

COVER SHEET

An original, three copies, and a compact disc
of this report (saved in PDF format)
was submitted August 31, 2010 to:

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

Name of County: San Luis Obispo

Name of County Mental Health Director: Karen Baylor, Ph.D, LMFT

Name of Contact: Frank Warren

Contact's Title: MHSA Division Manager

Contact's Unit/Division: MHSA

Contact's Telephone: 805-788-2055

Contact's Email: fwarren@co.slo.ca.us

CHECKLIST OF THE 2010 CULTURAL COMPETENCE PLAN REQUIREMENTS CRITERIA

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



Cultural Competence Plan

**San Luis Obispo County
Behavioral Health
Department
Mental Health Services**

**Submitted to CA Department of
Mental Health
August 31, 2010**



Table of Contents

Introduction	1
Cultural Competence.....	1
Key Objectives and Recommendations.....	2
Criterion I. Commitment to Cultural Competence	4
Section I. County Mental Health System commitment to cultural competence....	4
Section II. County Recognition, Value, and inclusion	6
Section III. County Cultural Competence/Ethnic Services Manager	13
Section IV. Budget resources target for culturally competent activities	15
Criterion 2. Updated Assessment of Service Needs	17
Section I. General Population	17
Section II. Medi-Cal population service needs.....	18
Section III. 200% of Poverty population and service needs.....	21
Section IV. MHSA Community Services and Supports (CSS)	25
Section V. Prevention and Early Intervention (PEI) Plan	29
Criterion 3. Strategies and Efforts for Reducing Mental Health Disparities.....	30
Section I. Identified unserved/underserved target populations (with disparities)	30
Section II. Identified disparities (within the target populations)	33
Section III. Identified strategies/objective/actions/timelines	37
Section IV. Additional strategies and lessons learned.....	43
Section V. Planning and Monitoring of identified strategies to reduce mental health disparities.....	47
Criterion 4. Client/Family Member/Community Committee: Integration of Committee within the County Mental Health System.....	52
Section I. Cultural Competence Committee Goals and Objectives.....	52
Section II. Cultural Competence Committee Responsibility.....	54
Criterion 5. Culturally Competent Training Activities	61
Section I. Required Staff and stakeholder annual cultural competence training	61
Section II. Annual cultural competence training.....	63
Section III. Relevance and Effectiveness of Trainings.....	70
Section IV. Counties incorporation of Client Culture Training.....	73
Criterion 6. County’s Commitment to Growing a Multicultural Workforce	79
Section I. Recruitment, hiring, and retention.....	79
Criterion 7. Language Capacity.....	82
Section I. Increase bilingual workforce capacity	82
Section II. Services to persons with Limited English Proficiency (LEP)	84
Section III. Bilingual staff at all points of contact.....	87
Section IV. Services to all LEP clients at all points of contact	89

Section V. Required translated documents, forms, signage, and client informing materials	91
Criterion 8. Adaptation of Services.....	94
Section I. Client driven/operated recovery and wellness programs	94
Section II. Responsiveness of mental health services	97
Section III. Quality of Care: Contract Providers	102
References.....	105
Appendix.....	106
Appendix 1: Program Mission and Goals	
Appendix 2: General Treatment Considerations	
Appendix 3: Workforce Education Training Plan	
Appendix 4: Quarterly Cultural Competence Newsletter	
Appendix 5: Ethnic Services Manager Description	
Appendix 6: Collaborative Psychiatric Epidemiology Surveys (CPES)	
Appendix 7: Medical Necessity	
Appendix 8: Servicios Sicologicos para Latinos	
Appendix 9: LOP Presentations	
Appendix 10: LOP Staff	
Appendix 11: LOP Community Sites	
Appendix 12: LOP and Safe Site Protocol	
Appendix 13: LOP Client Satisfaction Questionnaire	
Appendix 14: Cultural Competence Committee bylaws	
Appendix 15: Organizational Chart	
Appendix 16: Cultural Competence Committee Roster	
Appendix 17: Contract Scope of Services for Dr. Ortiz	
Appendix 18: PQI/Quality Management Agenda	
Appendix 19: CCC Agenda	
Appendix 20: CCC Minutes	
Appendix 21: Local CCPR Planning	
Appendix 22: Cultural Competence Committee Report	
Appendix 23: WET Training Plan	
Appendix 24: Training Evaluation reports	
Appendix 25: Draft Education and Training Policy	
Appendix 26: WET Workforce Assessment	
Appendix 27: SLOBHD's Culturally Competent, Multi-Lingual Services Policy	
Appendix 28: Lobby Posting	
Appendix 29: SLOBHD's Bilingual Certification Policy	
Appendix 30: FSP Program Description	
Appendix 31: County Mental Health Services 2010 Bilingual staff list	
Appendix 32: Provider List of Behavioral Health Clinics and Contract Providers	
Appendix 33: Provider List Availability Policy	
Appendix 34: Template of Client Letter in Spanish	
Appendix 35: Master Service Plan Form	
Appendix 36: Beneficiary Handbook Policy	

Appendix 37: PEI Stakeholder Process Example
Appendix 38: LOP Client Satisfaction Questionnaire results
Appendix 39: Informed Consent Form
Appendix 40: Release of Information; Authorization Use/Disclose Protected Health Info
Appendix 41: LOP Brochure
Appendix 42: Lobby Materials Check List
Appendix 43: Beneficiary Handbook Samples
Appendix 44: TBS Forum Flier
Appendix 45: Reports on TBS Forums
Appendix 46: CSCR Annual Report
Appendix 47: SLOBHD Contract Special Conditions section
Appendix 48: California Brief Multicultural Competence Scale
Appendix 49: Sample Page from Employee Quality Improvement Study
Appendix 50: Grievance Process Policy
Appendix 51: Distribution of Translated Materials Policy
Appendix 52: Readability of MediCal Informing Materials
Appendix 53: MHSA Peer and Family Support Services
Appendix 54: MAC Email Announcement Agenda

Introduction

The San Luis Obispo County Behavioral Health Department, which houses the Mental Health Division, is committed to developing a system of care which serves an increasing, changing and diverse population in the County. The system must strive to ensure cultural competence at all levels of the organization.

In order to accomplish this goal, the Cultural Competence Committee, formed in 1996, consisting of staff members from the various programs of the Behavioral Health Department as well as community partners, continues to assess, implement, and monitor policies and practices which assure effective services are provided in cross-cultural situations. The committee members, representing diverse cultural backgrounds and other special interests, have provided input and insight in order to make the following report an active document which will inform the County's mental health system for years to come.

This Cultural Competence Plan has been prepared to provide guidelines to help the Behavioral Health Department in San Luis Obispo County become a more culturally competent organization and to ensure that diverse populations in the county receive mental health services that are culturally appropriate throughout the mental health system.

Cultural Competence

La Frontera Inc., an organization based in Pima County, Arizona, developed a cultural competence self assessment manual titled "Building Bridges", which has been used by the Cultural Competence Committee since 2003. In this assessment manual, culture is defined as follows: "The term culture is used in a broad inclusive sense. It includes race, ethnicity, gender, sexual orientation, primary language, spiritual life, age, and physical condition. Culture is also a multifaceted concept. It incorporates cultural objects such as music, art and clothing; ways of living such as kinship patterns, communication styles and family roles; as well as beliefs or values such as religion, attitudes towards time and views of the natural world." With this definition as a starting point, the committee began a series of discussions to define and operationalize the concept of cultural competence for the mental health system.

According to the Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, cultural competence includes:

Attaining the knowledge, skills, and attitudes to enable administrators and practitioners within system of care to provide effective care for diverse populations, i.e., to work within the person's values and reality conditions. Recovery and rehabilitation are more likely to occur where managed care systems, services, and providers have and utilize knowledge and skills that are culturally competent and compatible with the backgrounds of consumers from the four underserved/underrepresented racial/ethnic groups, their families, and communities.

Cultural competence acknowledges and incorporates variance in normative acceptable behaviors, beliefs and values in determining an individual's mental wellness/illness, and incorporating those variables into assessment and treatment.

Finally, the following operational definition, provided by the Health Resources and Services Administration (Maternal and Child Health Bureau, Title V Block Grant Program Guidance, 2003), was utilized for the foundation of this plan:

Cultural competence is “the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multi-cultural staff in the policy development, administration and provision of those services.”

Key Objectives and Recommendations

In response to the Department of Mental Health's 2010 CCPR requirement, the SLOBHD is developing a comprehensive plan and has chosen to include key objectives to monitor over the next three years. The County's Cultural Competence Plan, submitted to the State on August 31, 2010 details strategies which have been employed over the past three years as part of the Mental Health Services Act (MHSA) community stakeholder processes and implementation of the various components.

Based on the material presented herein, data analyses, CCPR planning and stakeholder discussions, and lessons learned responses, the following key objectives will be adopted and monitored over the next three years:

- The SLOBHD will develop and institute a Training Policy which includes requirements for staff development in cultural competence and demonstrated improvements in service to diverse clients.
 - Strategies to be employed include the use of E-Learning to provide core competency training and education for all staff. Other strategies include development of pre-post measurement tools to assess staff capacity, skill development, retention of core competency training and changes in practice and behavior over time. Other strategies include collaboration and partnering with other county agencies that provide training on core topics vital to staff development.
- The Cultural Competence Committee (CCC) will increase cultural competence training for mental health system providers by two activities per year.
 - Strategies to accomplish this objective include the aforementioned networking with community partners who can provide quality training for mental health professionals. The County and its CCC will also broaden the approach to cultural competence training to include activities which improve the mental health system's capacity to serve cultural populations (e.g. LGBTQ, Veterans, consumers and family members). One strategy being developed for this objective is built in the County's "Innovation" (MHSA) plan, which will create a

consumer/family member training panel to deliver training workshops for providers.

- The CCC will increase membership of consumers and family members by one member annually over the next three years.
 - This objective is critical to enhance the diversity of the Committee which serves to improve cultural competence principles across the SLOBHD's programs. The main strategy to accomplish this objective will be the establishment of membership policy requiring the committee to have at least one seat filled by a consumer/family member. This will increase recruitment efforts and partnerships with community organizations, such as the Peer Advisory and Advocacy Team (PAAT) with Transitions Mental Health Association, a community-based organization.
- The Committee will identify other underserved populations reflecting cultural needs in order to provide services and support within the County system. This will be measured by an increase in CCC membership to include representatives of currently unrepresented communities over the next two years.
 - The strategies to meet this objective include working with the County's Prevention and Early Intervention (PEI) programs which have built relationships and partnerships with organizations serving cultural populations often underserved in the mental health system, along with expanded services with the Latino population. These include Asian/Pacific Islanders, LGBTQ, veterans, older adults, TAY, and consumers.
- The CCC, as part of its mission to "ensure that cultural diversity is incorporated into all levels of San Luis County Behavioral Health Department," will develop measures over the next year to ensure a process of review and recommendations for each Department service level.
 - This objective will need to include an expansion of the CCC's review process for documents and translation services aimed at the Spanish-speaking community; staffing recruitment and recommendations, and presentations made to various Department programs currently not represented in the CCC. Strategies to meet this objective include establishing CCC policy to review all SLOBHD programs that serve diverse clients (including those of the Drug and Alcohol Services Division) to assure cultural competence policies and procedures are in place.

CRITERION 1

COUNTY MENTAL HEALTH SYSTEM

COMMITMENT TO CULTURAL COMPETENCE

I. County Mental Health System commitment to cultural competence

The county shall include the following in the CCPR:

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

San Luis Obispo County's Mental Health Services, the State-identified Mental Health Provider (MHP), created a Cultural Competence Plan in 1998. That document, provided in response to State managed care requirements, was updated in 2003 and 2004, and continues to inform policy for the San Luis Obispo County Behavioral Health Department (SLOBHD), which now houses the County's mental health and alcohol and drug divisions. This current plan will continue to provide a foundation for policies, procedures, and practices that reflect the SLOBHD's recognition and value of racial, ethnic, and cultural diversity within the County's Mental Health System.

The San Luis Obispo County Behavioral Health Department's Mental Health Services established the following Mission Statement, which serves as a banner for all official public records, including the annual budget documents (Appendix 1):

Mental Health strives to assist individuals of all ages affected by mental illness in their recovery process to achieve the highest quality of life by providing culturally competent, strength based and client and family centered services based on best practices.

