.1** |

**Table 6.3: WORKFORCE NEEDS ASSESSMENT**

III. LANGUAGE PROFICIENCY

| **Language, other than English** | **Number who are proficient** | **Additional number who need to be proficient** | **TOTAL (2)+(3)** |
|---|---|---|---|
| (1) | (2) | (3) | (4) |
| 1. Spanish | Direct Service Staff 151<br>Others 46 | Direct Service Staff 85<br>Others 9 | Direct Service Staff 236<br>Others 55 |
| 2. Tagalog / Filipino Dialect | Direct Service Staff 12<br>Others 2 | Direct Service Staff 2<br>Others 1 | Direct Service Staff 14<br>Others 3 |
| 3. Chinese (Mandarin or Cantonese) | Direct Service Staff 9<br>Others 1 | Direct Service Staff 5<br>Others 1 | Direct Service Staff 14<br>Others 2 |
| 4. Vietnamese | Direct Service Staff 4<br>Others 0 | Direct Service Staff 1<br>Others 0 | Direct Service Staff 5<br>Others 0 |
| 5. Russian | Direct Service Staff 4<br>Others 1 | Direct Service Staff 0<br>Others 0 | Direct Service Staff 4<br>Others 1 |
| 6. American Sign Language (ASL) | Direct Service Staff 12<br>Others 0 | Direct Service Staff 0<br>Others 0 | Direct Service Staff 12<br>Others 0 |
| 7. Farsi | Direct Service Staff 4<br>Others 0 | Direct Service Staff 2<br>Others 0 | Direct Service Staff 6<br>Others 0 |

***B. Compare the WET Plan assessment data with the general population, Medi-cal population, and 200% of poverty data. Rationale: Will give ability to improve penetration rates and eliminate disparities.***

***Table 6.4:*** *Comparison of WET Assessment Data, County Population, Medi-Cal, 200% Poverty Level*

| | | | | WET Assessment | | | |
|---|---|---|---|---|---|---|---|
| Race/Ethnicity | County Population | Medi-Cal Population | 200% Population | Consumers Served | County Staff | Direct Service | Non-Direct Service |
| White | 48.63% | 21.54% | 29.83% | 35.65% | 46.01% | 46.04% | 45.90% |
| Hispanic | 24.23% | 38.34% | 38.58% | 17.94% | 11.15% | 10.41% | 13.48% |
| African-American | 9.29% | 21.64% | 15.43% | 30.23% | 19.00% | 20.12% | 15.49% |
| Asian/Pacific Islander | 13.82% | 10.08% | 12.19% | 6.15% | 7.42% | 6.90% | 9.06% |
| Native American | 0.43% | 0.33% | 0.48% | 0.64% | 0.35% | 0.47% | 0.00% |
| Other | 3.61% | 8.07% | 3.50% | 9.40% | 16.06% | 16.06% | 16.06% |

- Latinos are underrepresented in the county staff population when compared to all the populations listed above. Latinos in the county, Medi-Cal and 200% poverty population comprise of 24.2%, 38.3% and 38.6% of those populations respectively; and yet only make up 11.15% of the county staff population. Also within the county staff population, the group is still underrepresented when compared to the direct and non-direct service staff.

- African Americans are over-represented when you compare the county staff population to the county general population. African Americans represent 9.3% of the general population and 19% of the county staff population. However, the African American group is underrepresented when comparing the county staff population to that of the consumers served. In this case, this ethnic group comprises of 30.2% of the consumers served and only 19% of the county staff.

- Asians and Pacific Islanders are underrepresented in the County Staff population when compared to the general, Medi-Cal and 200% population. This group represents 7.42% of the County staff population but 13.82%, 10.08% and 12.2% of the general, Medi-Cal and 200% poverty population respectively. However, this ethnic group is represented when the County Staff population is compared to the Consumers served.

- Since it is evident from the analysis above that Latinos have the highest disparity, the goal of the county mental health system would be to hire more Latinos in order to increase the penetration rate and subsequently creating a workforce that reflects the population of the consumers it serves.

***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* - Based on feedback received from DMH, Contra Costa Mental Health did not receive WET plan summaries from DMH at the time their plan was approved. This information was provided by Marina Augusto of the Department of Mental Health (DMH).

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

The workforce needs assessment in the WET Plan was used to create action plans that would help meet the workforce needs in the Contra Costa County mental health system. All action items were created around the MHSA WET Proposed Guidelines (DMH Info Notice 07-14).

CCMH WET Plan has 13 Action Items that were created around the WE&T strategies/objectives and funding categories as outlined in the proposed guidelines.

**Table 6.5: WET Funding Categories, Action Items and Strategies**

| Funding Category | Action Items | WE&T Strategies/Objectives |
|---|---|---|
| Workforce Staffing Support | WE&T Coordination | • Expand postsecondary education capacity<br>• Expand loan repayment, scholarship programs<br>• Create stipend programs<br>• Promote employment of clients and family members in MH system<br>• Develop training curricula in accordance with MHSA values<br>• Promote distance learning techniques<br>• Incorporate cultural competency in al training and education programs<br>• Establish regional partnerships<br>• Increase Mental Health career development opportunities<br>• Promote meaningful inclusion of client and family members in all training and education programs. |
| Training & Technical Assistance | Staff Development Training Initiative | |
| | Mental Health Training for Law Enforcement | |
| Mental Health Career Pathways Programs | Consumer Employment Strategies – SPIRIT program Expansion & Enhancement | |
| | Family Member Employment Strategies | |
| | Developing Mental Health Concentration in High School Academies | |
| | Community College Partnerships: Psychosocial Rehabilitation Certificate (PSR) | |
| | Psychiatric Technician Program | |
| Residency, Internship Programs | Expand Graduate Level Internship Opportunities | |
| | Psychiatry Workforce Development | |
| | Nursing Workforce Development | |
| Financial Incentive Programs | Scholarship Program for Bachelors Level Degrees | |
| | Scholarship Program for Master's Level Degrees | |

**Workforce Staffing Support**

Action #1: Workforce Education & Training (WET) Coordination

The Workforce Training Advisory Group plays an integral part in supporting the activities of the Workforce Education and Training plan. The group consists of CCMH admin staff; support staff; clinicians; and consumers and family member representatives. The group meets the fourth Monday of every month. These meetings are vital in shaping the execution of the WET plan and ensure that trainings are culturally competent and meet the needs of county staff and CBOs. Trainings and technical assistance are offered to CCMH staff, community-based organizations and network provider staff on an on-going basis. To ensure that family members, consumers, and underserved/underrepresented communities were included as trainers and participants, efforts are made to conduct trainings that are led by consumers. Consumers who participate as trainers are central to the SPIRIT program curriculum. SPIRIT is a consumer-lead course that includes guest lecturers who are consumers. Class sessions led by consumers cover topics such as *Ex-Patient Movement and Recovery Concepts, the Mental Health Services Act, Consumer Employment,* and *Strategies for How to Become an Effective Consumer Advocate*.

As outlined in the WET plan, CCMH has continued work with local education institutions to enhance programs that address the workforce needs in mental health. The increase of available information related to regional education and employment opportunities, including internships, has led to a successful intern orientation for FY 09-10. Twenty one students participated in Contra Costa's intern program in FY 08/19, and worked in a variety of placements, such as Chris Adams center, County Children and Adult clinics and Contra Costa Regional Medical Center. Increasing the availability of information related to educational and employment activities supports the development of the psychiatric workforce in the county. For FY 10-11, twenty-two students have been recruited to be part of CCMH Intern Program.

**Training and Technical Assistance**

Action #2: Staff Development Training Initiative

Trainings that advance staff competencies, contribute to job satisfaction and retention, and serve to attract new employees are central to CCMH's staff training initiative. As part of CCMH's efforts, during FY 08-09, there were over 20 staff development training opportunities, including *Law, Ethics and Confidentiality in Behavioral Health, Addressing Inequities in Health,* and *Youth Suicide and Self-Harm*.

CCMH has worked to increase its internal agency capacity by identifying staff and conducting trainings for which they serve as internal experts and offer technical assistance on best practices. Included in the training list for FY 08-09 are trainings which include CCMH staff as "subject matter experts". During FY 08-09, CCMH staff conducted 16 of these training sessions, covering topics such as *Documentation, Partnership Plan, CALOCUS,* and *Subpoena training* for various audiences, including Community Support Workers, nurses, and interns.

In addition to on-site trainings, conferences, and face to face meetings, the option for internet-based learning was explored to enhance staff trainings in Contra Costa County. During FY 08-09, CCMH staff participated in an online meeting with Essential Leaning to view a demonstration of their product and invited a number of staff members to pilot the online *Law and Ethics* course. Following the end of the course, a survey was administered to the participants and found that for most survey

items, a majority of the respondents were generally satisfied with the course. In the spring of 2009, CCMH staff reviewed Essential Learning's Community Access Site through which consumers, family members and advocates could access selected online curriculums and updates. CCMH plans to adopt Essential Learning in fall 2010.

Finally, during fall 2008 the planning process for the "Recovery in Diverse Communities Conference" was initiated. The Recovery Planning Group was created in October 2008 and includes members from CCMH Administration, community stakeholders, as well as consumers. CCMH plans to hold the conference in spring 2011. The main focus of the Planning Group is to:

- Refine the purpose of conference to encourage multicultural communities involved in reducing disparities to work together to share their expertise, and
- To raise awareness of the recovery model and bring multicultural communities together to share their expertise in addressing health disparities

Action #3: Mental Health Training for Law Enforcement

In order to help local law enforcement safely and effectively respond to crisis situations involving mental health consumers, Crisis Intervention Training (CIT) are offered at least once a year. In FY 08/09, there were thirty five training (35) attendees in each session from agencies such as the Sheriff's department, and law enforcement from Concord, Pleasant Hill, and Pittsburg. Consistent with the philosophy of MHSA, consumers and family members were included as guest speakers for the training. Consumers were invited to share their past experience involving law enforcement; suggest methods to communicate more effectively with consumers and their families; and provide insight related to promoting an integrated service experience with law enforcement. In order to support Contra Costa's diverse mental health consumer population, cultural issues were addressed throughout the trainings. Topics related to gender issues, non-verbal cues, and languages were addressed by the presenters throughout the training session to bring awareness and offer strategies to handle specific situations. Participant evaluation of these initial CIT trainings has yielded positive responses. To continue this trend, annual CIT trainings will be provided annually to support local law enforcement, ultimately improving the interactions between mental health consumers, their families and law enforcement in the county.