San Luis Obispo County employees, including candidates for employment in the Behavioral Health Department, are provided the following statement by the County Administrative Officer at the onset of any human resources activity:

The County is an equal opportunity employer committed to a program of Affirmative Action. Objectives are directed toward assuring equal opportunity in selection / promotion, pay, and job assignments. Recruitment and realistic selection procedures have been established to ensure non-discrimination on the basis of political or religious opinions or affiliations, age, sex, race, color, national origin, marital status, disability, sexual orientation or other non-merit

factors. In addition, the County complies with the provisions of the Americans with Disabilities Act in hiring and retaining employees.

Mental Health Services policies include a statement of General Treatment Considerations (Appendix 2), which includes the following statement:

Client's unique cultural needs and strengths must be a primary factor in treatment formulation and ongoing care. The Recovery Model, based on optimism, wellness and client empowerment, should be used as a guiding principle for treatment.

As described throughout the rest of this document, training in cultural competence is at the Department's core. SLOBHD's engagement in the Mental Health Services Act (MHSA) components and their planning processes has allowed for the development of training plans and policies which will increase staff and community partner capacity around improved services which value the community's racial, ethnic, and cultural diversity. As demonstrated in the County's Workforce Education and Training Plan's (Appendix 3) "Action #5: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff."

The purpose of cultural competence training is to develop understanding, skills and strategies to assist in embedding cultural competence into the MHSA implementation process and support of cultural competence integration in San Luis Obispo County. Our hope is that the training will provide the tools and skills necessary to increase the County's capacity for the delivery of culturally relevant services therefore resulting in better outcomes for the County's culturally diverse clients.

Please see the Appendix section for the following documents:

- County of San Luis Obispo Civil Service Rule 16: Equal Employment Opportunity
- San Luis Obispo County Policy Against Discriminatory Harassment

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

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

1. Mission Statement;
2. Statements of Philosophy;
3. Strategic Plans;
4. Policy and Procedure Manuals;
5. Human Resource Training and Recruitment Policies;
6. Contract Requirements; and
7. Other Key Documents (Counties may choose to include additional documents to show system-wide commitment to cultural and linguistic competence).

During the on-site compliance review, the State will be able to review documents which demonstrate the County's commitment to cultural and linguistic competence services reflected throughout the entire system, including the following:

- The County Mental Health Department Mission Statement, as listed in the annual budget documents.
- Strategic Plans, including the aforementioned Managed Care Cultural Competence plans from 1998, 2003, and 2004; and MHSA plans which clearly outline the role of cultural competency in providing quality services.
- Policy and Procedure Manuals, including the Department's Cultural Competence Committee bylaws, meeting minutes, and newsletters.
- Human Resource policy documents including the County of San Luis Obispo Civil Service Commission Rules & Ordinances, Procedural Guidelines, and the San Luis Obispo County Policy Against Discriminatory Harassment
- Contracts, which outline requirements for culturally competent services.

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

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

The county shall include the following in the CCPR:

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

The Cultural Competence Plan Requirement has been compiled and completed by staff in the San Luis Obispo County Behavioral Health Department. Due to the agency's important partnerships with community providers and stakeholders, some sections were completed in collaboration with, or reviewed by, community partners.

A. SLOBHD has identified that mental health services are often out of reach for some racial, ethnic, cultural, and linguistic communities in our county. Outreach and service provision to meet the needs of these communities is a key priority for the Department and its partners. Through the process of developing the county's Mental Health Services Act (MHSA) planning and implementation, SLOBHD and its partners have made access and engagement key targets for improvement within those communities with mental health disparities.

The most dominant disparity in San Luis Obispo County, which cuts across all of the community issues identified in various MHSA community stakeholder processes, is the under representation of Latino individuals. This imbalance in service access is made

even more dramatic considering the relatively high proportions of Latinos in the poverty population with the health and access problems associated with poverty status. The County has first, and foremost, sought to engage leaders of the Latino community along with consumers and family members in participating in MHSA planning activities. Meetings, focus groups, presentations, and conversations have been held throughout the local Latino community to give voice to the needs of many individuals detached from the mental health system by culture and language. Responses have included a greater priority on hiring practices which engage Latino professionals, as well as targeted outreach and clinical operations which provide culturally competent mental health services.

Older adults represent another large and often underserved population – and one with a distinct cultural divide at the foundation of its disparities in accessing services. Older adult suicides happen more frequently in San Luis Obispo County than on average in California (CDPH, 2010). Again, the County has utilized the MHSA planning processes to better engage and build partnerships with the older adult community. Leaders of senior care organizations, retiree agencies, and senior consumers have participated in stakeholder processes sharing their unique concerns and needs. Responses have ranged from efforts to increase prevention and early intervention activities which seek to reduce depression and anxiety which debilitates many of our seniors; while clinical operations have expanded to include older adult Full Service Partnerships (FSP) throughout the county.

County staff and stakeholders have also identified those groups often left out of age and ethnicity counts when assessing those under served. Homeless, veterans, and the LGBTQ communities each have unique cultural qualities, and are also key focus populations for SLOBHD. The homeless population is fluid and difficult to engage for many reasons. Recent efforts have put more emphasis on outreach into the field and utilizing existing infrastructure (i.e. shelters, Social Services, food banks) to get information and services to homeless individuals and families.

Veterans and homosexual (and bi-sexual) individuals are often at high risk for suicide and depression and although they have distinct cultural needs, efforts have been made to increase the County's outreach and engagement for these communities. Local veterans are being engaged in MHSA planning around Prevention and Innovation to offer unique approaches to combat the impending influx of soldiers returning to the community. San Luis Obispo County has a large concentration of National Guard personnel who are not provided with the same level of mental health care made available to regular military – despite their increased participation in the theater of war. LGBTQ college students are coming to the table and working with the Department to develop social marketing strategies which address suicide prevention, substance use and abuse, and increasing wellness and resiliency.

In each of these identified communities youth are a focus for outreach and engagement. Latino youth are underserved and in need of both prevention and treatment strategies which address both the issues of ethnicity and development. County programs include

those which address families at various stages of acculturation and build skills and strengths for managing the pressures and stress of school, work and community while building knowledge around the signs and symptoms of mental illness with the goal of increasing access to services. Youth are met in schools, churches, and community centers in safe, welcoming, culturally proficient settings.

Although older adults are a focus for outreach, many grandparents and retirees in the county have taken on the responsibility of raising children and teens. These arrangements are often strained and outreach programs and support groups have been developed with community partners to build skills amongst those aging adults having to navigate the ever-changing youth culture.

Youth consumers and community members also take part in MHSA stakeholder activities and are given a strong voice in County planning. Transitional Age Youth have helped craft Innovation plans, and within the behavioral health community, many youth have participated as members of Boards and Advisory committees addressing and affecting issues ranging from adolescent substance use to suicide prevention to school-based policy.

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.

B. San Luis Obispo County's Mental Health System is strengthened by its foundation which is made up of partnerships amongst many diverse organizations, individuals, providers, families, and clients. These partnerships reflect the County's ethnic and linguistically diverse makeup. SLOBHD partners include other county agencies such as Probation and Social Services, while community partners include agencies which serve the same clients and families within our county's mental health system. These organizations, along with consumers and family members, and other local government and community-based providers, are engaged in system planning for mental health services.

The County's Mental Health Board helps the SLOBHD meet mandates as outlined in the Welfare and Institution Code 5604.2. This states that the local mental health board shall do the following: review and evaluate the community's mental health needs, services, facilities and special programs and advise the governing body (Board of Supervisors) and the local mental health director as to any aspect of the local mental health program. The Mental Health Board supports the countywide goal of a healthy community through its actions and recommendations.

The local Mental Health Board has representatives including behavioral health providers and practitioners, professionals from the County Office of Education, law enforcement agencies, local recovery and wellness organizations, and members of the local NAMI

chapter. To assure engagement with consumers and their families, the Board's bylaws require the following:

Fifty percent or more of members shall be consumers or the parent, spouse, sibling, or adult children of consumers who are receiving or have received mental health services. At least twenty percent of these members shall be direct consumers. Of the total membership 20% shall be families of consumers.

The current Board membership does not include any bilingual individuals. Ongoing recruitment efforts are focused on promoting the need for a Board which accurately reflects the ethnic, racial, and cultural diversity of the county. Efforts include the Membership Committee's role in identifying new, potential members to replace members who exit due to resignation or term-limits. The Board is currently seeking strategies which increase exposure to diverse populations and individuals who may provide new perspectives to the Board.

Another key programming opportunity for this type of partnership is evident in the MHSA community planning and stakeholder processes. Each of the County's required stakeholder meetings have included consumers, family members, and professionals representing the ethnic and linguistic diversity of the County. Because of the efforts of the County to include all voices in its MHSA planning, each approved plan (CSS, PEI, WET, and pending Innovation) has identified the cultural and linguistic needs of the community and target populations.

The Cultural Competence Committee is made up of staff, partner providers, and consumers. The Committee seeks to provide the County's mental health system with guidance and oversight to assure policies and procedures are in place to improve cultural competence. The group meets regularly and reviews agency processes, forms, and programs to provide input towards increasing the County's capacity to deliver services which reduce disparities. The Committee produces a quarterly newsletter (Appendix 4) for staff and providers which includes training information, articles on specific wellness and recovery strategies, and features which provide deeper insight into cultural needs of consumers throughout San Luis Obispo County.

The mission of the Cultural Competence Committee is to ensure that cultural diversity is incorporated into all levels of San Luis County Behavioral Health Department. Given that since the year 2000, ethnic minorities exceed 50% of the population in California, and that the state demographics include diverse racial, ethnic and cultural communities, the Cultural Competence Committee is dedicated to eliminating cultural, linguistic, racial and ethnic disparities in the populations served by the SLOBHD.

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.
--

C. The County's Workforce Education and Training (WET) component of the Three-Year Program and Expenditure Plan addresses the shortage of qualified individuals who provide services in this county's public mental health system. This includes community based organizations and individuals in solo or small group practices who provide publicly-funded mental health services to the degree they comprise this County's Public Mental Health System workforce. The Workforce Education and Training component is consistent with and supportive of the vision, values, mission, goals, objectives and proposed actions of California's MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan), and this County's current MHSA Community Services and Supports component.

San Luis Obispo County WET continues to make extensive use of community, consumer/family member, and ethnic minority stakeholders. To identify workforce education and training needs, San Luis Obispo County continues a planning process that includes several focus groups, planning meetings, and interviews with key stakeholders. This group has naturally transitioned into a training committee. The goal of the training committee was to encourage consumer and family member participation, to collaborate with community and regional stakeholders, and to identify specific projects that San Luis Obispo could address to meet the needs of the mental health workforce, with emphasis on the inclusion of consumer/family members and underserved populations.

The Training workgroup continues to consider the workforce development needs of the mental health system throughout San Luis Obispo County and to develop strategies and educational programs that meet the needs of the community and support the key concepts of the MHSA. In preparation of the Workforce Education and Training component, San Luis Obispo attended meetings held by the Southern Region Workforce Collaborative. These meetings helped identify regional trends in workforce shortages, addressed the specific needs of consumers and family members, discussed the lack of parity amongst underserved ethnic minority populations receiving mental health services, and introduced educators who would later be key stakeholders in the planning process. Workshops sponsored by California Institute of Mental Health (CiMH) also provided opportunities for collaboration.

The next step of the planning process was to survey all Behavioral Health Department staff to obtain their input on workforce needs, the direction of the workforce education and training plan, and their personal educational and career goals. A 20-question Staff Education and Training Survey was distributed to all mental health staff. Staff was grouped by level of education to address their specific needs and pathways. Staff feedback was incorporated into meetings with colleges to address workforce needs and potential educational program capacity. Additional planning meetings were held with educational stakeholders including Cuesta College and California Polytechnic State University. Workforce needs and educational institution capacity was discussed, and as a result, new career pathway programs have been added to benefit San Luis Obispo County. This required coordinating and convening several key decision makers and organizational leaders to make informed decisions without the delay of extensive

preparatory or follow up meetings that their schedules did not allow. The results of these collaborations are not only strong regional partnerships, but new certificate programs at Cuesta College.

Additional focus groups, interviews, and information sessions were held with our Community Based Organizations (CBO), such as Transitions Mental Health Services (T-MHA) and Family Care Network (FCNI), the Mental Health Board, the Behavioral Health Services Substance Abuse Program, MHSA Latino Outreach Program and local Spanish-speaking support groups. Ideas and recommendations concerning workforce development received throughout the process are incorporated or addressed in the Workforce Education and Training plan.