**Mental Health Career Pathways Programs**

Action #4: Consumer Employment Strategies - SPIRIT Program Expansion & Enhancement

Contra Costa Mental Health, in conjunction with Contra Costa College in West County, offered the Service Provider Individualized Recovery Intensive Training (SPIRIT) Program during the 2008 spring semester. SPIRIT is a 14-week consumer training program followed by a supervised internship. During FY 08-09, SPIRIT was negotiated with Contra Costa College by Vidya Iyengar, John Hollender, and Anna Lubarov, along with the help of consultant Tim Stringari, who created the application materials for CCMH to include SPIRIT in the college catalog. To support collaborations with contract agencies, the Coordinator of the Office for Consumer Empowerment (OCE), Susan Medlin, provided training workshops to the clerical staff and the interns. Additionally, she conducted presentations for nurses and clinical staff during on-site meetings at contract agencies to inform and educate staff regarding the SPIRIT program.
During the 2008-2009 school year, the SPIRIT program experienced a successful term with 35 students enrolled and 32 students completing their internships at various agencies such as Contra Costa Mental Health and with contract agencies such as Anka Behavioral Inc, Rubicon, and Crestwood. To provide ongoing support and resource sharing, the SPIRIT club was created as a

network for students after graduation. The SPIRIT club is coordinated by SPIRIT alumni Hillary Westbrook from the Office for Consumer Empowerment (OCE), and is assisted by other OCE staff members. The club has 76 SPIRIT graduate contacts, from which about a fourth participate in club-sponsored events. The SPIRIT course and alumni network continues to be a valuable piece to the mental health recovery for consumers in Contra Costa demonstrated by the success and growth of the program. Students that enrolled for the school year 2009-2010 are scheduled to graduate August 13, 2010.

Action #5: Family Member Employment Strategies

In 2008, CCMH initiated a training program for family member employment in the public mental health system. CCMH explored integrating existing curriculum and collaborating with subject matter experts to guide the structure of a family member training program for employment. In efforts to formalize the family support worker position, CCMH staff recommended updates to the duties and responsibilities to the family support worker position. To support the engagement of consumers and family members as employees, a number of staff development trainings were offered to family partner staff/volunteers. As outlined in the WET plan, trainings in 2008 covered topics such as *Documentation, VanDenBerg High Fidelity Wraparound, Strengths, Needs, Culture Discovery (Part I): What is Culture,* and *Strengths, Needs, Culture Discovery (Part II): Changing Deficit-Focused Dialogue to Strengths*. In 2009, training sessions covered topics such as *Wraparound Training* and *Transitioning*, to help parent partners gain necessary skills to be effective advocates and navigate through the system; become less dependent on the traditional services and build upon the community and natural supports.

Action #6: Developing MH Concentration in High School Health Academies

During FY 09-10, a group of individuals were identified as Subject Matter Experts (SME) in the development of a High School Mental Health Curriculum. These individuals include Mental Health Clinical Staff and High School Educators (Principal and Instructor). The Training Advisory Workgroup (TAW) has delegated some of its members to recruit more SME in the development of this curriculum, and also look for High school academies that are interested in developing a mental health concentration within their existing programs. The workgroup, of Subject Matter Experts, began meeting in June 2010.CCMH plans to receive technical assistance from Erik Rice of Stanford University. The Greater Bay Area MH & Education Workforce Collaborative has contracted with Erik Rice to provide technical assistance & consultation for Greater Bay Area county mental health departments who seek to develop or are in the process of developing mental health career partnerships/pathways with local high schools. CCMH plans to have a curriculum developed by January 2011.

Action #7: Community College Partnerships - Psychosocial Rehabilitation Certificate (PSR)

Building on the partnership with Contra Costa College, CCMH worked to implement the Psychosocial Rehabilitation Certificate Program during FY 08-09. Contra Costa Mental Health initiated working with the California Association of Social Rehabilitation (CASRA) in January 2009 for a year-long contract in the amount of $35,000 to provide consultation and technical assistance with regard to the development of the PSR program at CCC. Two consultants, Tim Stringari and Debra Brasher, participated in the planning to include new PSR detail in CCC's curriculum.

The PSR certificate consultation and coursework recommendations were developed in June 2009 by consultant Tim Stringari. Based on conversations with Contra Costa Mental Health and Contra Costa

College and recommendations from Tim Stringari, a proposal was submitted to Contra Costa College, which included the following recommendations:

- Add two new courses in PSR curriculum which will be collaboratively developed and integrated in to existing Human Services curriculum and would make up the core of a new 12 unit *Certificate of Specialization in Psychosocial Rehabilitation*
- Provide in-service trainings for faculty and staff related to PSR and the Recovery paradigm, teaching techniques and students with psychological and psychiatric disabilities.

The PSR program has been developed and classes expected to begin fall 2010. Additionally during FY 08-09, the PSR Advisory Group met to assist with the promotion and recruitment for the PSR program. Twenty four individuals representing consumers, family members, community-based providers, CCMH, as well as the Department of Rehabilitation and Contra Costa College were included in the Advisory Group. Betty Dahlquist of CASRA facilitated the advisory meetings, which focused on the following areas:

- To identify and build upon employment opportunities for graduates
- To identify and build upon opportunities for educational support, including employers, the Department of Rehabilitation, NAMI and other local advocacy groups and the community college itself.
- To review and contribute to the development of the curriculum for the 2 proposed courses.
- To develop recruitment strategies for multiple audiences: e.g., current CCMH staff, SPIRIT graduates, students in other human services programs, other social service providers, etc.
- To develop an evaluation protocol to provide data on whether the project is meeting its goals.

Action #8: Psychiatric Technician Program

Members of the Training Advisory Workgroup (TAW) are currently holding discussions on how to effectively implement this action item. The CCMH Medical Director will oversee the planning and implementation of this action item. Contact has already been made with University of California, San Francisco, to explore developing a Psychiatric residency and/or Fellowship program for CCMH. The goal here is also to promote the development of culturally relevant, recovery-oriented curriculum and experience to include both County and CBO systems of care. CCMH plans to begin implementation of this item by fall 2010.

**Residency & Internship Programs**

Action #9: Expanding Graduate Level Internship Opportunities

Providing graduate level internship opportunities is imperative for supporting the success of the county's mental health workforce. These opportunities provide exposure to the mental health field, an opportunity to integrate current best practices, and encourage recruitment from the graduate pool. In FY 08-09, twenty (21) interns participated in the Mental Health Internship program, of which fourteen provided outpatient services in our clinics. Seven interns provided services in other settings, such as hospitals, where they were part of treatment teams.

The placement of interns in both clinics and hospitals has enhanced care for mental health consumers in Contra Costa County. Specifically, the services that were provided by those working in our outpatient mental health clinics include 1,825 distinct services to 135 unduplicated consumers. Because the services provided in settings such as the hospital are not provided by individuals, but by the treatment team, the numbers of services and the unduplicated client count for services specifically provided by the interns working in these settings are unavailable.

In order to build a more culturally and linguistically diverse workforce that appropriately serve consumers and families in the community, CCMH will continue to put an emphasis in the recruitment of bilingual/bicultural interns with consumer/family member experience. Students with bilingual skills will receive a higher differential salary and development of these skills in mental health practice will be emphasized as part of their training program.
For FY 10-11, twenty-two interns have been recruited to be part of CCMH Intern Program.

Action #10: Psychiatry Workforce Development

To help alleviate the shortage of needed staff in psychiatry, such as psychiatrists, nurses, and licensed technicians, Contra Costa is working to expand the professional shortage designation areas to include more of the county. This state designation allows for incoming psychiatric staff to be eligible for various state loan forgiveness programs, thereby making Contra Costa a more attractive option for employment for new graduates. Contra Costa currently has two professional shortage area designations granted by the state (Central Richmond and North Antioch). Recently an application was submitted requesting Brentwood, an area in East County, to be designated as a mental health professional shortage area. Additional areas are also currently being examined in order to expand the geographic areas eligible for loan forgiveness. The outcome of the designation process will complement our work to enhance the psychiatric workforce in the county.

Preliminary discussion around developing the Psychiatry Workforce in Contra Costa County was initiated during FY 08-09. The two main ideas developed during these discussions included creating a Contra Costa College-based Community Psychiatry Fellowship in association with UCD or UCSF and creating a Community Psychiatry elective for psychiatry residence in either UCD or UCSF. Contact has already been established with these institutions and discussions are being held on strategies to effectively recruit from these institutions. Future plans to develop the County's workforce include getting buy-in from CCMH administrative staff and affiliated Universities and developing a curriculum.

Action #11: Nursing Workforce Development

During FY 08-09, CCMH had an executed contract affiliation agreement between the Regents of the University of California, San Francisco and School of Nursing for the clinical placement of nurse interns in CCMH's clinical internship program. In order to build a more culturally and linguistically diverse workforce that appropriately serve consumers and families in the community, CCMH will continue to put an emphasis in the recruitment of bilingual/bicultural interns with consumer/family member experience. Students with bilingual skills will receive a higher differential salary and development of these skills in mental health practice will be emphasized as part of their training program.

In February 2009, Pittsburg Mental Health Center was designated as UCSF's first student clinical rotation, which ended November 24, 2009. The creation of clinical placement protocols was developed with input from Program Managers, Psychiatrist and Nursing staff. During their placements, students participated in CCMH internship orientation program and required HIPPA, EMTALA, and CPI trainings. Following the students' rotation, verbal feedback obtained from UCSF interns, instructors, and a CCMH psychiatrist regarding student clinical rotation has been outstanding, as clinical objectives have been met and placements have been excellent. CCMH has a longstanding contract affiliation agreement with Samuel Merritt College; however, during 2008-2009, we did not receive nursing placement request from their university. Outreach and recruitment efforts to Samuel

Merritt College and UCSF University, will continue for subsequent years. Nurses have been recruited and ready for placement for FY 2010/2011.

**Financial Incentive Programs**

Action # 12: Scholarship Program for Bachelors Level Degrees

In June 2010, CCMH began the program development for the Scholarship and Loan Repayment program for county staff that are currently or planning to pursue a Bachelors Level degree or Masters Level degree. The program is designed to pick a total of 10 individuals (5 for the Bachelors Level Degree; and 5 for the Masters level Degree), who would be awarded funds to pay back their student loans. Interested applicants are required to submit specific documents in order to be considered for the program. Mental health staff awarded under this program must complete a minimum two-year service obligation and maintain either full-time or part-time practice.

CCMH plans to pick the awardees by spring 2010. A panel will be selected by the Training Advisory Workgroup, to review all applications and make a recommendation to the Mental Health Director for review and final approval.

The most qualified applicants will be employed in hard-to-fill or hard-to-retain position in Contra Costa Mental Health Division. Priority consideration will be given to applicants best suited to meet the cultural and linguistic needs and demands of mental health consumers. Priority consideration will be given to those applicants whose background and commitment indicates the likelihood of long-term employment in the public mental health system even after the service obligation has ended.

Action #13: Scholarship Program for Masters' Level Degrees

This action item is part of the program development and implementation of Action Item #12. The Bachelors and Masters Level Loan Repayment and Scholarship Program are being developed in a manner in which they would be implemented with exactly the same time-frame. Five individuals would be selected under the Masters Level Scholarship program and be awarded funds to pay back their student loans. This item has the same review and selection process as Action #12.

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

We have learned that it is not best to offer trainings without knowing the training needs of your target audience (staff, consumers/family members, contractors). Without the knowledge of the training needs of your target audience, there a high possibility of people not showing up for trainings and in most cases these trainings have to be cancelled. In an effort to eliminate this issue, the County is scheduled to administer a training survey in August 2010. The survey will be used to collect feedback from county staff and CBOs to assess their needs and for the county to provide trainings according to those needs that are integral to the work staff performs.

In the WET plan it was stated that we would convene the Training Advisory Workgroup at least three times annually, but because of the increased need for support in rolling out the activities of the WET plan, the TAW members meet monthly – every fourth Monday of the month. TAW plays a major role in the implementation of the WET plan.

During the initial implementation efforts of the WET plan, there were a lot of trainings that the County had to offer but in order to provide Continuing Education Units we had to go through the Accrediting Agencies like the Boards of Registered Nurses and Board of Behavioral Sciences. The

process of getting these trainings approved could range from a month and a half to three months. In an effort to save time and provide these trainings in a timely manner, the County applied to some of the Accrediting agencies and we were given approval to provide units. We have in-house specialists that review and approve courses to see if they meet the requirements for offering CEU's. Contra Costa County Mental Health has been approved as a Continuing Education (CE) Provider by the following boards: Board of Behavioral Sciences (BBS); Board of Registered Nursing (BRN); and The California Foundation for Advancement of Addiction Professionals (CFAAP).

***F. Identify county technical assistance needs.***

Technical assistance on the following items would be very beneficial to CCMH:

- Loan Repayment Programs for County Staff
- Development of High School Curriculums or MH Concentration in High School Academies
- Methods on doing follow-ups to training

# CRITERION 7: LANGUAGE CAPACITY

**I. Increase bilingual workforce capacity**

***A. Evidence of dedicated resources and strategies Contra Costa is taking to grow bilingual staff capacity.***

Workforce Needs Assessment (WET) Plan

Addressing strategies to build the County's bilingual staff capacity to address our county's language needs was central to the CCMH Workforce Education and Training (WET) plan. In 2008, a workforce needs assessment was performed as part of the planning process for the WET component of MHSA to assess the current make up of mental health staff. A closer look at the ratio of the demographics of providers compared to the demographics of the population served revealed specific staffing needs unique to Contra Costa County. In Contra Costa County, mental health service providers and staff are predominantly of Caucasian decent. When the composition of the mental health workforce is compared to the population of the County, the most underrepresented ethnic groups in the mental health workforce are Latino, African American, and Native American staff members, as illustrated in Table 7.1.

**Table 7.1: Contra Costa County Mental Health- Staff to Client Ratio**[x]

| *Race/ Ethnicity* | *County Staff (All FTE's)* | *CBO/Network (All FTE's)* | *Total Staff (FTE's)* | *Total Direct Service Staff (FTE's)* | *Total Clients* | *Total Staff FTE: Client Ratios* | *Direct Service Staff Only FTE Client Ratios* |
|---|---|---|---|---|---|---|---|
| White/ Caucasian | 168.3 | 532.7 | 701 | 531.8 | 6824 | 1:10 | 1:13 |
| Hispanic/Latino | 41.3 | 128.6 | 169.9 | 120.2 | 2580 | 1:15 | 1:21 |
| African American/Black | 43.8 | 245.7 | 289.5 | 232.4 | 3871 | 1:13 | 1:17 |
| Asian/ Pacific Islander | 23.7 | 89.4 | 113.1 | 79.7 | 848 | 1:08 | 1:11 |
| Native American | 1 | 4.4 | 5.4 | 5.4 | 121 | 1:22 | 1:22 |
| Multi-Race or Other | 61.8 | 182.9 | 244.7 | 185.5 | 827 | 1:03 | 1:04 |
| Total | 339.9 | 1183.6 | 1523.5 | 1155 | 15071 | 1:10 | 1:13 |

Internship Program (Graduate-Level and Nursing Internship)

Creating opportunities for employment in public mental health and providing support through scholarships is a large part of the County's WET plan. Recognizing the shortage of bilingual/bicultural staff in the system, the WET plan also targets outreaching to communities not typical of the current workforce demographic. The County provides graduate-level internship opportunities for master's level social work and psychology students, and doctorate level psychiatry students. The WET plan includes expanding graduate level internship opportunities with an emphasis on the recruitment of bilingual/ bicultural individuals and with consumer/ family member experience.

To support the efforts to encourage underrepresented students to enter the workforce, John F. Kennedy University in Contra Costa County created a Counseling Psychology program focused on Latino/Hispanics for MFT licensure. The County works in conjunction with JFK University to provide interns a higher differential for speaking a second language and pair them with mentors to develop and support skills in mental health practice. Funding dedicated to the internship program is $406,962 for five years beginning in FY 2009-10.

Enhancing the psychiatric nursing workforce is also a focus of the County's plan. Through the WET plan, the County provides clinical rotation placement for psychiatric nursing students in a participating clinic where supervisory staff are able to support the development in bilingual skills in mental health. As a bilingual student worker, the interns are provided a higher differential pay and benefits. An annual amount of $85,225 for five years is dedicated to supporting the psychiatric nursing workforce. Lastly, through the WET plan, the County provides scholarships for bachelor's and master's level students, with efforts to encourage consumers and family members to pursue a college degree and increase workforce diversity and language capacity. These scholarship programs are funded at $23,000 for bachelors and $28,740 for master's level beginning FY 2009-10 for three years.

Workforce Assessment Survey

In spring 2011, Mental Health Administration plans to conduct a survey assessing the workforce of the county mental health system. This effort to re-assess the composition of the workforce is also mandated by the County's quality improvement plan, ensuring regular monitoring of staff ratios and identification of language access needs. The survey will allow an assessment of the appropriateness of amount and type of flagged positions, given the changes in demographics and variation between regions in county.

Resources Dedicated to Meeting Language Needs (Interpretation Services)

Contra Costa County has two main contracts for interpretation and translation services, WINDRIX and International Effectiveness Center (IEC) for its interpreter services. The County's contract with Windrix (initiated in 12/2002), which is the contract through which medical transcription is done, is $165,000 for FY 2009-2010. The County's also utilizes the International Effectiveness Center, who provides translation and interpretation for all of the Health Services Division. The annual contract amount for the Health Services Division is $200,000.

CCMH is part of a Health Care Interpreter Network (HCIN); a service made available by Contra Costa Health Services Department (CCHSD). CCHSD contracts with HCIN for video and phone interpreter services, at an amount $173,086 annually. Similarly, the Health Services Department contracts with Language Line Services for phone interpretation at an amount $400,000 annually.

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

***A. The County has evidence of policies, procedures, and practices in place for meeting clients' language needs.***

Below is an excerpt from CCMH Policy #118. It is an example of the practice in place the county uses in meeting clients language needs.

**Excerpt *Policy # 118: "Guidelines for Providing Linguistic Access to Limited English Proficient Person (LEP) and Deaf/Hearing Impaired Clients in the Mental Health Division"***

III. POLICY:

Language interpretation and translation services will be available to LEP or deaf/hearing impaired clients by utilizing staff resources inside the county, contracting agency providers, individual providers, or professional interpreters. CCMHP recognizes that culture is a factor that must be weighed in the process of finding a clinician for the client, and in making services accessible to LEP and deaf/hearing impaired clients. CCMHP has a variety of bilingual staff, as well as professional interpreters available (through contractual arrangement). These resources are available at various sites throughout the county and can be utilized, when needed, to assist LEP and/or deaf/hearing impaired clients in receiving culturally competent mental health services. Furthermore, outside contractors, including individual providers, offer much more language capacity than is available with county staff, and this resource should be utilized to remove linguistic barriers to the mental health system.

As outlined in Contra Costa Health Services Division Policy # 118, CCMH is required to provide linguistic resources to serve clients with limited English proficiency. This resource is utilized to remove linguistic barriers, increase cultural competent care in the mental health system and, overall, mitigate health disparities. Guidelines for the translation and interpretation services of CCMHP mental health clients are outlined in this policy and ensure that language and/or sign language interpreter services are available, utilizing staff resources inside the county, contract agency providers, individual providers, or professional interpreters.

Toll Free 24-Hour Phone Line

CCMHP's toll-free 24-hour phone line: *the Contra Costa Mental Health ACCESS Line*, is available for persons seeking mental health care and has the capacity to handle calls in case a language other than English is needed by the client. Clients who need language access through the ACCESS phone line are initially prompted by the greeting to select the type of language they need. If the language is one of the languages spoken by the Access Line staff, the call will route directly to the appropriate staff person. If the language is not readily available through the staff, the call will then be routed to the interpreter line, during which a representative will interpret for the client while being interviewed by the Access Line staff.