In the last 10 months, over 100 hours of training have been offered to Behavioral Health staff, community partners, consumers and their family members. Over 1,400 individuals have received training in the following topics: cultural competence, wellness and recovery, co-occurring, and law and ethics.

Through the Southern Counties Regional WET Partnership, SLOBHD has joined Ventura, Kern, and Santa Barbara Counties conducting intensive training in cultural competency. This program will focus on the “Shifting Cultural Lenses” (SCL) model, developed by Steve Lopez, over the next five years.

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

D. In reviewing the documents and practices identified above, the County has outlined areas of success and areas where more attention is needed to assure cultural competence is embedded in the mission and vision of each SLOBHD service. It is the County’s intention to develop further Statements of Philosophy across divisions and programs which accurately captures the SLOBHD’s commitment to cultural and linguistically competent services reflected throughout the entire system.

The Cultural Competence Committee (as outlined and described in Criterion IV) has made a strong effort in recent years to expand its membership beyond ethnic group representation. Recent and current representation includes other underserved populations such as the Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) community, older adults, educators meeting WET targets, and consumers. However, consumer representation has been the most difficult to recruit and maintain. This is partly due to needed support for consumer and family members attending the meetings, and partly due to a need for more training. The Committee is committed to expanding the role of consumers and family members in the Cultural Competence activities of the Department and community mental health system.

Other areas for expansion for the Department as well as the Cultural Competence Committee include engaging other sub-populations and cultures such as the spiritual community. Many consumers and family members find their way to services through

spiritual outreach and the SLOBHD has begun exploring more avenues for partnerships. Media contact and advocacy is another area where growth is needed, and training is underway with staff to increase the Department's public dialogue around mental health issues.

The Workforce, Education, and Training (WET) efforts of the County have included successful strategies which have already (the first year of programming is ending as this document is being prepared) demonstrated improvements and lessons learned in building a culturally competent workforce. The WET Scholarship program has engaged approximately 100 new students in the field of mental health services, including many new bilingual clinicians-in-training. The scholarships have also allowed current providers to build capacities in cultural issues by returning to, or expanding on, a higher education program.

Other successes include the use of online evaluation tools to assess training. These surveys have had far higher rates of return than paper/pencil methods of the past, and the WET Coordinator and team are now working on utilizing those tools in the development of pre and post test to further assess the skill development and retention of core competency training.

The WET 3-year training plan has been implemented and addresses some of the lessons learned including the need to expand training across the service delivery system. Areas of growth include creating cultural competence training for clerical and administrative staff to further improve the Department's service responses. Outreach is being done to build partnerships with other community organizations that offer relevant training. Electronic-learning tools are being explored to increase staff capacity around a large host of issues. Finally, the Department is an active member of the Southern Counties Regional Partnership and will benefit from training opportunities, including upcoming events with Steve Lopez.

E. Identify county technical assistance needs

E. SLOBHD would like to receive technical assistance in the form of examples of strong mission and vision statements and other statements of philosophy which capture the need for a commitment to cultural and linguistically competent services reflected throughout the entire system. Other technical assistance which would benefit the County includes training and strategies to improve recruitment of culturally diverse Board and committee members.

Staff and partner provider training needs are currently being met through the County's WET plan and Cultural Competence Committee. The Behavioral Health Department is currently developing core competency training, utilizing "e-learning" tools. Technical assistance in the form of core competency policy development, and baseline training standards for mental health professionals would provide the Department with key objectives for future cultural competence plans.

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

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

The county shall include the following in the CCPR:

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

The County's Cultural Competence/Ethnic Services Manager (CC/ESM) meets with, and has direct access to, the Behavioral (Mental) Health Director regarding issues impacting mental health issues related to the racial and ethnic populations within the county. The CC/ESM promotes and coordinates quality and equitable care as it relates to racial and ethnic populations with both county-operated and contracted mental health programs. The staff position reviews service utilization data and actively participates in local mental health planning and projects that respond to the needs of the county's racial and ethnic population.

In July 2008, Nancy Mancha-Whitcomb, LMFT, was assigned to be the Cultural Competence/Ethnic Services Manager (CC/ESM) for the SLOBHS. This assignment was made by Dr. Karen Baylor, the County Behavioral Health Director.

In her capacity as Ethnic Services Manager, Ms. Mancha-Whitcomb is required to participate in monthly teleconferences hosted by the CMHDA Ethnic Services Committee/Southern Region. She attends quarterly face-to-face meetings of the Southern Ethnic Services Committee, as well as quarterly Statewide meetings for the Ethnic Services Committee in Sacramento. Ms. Mancha-Whitcomb has attended various trainings and conferences that address cultural competency and cultural disparities which are held throughout the year including the Cultural Summit held annually. As ESM, Ms. Mancha-Whitcomb is responsible for disseminating information gained from these meetings and trainings to staff in county clinics as well as participating Community Based Organizations in the County of San Luis Obispo.

In addition, Ms. Mancha-Whitcomb is active in the Cultural Competency Committee in reviewing policy and practices. She has focused on services for the primary threshold populations receiving mental health services, which in San Luis Obispo County is primarily the Spanish speaking population. Ms. Mancha-Whitcomb is an active leader in assuring MHA practices remain culturally competent.

The Director recognizes the role and function of the CC/ESM within the organization by allocating sufficient time for the performance of job responsibilities and duties. Additionally, the Director promotes the CC/ESM's influence in policy and program change by considering and following the CC/ESM's recommendations for change in human resources, ethnic and culturally specific services and all other related areas.

B. The responsibilities of the designated CC/ESM are as follows:

- Takes lead responsibility for the development and implementation of cultural competence planning within the organization.
- Identifies local and regional cultural mental health need of ethnically and culturally diverse populations as they impact county systems of care and makes recommendations to the local Mental Health Director, CMHDA, and the State Department of Mental Health.
- Participates and advises on planning, policy, compliance, and evaluation components of the county system of care, and makes recommendations to the County Director or management team that assure access to services for ethnically and culturally diverse groups.
- Promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial and ethnic populations. This includes, but is not limited to, reviewing local proposals to augment or decrease services to the local community, participating in various mental health advisory groups/task forces, facilitating educational training to organizational units within and outside the local mental health department.
- Tracks penetration and retention rates of racially and ethnically diverse populations, and develops strategies to eliminate disparities.
- Participates in the cultivation of network to promote an array of mental health programs and activities that are specific to underserved populations.
- Maintains an active advocacy, consultative, and supportive relationship with consumer and family organizations, local planning boards, advisory groups and task forces, the State and other mental health advocates.
- Assists in the development of system-wide training that addresses enhancement of workforce development and addresses the training necessary to improve the quality of care for all communities and reduce mental health disparities.
- Attends trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system.
- Attends meetings as required by the position including, but not limited to CMHDA Ethnic Services, Full Association and other committee meetings, regional ESM regular meetings, various State meetings, meetings convened by various advisory bodies, and other meetings as appropriate.
- Responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC). The BCC Committee shall be made of Ethnic Services Manager and three bilingual staff members at least one of whom will be a native speaker of the threshold languages within the county.

The BCC will be responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-100 for each of the areas described below. The checklist will include, but not be limited to:

1. Fluency, the ability to communicate with ease, verbally and non-verbally.
2. Depth of vocabulary including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.
3. Grammar, appropriate use of tense and grammar.
4. Cultural considerations related to the potential client.

The certification process will be conducted by two bilingual committee members, one of whom will be the committee's identified native speaker. The certification interview will follow a standard initial assessment format. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate will be given an opportunity to make any remarks she or he may wish for clarification.

The SLOBHD Cultural Competence /Ethnic Service Manager Areas of Responsibility for FY 2010-2011, a written description of the cultural competence responsibilities of the designated CC/ESM, is provided in Appendix 5.

IV. Identify budget resources targeted for culturally competent activities

The county shall include the following in the CCPR:

- A. Evidence of a budget dedicated to cultural competence activities.
- B. A discussion of funding allocations included in the identified budget above in Section A., also including, but not limited to, the following:
 1. Interpreter and translation services;
 2. Reduction of racial, ethnic, cultural, and linguistic mental health disparities;
 3. Outreach to racial and ethnic county-identified target populations;
 4. Culturally appropriate mental health services; and
 5. If applicable, financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers.

The County is committed to providing necessary fiscal resources in order to support cultural competence activities:

A. Below are cultural competent activities included in the FY 2010-11 Adopted Budget for SLOBHD:

- The SLOBHD has appropriated \$569,731 for Mental Health Services Act (MHSA) Latino Outreach and Therapy Services (Community Services and Supports program) and Latino Outreach and Engagement Services (Prevention and Early Intervention program). Both programs include 3.60 FTE permanent positions.
- The SLOBHD has appropriated \$25,781 for Cultural Competence Training in the MHSA Workforce Education and Training (WET) program.
- The SLOBHD has appropriated \$90,205 for the Clinical Bilingual Internship action in the MHSA WET program for bilingual Interns to work in three separate clinics.
- The SLOBHD has appropriated \$5,686 for phone interpreter services provided by Language Line for use by all clinics.
- The SLOBHD has appropriated \$17,196 for bilingual differential pay for the Mental Health Core Budget (\$8,076) and Mental Health Services Act Budget (\$9,120). Of the \$9,120 for MHSA bilingual pay, \$3,600 is reported above for the Latino Outreach and Therapy Services program, \$1,200 is included above for the Latino Outreach and Engagement Services program, and \$1,680 is included above for the Clinical Bilingual Internship action.

The total budget for cultural competence activities is \$702,119.

B. The majority of cultural competence activities in the FY 2010-11 Adopted Budget for SLOBHD are funded by MHSA allocations. Below is the detail by program:

- The Latino Outreach and Therapy Services program is funded by the MHSA Community Services and Supports allocation (\$448,463) and Medi-Cal (\$10,046) and EPSDT (\$2,973) revenue.
- The Latino Outreach and Engagement Services program is funded by the MHSA Prevention and Early Intervention allocation (\$108,249).
- The Cultural Competence Training is funded by the MHSA WET allocation (\$25,781).
- The Clinical Bilingual Internship action is funded by the MHSA WET allocation (\$90,205).

The interpreter services provided by Language Line are funded by County General Fund Support and Realignment (\$5,686).

The bilingual differential pay for County staff assigned to Mental Health core is funded by County General Fund and Realignment (\$8,076). The MHSA bilingual pay (\$9,120) is funded by Community Services and Supports allocation (\$5,520 of which \$3,600 is included above in the Latino Outreach and Therapy Services program), MHSA Prevention and Early Intervention allocation (\$1,920 of which \$1,200 is reported above in the Latino Outreach and Engagement Services program) and Workforce Education and Training allocation (\$1,680 and this amount is included above in the WET Internship Program).

Total funding required for cultural competence activities is \$702,119. Note: this does not include the WET regional allocation (to be determined) for cultural competency training.

CRITERION 2

COUNTY MENTAL HEALTH SYSTEM

UPDATED ASSESSMENT OF SERVICE NEEDS

I. General Population

The county shall include the following in the CCPR:

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

A. **Table 1** displays the most recent published Census data (*2006-2008 American Community Survey*) for San Luis Obispo County. According to the 2006-2008 census updates there are 262,238 residents, 102,696 households, and 63,238 families in the county. The racial makeup of the county is 85.5% White, 1.9% Black or African American, .9% Native American, 3.1% Asian, 0.1% Pacific Islander, 5.4% from other races, and 3.1% from two or more races. 18.8% of the population is Latino of any race. 17.5% are of German descent, 13.4% English, 12.4% Irish, 3.4% American and 5.7% Italian ancestry. 83.6% spoke English only and 12.8% speak Spanish.

Of the 102,696 households, 25.8% had children under the age of 18 living with them, 48.4% were married couples living together, 8.5% had a female householder with no husband present, and 38.4% were non-families. 26.4% of all households were made up of householders living alone and 9.8% had someone living alone who was 65 years of age or older. The average household size was 2.39 and the average family size was 2.90.

The population spread is 18.9% under the age of 18, 24.3% from 10 to 24, 35.1% from 25 to 44, 26.4% from 45 to 64, and 14.3% are 65 years of age or older. The median age is 37.6 years.

For every 100 females there are 107 males.

Migrant seasonal farm workers and non-farm workers. make up a large subpopulation often not included in the census data. As of the most recent enumeration study (Larson, 2000) San Luis Obispo County has 9,272 migrant seasonal farm workers, and 16,500 migrant seasonal farm workers and non-farm workers.