Health Care Interpretation Network (Video Interpretation)

The County has recently added new technology to increase linguistic access. In 2010, CCMHP began installing video interpretation units through the Healthcare Interpreter Network (HCIN) in the county clinics. The Healthcare Interpreter Network is a collaborative of hospitals and healthcare providers sharing trained healthcare interpreters through an automated video/voice call center system. There are 170 languages available on demand through this system, including Spanish, Cantonese, Mandarin, Vietnamese, Lao, Mien, Cambodian, Hmong, Korean, Russian, Farsi, Armenian Hindi and American Sign Language. Video units are first being piloted in the eastern region of the county, where there is a high concentration of Latino patients. Once the video units have been installed in the clinic, county staff provides trainings for the clinicians and line staff on how to use the devices. Installation in the Central and West County Mental Health Clinics are expected to occur in late 2010.

Training for staff who may need to access the 24-hour phone line to meet the client's linguistic capability has been in practice through Public Health's training of Language Line. With the roll out of HCIN in County clinics, training for the video units will be coupled with brief refresher training in the use of the Language Line.

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

Clients are informed in writing in their primary language of their rights to language assistance services. To view a copy of this posting, please see Appendix E (Interpreter Services poster). This notice is posted in all clinics to inform clients of their right to this service.

***C. Evidence that Contra Costa County accommodates persons who have LEP by using bilingual staff or interpreter services.***

All mental health providers are obligated to accommodate clients who have limited English proficiency as required by Policy 402PCS. Flagged positions are another means to recruit appropriate staff. To address the regional language needs, the County actively seeks to fill positions with staff who speak another language to serve mental health clients. Interpreter services are always available in the clinics. Total costs for face-to-face and phone translation are monitored by MHA, through data and budget tracking as outlined in the County's Quality Management plan for language access.

***Excerpt from HSD Policy #402 PCS: Access to Services for Limited English Proficient (LEP) Persons***

| | |
|---|---|
| ***PURPOSE*** | ***To comply with federal law, CCHS provides interpretation services and translation of written materials to ensure access to services and effective, accurate and timely two-way communication with all Limited English Proficiency (LEP) patients/clients, including those who are deaf or hearing-impaired.*** |
| **POLICY** | ***The key to meaningful access for LEP persons is effective communication. To ensure meaningful access to CCHS, all Limited English Proficient (LEP) patients/clients will be provided language assistance services at no cost to them. Language assistance services include a) interpretation by bilingual staff, contract interpreters, or telephone interpretation services; and b) translation of written materials.*** |

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

Historically, CCMH has struggled with recruiting and retaining well-trained, diverse staff members who are bilingual. Although the County has other means of interpretation services, the lack of the number of staff with language capacity inhibits the quality of care for LEP clients. Identified in the WET plan were shortage areas and hard-to-fill positions, including LCSW, psychiatrists, licensed clinical psychologists, MFT, licensed supervising clinician, RNs, and psychiatric nurse practitioners. The intention of the County's WET plan is to help alleviate the shortage of staff and clinicians in the workforce who reflect the culture and background of the clients we serve.

Through providing several modes of interpreter services, the County has learned in-person interpretation services is costly, a lesson learned through a recent utilization analysis by region and language type (i.e. which languages are requested the most in individual clinics and regions). In addition, the expense for interpretation services in the clinic for patients who do not show for their appointment is an added cost to CCMH. After piloting the HCIN video interpretation unit, the County has found the monitors to be effective and provide significant cost savings. A report based on the results of the pilot is currently being developed and recommendations will be made on how the county can integrate the video units in all clinics across the regions. The report and recommendations will be available September 2010.

***E. Identify Contra Costa's technical needs***

- Available channels and networks demonstrating strategies in recruiting and retaining multilingual/multicultural staff.

- New methods to effectively and efficiently serve LEP clients. This would contribute to ongoing efforts and also promote high level of competence that fosters better service delivery to the LEP population.

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

***A. Evidence of availability of interpreter and/or bilingual staff for the languages spoken by the community***

Signage informing clients of interpreter services are included in this Plan (Attachment E). This notice includes the main languages offered by Language Interpreter Services and contact information.

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

Interpreter services are offered and provided to clients and the response to the offer is recorded. This is outlined in HSD Policy #402PCS:

> ***Excerpt from HSD Policy #402 PCS: Access to Services for Limited English Proficient (LEP) Person***
>
> ***PROCEDURE***
>
> ***G. Documenting Patient/Client's Primary Language***
>
> ***For all persons, including deaf or hearing-impaired persons, record in patient/client's record or file, the patient/ client's primary language and whether an interpreter is needed.***

When patients are seen in the clinics, language services are offered to patients who need assistance. About 170 different languages are available over the phone and video units for clients when they come in for mental health care. These requests are recorded on the clients' record in the clinic. Quarterly reports of these expenses are generated for tracking and quality management purposes.

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

Below is an excerpt from Policy # 402PCS, showing evidence, as a procedure, that contract and agency staff that are linguistically proficient in threshold languages are offered to clients to provide interpretation services.

***Excerpt from HSD Policy #402 PCS: Access to Services for Limited English Proficient (LEP) Person***

***PROCEDURE***

***C. Spoken Interpretation Services for Limited English Proficiency (LEP) Patients/Clients.***

1. When interpreter services are required for LEP patients/clients, utilize bilingual personnel or contract interpreters, based on your Division procedures.

2. If interpretation as described in #1 is unavailable within a reasonable time, utilize the contracted telephone interpretation services based on your Division procedures.

***D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence***

Contra Costa County requires bilingual employees to take a bilingual exam through the County Personnel Department. The testing of County employees to demonstrate their linguistic capability ensures a level of linguistic competence of employees who will provide interpretation in the clinical setting. Additionally, interpreters who are on the HCIN network must complete an extensive screening process to participate as a network provider for translation services. The requirement for interpreters to be used on HCIN is 40 hours of (approved) health care interpreter training and a passing score on the Language Line Interpreter Skills test (a national standard for certifying interpreters). Our interpreters are hired through the county's formal hiring process and must have medical interpretation experience and pass the oral boards for their classification. The interpreters are evaluated yearly and are monitored on the network, using a formal complaint process which only allows 2 complaints before removal from the system.

In addition, part of the procedure under Policy #402PCS requires the testing of bilingual staff/provider (see excerpt below)

***Excerpt from HSD Policy #402 PCS: Access to Services for Limited English Proficient (LEP) Person***

***PROCEDURE***

***D. Testing the Skills of Bilingual Staff/Providers.***

***1. Qualified staff/providers of healthcare interpreting in CCHS shall include:***

***a) Documented by Personnel Division approved testing process***

***b) Healthcare interpreters who have received training and meet CCHS qualifications for the provision of healthcare interpreting***

***c) CCHS bilingual designated employees who are licensed and certified to provide medical, nursing, medical technician or social work services and who have been determined to be bilingual through CCHS Personnel Division processes.***

***d) Contracted Interpreter services that have met the qualifications of healthcare interpreting deter- mined by CCHS***

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**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***

Included in CCMH's policies around Cultural Competency Plan are Policy 402PCS and Policy 118, which are used to guide the process of linking LEP clients with language services.

***B. Provide a written plan for how clients who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.***

Contra Costa Mental Health ensures that all clients who seek care in the County, regardless of language, are able to access linguistic, culturally appropriate services and quality care. For clients who do not meet the threshold language requirements the following protocol is followed to ensure they receive care in their preferred language:

*Protocol*

Clients contact CCMH's Access Line in order to complete an initial assessment and to be referred to an appropriate location for care (based on language need, geography, specialty, etc). During the initial call with a clinician through the Access Line, a client has the option of speaking to a representative in 5 of the readily available languages spoken by on-site staff. If the client needs assistance in a language other than the ones available, the Access Line utilizes HCIN and Language Access Line, which calls on the assistance of a telephone interpreter. The Access Line staff person will then work with the client to schedule an appointment. An appointment will be scheduled during specific times designated for visits with clinicians who speak the identified language. This method of providing an actual practitioner who speaks the identified non-threshold language reduces the need to bring in a contracted interpreter, thus saving cost. When an appointment with the identified clinician is not available or the client speaks another language not provided by the appropriate in-house clinic staff, the clinic may utilize the Health

Care Interpreter Network, the video interpretation vendor which is the primary choice, or IEC for face to face interpretation.

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

- ***a) Prohibiting the expectation that family members to provide interpreter services,***
- ***b) Clients may choose to use a family member or friend as an interpreter after being informed of the availability of free interpreter services; and***
- ***c) Minor children should not be used as interpreters***

In accordance with Title VI of the Civil Rights Act of 1964, CCMH's Policy 402-PCS-Procedure F demonstrates the County's compliance with Title VI of the Civil Rights Act of 1964.

***Excerpt from HSD Policy #402 PCS: Access to Services for Limited English Proficient (LEP) Person***

***PROCEDURE***

*F. Use of Family or Friends as Interpreters for LEP and Deaf or Hearing-Impaired Patients/Clients*

1. ***Minors are not to be used as interpreters.*** *A minor is someone less than 18 years old.*

2. ***Do the following before using adult family or friends of the patient/client to provide interpretation:***

   ***(a) Inform the patient/client in their language of their right to an interpreter at no cost.***

   ***(b) If the patient/client expresses a desire to use a friend or family member, document the decision in the patient/client record or file. Communicate to the patient that you will also need to access a trained medical interpreter to provide interpretation that insures patient safety, the effectiveness of the clinical encounter is not compromised nor confidentiality is violated, such as HIV counseling, domestic violence, substance abuse, etc.***

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

The following materials (items A-E below) will be available for review during the compliance visit:

***A. Culturally and linguistic appropriate written information for threshold languages***

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

***C. Consumer satisfaction survey translated in threshold languages, including a summary report of the results***

***D. Mechanism for ensuring accuracy of translated materials in both language and culture***

***E. Mechanism for ensuring translated materials is at an appropriate reading level***

# CRITERION 8: COUNTY MENTAL HEALTH SYSTEM ADAPTATION OF SERVICES

**I. Client driven/operated recovery and wellness programs**

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

The Contra Costa Mental Health Plan (CCMH) values and provides services which are client-driven, peer-operated, and recovery-oriented to reach consumers with racially, ethnically, linguistically, and culturally diverse differences within the community. In addition, the Mental Health Services Act provides funding which has made it possible to develop programs that provide services to targeted populations identified by the community and our stakeholders as in need of specific supports. These programs include both county-operated and contracted peer provided services and supports and are described below:

*Office for Consumer Empowerment (OCE)*

The Office for Consumer Empowerment (OCE) is a peer implemented branch of the CCMH Administration and is responsible for representing the consumer perspective in all planning and policy development, as well as promoting and facilitating the involvement of consumers in CCMHP processes. The OCE provides outreach and engagement to persons with lived mental health experience to facilitate recovery and wellness education through presentations and individual peer support in diverse areas of the community.

Since 1994, the OCE has overseen and implemented the Mental Health Service Provider Individualized Recovery Intensive Training (SPIRIT) Program. SPIRIT is a recovery-oriented, hope-based, educational program, operated in collaboration between the CCMH; Mental Health Consumer Concerns (MHCC), a local peer-operated mental health consumer organization; Contra Costa College; and seventeen other community mental health provider organizations. SPIRIT is taught as a series of three college accredited courses by peers to peers, for the purpose of teaching wellness and recovery strategies, and the skills needed to prepare for acquiring an entry level position at a community mental health organization. Additionally, students complete an eight week internship with a local mental health agency to gain hands-on experience working as a peer provider.

SPIRIT provides services specific to the many needs of its students, including those of African American, Latino, Asian and LGBTQQI2-SPIRIT communities; providing a wide range of perspectives that drive the discussion and education in the classroom. Students are taught about alternative treatments and wellness tools used by diverse cultural groups as well as traditional treatment and self-healing techniques. Peer counseling is demonstrated and practiced to meet the needs of each individual with whom the students engage.

The OCE also collaborates with consumers, family members, and mental health providers to reduce stigma within the community and the mental health system. OCE staff work with Mental Health Consumer Concerns to plan, recruit, train, and coordinate the CCMHP Speakers Bureau. Consumers, family members, and staff members participate in presenting a recovery and wellness perspective, by providing presentations to target people in the community, who have frequent contact with consumers. The Speakers' Bureau also provides cultural competency trainings in client culture to mental health staff.

The campaign to reduce stigma will be guided by the CCMH Wellness & Recovery Task Force. This taskforce was convened in the late 1990s to run an Anti-Stigma Campaign. It has since disbanded and is being reconvened in the beginning of FY 2010/2011. The OCE will be targeting representatives of underserved populations when recruiting consumers, family members, and providers to serve on the taskforce. The Wellness & Recovery Task Force will develop a consistent core message for the members of the Speakers' Bureau to deliver to each audience. This message will clearly outline that recovery is real and is individual to each person according to their perspective, strengths, and needs. The Wellness &

Recovery Task Force will also guide the "Mental Health Perspectives" episodes which we are developing to educate the community on CCTV, the county-run cable television station. These television episodes will illustrate the perspective and issues of stakeholders who are from all parts of the community. The Wellness & Recovery Task Force will also help plan the CCMH recovery conference, and initiate specific consumer subcommittees, which will look at issues important to consumers regarding the mental health system of care, including how to deliver services which are client-driven and respective of cultural differences.

The OCE is collaborating with the Putnam Clubhouse and Mental Health Consumer Concerns to produce a series of ten-minute episodes on DVD. The episodes will be designed to educate consumers about empowerment and recovery, and showcase community resources where consumers can receive services that teach self-help skills for mental health wellness. The recovery education episodes will be shown in the waiting rooms of Adult Mental Health Services clinics and will focus on issues that affect people of diverse cultures.

*Mental Health Consumer Concerns, Inc. (MHCC)*

Established in 1976, Mental Health Consumer Concerns, Inc. (MHCC) is a peer led and operated non-profit organization which provides a variety of community-based mental health wellness and peer support services, as well as mandatory patients' rights advocacy services. In 1981, MHCC sought and became the first client group in California to be awarded a Patients' Rights Advocacy contract. MHCC collaborates with CCMH and county mental health contract provider organizations to provide many specialized peer services to meet the needs of individuals from all parts of Contra Costa County.

Through the three MHCC Wellness and Recovery Centers located in Antioch, Concord, and Richmond, and through their other client-operated services, consumers are able to access support groups, peer support, and wellness services. These include:

- Outreach
- Assisting clients to coordinate medical, mental health, medication and other personal services
- Wellness Recovery Action Plan (WRAP)
- Tender Loving Care Project Services (TLC)
- Patients Rights and Advocacy (PRAT)
- SPIRIT
- Support Groups
- Workshops and Classes
- Physical Health/Exercise Activities
- Nutrition Education
- Smoking cessation classes
- Anti-stigma campaign

Recently, MHCC has begun to explore a relationship with the CCMH Older Adult Clinic, in order to provide wellness and recovery services for older adults who may be isolated, and who are traditionally not able to access mental health wellness and recovery services. MHCC is also currently exploring methods of providing culturally competent services to meet the needs of persons throughout the county who have differing linguistic needs. They are developing supports using peer ambassadors who will outreach and engage these individuals in their homes, faith based organizations, and communities.

*Contra Costa Clubhouse*

The Contra Costa Clubhouse, known locally as the Putnam Clubhouse, is located on the border of the East and Central regions of the county. The Putnam Clubhouse is a peer-run organization with a focus on vocational and employment services. A Clubhouse is a membership-based community where people recovering from persistent mental illness come to rebuild their lives. Clubhouse members share ownership and responsibility for the success of the organization. They work in a unique partnership with a small staff, building on strengths instead of focusing on illness. The Clubhouse provides an accepting place to spend the day, valuable work to perform within the organization, opportunities to socialize with friends and co-workers, and provide access to employment within the wider community.

By design the Clubhouse is de-stigmatizing with its focus on recovery and its approach toward the recovery process. Furthermore, the Clubhouse members are actually volunteers themselves, which effectively infuses the rich diversity of the community into the overall operation of the agency. Currently, there is one staff person who is Latina and bilingual Spanish, and another staff person who is Asian Indian. The Clubhouse members are volunteers who help run the program, and their diversity and language capacity is key when integrating new members. Currently, there are members who are fluent in Korean, Spanish, Vietnamese, Pashtu/Dari, Hindi, Cantonese, Russian, and Farsi. The infusion of diversity and language capacity by membership and volunteerism is key to the success of the Clubhouse as it integrates itself as a valuable asset to the community.

The Clubhouse in Contra Costa County, in the central region, is providing people living with the effects of mental illness a low-cost option for gaining respect, hope, and unlimited opportunity to access the same world of friendship, housing, education, and employment as the rest of the community. The Clubhouse provides each member the opportunity to participate in a Work-Ordered day, employment programs, educational opportunities, and gives support in acquiring and keeping affordable housing, good mental health and general medical services, and government disability benefits. They are exposed to a variety of wellness and recovery tools, and to other resources that individual members may need to promote recovery.

*Center for Human Development (CHD)*

The Center for Human Development (CHD) is a community-based, non-profit organization, of volunteers and staff that offers a wide range of services for at-risk youth, individuals, families, and communities in the Bay Area. CHD has been providing programs and supports that focus on wellness, youth leadership, conflict resolution parenting skills and other issues of importance to consumers and family members, since 1972.

In 2006, CHD initiated the African American Health Conductors Pilot to address issues of health inequities by African Americans in east Contra Costa County. Their goal is to assist African American families to access community and public systems that traditionally have not meet their needs due to organizational complexity, cultural capacity, and trust level. This pilot focused on providing health education and navigation services, and in 2009, CHD collaborated with the Contra Costa Health Services Reducing Health Disparities Unit, to expand their focus to include mental health outreach and access. The African American Health Conductors provide preventive services in the community where people go for routine activities, and help persons that do need mental health services to access them more easily. The program specifically targets the African-American community in order to reduce the barriers that they experience with accessing care. The African American Health Conductors provide peer support, and educate African-American residents about health, mental health, and community resources, building bridges between healthcare systems and their communities.

*Rainbow Community Center (RCC)*

The Rainbow Community Center (RCC) is a community-based, non-profit organization that began as a satellite of the Berkeley-based Pacific Center for Human Growth. Their mission is to "foster a sense of community among Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) persons and enhance their lives by providing social opportunities, health and wellness services, and advocacy and educational programs."

In 2009, in a partnership with the Pacific Center for Human Growth, the Center for Human Development and Cal State East Bay School of Social Work, the RCC began implementation of the LGBT Community Mobilization and Social Cultural Communities Project in order to decrease isolation, depression and suicidal ideations among members of the LGBTQ community in Contra Costa County. RCC describes the key activities for the project include providing "a) a series of social support groups that are designed to promote resilience and build a sense of community affiliation in an effort to reduce stigma and isolation; b) social support services expanded to include depression and suicidal assessments among program participants; c) services that are designed to improve communication and support for LGBTQ youth with their heterosexual family members and among LGBTQ "families of choice"; d) creating an information and referral system that links LGBTQ community members into culturally competent mental health services". The project targets youth, adults, and older adults within the LGBT community. Services include one-on-one mental health counseling, client-run wellness support groups for LGBTQ seniors, men, women, and people who have AIDS, individual client-led social activities for men, women, and seniors, separate therapeutic groups for LGBTQ youth and their families, and a food pantry.

**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.***

As a first step to entering Contra Costa's mental health system, clients contact the Access Line. The Access Line offers a choice of seven languages (Spanish, Vietnamese, Farsi, Tagalog, Chinese, Russian and Mien) and has an in-house clinician who handle calls that require Spanish, Tagalog and Urdu interpretation; if the client needs a language that is not on this list, the client will chose an option that routes the call to a clinician who patches in the HCIN interpretation service (or Language Line is HCIN is not available). This process ensures that all clients, regardless of language preference, will be able to have access to mental health care.

Within the County, there are programs that have historically served clients who have cultural and language preferences in the community. As illustrated in the Contra Costa's services listing (available under "Find Mental Health Services" <http://cchealth.org/services/mental_health/>) the County has a number of facilities that have the capacity to serve different communities. Clients who express a preference for a service provider who has language and cultural capacity, the Access Line is able to facilitate visits to these sites. For example, Familias Unidas, a contract provider of mental health services in West County has the capacity to assist clients who may have a cultural or linguistic preference.