Table 1 - San Luis Obispo County Demographics	Number	Percent
Total population	262,238	
Male	135,551	51.7
Female	126,687	48.3
Median age (years)	37.6	(X)
Under 5 years	13,178	5.0
18 years and over	212,740	81.1
65 years and over	37,388	14.3
One race	253,979	96.9
White	224,177	85.5
Black or African American	4,952	1.9
American Indian and Alaska Native	2,435	0.9
Asian	8,243	3.1
Native Hawaiian and Other Pacific Islander	142	0.1
Some other race	14,030	5.4
Two or more races	8,259	3.1
Latino (of any race)	49,172	18.8

Source: U.S. Census Bureau, 2006-2008 American Community Survey

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

The county shall include the following in the CCPR:

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

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

Using current CAEQRO data, the following section demonstrates the County's Medi-Cal population service needs and disparities within. The following response will examine Medi-Cal population service needs in terms of race/ethnicity, age group, and gender.

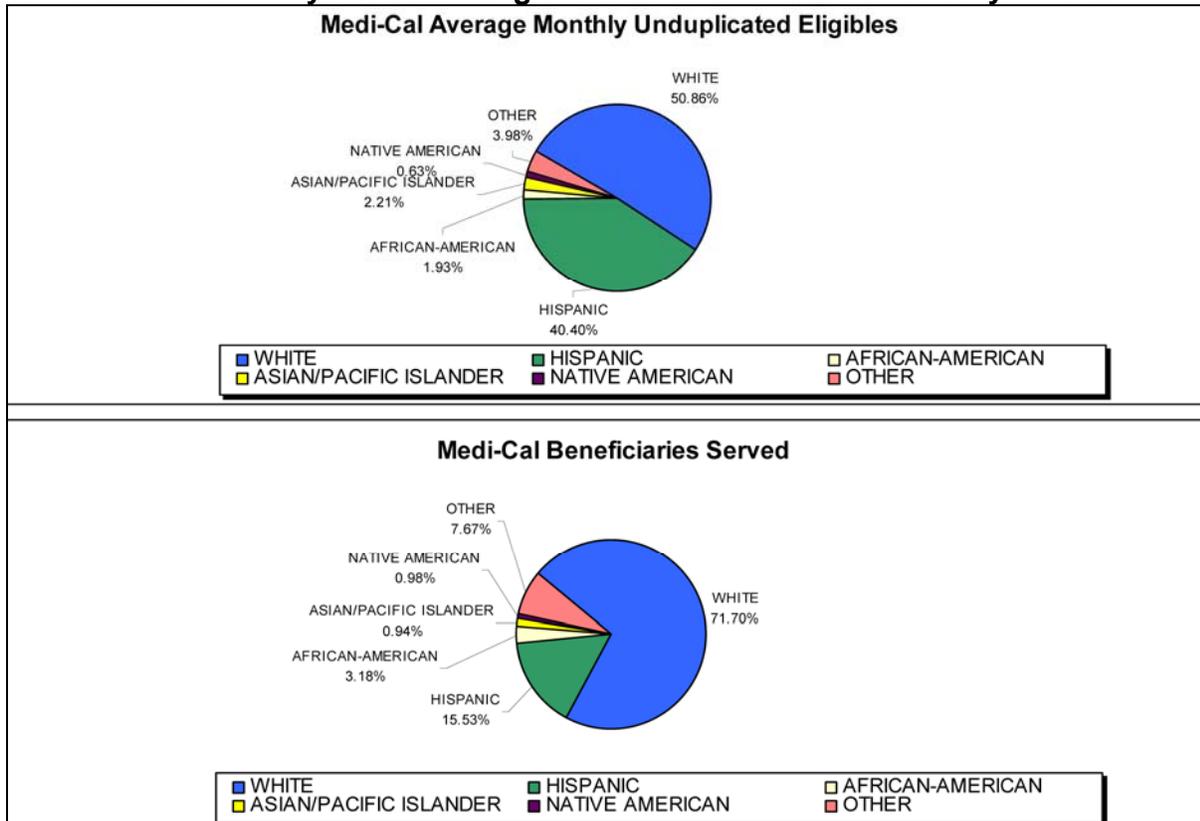
A. **Table 2** is taken from the 2009-2010 CAEQRO report for San Luis Obispo County and identifies the proportion of White (51%), Latino (40%), Asian/Pacific Islander (2%), African American (2%), Native American (<1%) and other (4%) races which make up the County's Medi-Cal population.

Table 3 displays data provided by CAEQRO (APS Healthcare) which gives a snapshot of utilization and penetration rates for race/ethnicity as well as age and gender. Adults,

ages 18-59 make up the largest eligible group, averaging 14,000 unduplicated eligibles per month. Youth, age 6-17 make up a quarter of the eligibility in the county. The table also demonstrates females as making up more than 55% of the eligibility on a given month.

Disparities and analysis will be described in the next section.

Table 2 - SLO County Medi-Cal Eligibles vs. Beneficiaries Served by Race/Ethnicity



Source – San Luis Obispo County MHP CAEQRO Report FY 09-10

B. As **Table 2** clearly demonstrates white persons are the largest group of eligibles and beneficiaries. White people make up 51% of the eligible population, and receive 72% of services. This creates a disparity for other races which make up an inequity between eligibility and service. The largest inequity is amongst Latino persons who make up 40% of the eligible and receive only 16% of services. Another disparity exists for Asian/Pacific Islanders who make up over 2% of the eligible population, yet receive less than 1% of services. In contrast, African Americans make up nearly 2% of the eligible population while receiving just over 3% of the County’s services. Less than half of the eligible Latino and Asian/Pacific Islander Medi-Cal eligible populations are served. **Table 3** demonstrates these disparities in the low penetration rates for the same ethnic categories.

Both evident disparities have a common denominator which is language. While the Latino population faces a larger disparity, it is also important to note the inequity which

exists for Asian clients who make up the County's second largest non-white ethnicity. In both cases language and the lack of linguistic and culturally competent providers may be barriers for service. As outlined in other sections of this report, the County has made efforts and continues to make strides towards building a culturally and linguistically competent workforce. The most critical factor is to have the ability to serve clients in their native language and establish solid trust and communication. It is apparent that the lack of bilingual staff that can provide services in a variety of Asian languages is also a barrier.

Table 3 - SLO County Medi-Cal Eligibles vs. Beneficiaries Served by Race/Ethnicity

Source – San Luis Obispo County MHP CAEQRO Report FY 09-10

Medi-Cal Approved Claims Data for San Luis Obispo County MHP Calendar Year 2009			
	Average Number of Eligibles per Month (4)	Number of Beneficiaries Served per Year	Penetration Rate
TOTAL			
	33,089	2,777	8.39%
0-5	6,346	138	2.17%
6-17	8,500	934	10.99%
18-59	14,074	1,561	11.09%
60+	4,171	144	3.45%
Female	18,728	1,467	7.83%
Male	14,362	1,310	9.12%
White	16,834	2,013	11.96%
Latino	13,287	428	3.22%
African-American	602	82	13.62%
Asian/Pacific Islander	691	28	4.05%
Native American	183	28	15.30%
Other	1,494	198	13.25%

The County continues to examine the disparity with Latinos and has identified issues of poverty, geographic barriers, transportation, and cultural beliefs as being major factors in determining access for Latino clients. The county (as noted in Criterion 2, Section I) has a large subpopulation of migrant farm workers, and has increased efforts in recent years to provide outreach and education within the communities which support families "living in two cultures." This same examination may be important to assess the disparity with Asian/Pacific Islanders, although many of the same barriers will exist. The county's tourism, agriculture, and seasonal economies support opportunities for monolingual Asian immigrants representing many languages not spoken by providers in the mental

health system. Also, the local colleges and University have increased Asian populations in the past ten years, which has contributed to the overall subpopulation growth. Cal Poly places in the top 10 schools in the nation in granting degrees to Latino, Asian and other minority students in agriculture, architecture and engineering (Cal Poly, 2009). While language may not be a factor in all issues of disparity with Latino and Asian eligibles, it can be assumed that cultural beliefs, stigma, and lack of outreach serve as barriers to access.

Table 3 also demonstrates a disparity amongst the county's youngest (0-5) and oldest (60+) eligibles. Both age categories have a penetration rate below 5%. This disparity is being addressed in various County programs which have identified issues such as outreach for older, withdrawn adults as being a strategy to combat this barrier to service. Children under 5 often do not seek services as mental health issues often go unnoticed or diagnosed until children are placed in social contexts, such as school.

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

The county shall include the following in the CCPR:

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

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

The following data tables should be viewed in the context of the 2000 Census report: San Luis Obispo County's population was 76% White, 16% Latino, 3% Asian, 2% Black and 1% American Indian. All data reported below are based on projections of 2004 census statistics and Mental Health Utilization statistics from fiscal year 2008 - 2009. Prevalence rate and poverty population statistics are based on the statistics provided by the Department of Mental Health. Poverty data refer to Department of Mental Health statistics associated with persons with incomes less than 200% of poverty level.

A. The following tables provide a 200% of poverty calculation and summary of client utilization (minus Medi-Cal population). The Medi-Cal client estimate is based on current-year percentage of Medi-Cal vs. non-Medi-Cal services for the County (.497 rounded to 50% of total clients served). Poverty Prevalence Rates have been adjusted to reflect State and county-specific reports (2007) of Collaborative Psychiatric Epidemiology Surveys (CPES, Appendix 6).

The tables provide population estimates based on the most recent updated Census projection (2004), broken down by gender and ethnicity as projected by the CPES. The next column details the poverty population (persons with incomes less than 200% of poverty level) provided by the Department of Mental Health (CPES). The estimated

Medi-Cal recipients in each category are then subtracted from the poverty population to arrive at the poverty population minus the Medi-Cal population. This figure is then multiplied to the estimated prevalence rate (CPES) to determine the estimated SMI or SED poverty population.

Ages are grouped as Children and Youth (0-17) and Adults (18+). To understand the calculations, **Table 4** demonstrates the following:

- 17,002 children/youth below 200% of poverty, **minus 1,072 Children and Youth Medi-Cal beneficiaries** = 15,930 children and youth as a priority population to address;
- Multiply this figure of 15,930 by the 8.75% average prevalence rate = **1,393** Children and youth with SMI or SED **under 200% of poverty** (without Medi-Cal)

Table 4 - Children and Youth Poverty Population Estimates

	Population	Population <200% Poverty	Medi-Cal Clients	Unserviced Poverty Pop.	<200% Poverty Prevalence	Estimated SMI/SED Poverty Pop.
Female						
African American	270	109	15	94	8.99%	8
Asian/Pacific Islander	570	125	5	120	8.63%	10
Latino	7,070	4,511	79	4432	8.69%	385
Native American	186	32	5	27	8.51%	2
White	15,932	3,162	373	2789	8.82%	246
Other	855	222	37	185	8.88%	16
Total Youth Female	24,883	8,161	514	7647	8.75%	669
Male						
African American	342	118	16	102	8.99%	9
Asian/Pacific Islander	596	136	6	130	8.63%	11
Latino	7,479	4887	86	4801	8.69%	417
Native American	205	34	6	28	8.51%	2
White	17,208	3426	404	3022	8.82%	267
Other	911	240	40	200	8.88%	18
Total Youth Male	26,741	8,841	558	8283	8.75%	724
Total Youth	51,624	17,002	1072	15930	8.75%	1393

B. The following analyses summarize the apparent disparities in the data presented in **Tables 4** through **7**.

Children and Youth

Table 4 shows the relative totals of unserved < 200% Poverty youth, with males and females displayed comparatively. Males make up 52% of children and youth.

The Children and Youth table demonstrates that while White males and females make up 64% of the Children and Youth population, they only represent 38.75% of the poverty population. By contrast, Latino youth make up 28% of the county population, while representing 55% of the poverty population. This creates a serious potential gap in service which can be seen in **Table 6**.

Both male and female Latinos in the poverty population face a disparity in service when compared with the general population, and those served by Medi-Cal. Although Latino youth make up the second largest beneficiary group at 15%, **Table 6** estimates 42% of that poverty group would be unserved. By contrast white youth in the poverty population stand to be overserved by 35% based on utilization rates.

African-American children and youth yield a small but evident disparity by making up 1.18% of the youth population, and 1.33% of the poverty population. However, the group is slightly overserved by 1.68%. In contrast, Asian/Pacific Islander youth who make up 2.25% of the children and youth population and only 1.5% of the poverty population are estimated to be underserved.