More recently, CCMH launched an LGBTQ initiative in efforts to increase providers' cultural awareness and sensitivity to a population that has historically been underserved. Selected providers were given a Cultural Competency Self-Assessment Survey to determine their readiness to serve the LGBTQ clients and their families. From this assessment, the County will be able to plan for appropriate trainings and services. For example, in 2010, CCMH sponsored a training series about the LGBTQ community and

mental health. There are a number of trainings that will be available for staff periodically regarding the unique issues in treating this population of mental health clients.

***B. Evidence that the county informs clients of the availability of the above listing in their member services brochure. If it is not already in the member services brochure, the county will include it in their next printing or within one year of the submission of their CCPR.***

The member services brochure currently utilized by Contra Costa County follows the same format mandated by all counties in California by DMH. Contra Costa County Mental Health provides specialized mental health services including culturally focused programs. Clients who are interested in these types of services are referred to them upon contacting the Access Line.
Further evidence the county informs clients of the availability of these services can be found on our County's website <http://cchealth.org/groups/mental_health/>

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

To ensure beneficiaries of Contra Costa Mental Health Plan (CCMHP) receive all the informing materials upon first accessing services and upon request, the County has Policy 827 "Availability of Beneficiary Brochures and Other CCMHP Informing Materials". It is CCMH policy that all CCMH materials will be given to beneficiaries and/or parents of minors at the initial intake visit and upon request. These materials, which include the CCMHP Guide to Medi-Cal Mental Health Services, Consumer Grievance Review Request, Appeal Request, Request to Change Providers and Consumer Suggestions, are also available in beneficiary waiting areas.

***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.***

In order to facilitate the ease with which culturally and linguistically diverse populations can obtain services, CCMH has examined demographic data to facilitate the planning of mental health services throughout the county. Through examining the unique demographic makeup of the County's regions, as well looking at Medi-Cal utilization data, Contra Costa has strategically placed clinics and network providers in areas to serve populations with unique cultural, linguistic or geographical needs. For example, two of the County's CBOs provide mental health services located in parts of the county where a high concentration of Latino and Asian families reside.

CCMH also considers the needs of underrepresented populations when planning for appropriate staffing at our mental health clinics. In order to more effectively serve clients from different cultural backgrounds and who may have limited English proficiency, the County actively seeks well-trained, diverse potential individuals to join as staff members. Currently there are 35 flagged positions in the Mental Health Division for Spanish, Vietnamese, American Sign Language, and Chinese-speaking staff positions. The providers who are contracted by the County to provide mental health services also actively seek bilingual staff. The providers on the County's network provide services in a wide array of languages, including Arabic, Japanese, Spanish, Vietnamese, Tagalog, Russian and Hindi.

To serve clients who need mental health services in languages that are not offered by the bilingual staff, the County clinics are able to utilize the interpretation services through HCIN's video interpretation service (as detailed in Criterion 7) and Language Line (Mental Health's telephone interpretation service). To ease access and overcome linguistic barriers to care, our County clinics have HCIN to serve clients in 170 languages.

Additionally, CCMH also has programs available to the LGBTQ community to reduce barriers to culturally appropriate and competent mental health care. The County has identified several Health Services staff whose specific purpose is to provide personal assistance in accessing and receiving services to LGBTQ clients. These personal navigators represent different divisions in the Health Services Department, such as Alcohol and Other Drug Services (AODS), Contra Costa Regional Hospitals and Clinics, Public Health and CCMH. There are also specific contract providers across the county that specializes in providing services to the LGBTQ community. The Gender Spectrum, Rainbow Center, RYSE, the Center for Human Development, and El Cerrito's program (through PEI contract to serve adolescents) are a few of the contract providers whose focus is serving this community.

**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.***

Contra Costa County Mental Health actively recruits network providers and staff who are fluent in languages other than English and who represent the communities in which they serve, with concentration of efforts to place them geographically as informed by the data analysis on the County's patient population. The County has also had a long standing relationship with several community-based organizations that specialize in serving different cultural communities. These organizations include Familias Unidas who specialize in serving Latino clients and Community Health for Asian Americans who serve the Asian clients in the eastern region of our county. They are contracted to provide services for mental health patients in areas where there are high concentrations of Latinos and Asian Americans in efforts to increase access to a vulnerable and underserved population. Network providers who also have the ability to provide specialty mental health services in other languages are also sought after by the County. Staff positions are flagged according to the language needed in that geographic region.

For a comprehensive list of all county owned and operated clinics, community based organizations and network providers, please go to our website, http://cchealth.org/services/mental_health/ to view the County's provider list, by region and specialty.

**IV. Quality Assurance**

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

The following is a descriptive list of several outcome measures CCMH uses to measure culturally relevant consumer outcomes. For the overall County Mental Health System, the following measures are utilized for outcome data:

- Child and Adolescent Needs and Strengths (CANS) – A tool, developed by the Praed Foundation, for use in service delivery systems that address the developmental needs of children, adolescents, and their families. It is a tool developed to assist in the management and planning of services to children and adolescents and their families with the primary objectives of permanency, safety, and improved quality in of life.
- Child Adolescent Level of Care Utilization System (CALOCUS) – A tool to determine the level of Care for all initial admissions and re-assessments for continued treatment.
- Performance Outcome and Quality Improvement (POQI) – A survey intended to collect feedback from consumers regarding their experience with County mental health services and staff.

In addition to measuring outcomes for the system of care, the following measures are used for the consumers who participate in the Mental Health Services Act programs:

- Full Service Partnership Key Event Tracking Form- This standardized form for all clients enrolled in MHSA's FSP program aids in improved coordination of care for high-need clients.
- Milestone of Recovery Scale (MORS) – A selected number of Full Service Partnership programs are piloting this survey tool to evaluate the effectiveness of the County's mental health programs and systems.
- PEI Outcome Measurement Tool – This tool is currently being developed for the numerous PEI projects to measure outcomes as outlined in their goals and objectives
- WET Outcome Measurement Tool –This annual evaluation of the achieved outcomes under the WET plan examines training goals and objectives

***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;***

To measure staff experience with the organization's ability to value cultural diversity in the workforce and through its services, CCMHP is slated to administer several surveys to its staff.

*Cultural Competence Assessment Tool for Staff*

This tool is a survey that is used to measure the cultural competence of the programs/units in the Mental Health Division of Contra Costa County. The tool is used to receive information from staff, to gather sufficient data for statistical purposes in order to efficiently measure factors that affect cultural competence and to identify where improvements are needed for better competence. This assessment is administered annually to all staff of the County mental health system.

*Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Two-Spirit (LGBTQQI2-S) Cultural Competency Self Assessment Survey*

Additionally, in 2010 CCMH will administer the Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, and Two-Spirit (LGBTQQI2-S) Cultural Competency Self Assessment Survey for a sample of the County's providers. The tool is intended to help CCMH providers assess their readiness to serve LGBTQQI2-S consumers and their families.

*CCMH Training Survey*

The CCMH Training Survey will be used to gather information from county staff to assess their training interests and to assist the county in providing relevant and cultural competent trainings to staff. The survey covers a wide array of subjects to gauge staff interest with such topics as Leadership/Management, Clinical Training and Language Skill Development. This training survey is scheduled to be administered in August 2010 to all staff.

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

The purpose of the Consumer Grievance Policy is to promote consumers' access to medically necessary, high quality, consumer-centered mental health services by responding to consumers' concerns in a sensitive and timely manner. The policy is also intended to protect the rights of consumers during the grievance process; and monitor track and analyze consumer grievances.

*Processing Grievance and Complaints Data*

Data related to the grievance and appeals against CCMH providers are reviewed and analyzed by the Quality Improvement Coordinator. Resolution process data is analyzed and reviewed by the Quality Management Committee. CCMHP currently looks at the data and compares the data by geographic region and specific providers.
It is also policy of CCMH to log Grievance and Complaints data in a centralized database. The log includes at least the following:

- Name of consumer
- Date of receipt of the grievance
- Date acknowledgement of receipt sent
- Nature of the problem
- Final Disposition of a grievance
- Date written decision set to consumer or
- Documentation of the reason(s) that there has not been final disposition of the grievance.

Although historically the data analysis has been focused on looking at the type of grievances in relation to provider and region, as part of the CCPR, a periodic review of the grievance and complaint data will be implemented to ensure ethnic beneficiaries are not disproportionately affected. This analysis will begin in fourth quarter of 2010. The data analysis will include ethnicity, age and gender of the beneficiaries filing grievances. It will be voluntary for beneficiaries to provide demographic information.

# APPENDICES

## **APPENDIX A:** ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| CBO | Community Based Organizations |
| CCMH | Contra Costa Mental Health |
| CCMHP | Contra Costa Mental Health Plan |
| CCPR | Cultural Competency Plan Requirement |
| CPAW | Consolidated Planning and Advisory Workgroup |
| CSS | Community Services and Supports |
| DMH | Department of Mental Health |
| FSP | Full Service Partners |
| HCIN | Health Care Interpreter Network |
| HSD | Health Services Department |
| LAC | Language Access Committee |
| LGBTQQI2-S | Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Inter-Sexed, 2-Spirit |
| MHSA | Mental Health Services Act |
| OCE | Office for Consumer Empowerment |
| PEI | Prevention and Early Intervention |
| RHD | Reducing Health Disparities |
| TAW | Training Advisory Workgroup |
| WET | Workforce Education and Training |

## **APPENDIX B:** 2008 CAEQRO DATA: MEDI-CAL APPROVED CLAIMS DATA FOR CONTRA COSTA COUNTY MHP


| | |
|---|---|
| Date Prepared: | May 12, 2009 / Version 1.0 |
| Prepared by: | Hui Zhang, APS Healthcare / CAEQRO |
| Data Sources: | DMH Approved Claims and MMEF Data - Notes (1) and (2) |
| Data Process Dates: | April 28, 2009, April 22, 2009, and January 27, 2009 - Note (3) |

| | CONTRA COSTA | | | | | LARGE | | 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** | | | | | | | | | |
| | 125,645 | 10,387 | $61,344,755 | 8.27% | $5,906 | 6.32% | $4,159 | 6.19% | $4,614 |
| **AGE GROUP** | | | | | | | | | |
| 0-5 | 22,728 | 460 | $3,921,531 | 2.02% | $8,525 | 1.43% | $3,444 | 1.40% | $3,778 |
| 6-17 | 32,834 | 3,428 | $28,598,322 | 10.44% | $8,343 | 7.66% | $5,339 | 7.81% | $6,088 |
| 18-59 | 49,966 | 5,781 | $26,380,812 | 11.57% | $4,563 | 9.13% | $3,682 | 8.56% | $3,947 |
| 60+ | 20,119 | 718 | $2,444,090 | 3.57% | $3,404 | 3.47% | $2,864 | 3.40% | $2,937 |
| **GENDER** | | | | | | | | | |
| Female | 72,764 | 5,814 | $27,132,482 | 7.99% | $4,667 | 5.83% | $3,635 | 5.65% | $4,032 |
| Male | 52,882 | 4,573 | $34,212,273 | 8.65% | $7,481 | 6.96% | $4,737 | 6.90% | $5,238 |
| **RACE/ETHNICITY** | | | | | | | | | |
| White | 27,064 | 3,703 | $19,204,440 | 13.68% | $5,186 | 11.80% | $4,097 | 11.72% | $4,621 |
| Hispanic | 48,171 | 1,863 | $9,717,970 | 3.87% | $5,216 | 3.47% | $3,745 | 3.41% | $4,448 |

| | CONTRA COSTA | | | | | LARGE | | 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 |
| African-American | 27,193 | 3,140 | $21,069,682 | 11.55% | $6,710 | 9.97% | $5,004 | 10.10% | $5,026 |
| Asian/Pacific Islander | 12,668 | 639 | $3,574,747 | 5.04% | $5,594 | 4.42% | $3,193 | 4.39% | $3,329 |
| Native American | 416 | 66 | $553,934 | 15.87% | $8,393 | 12.44% | $4,748 | 10.69% | $4,994 |
| Other | 10,137 | 976 | $7,223,982 | 9.63% | $7,402 | 8.65% | $4,957 | 8.96% | $5,491 |
| **ELIGIBILITY CATEGORIES** | | | | | | | | | |
| Disabled | 23,794 | 5,050 | $31,182,780 | 21.22% | $6,175 | 19.55% | $4,281 | 19.52% | $4,543 |
| Foster Care | 1,406 | 857 | $7,772,601 | 60.95% | $9,070 | 55.98% | $6,665 | 58.11% | $7,262 |
| Other Child | 51,662 | 2,743 | $17,931,284 | 5.31% | $6,537 | 3.82% | $3,861 | 4.04% | $4,524 |
| Family Adult | 21,811 | 1,705 | $2,945,096 | 7.82% | $1,727 | 4.76% | $1,784 | 4.50% | $2,108 |
| Other Adult | 28,835 | 396 | $1,512,994 | 1.37% | $3,821 | 0.97% | $3,034 | 0.96% | $3,083 |
| **SERVICE CATEGORIES** | | | | | | | | | |
| 24 Hours Services | 125,645 | 618 | $7,350,727 | 0.49% | $11,894 | 0.50% | $8,136 | 0.46% | $8,147 |
| 23 Hours Services | 125,645 | 1,461 | $2,373,432 | 1.16% | $1,625 | 0.46% | $1,770 | 0.31% | $1,653 |
| Day Treatment | 125,645 | 347 | $5,060,658 | 0.28% | $14,584 | 0.12% | $10,492 | 0.11% | $11,161 |
| Linkage/Brokerage | 125,645 | 2,402 | $4,025,713 | 1.91% | $1,676 | 2.67% | $962 | 2.73% | $913 |
| Outpatient Services | 125,645 | 7,917 | $29,076,854 | 6.30% | $3,673 | 5.05% | $2,605 | 5.19% | $3,066 |
| TBS | 125,645 | 251 | $4,556,826 | 0.20% | $18,155 | 0.06% | $13,289 | 0.05% | $15,733 |
| Medication Support | 125,645 | 5,266 | $8,900,545 | 4.19% | $1,690 | 3.57% | $996 | 3.31% | $1,162 |

Footnotes:

1 - Report of approved claims based on Medi-Cal recipient's "County of Fiscal Responsibility". The report includes approved claims data on MHP eligible beneficiaries who were served by other MHPs

2 - Includes Short-Doyle/Medi-Cal (SD/MC) and Inpatient Consolidation (IPC) approved claims for those whose aid codes were eligible for SD/MC program funding

3 - The most recent processing dates for SD/MC and IPC approved claims and MEDS Monthly Extract File (MMEF) respectively by DMH for the indicated calendar year and data included in the report

4 - County total number of yearly unduplicated Medi-Cal eligibles is 156,882

## **APPENDIX C:** EXAMPLES OF BUDGET RESOURCES DEDICATED TO CULTURALLY COMPETENT ACTIVITIES FOR FY 09-10

| Program Name | Amount | Service Description |
|---|---|---|
| Native American Health Center:<br>• Native American Wellness Center | $213,422 | The Native Wellness Center is designed to build a strong community, strengthen family communications, and help Native Americans navigate the complex human service systems in Contra Costa County. |
| Rainbow Community Center<br>• LGBT Community Mobilization & Social Support Project | $ 138,955 | **Lesbian, Gay, Bisexual, Transgender, Queer and Questioning**. RCC provides a community-based social support program designed to decrease isolation, depression and suicidal ideation among members of the(LGBTQ) community |
| YMCA of the East Bay:<br>• One Family at a Time | $ 178,125 | YMCA serves primarily **African American and Latino families** in an area of high poverty and violence to improve access to health and mental health care. |
| La Clinica De La Raza<br>• Vias de Salud (Pathways to Health); and<br>• Familias Fuertes (Strong Families) | $ 256,750 | La Clinica has implemented 2 programs serving the **Latino Community** one is an assessment screening tool to identify social isolation ,depression, substance abuse and domestic violence and to provide immediate intervention and group follow up for those identified. They are also providing parenting classes to support families. |
| Jewish Family & Children's Services of the East Bay | $159,699 | JFCS provides mental health education and navigation to the immigrant communities including, **Latino, Afghan, Bosnian, Iranian, and Russian Communities**. They are also training county and community agencies on how better to work with immigrants from these cultures. |
| Center for Human Development<br>• African American Health Conductors; and<br>• Senior Peer Outreach Program | $144,000 | CHD has 2 separate programs: Mental Health Education and Navigation to the **African American** Community in their African American Health Conductors Program. |

| Program Name | Amount | Service Description |
|---|---|---|
| | | The Youth Senior Peer Counseling Program pairs **Youth and Seniors** to decrease senior isolation and provide youth growth and training opportunities. |
| YMCA of the East Bay | $253,225.00 | YMCA serves primarily **African American and Latino families** in an area of high poverty and violence to improve access to health and mental health care. They support block by block community organizing and events to improve life skills and promote social change. |
| Community Health for Asian Children and their Families | $1,211,949 | School and community based mental health services for Asian children and their families and west county drug court. |
| Desarollo Familiar, Inc | $130,000 | EPSDT services to Latino children and families. |
| Translation Services: Windrix Transcription Inc | $165,000 | Provide medical transcription for ADA accommodation or worker compensation due to claims. |
| Interpretation Services: International Effectiveness Center | $220,000 | Provides interpretation services to non-speaking consumers. |

## **APPENDIX D:** CONTRA COSTA MENTAL HEALTH TRAINING CALENDAR (FY 2009-2010)

| Training Event | Description of Training | Length of Training and How Often | Attendance by Function | No. of Attendees and Total | Date of Training | Name of Presenter |
|---|---|---|---|---|---|---|
| Conflict Management | This workshop focuses on interpersonal communication and relationships with coworkers, supervisors, subordinates, and customers. Participants learn how their behavior and attitudes impact others and how to positively deal with difficult behaviors. | 3 hours; Annual | Direct Services (County & Contractor); Interpreters; Support Services | 30 | 7/29/09 | Jaimie Jones, UC Davis |
| Impact of Trauma in Lives of Older Adults | In this workshop participants will examine the impact of trauma on the lives of older adults. Losses associated with trauma are usually those that are external: death of loved ones; early child physical or sexual abuse; decreased health; automobile accidents; loss of a home by fire. | 1 day; Annual | Direct Services (County & Contractor); Interpreters; Administration/ Management | 61 | 9/30/09 | Patrick Arbore, Ed.D |
| Reducing Health Disparities-Pride Initiative Launch | A training to identify a vision for an equitable healthcare system looks like in CCMH for LGBTQQI patients; identify systemic problems that interfere with LGBTQQI patients getting quality services; identify key health issues and disparities in this community; and recommend strategies to include a formal Pride Action Plan | 1 day; one time | Administration/ Management; Direct Services (County) | 39 | 10/8/09 | Caitlin Ryan, James Beaudreau, Tim Berthold |
| Reducing Risk and Promoting Well-Being for LGBT Youth: The Critical Role of Family Support | Dr. Caitlin Ryan discusses her work on the Family Acceptance Project, the first major study of LGBT youth and their families. | 0:43 minutes; on demand as podcast | Direct Services (Contractors) | N/A (Podcast) | (podcast) | Dr. Caitlin Ryan |
| Providing Culturally Competent Care to Gay, Lesbian, Bisexual and Transgender Clients and Patients | Workshop to understand the health and social service needs of GLBT clients; Identity factors that influence access to care and quality of care for GLBT clients; Enhance skills for discussing GLBT issues with colleagues and clients; | 3 hours; on demand as online course | Direct Services (County & Contractor); Interpreters; Administration/ Management | N/A (External) | 6/1/09-6/10/09 | Marisa Howard-Karp |
| Mental Health Across Cultures | A cultural context for mental health issues | 2 hours; Annual | Direct Services (County & Contractor); Interpreters; Administration/ Management | N/A (External) | 10/29/2009 | Jewish Family & Children's Services |
| African American Cultural Issues in Children's Mental Health | A training that identifies issues pertinent to the African American community when considering mental health issues in children. | .5 day Annual | Direct Services (County-Interns: MFT, LCSW, Phd, PsyD) | 13 | 11/18/2009 | Lynor Jackson Marks |