Table 5 - Adult Poverty Population Estimates

	Population	Population <200% Poverty	Medi-Cal Clients	Unserved Poverty Pop.	<200% Poverty Prevalence	Estimated SMI/SED Poverty Pop.
Female						
African American	2126	472	24	448	7.55%	34
Asian/Pacific Islander	3266	1167	8	1159	3.54%	41
Latino	16,271	6,888	126	6762	6.83%	462
Native American	684	188	8	180	9.42%	17
White	76,680	18,255	593	17662	8.68%	1533
Other	1719	656	58	598	9.50%	57
Total Adult Female	100,746	27,626	817	26809	7.59%	2144
Male						
African American	2304	511	26	485	7.55%	37
Asian/Pacific Islander	3539	1265	9	1256	3.54%	44
Latino	17,627	7,463	137	7326	6.83%	500
Native American	742	203	9	194	9.42%	18
White	83,069	19,776	643	19133	8.68%	1661
Other	1862	710	63	647	9.50%	61
Total Adult Male	109,143	29,928	887	29041	7.59%	2322
Total Adult	209,889	57,554	1704	55850	7.59%	4465

Adults

Table 5 shows the relative totals of unserved < 200% Poverty adults, age 18+, with males and females displayed comparatively. Males make up 52% of adults.

The Adult Poverty Population table demonstrates that while White males and females make up 76% of the Adult population, they only represent 66% of the poverty population. By contrast, Latino adults make up 16% of the county population, while representing 25% of the poverty population. This creates a serious potential gap in service which can be seen in **Table 7**.

Table 6 - Children and Youth Unserved Poverty Population Estimates

	% of Medi-Cal Beneficiaries	<200% Poverty Pop. %	Estimated Disparity
Female			
African American	2.95%	1.26%	-1.69%
Asian/Pacific Islander	1.00%	1.55%	0.55%
Latino	15.40%	57.60%	42.20%
Native American	1.00%	0.34%	-0.66%
White	72.50%	36.79%	-35.71%
Other	7.13%	2.46%	-4.67%
Male			
African American	2.95%	1.27%	-1.68%
Asian/Pacific Islander	1.00%	1.55%	0.55%
Latino	15.40%	57.60%	42.20%
Native American	1.00%	0.33%	-0.67%
White	72.50%	36.80%	-35.70%
Other	7.13%	2.45%	-4.68%

Both male and female Latinos in the poverty population face a disparity in service when compared with the general population, and those served by Medi-Cal. Although Latino

adults make up the second largest beneficiary group at 15%, **Table 7** estimates 6% of that poverty group would be unserved. Impoverished adult Asian/Pacific Islanders also stand to be underserved, based on these estimates. By contrast all other ethnicity groups show service matches or potential overservice.

Differences amongst the gender groups show few, if any, disparities, when summarizing the poverty level.

Table 7 - Adult Unserved Poverty Population Estimates

	% of Medi-Cal Beneficiaries	<200% Poverty Pop. %	Estimated Disparity
Female			
African American	2.95%	1.58%	-1.37%
Asian/Pacific Islander	1.00%	1.91%	0.91%
Latino	15.40%	21.55%	6.15%
Native American	1.00%	0.79%	-0.21%
White	72.50%	71.52%	-0.98%
Other	7.13%	2.65%	-4.48%
Male			
African American	2.95%	1.58%	-1.37%
Asian/Pacific Islander	1.00%	1.91%	0.91%
Latino	15.40%	21.55%	6.15%
Native American	1.00%	0.79%	-0.21%
White	72.50%	71.52%	-0.98%
Other	7.13%	2.65%	-4.48%

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

The county shall include the following in the CCPR:

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

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

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

Data provided in this section is taken from the County’s **Community Services and Supports (CSS)** population assessment and service needs. The original Plan was submitted to the State in 2005, and revised in 2006.

A. The following data tables, taken from the County's approved CSS Plan, should be viewed in the context of the 2000 Census report and the 2004 Census projection: San Luis Obispo County's population was 76% White, 16% Latino, 3% Asian, 2% Black and 1% American Indian. Population estimates for Transitional Age Youth (TAY) and Older Adults were calculated based on Plan requirements and may indicate some duplication. Because the projected populations are based on age groupings, and the analysis remains statistically consistent; no updates to the poverty estimates have been made to these data tables or the disparity analysis which follows.

Table 8 - CSS Children and Youth Population Assessment

CHILDREN AND YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	9	28	636	797	1,470	32%	17,111	25%	51,624	20%
African American	2	2	24	20	48	3%	299	2%	612	1%
Asian Pacific Islander	0	0	7	3	10	1%	254	1%	1,166	2%
Latino	1	2	123	142	268	18%	8,060	47%	14,549	28%
Native American	0	0	5	4	9	1%	226	1%	391	1%
White	5	24	449	611	1,089	74%	7,849	46%	33,140	64%
Other	1	0	28	17	46	3%	423	2%	1,766	3%

Table 9 - CSS Transition Age Youth Population Assessment

TRANSITION AGE YOUTH	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	4	17	406	366	793	17%	21,116	30%	44,200	17%
African American	0	1	8	13	22	3%	368	2%	949	2%
Asian Pacific Islander	0	0	4	4	8	1%	312	1%	2,430	6%
Latino	1	2	63	49	115	15%	9,949	47%	5,153	12%
Native American	0	0	3	3	6	1%	279	1%	378	1%
White	3	13	312	292	620	78%	9,687	46%	34,274	78%
Other	0	1	16	5	22	3%	522	2%	1,016	2%

Table 10 - CSS Adult Population Assessment

ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	45	74	1,565	1,182	2,866	63%	43,409	62%	157,215	60%
African American	3	6	37	42	88	3%	451	1%	4,149	3%
Asian Pacific Islander	0	0	17	13	30	1%	1,617	4%	6,014	4%
Latino	1	7	152	112	272	9%	10,100	23%	29,306	19%
Native American	3	0	19	11	33	1%	448	1%	1,357	1%
White	38	60	1,308	984	2,390	83%	29,744	69%	113,832	72%
Other	0	1	32	20	53	2%	1,049	2%	2,557	2%

Table 11 - CSS Older Adult Population Assessment

OLDER ADULT	Fully Served		Underserved/ Inappropriately Served		Total Served		County Poverty Population		County Population	
	Male	Female	Male	Female	Number	%	Number	%	Number	%
TOTAL	4	8	123	79	214	5%	9,129	13%	51,195	20%
African American	0	0	0	0	0	0%	71	1%	557	1%
Asian Pacific Islander	0	0	1	1	2	1%	206	2%	1,019	2%
Latino	0	0	6	9	15	7%	1,270	14%	2,862	6%
Native American	0	0	2	0	2	1%	63	1%	297	1%
White	4	8	113	67	192	90%	7,382	81%	45,943	90%
Other	0	0	1	2	3	1%	137	2%	517	1%

B. In analyzing disparities among Mental Health recipients the selected populations were compared across ethnic and age groups: total County Population; the County Poverty Level population; and total number of clients served by the county mental health system for the fiscal year 2004-2005.

Table 8 illustrates the distribution of services to youth by gender and ethnicity. These statistics mirror the findings in the previous discussion of unserved populations. Latino youth are the most underserved group among the youth population. Service levels indicate that Latino youth received 18% of all youth services while they represent 47% of the County poverty population and 28% of the overall County population. Asian/Pacific Islander children and youth also maintain a disparity, albeit on a smaller scale. However, in this age group, as in the sections to follow, this population is underserved by a greater margin than any other ethnic group. For instance Asian/Pacific Islander youth are 1% served versus being 2% of population. Their

disparity is 100%. Latinos, who make up a much larger number of clients and eligibles, are served at 18%, while they represent 28% of the population. This is a 64% disparity.

Table 9 again reflects similar trends to those identified in the discussion of unserved populations. Here transition age youth (TAY) represent only 17% of the mental health services delivered while representing 30% of the county poverty population and 17% of the overall county population. The higher numbers of TAY in the county poverty population suggest higher risk factors for this group that would support an increased effort in servicing this age group. Within this age group, the Latino ethnic group stands out as the least well served. In 2004, Latinos represented only 15% of the total TAY served by SLOBHD while representing 47% of the county poverty population. Here, Asian/Pacific Islanders make up 6% of the sub-population, yet only 1% are served. This disparity is 600%

Table 10 shows a relative balance in the overall numbers of adults served with approximately 60% reflected in numbers receiving services, county poverty population and county total population. Among those served, however, there continues the lack of penetration in the Latino population. Latinos received 9% of Mental Health services while they represented 23% of the county poverty population and 19% of the overall county population. Here the Asian/Pacific Islander disparity is 400%

Table 11 shows the total number of older adults served was 5%. This contrasts with older adults representing 13% of county poverty population and 20% of the total county population. Because of the small numbers of individuals served as well as the relatively small numbers represented in the county poverty population, racial/ethnic comparisons within the older adult population are difficult to project. However, the Latino population continues to represent an ethnic group that is underserved. In the older adult population they received 7% of services while they represent 14% of the county poverty population. This suggests that the older adult Latino poor are significantly underserved in the county.

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

The county shall include the following in the CCPR:

- A. Which PEI priority population(s) did the county identify in their PEI plan? The county could choose from the following six PEI priority populations:
 - 1. Underserved cultural populations
 - 2. Individuals experiencing onset of serious psychiatric illness
 - 3. Children/youth in stressed families
 - 4. Trauma-exposed
 - 5. Children/youth at risk of school failure
 - 6. Children/youth at risk or experiencing juvenile justice involvement

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

A. The County chose to address all six of the PEI priority populations in its plan. Priority populations were not ranked, and the PEI plan serves all six groups.

B. Stakeholders in the PEI Planning Process were charged with review and analysis of the community's needs and desires, as expressed through data collection, focus groups, work groups, and surveys. The stakeholders reviewed over a thousand surveys which gathered public opinion as well as professional experience around mental health issues. The surveys also collected public (including consumer) and professional viewpoints regarding those populations at greatest need. The stakeholders then determined the key community needs for response and narrowed priority services to the targeted populations.

In order to gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. Each group then addressed the specific nature and needs of the PEI priority populations within each age cohort. Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, target groups and strategies that are most realistic, feasible and best use of PEI funds. Their recommendations were brought to the full PEI Community Planning Team in order to develop the projects included in the final PEI plan.

CRITERION 3

COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

- 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).

In recent years, mainly due to the MHSA Planning Processes, the County has collected data and stakeholder input in order to identify unserved and underserved target populations. This process has also yielded information regarding disparities which adversely affect their ability to access services, and strategies which improve access for those populations.

A. The following responses identify the target populations, with disparities, within each of the above selected populations (Medi-Cal, CSS, WET, and PEI priority populations).

Medi-Cal population:

- As per the SLOBHD's description of "Medical Necessity" (Appendix 7), the County observes California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services. Medi-Cal beneficiaries must meet criteria outlined below to be eligible for services:
 1. Be diagnosed by SLOBHD with a criteria diagnosis in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association
 2. Must have at least one of the criteria impairments as a result of the mental disorder(s) listed in subdivision (1) above.
 3. Must meet each of the intervention criteria listed within the listed Code.
 4. Minor beneficiaries are eligible when criteria listed in Section 18310.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental

Health Services for Eligible Beneficiaries Under 21 Years of Age (Appendix 7) are met.

- There is a barrier for those who do not meet required eligibility to access primary Medi-Cal services from the County Mental health Services.

Community Services Support (CSS) Full Service Partnership population:

- As per the SLOBHD's Full Service Partnership (FSP) Program Description (Appendix 30), the County provides four Full Service Partnerships (FSP) utilizing "whatever it takes", wraparound-like, intensive, community based mental health services and supports to a focal population of individuals with mental illness. The program is founded on a strength-based, solution-focused, culturally-competent, client/family- model to help individuals accomplish wellness, recovery, and resiliency in their lives and remain in their community. Target populations include:

1. Children and Youth, 0-17 years old, with one or more of the following characteristics:

- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Foster Youth with multiple placements
- Risk of out-of-home placement
- In juvenile justice system

2. Transitional Age Youth (TAY), 16-21 years old, that have one or more of the following characteristics:

- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Co-Occurring substance abuse issues.
- Foster Youth with multiple placements, or aging out/have aged out.
- Recently diagnosed with a mental illness

3. Adults, 18-59 years old, that have one or more of the following characteristics:

- At risk for involuntary institutionalization
- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Co-Occurring substance abuse issues.
- Homeless or at risk of becoming homeless

4. Older Adults, ages 60+, that have one or more of the following characteristics:

- "High Utilizers" of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Homebound – unserved

- Homeless or at risk of becoming homeless
- Co-Occurring substance abuse issues.
- Presenting with mental issues at their primary care provider's office

Workforce, Education, and Training (WET) priority populations:

- The County chose to address the following priority populations in its plan, based on its targets to grow a multicultural workforce:
 1. Behavioral Health clinicians and support staff
 2. Community Based Organizations serving mental health clients
 3. Bilingual and culturally diverse clinicians
 4. Clinicians specializing in co-occurring disorders
 5. Undergraduate and Graduate students seeking a career in Behavioral Health
 6. Mental Health consumers seeking education and/or a career in the field of Behavioral Health
 7. Criminal justice personnel who intervene with the mental health population.
 8. Consumers, family members, reentry and current students interested in working in the mental health field.

Prevention and Early Intervention (PEI) priority populations:

- The County chose to address all six of the PEI priority populations in its plan:
 1. Trauma Exposed Individuals
 2. Individuals Experiencing Onset of Serious Psychiatric Illness
 3. Children and Youth in Stressed Families
 4. Children and Youth at Risk for School Failure
 5. Children and Youth at Risk of or Experiencing Juvenile Justice Involvement
 6. Underserved Cultural Populations

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).

Stakeholders in the PEI Planning Process were charged with review and analysis of the priority populations and community's desires, as expressed through data collection, focus groups, work groups, and surveys. The stakeholders then determined the key community needs to respond, and narrowed priority populations to targeted groups. From there, the stakeholders reviewed the strategies that were appropriate for the needs and populations as well as matched community recommendations (592 viable PEI strategies were submitted). They then began combining ideas that would ultimately lead to final programs and projects.

The Planning Team formulated criteria it would use to prioritize options, (such as the balance between prevention and early intervention programming, serve a few groups more in depth rather than many groups but “lightly”), and adopted guiding practices that would be universal to the all the PEI projects. These included cooperative and coordinated services, easy access, utilize existing strategies before starting something new, maximize existing natural relationships, serve whole family units rather than just the “problem” individual,” and vary services to be culturally aware and appropriate (these were themes from the community at large).

In order to gain from the wisdom and diversity of more stakeholders, three age-specific Workgroups were created: Children/Youth; TAY/Adult; and Older Adult. Each group then addressed the specific nature and needs of the PEI priority populations within each age cohort. Each Workgroup utilized the broad community input data, conducted research, and applied their own expertise and experience to determine specific needs, target groups and strategies that are most realistic, feasible and best use of PEI funds. Their recommendations were brought to the full PEI Community Planning Team in order to develop the projects included in the final PEI plan.

II. Identified disparities (within the target populations)

The county shall include the following in the CCPR:

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

A. The most dominant disparity in San Luis Obispo County, which cuts across all of the Medi-Cal, CSS, WET, and PEI’s priority/targeted populations, is the under representation of Latino individuals. This imbalance in service access is made even more dramatic considering the relatively high proportions of Latinos in the poverty population with the health and access problems associated with poverty status. Latinos are 18.8% of the total county population of 262,238 but they represent a total of 28% of the poverty population. To further compound ethnic and cultural barriers, a high percentage of the prevalent unrepresentative Latino population in our county reside in the rural areas (communities with populations less than 3000 and/or located 15-30 miles from services), thus exacerbating access, transportation and information distribution difficulties associated with serving minority groups.

Medi-Cal and CSS Populations

Within the overarching Latino service imbalance, the disparity between the percentage of Latino Youth and Transition Age Youth receiving services is underrepresented, compared to their numbers in the poverty population. A very telling disproportionate service pattern exists, with approximately 18% of services going to Latinos while that same group represents 47% of the Youth and Transition Age Youth poverty population age groups. In a similar fashion, when reviewing the unserved population, Latino Youth

and Transition Age Youth represent the highest combined percentages of unserved among the youth and transition age groups.

Among adults, Latinos again represent a relatively low percentage of those served (9%) compared to their percentage of both in the poverty level population (23%) and in the total County population (18%). Among the Older Adult Latino age group, the total service number is similarly depressed as compared with the Caucasian group served. It is estimated that because of the acculturation process, older Latinos will find even more cultural and linguistic barriers than their younger adult counterparts and therefore represent a greater access disparity based on this potential imbalance in culture and linguistic barriers.

Among the Adult Latino group there is also significant disparity between services received by males versus females, with females receiving approximately 33% more services than males.

In 2004, SLOBHD conducted a study to assess the characteristics which influence the local Latino population's underutilization of Mental Health Services. The survey was administered to 200 Spanish speaking low income Latinos who resided in the County. All 200 surveys were completed by those who were Spanish literate and illiterate. The results showed that the following variables affect utilization of mental health services:

- Latinos did not feel comfortable accessing services in a government building. They perceive the government as an authoritarian entity and were intimidated by it;
- Some of the Latinos who had attempted to receive services from the County Behavioral Health Department reported that the experience was confusing and involved telling personal information to various persons prior to being assigned a therapist. Some reported that after sharing personal information they were told that their problem was not serious enough to qualify for services;
- Latinos reported difficulty trusting someone who was not from their own culture and were concerned they would not be understood because of the differences in life experiences; and
- Latinos preferred someone who spoke Spanish rather than having an interpreter. They found the interpreter to interfere with the flow of information.

On a much smaller scale, Asian/Pacific Islanders maintain a service disparity across age and gender groups. It is most pronounced with Transition Age Youth. More examination and study of this inequity is needed to determine strategies to better address reducing this disparity.

Workforce, Education, and Training

- **Behavioral Health clinicians and support staff:** There is a need for additional bilingual/bicultural staff in all classifications, especially in the threshold language

of Spanish, which is difficult to recruit based on community capacity, cost of living, and factors including limited local schooling for professionals. Psychiatrists and Registered Nurses that work at the Psychiatric Health Facility (PHF), as an example, are very hard to recruit. The County faces competition for salary equity from institutions such as the Atascadero State (Psychiatric) Hospital and the California Men's Colony, a State prison; both of which pay much higher wages for qualified staff.

- **Community Based Organizations serving mental health clients:** The County's WET Plan addresses the need for the development of Community Based Organizations (CBOs) who serve mental health clients. The county has tremendous CBOs providing support, education, wellness and recovery services, yet there is still a disparity for those organizations that do not have the capacity or cultural competence to appropriately serve those clients who, for one reason or another, need services outside of what County Mental Health can provide.
- **Bilingual and culturally diverse clinicians:** Those staff and clinicians who are bilingual and culturally diverse are often placed in demanding positions to handle larger clinical case loads while also serving as outreach workers. This places an increased demand on keeping these positions filled.
- **Clinicians specializing in co-occurring disorders:** It is a County priority to have appropriately trained and skilled therapists and clinicians who serve clients presenting both mental illness diagnoses and addiction issues. Like many other California counties have attempted to do in recent years, SLOBHD has sought to integrate mental health and alcohol and drug services. Disparities which reduce these clinicians' ability to serve include the challenge of having to navigate difficult confidentiality issues, medicinal ethics, and a lack of professional education and development.
- **Undergraduate and Graduate students seeking a career in Behavioral Health:** Local colleges, including Cal Poly (California Polytechnic State University, San Luis Obispo) offer limited psychology and counseling programs. College admissions for native Spanish-speakers in California are traditionally low (Atkinson, 2003). Locally, there is a small pool of graduate students looking for work; however the pay for license-track trainees is minimal at best.
- **Mental Health consumers seeking education and/or a career in the field of Behavioral Health:** Consumers seeking education which would prepare them for work in the mental health field are faced with several barriers in San Luis Obispo County. These include the cost of University education, impacted schools which only take highly competitive academic applicants and recruitment efforts which rarely target those with mental illness. Of course, the weakened job market in California has also impacted the availability of career positions, making those recruitment even more competitive. Mental health consumers face the stigma of professionals, among others, working alongside peer counselors.
- **Criminal justice personnel who intervene with the mental health population:** The target population of criminal justice personnel who intervene with the mental health population includes those first-responders who have intensive interactions with the mentally ill and their families. Training in mental health issues and

cultural competency is often limited by resources and scheduling pressures for other training which may have more salient impact for communities.

- **Consumers, family members, reentry and current students interested in working in the mental health field:** There is a significant shortfall in the mental health workforce in regard to the employment of consumer and family staff throughout the system. The demand for bilingual service providers is so high that the County must turn to programs which develop consumer and family workforce opportunities. Some of the County's community-based partners have recovery programs which employ consumers, but similar models have not been developed in County programming. There is a need to employ consumer staff in regular benefited positions versus relying on practices including volunteers, stipends, and personal service contracts.

Prevention and Early Intervention:

- **Trauma Exposed Individuals:** Disparities include reduced access by those who may avoid seeking services for the psycho-social effects of the traumas they have experienced.
- **Individuals Experiencing Onset of Serious Psychiatric Illness:** Disparities include reduced access by those unlikely to seek services from traditional mental health services due to stigma, or lack of understanding of their illness.
- **Children and Youth in Stressed Families:** Disparities include lack of services and reduced access due to stigma, and inability to engage parents and caregivers in providing access.
- **Children and Youth at Risk for School Failure:** Disparities include lack of services and reduced access due to stigma, and inability to engage school systems in increasing access to services.
- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement:** Disparities include lack of services and reduced access due to stigma, and fear of further juvenile system involvement.
- **Underserved Cultural Populations:** Disparities include lack of services and reduced access due to stigma, language barriers, lack of culturally-sensitive locations and hours, and limited understanding of other systems which may support access (i.e. schools which cannot communicate with monolingual parents).

III. Identified strategies/objectives/actions/timelines

The county shall include the following in the CCPR:

- A. List the strategies identified in CSS, WET, and PEI plans, for reducing the disparities identified.
- B. List the strategies identified for each targeted area as noted in Criterion 2 in the following sections:
 - II. Medi-Cal population
 - III. 200% of poverty population
 - IV. MHSA/CSS population
 - V. PEI priority population(s) selected by the county, from the six PEI priority populations

The following section outlines SLOBHD's strategies and objectives which guide its approach to culturally competent activities. Programs described here range in scope from clinic-based therapeutic services, to community partnerships, to public education and engagement.

A. The strategies identified in the County's CSS, WET, and PEI plans are described here to provide a comprehensive demonstration of how San Luis Obispo County is addressing disparities in service throughout its system of care.

Community Services and Supports (CSS)

The County established a partnership with Silvia Ortiz, PhD. who has conducted extensive research to determine best practice approaches to overcoming disparities with Latino consumers. Her paper, "Servicios Sicologicos Para Latinos: A Latino Outreach Program: Addressing Barriers to Mental Health Service" (Appendix 8) outlines local research described in the previous Criterion, and outlines the services which anchor the CSS strategies in San Luis Obispo County.

Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP) offers culturally appropriate psychotherapy services to the monolingual, low income Spanish speakers and their bilingual children. The model for LOP is based on the findings of Dr. Ortiz' research and the finding of the County study conducted in 2004 (CSS). The program has been successful in establishing a community based model that provides psychotherapy, medication evaluation, psychotherapy groups, parenting groups for parents whose child is a ward of the court, substance abuse groups, and educational workshops (Appendix 9) to the Spanish speaking community and their bilingual children.

The client's access to services is conducted in a manner that minimizes telling the personal story to multiple persons and navigating through a bureaucracy. The clients are referred to the Director of LOP, Silvia Ortiz, Ph.D. who directly assigns the client to the therapist that conducts the intake and provides therapy. This method of accessing

services addresses the barrier described in Criterion 3, Section IIA, which speaks to the difficulty of telling the personal story to various persons prior to receiving treatment; and is respectful of the findings of Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, (2001) and Cheung (1990) that indicate clients get lost when they try to navigate through the bureaucracy of the agencies that provide mental health services.

All LOP therapists are bicultural and bilingual. The director of the program and two of the therapists are immigrants from Colombia and Mexico, respectively. The other two therapists are first generation in the United States (Appendix 10). The ethnicity of the therapist and their cultural backgrounds address the concerns stated in Criterion 3, Section IIA. By being Spanish speaking Latinos/Latinas the therapists can increase the probability of retaining the client because as noted by Lehman, E.W., Harrison-Ross, P. & Seigal, K. (1982) there is a decrease in dropout rates when there is an ethnic and language match between mental health professional and ethnic minority client. This match, as indicated by Casa, Pavelski, Furlong & Zanglis (2001) also facilitates the ability to share world views and enables the therapist to enter the Latino client's paradigm.