| Training Event | Description of Training | Length of Training and How Often | Attendance by Function | No. of Attendees and Total | Date of Training | Name of Presenter |
|---|---|---|---|---|---|---|
| Gang Involvement | Through this training, Parent Partners are able to help parents and educators recognize the latest trends in schools and to able to direct parents and educators to community resources throughout the county and in their region. | 2 hours; Annual | Direct Services (County) | 40 | 12/1/09 | Dianna Collier |
| Transitioned Aged Youth | Through this training, Parent Partners are able to help parents and educators recognize the latest trends in schools and are able to direct parents and educators to community resources throughout the county and in their region. | 2 hours; Annual | Direct Services (County) | 40 | 12/1/09 | Dianna Collier |
| Historical Trauma in the African-America Experience: New Directions for Engagement | To provide participants with awareness, knowledge and effective engagement strategies in order to enhance services for African American/Black clients, families and communities. | 1 day; one time | Direct Services (County & Contractor); Support Services; Administration/ Management | N/A (external) | 2/10/2010 | David Wee, LCSW, et al. |
| The Impact of Family Acceptance & Rejection on the Health & Mental Health of LGBTQ2-S Youth | In this workshop participants will examine the impact of family acceptance and rejection on promoting well-being and increasing risk for health and mental health problems for LGBT young people. Participants will also identify at least four specific family reactions to an adolescent's LGBT identity that affect the youth's risk and well-being for negative and positive health and mental health outcomes | 2 hours; Annual | Administration/ Management | 23 | 2/16/2010 | Dr Caitlin Ryan, PhD |
| Stigma, Confidentiality, Crisis Intervention | Training series to help overcome cultural barriers to getting help for mental health issues | 2 hours; Annual | Direct Services (County & Contractor); Interpreters; Administration/ Management | N/A (external) | 2/18/2010 | Jewish Family & Children's Services |
| "Don't Fence Me In" Isms Spring Workshop | To understand the landscape of gender, sexual, racial, cultural identities, the oppressive nature of labels and how we can practice inclusion with clients, colleagues and communities of multiple identities. | 1 day; one time | Direct Services (County & Contractor); Support Services; Administration/ Management | N/A (External) | 3/18/2010 | Larry Lee, LCSW |
| Moving Toward Best Practices in Serving the LGBT Community in California | Workshop to increase cultural responsiveness in serving the LGBT community | 1 day; one time | Direct Services (County & Contractor); Support Services; Administration/ Mgmt | N/A (External) | 4/15/2010 | LGBT TRISTAR |

| Training Event | Description of Training | Length of Training and How Often | Attendance by Function | No. of Attendees and Total | Date of Training | Name of Presenter |
|---|---|---|---|---|---|---|
| Recovery Training (Intern Training) | A training session to understand recover concepts and client culture in Mental Health | 1 day; Annual | Direct Services (County-Interns: MFT, LCSW, PhD, PsyD) | 15 | 4/21/2010 | Susan Medlin |
| Access to Resources for Limited English Speaking Populations | A panel of community agencies and providers | 1 day; Annual | Case managers, direct services providers, interpreters, and program coordinators | N/A (External) | 4/22/2010 | Jewish Family & Children's Services |
| Capacity Building for Ethnic and Culturally Focused Community Based Organizations | To provide strategies and tools for developing organizational capacity of ethnic and cultural focused CBOs<br><br>To foster successful partnerships between County Mental Health Services and ethnic and cultural focused CBOs in the implementation of mental health prevention and early intervention activities through the Mental Health Services Act (MHSA). | 2 Days; Annual | Direct Services (County & Contractor); Support Services; Administration/ Management | N/A (External) | 5/6/2010 | CiMH |
| Military Culture 101: Basics of Military culture | A basic understanding of the nuances of the military culture. | .5 day Annual | Direct Services (County & Contractor); Support Services; Administration/ Management | N/A (External) | 5/19/2010 | CPT (CA) Lance Friis, LMFT |
| Addressing Trauma, Grief and Loss in Military Children | Explaining that their parent has changed or died is even more difficult. We are hosting this webinar to help our military families who have to endure these challenges. The webinar will discuss strategies for discussing these sensitive issues with children. | 1.5 hours; on demand as webinar | Direct Services (County & Contractor); Support Services; Administration/ Management | N/A (Webinar) | 5/27/2010 | Dr. Jeanette Betancourt, Ed.D and CAPT Russell Shilling, Ph.D., MSC, USN |
| Creating an LGBTQ Safe Space | Amanda Richards, MA, LADC, program director at PRIDE Institute, will go through some practical things you can do to make your space and your work life more LGBT friendly. | On demand as webinar | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (Webinar) | 6/2/2010 | Amanda Richards (Pride Institute) |
| Addressing Mental Health Issues in Primary Care: IMPACT Model | This webinar will explore the improving mental health is primary health care settings with examples from other organizations who utilize the IMPACT model. | On demand as webinar | Direct Services (County & Contractor); Support Services | N/A (Webinar) | 6/3/2010 | CiMH |

| Training Event | Description of Training | Length of Training and How Often | Attendance by Function | No. of Attendees and Total | Date of Training | Name of Presenter |
|---|---|---|---|---|---|---|
| Implementing Recovery-Oriented Practices 1: Emerging Trends in Program and Workforce Development | This webinar will present and explore implementation strategies on mental health recovery-oriented services. | 1.5 hours; on demand as webinar | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (Webinar) | 6/8/2010 | Larry Davidson, Ph.D., et al. |
| Families Matter: Rethinking Approaches to Reduce Risk and Promote Well-Being for LGBT Youth | New research from the Family Acceptance Project (FAP) shows how family acceptance and rejection affects their health and mental health. | 1 day; Annual | Direct Services (County & Contractor) | 88 | 6/9/2010 | Caitlin Ryan, Institute Ph.D., ACSW |
| Bridging differences in the "cultures" of PC/MH/SU | Presentation describing the integration of Primary Care, Mental Health, and Substance Use in various counties | On demand as webinar | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (Webinar) | 6/10/2010 | CiMH |
| Entrecruzando Nuestros Caminos: Opening the doors to Hispanic/ Latino Peer Providers | The presenter will describe a new consumer-provider training program that focuses on recovery and rehabilitation skills as the foundation of Hispanic/ Latino peer education. | On demand as webinar | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (Webinar) | 6/15/2010 | Maria E. Restrepo-Toro, M.S. |
| Moving Toward Best Practices in Serving the LGBTQQI2S Communities in Contra Costa County | Workshop Presented LGBT-TRISTAR is an introduction to the lesbian, gay, bisexual and transgender (LGBT) community and its diversity, and to the issues, challenges and opportunities that are associated with providing mental health and alcohol and other drug (AOD) prevention, treatment and recovery support services to LGBT consumers. | 1 day; Annual | Direct Services (County & Contractor); Support Services; Community Based Organizations | 46 | 6/18/2010 | Michele Eliason, PhD |
| Cultural Diversity in Chemical Dependency Treatment | The workshops offer actual application of techniques in dealing with chemical dependency and mental health problems, based upon the education and experiences of the presenters. | 1 day; Annual | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (External) | 6/22/2010 | Georgette Cobbs, MA |
| Training Institute on Engaging Men and Boys to Prevent Domestic and Sexual Violence | Training where participants share the history of domestic and sexual violence movements; gaining insight into the role of men in the movement over the years; sharing accomplishments, challenges, and lessons learned, deepening the understanding and definition of men's work in domestic and sexual violence prevention today. | 2 days; one time | Direct Services (County & Contractor); Support Services; Community Based Organizations; General Public | N/A (External) | 6/23/2010 | Tony Porter, et al. |

| Training Event | Description of Training | Length of Training and How Often | Attendance by Function | No. of Attendees and Total | Date of Training | Name of Presenter |
|---|---|---|---|---|---|---|
| Anti-Stigma, Race & Culture | A summer workshop which includes sessions such as Exploring Racial and Cultural Selves, NAMI, MHSA and the Anti-Stigma Movement, and The Dangers of Stereotypes. | 2 days; one time | Direct Services (County & Contractor); Support Services; Community Based Organizations | N/A (External) | 6/24/2010 | California Institute for Integral Studies |

**APPENDIX E:** INTERPRETER SERVICES POSTING

## **APPENDIX F:** TRAINING EVALUATION TEMPLATE

*Training Title*
*Date*
*9:00am-5:00pm*
*Trainer Name*

**Please complete this form carefully. Your comments are used to evaluate current workshops as well as to determine future offerings.**

**Licensure (MFT, LCSSW, PsyD., etc.):_____ Name optional):_____**

**Title/Organization (optional): _____**

Please rate the following:

| | Agree | | Disagree | Neutral |
|---|---|---|---|---|
| 1. The presentation was clear and to the point. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 2. The presenter was knowledgeable and well prepared. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 3. The presenter was enthusiastic and effective. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 4. The level of interactivity was appropriate for this conference. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 5. The training increased my knowledge/skills re: the topic presented. | | 1 | 2 | 3 |
| 4 5 | | | | |
| 6. The handouts contributed to the effectiveness of the training. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 7. The conference content was relevant/appropriate. | | 1 | 2 | 3 |
| 4 5 | | | | |
| 8. The objectives of the conference were clearly stated. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 9. The objectives of the conference were achieved. | | 1 | 2 | 3 |
| 4 5 | | | | |
| 10. The conference location was convenient/accessible. | 1 | 2 | 3 | 4 |
| 5 | | | | |
| 11. Overall rating of the facility. | | 1 | 2 | 3 |
| 4 5 | | | | |
| 12. Overall rating of the conference. | | 1 | 2 | 3 |
| 4 5 | | | | |

1. Briefly describe what information you anticipate will be most useful when working with clients.
2. Do you have a suggestion on what would have improved THIS conference?
3. Ideas for future trainings

# REFERENCES


[i] State of California, Department of Finance, E-3 Race / Ethnic Population Estimates with Age and Sex Detail, 2008. http://www.dof.ca.gov/research/demographic/data/e-3/

[ii] Insyst (CCMH Billing and Information) Database. Contra Costa County Mental Health Division.

[iii] *ibid*

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