Workforce Education and Training (WET)

The County's WET plan addresses the disparities of recruitment, training, and education of qualified individuals who provide services in this County's Public Mental Health System by the utilizing the following strategies:

- **Workforce Education and Training Coordinator and Intern:** This strategy reassigned a Mental Health Therapist to 20 hours per week as the WET Coordinator in December of 2008. A part-time WET intern was hired in the second year to assist in the planning and implementation of the WET plan. These positions coordinate the implementation of education and training strategies identified in the County, performing tasks such as conducting assessments of county staff, contract providers, consumers, youth, and family members' training needs; assisting in the development and implementation of a strategic training plan for SLOBHD; and participating both at a state and regional level to ensure coordination of training and to maximize training opportunities. The WET Coordinator and intern ensure that training exemplifies wellness, recovery, and resilience; is culturally competent; ensures a consumer/family-driven mental health system; promotes an integrated service experience; and incorporates the community collaboration process.
- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** San Luis Obispo County is working with Transitions Mental Health Association (TMHA), a community based organization, and their "Peer Advisory/Advocacy Team" (PAAT), to advocate and educate the community about mental health, wellness and recovery. TMHA supports an integrated system that reflects the principles of hope and choice, while promoting a recovery environment, encouraging education, honoring each individual's spiritual pathway, and embracing self-awareness and compassion for others.

The program is designed to market and outreach to consumers, family members, individuals from underrepresented racial/ethnic and cultural groups to minimize stigma and educate individuals served and their family members about their rights and responsibilities in the mental health system. Members of the peer advisory team are consumers and family members that co-facilitate recovery groups with SLOBHD staff. PAAT members have helped facilitate Co-occurring and Illness Management Recovery (IMR) groups. PAAT members are able to access training and classes in wellness, recovery, and resiliency to aid in the progression of entering the mental health field; and meet the needs of the consumers being served. PAAT members are offered classes in the Psychosocial Rehabilitation Certificate Program offered thorough a partnership with Cuesta College, a local community college, to increase training and to begin a career as a “paraprofessional.” This strategy addresses identified shortages in occupations, skills sets, and individuals with unique cultural and linguistic competence at SLOBHD and organizations providing services in the mental health system.

- **E-Learning** will be a valuable resource that will allow SLOBHD to develop, deliver and manage educational opportunities and distance learning for staff, consumers/family members, and community based organizations. Funding will be used to access an extensive course catalog and to customize courses to meet the specific, diverse needs of our community. Trainings will be wellness, recovery, and resiliency oriented. All employees, including consumer and family members, will be able to access trainings. The Cultural Competence Committee will be utilized in making recommendations for training curriculum and processes for accessing training. Training effectiveness will be monitored through evaluations, pre and post tests, as well as agency wide surveys, focus groups, and computer based message board discussions. This program is expected to be implemented by March of 2011.
- **Law Enforcement, First Responders and Crisis Intervention Training (CIT)**
Description: This strategy is to train law enforcement officers to handle crisis situations involving individuals with serious mental illness. This is conducted in collaboration with the local Police Officers Associations and community colleges, and involves police personnel, mental health professionals from both adult and children’s services, as well clients and family members from National Alliance on Mental Illness.
- **Integrating Cultural Competence in the Public Mental Health System:** While cultural competence is embedded in all actions of the WET Plan, this strategy focuses on specific technical assistance and trainings necessary to achieve Cultural and Linguistic Competency within the public mental health system. WET staff continues to coordinate and serve on the Cultural Competence Committee (as described in Criterion 4). This committee has taken part in the development of the cultural competence plan and developed recommendations for a year round training plan.
- **All Workforce Training in Co-Occurring Disorders:** WET stakeholders expressed extensive interest in promoting system-wide competencies in co-occurring disorders. Based on this interest, the County is providing workforce

training in treating individuals with co-occurring mental health and substance disorders in a culturally competent manner to staff and volunteers of the County and contracting CBOs, and to consumers and family members. SLOBHD seeks to create a system-wide integration of services that address the needs of unserved, underserved and inappropriately served individuals with co-occurring substance and mental health disorders. The Department developed a multi-modal technical assistance and training program and a team of “Change Agents” (Co-occurring Disorder Workgroup) helping guide knowledge into practice.

- **Psychosocial Rehabilitation Certification Program:** This strategy addresses identified shortages in occupations, skills sets, and individuals with unique cultural and linguistic competence at SLOBHD and community organizations providing services in the public mental health system. The program is designed to market and outreach to consumers, family members, individuals from underrepresented racial/ethnic and cultural groups, community mental health providers, and SLOBHD staff.
- **Bilingual Internship Program:** This strategy provides funding to support three part-time Bilingual students to gain experience and knowledge working in the public mental health system within a recovery approach. The Intern Program Supervisor tracks the number of interns obtaining employment with the County and with local community based organizations; and will begin to develop strategies for retaining interns in the behavioral health field.
- **Scholarships:** This strategy addresses shortages and diversity needs in the mental health workforce, and increases consumer and family member participation in the workplace by offering stipends and incentives to those individuals interested in pursuing education in delivering mental health care in the county. Through the WET Stakeholder process, it was determined that San Luis Obispo County is in need of licensed social workers, certified/trained paraprofessional direct service staff and diverse staff who are bicultural/bilingual. There is a critical need for Psychiatric Nurses and Psychiatrists. In addition, there is an identified need for mental health-trained supervisors and managers.

Prevention and Early Intervention

The County’s PEI plan addresses those disparities outlined in the previous section by first seeking to address stigma on a countywide, public basis. The Stigma Reduction campaign includes mass media approaches to public education as well as targeted outreach to the high-risk, underserved populations described in Criterion 3 Section I. Second, access is a foundational component of all PEI services including increased exposure of wellness messaging and early intervention services on campuses, in parent training forums, and with risk populations including seniors and TAY. Hours and availability of short, brief intervention counseling services has been expanded as well. Finally, the County’s cultural competence in providing PEI services is a major key in its strategies. All programs must increase both provider capacities to engage people in culturally appropriate services, and provide the public with warm, welcoming services which reduce those disparities linked to cultural competency gaps.

B. This section identifies further strategies per each targeted area examined in Criterion 2.

II. Medi-Cal Strategies

- The Latino Outreach Program (LOP) is able to provide services to those who meet medical necessity and those who have a diagnosis outside the realm of medical necessity such as substance abuse, marital problems, parent child relational problems, acculturation issues. The LOP reduces the barrier stated in Criterion 3, Section IA which highlights that SLOBHD cannot provide psychotherapy to people who do not meet the criteria for medical necessity. LOP is in the unique position that regardless of the diagnosis, cases can be opened under Medical Necessity or under CSS therefore no one is turned away based on a diagnosis.
- Other strategies have included the addition of bilingual therapists in the SLOBHD in order to expand services for those who do meet medical necessity.

III. 200% of Poverty Strategies

- LOP is embedded in the community to increase access for those unable to meet the economic need for transportation in the vast county. All workshops, groups, and trainings are provided in community sites. Psychotherapy is offered in Paso Robles, San Luis Obispo, Oceano, Arroyo Grande, and Nipomo at eight community sites (Appendix 11). The clients who receive services from LOP are able to access therapists, workshops and groups in a familiar community site in their own neighborhood.
- This strategy allows the program to break through the barrier stated in Criterion 3, Section IIA which addresses the discomfort of receiving psychotherapy in a government agency. The community based model also is consistent with the findings of Cheung's (1990), and Kiselica & Robinson (2001), which stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings".

IV. Community Services and Supports (CSS) Strategies

- **Full Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults and older adults.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life, feel better and be more satisfied with their lives. Support includes: vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support programs; outreach to unserved seniors; and expand services for persons with co-occurring substance abuse.
- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility.

- **Latino Outreach & Services** program reaches unserved and underserved limited-English speakers and provide community-based, culturally-appropriate treatment and support.
- The original CSS Mentally Ill Probationers Services program has been transitioned to a **Behavioral Health Treatment Court** offering support to adults who are mentally ill, on probation and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA.
- **School-Based Mental Health Services** for students offers intense, daily contact to address serious emotional disturbances.

V. Prevention and Early Intervention (PEI)

- **Trauma Exposed Individuals:** Strategies include increased engagement with schools, seniors, and high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. One example is the creation of a Student Assistance Program team at two middle schools which serve the largest Latino and poverty-based youth populations. These teams include a counselor specialized in risk assessment and trauma, along with a “Family Advocate” who meets with students and their families to build community linkage to needed resources, such as food, employment, and academic tutoring.
- **Individuals Experiencing Onset of Serious Psychiatric Illness:** Strategies include increased access to care on school campuses and in community centers where high risk populations (as mentioned above) will have more immediate responses from professional care and supports. Stigma reduction communitywide, including the “SLOtheStigma” media campaign, will increase knowledge and selective seeking-out of care. In its first six months, the website www.slothestigma.org attracted over 8500 unique visitors, 96% of whom indicated they would use the resources found on the website.
- **Children and Youth in Stressed Families:** Strategies include parenting education for both universal and selective populations to reduce stress; as well as increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency skills. One rewarding strategy has been the coordination of all county parent education offerings into an online family resource center website, www.sloparents.org. Available in Spanish, the website materials lead parents to targeted training, coaching, and education which deal with reducing stress in families and improving health outcomes.
- **Children and Youth at Risk for School Failure:** Strategies include increased engagement with schools, including counseling interventions for those youth exhibiting risk factors, and youth development opportunities to build resiliency skills. As mentioned above, the Student Assistance Programs launched countywide as part of PEI serve six high-need middle schools. All

county middle schools, through PEI, have received youth development project funding to increase youth opportunities for school bonding and life skill support through Friday Night Live programs.

- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement:** Strategies include increased engagement with transitional age youth, including wards of the court, at highest risk for juvenile system involvement. These strategies include job skills training and academic counseling. The “Successful Launch” program expanded the county’s Independent Living program targeted at youth emancipating from foster care. All community school and probationers preparing to graduate can now access life skill training, vocational development, higher education credits, and counseling services.
- **Underserved Cultural Populations:** Strategies include increased engagement with high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. Programs such as the Latino Outreach Program, which was originally created as part of CSS, were provided prevention and early intervention training to expand outreach and education opportunities to engage underserved populations.

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

The county shall include the following in the CCPR:

- A. List any new strategies not included in Medi-Cal, CSS, WET, and PEI. **Note:** New strategies must be related to the analysis completed in Criterion 2.
- B. Share what has been working well and lessons learned through the process of the county’s development of strategies, objectives, actions, and timelines that work to reduce disparities in the county’s identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

In preparing the CCPR the County conducted various staff meetings and held discussions regarding strategies not yet implemented, and those identified in recent months, after the implementation of nearly all MHSAs plans.

A. Since the development of CSS, the County has focused much of its approach to disparities through strategies brought forth in the MHSAs process. Outreach to underserved populations and improved services have been keystones of the past five years of planning and development. However, strategies have been developed outside of the Medi-Cal, CSS, WET, and PEI approaches. For instance:

- **Co-Occurring Disorders:** With training initiated through the WET plan, the County has embarked on developing a program of integrated service which will allow individuals with dual diagnoses of mental illness and substance addiction to

access integrated treatment. Until recently these individuals were faced with having to select which agency to engage in order to get help and care. Providers in the mental health system often turned the clients away to deal with their addiction issues first, and those entering the alcohol and drug programs were sent to mental health to get diagnosed before being able to assess their level of abuse or addiction. This created a gap in service and as the County merged its Drug and Alcohol and Mental Health divisions, the problem was identified. The treatment of co-occurring disorders needs to involve both systems and be “delivered in ways that are coordinated and collaborative” (Skinner, 2005). The Department is now integrating programming and practices which build supports for this group of consumers.

- **Innovation:** The State released MHPA funds in the past year for Innovation (DMH Information Notice 09-02) which allows each County to develop projects that will enhance learning around practices and strategies. San Luis Obispo County’s stakeholder process yielded several research-type projects that will address cultural competency and assess the efficacy of new practices. One area where the County hopes to build strategies is with Veterans. As the county’s large National Guard population begins to come home from the Middle East, local military officials came forth and acknowledged that stigma and access to services keep many service-people and their families out of the mental health system. Projects are being developed which will boost outreach and counseling strategies for this unique, cultural disparity.

Another Innovation project will address consumer and family education and feedback with providers in the mental health system. The County plans to develop training for providers with the goal of enhancing practitioner understanding of consumer and family issues, including the obstacles and perceptions which deter recovery and progress. This process will include engaging consumers and families to tell their stories and have a voice in improving provider services.

B. SLOBHD has identified several strategies and programs that are working well and lessons learned through the process of the County’s development of strategies intended to reduce disparities in the target populations of Medi-Cal, CSS, WET, and PEI.

The Latino Outreach Program, the major strategy addressing disparities in the Medi-Cal and CSS populations continues to be a successful model for reducing the disparities in access for Latino and Spanish-speaking clients. In the past five years bilingual staffing at SLOBHD has increased 20%; while Latino population client figures have grown 31% since 2006.

One aspect of the program which is working well is the clinical supervision provided for the therapists assigned to the program. County staff assigned to LOP receive clinical supervision from Dr. Silvia Ortiz. Even though the therapists are bicultural and bilingual, the concept of adjusting theories that have been developed by the European culture to the paradigm of the Latino’s world view remains vaguely undefined and can be very

difficult to implement. Group supervision and individual supervision is conducted in Spanish on a weekly basis to provide a venue for monitoring the delivery of culturally appropriate therapy. The concepts of family, curanderos, spirituality, immigration, acculturation, respect, trust, and working within the Latino paradigm are addressed in supervision. The integration of therapeutic theories and interventions into the Latino worldview is examined in supervision in the hope that the therapists remain true to a culturally sensitive model.

Other examples of successes and lessons learned with LOP include the following:

- In order to maintain a solid reputation among the network system and with the Latino population it is important that potential clients are not denied services on the basis of medical necessity. In the community, no low-cost, Spanish-speaking clinic servicing clients who do not meet medical necessity exists. Prior to the implementation of the LOP, Spanish speakers who did not meet medical necessity had no other recourse for receiving therapy. It is hopeful that community resources, including the non-profit Community Counseling Center will also enhance its cultural competency by developing services for those Spanish-speaking clients who do not meet medical necessity.
- The use of a “wait list” has been a valuable tool both for coordinating services and for tracking need. The wait list is ranked by the date on the referral from SLOBHD, or the call is received by either Dr. Ortiz or the other LOP therapists in the community centers. There is no preferential treatment based on level of severity. No preferential treatment is given to any of the agencies or persons referring the client. In case of emergencies, all callers are provided with the 24-Hour Mental Health Services (800) number. This allows everyone to have an equal opportunity to access therapy and eliminates the competition for preferential treatment. LOP averages 25-50 potential clients on the wait list monthly. Calls are periodically made to update potential clients on their status. Potential clients may also call to check on their status.
- Very clear lines of communication need to be maintained with the various sites which house LOP staff. Dr. Ortiz attends monthly meeting at family resource centers (FRC), including Systems Affirming Family Empowerment (SAFE) sites to review the status of cases which have been referred by the FRC’s family advocates; and to address procedural concerns. A protocol has been established to define operational procedure of the program at the three county SAFE Sites. These procedures help reduce confusion, and the therapists being utilized by the SAFE staff for only seeing LOP clients (Appendix 12).
- As a program that coexists in the community and within SLOBHD, clear lines of communication need to be maintained between the two. At times this has been challenging because of administrative turnover, the multitude of people who interface with the program, and the newness of the program. It would be helpful to establish a protocol to facilitate the interface of the two entities.

Workforce Education and Training (WET)

Examples of successes and lessons learned with WET include the following:

- The original WET planning did not include funding or development of a training room which could be equipped with computers and technology training aids. This has been identified as a need and the SLOBHD is currently looking into its Capital Facilities and Technology opportunities to develop such a resource.
- The development of the Electronic Learning initiative has been a morale boost for staff and will create many opportunities for staff to build capacity and for the Department to enhance its services. The SLOBHD is now working on the challenge of creating policy and procedures so that the product is used to its fullest.
- The E-Learning initiative will also benefit the Department's community partners, providing initial education to consumers and family members who are considering furthering their education and seeking advanced degrees. By taking courses on-line, individuals will be able to learn at their pace, develop a base understanding of mental health concepts and progress in their academic skill development.
- "Action 5" of the WET plan, Integrating Cultural Competence, has been adapted to provide stakeholders with better monitoring of funds. A need was identified to assure stakeholders that funds were being used efficiently, for instance training or hiring staff that were all ready proficient in Spanish or bicultural instead of trying to train a staff member to learn Spanish.
- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. This will be integrated with the three-year training plan, which has been successful for guiding training decisions and developing core competencies.
- Finally, the WET team has found success with and seeks further opportunities for collaboration and partnering with other county agencies that provide training on shared topics. This efficiency will be a key to sustainability of the three-year training plan.

Prevention and Early Intervention

After its first year of implementation, the County's PEI plan has yielded several areas of success. Examples of successes and lessons learned with PEI include the following:

- Foremost is in the County's PEI projects to reduce and eliminate stigma. The "SLOtheStigma" campaign launched in the winter of 2009-2010 has made a major impact on the community. Over 150,000 media impressions have been made, and the www.SlotheStigma.org website has demonstrated its capacity to drive individuals to needed mental health services and information. The campaign has used traditional media (i.e. billboards, television, print, and web) to show its centerpiece, a new documentary short on local people living with and recovering with mental illness.
- Other successful strategies have included "guerilla marketing" techniques such as saturation of messaging by t-shirt giveaways, unique poster placement, and a

critical mass demonstration in the county's largest weekly social event, the San Luis Obispo Downtown Farmer's Market in spring of 2010.

- The countywide PEI programs launched with a successful community forum which provided prevention training, program networking, and an excellent cultural competence presentation by Rocco Cheng, Ph.D. of Pacific Clinics.
- One need identified by the stigma reduction programs is improved materials and strategies for youth audiences. The SLOtheStigma documentary features adults telling their personal stories of recovery. While it is powerful for most audiences, staff have desired a stronger, more culturally competent message for younger audiences. PEI staff have been constructing a secondary school curriculum piece to be used in conjunction with the documentary and this strategy will be tested in the coming year.

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

The county shall include the following in the CCPR:

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

The County has worked to develop a system of planning and monitoring of the aforementioned strategies to reduce mental health disparities, including establishing objectives and monitoring outcomes.

A. The strategies identified in the County's CSS, WET, and PEI plans are described here to provide a comprehensive demonstration of how San Luis Obispo County is addressing disparities in service throughout its system of care.

Community Services and Supports (CSS)

- **Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP)** This program has been operative since 2005 and continues to provide services ranging from outreach presentations to clinical services for over 130 individuals

annually. The strategy is measured quarterly by reports of service, client outcomes, and client satisfaction. A copy of the LOP Client Satisfaction questionnaire is available in this document (Appendix 13).

- **Full Service Partnership** programs provide a broad range of mental health services and intensive supports to targeted populations of children, transition age youth, adults and older adults.
- **Client and Family Wellness Supports** provides an array of recovery-centered services to help individuals improve their quality of life, feel better and be more satisfied with their lives. Support includes: vocational training and job placement; community and supportive housing; increasing day to day assistance for individuals and families in accessing care and managing their lives; expanding client and family-led education and support programs; outreach to unserved seniors; and expand services for persons with co-occurring substance abuse.
- **Enhanced Crisis Response and Aftercare** will increase the number of mobile responders and add follow up services to individuals not admitted to the psychiatric health facility as well as to those discharged from the facility.
- The original CSS Mentally Ill Probationers Services program has been transitioned to a **Behavioral Health Treatment Court** offering support to adults who are mentally ill, on probation and have been court-ordered as a condition of their probation to obtain mental health treatment. Strategies include individual and group therapy, socialization, medication management, drug screens, and referrals to appropriate support groups such as AA.
- **School-Based Mental Health Services** for students offers intense, daily contact to address serious emotional disturbances.

Workforce Education and Training (WET)

- **Workforce Education and Training Coordinator and Intern:** This strategy has been in place since late 2008 and continues to provide coordination for all other WET projects.
- **Transitions Mental Health Association Peer Advisory, Mentoring, and Advocacy Team:** This strategy has been in place since 2009 and will continue to be monitored by PAAT activities and enrollment of consumers in education programs.
- **E-Learning** is expected to be implemented by March of 2011.
- **Law Enforcement, First Responders and Crisis Intervention Training (CIT) Description:** This strategy was implemented as part of WET in 2009, although other training has been provided to law enforcement through other local strategies in the past. This is monitored by attendance and will be evaluated over the next three years to assess whether improvements were made in law enforcement response to mental health-related crises.
- **Integrating Cultural Competence in the Public Mental Health System:** WET has been integrated in the Cultural Competence Committee even during the stakeholder process in 2008. This strategy is monitored by the WET stakeholder committee and milestones will include objectives described in Criterion 5.

- **All Workforce Training in Co-Occurring Disorders:** The Co-occurring Disorder Workgroup has begun implementing programming trials and has brought together staff from Mental Health and Drug and Alcohol Services to develop further integration. The Workgroup meets monthly to monitor this progress.
- **Psychosocial Rehabilitation Certification Program:** This strategy is ongoing, having launched in the past year. Over the next three years SLOBHD will monitor its impact by assessing growth in the workforce.
- **Bilingual Internship Program:** This strategy has been successful in engaging bilingual license-track interns to work within the mental health system. This is monitored by the WET team and SLOBHD management on a quarterly basis.
- **Scholarships:** This strategy launched in the past year and evaluation is still being conducted around the impact of the program.

Prevention and Early Intervention

- **The Stigma Reduction Campaign** was implemented in the fall of 2009 and it has reported impact data over the past nine months. This project is reported monthly and quarterly, as well as having site visits by SLOBHD with providers to assess success and needs.
- **Access Strategies** are embedded in each of the PEI projects. These strategies began in 2009 and are monitored by regular reporting and SLOBHD contract monitoring, including site visits and tests (“secret shoppers”). Hours and availability of short, brief intervention counseling services is being tracked by rosters and client satisfaction rates as well.
- **Cultural competence in providing PEI** is tracked in all programs including provider training events and evaluations, quarterly site visits, and client satisfaction rates.
- **Trauma Exposed Individuals and Children and Youth at Risk for School Failure:** One example of the strategies addressing these populations and their evaluation is the Student Assistance Program teams at two middle schools which serve the largest Latino and poverty-based youth populations, launched in the 09-10 school year. These programs are part of the County’s extensive PEI evaluation which includes regular tracking and reporting of pre-posts, student outcomes, and overall community impacts over time. This evaluation will take place over the next three years.
- **Children and Youth in Stressed Families** strategies include parenting education for both universal and selective populations to reduce stress and increase family communication outcomes. This adult-based program was implemented in fall of 2009 and the provider reports quarterly to the SLOBHD.
- **Children and Youth at Risk of or Experiencing Juvenile Justice Involvement:** The strategies utilizing job skills training and academic counseling through the “Successful Launch” program are reported quarterly and tracked measures include participant attendance, skills outcomes, and school performance. The program was launched in the 09-10 school year.

- **Underserved Cultural Populations:** The above-detailed LOP and TMHA programs were embedded in the PEI plan to increase engagement with high risk cultural populations (incl. Latinos, homeless, veterans, LGBTQ) to both educate those at higher risk for depression and the trauma caused by transitions, acculturation, discrimination, mortality, health, etc. and to provide skill building to better navigate difficult situations. These programs began in the fall of 2009 and are being tracked by quarterly and annual reports.

Medi-Cal & 200% of Poverty Strategies

- The Latino Outreach Program (LOP), as described above, is also a strategy delivered to decrease disparities amongst Medi-Cal eligible consumers. The strategy is measured quarterly by reports of service, client outcomes, and client satisfaction. A copy of the LOP Client Satisfaction questionnaire is available in this document (Appendix 13).

New Strategies from Section IV

- Strategies described in Section IV, Co-Occurring Disorders programs, and Innovation programs will be launched over the next year. Tracking and monitoring will include provider quarterly reports, site visits, pre-post tests, and client surveys.

B. The County currently has various levels of mechanisms 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. For instance, the PEI Plan and its projects are monitored by site visits, quarterly evaluative reports, and annual data analyses and reporting. The WET plan has built-in evaluation for training and other education initiatives, and will expand its pre-post testing over the next two years. Some programs within the CSS Plan, including LOP, also collect data at many points along the intervention providing quarterly and annual reporting. Other CSS and Mental Health Service programs collect basic data which the County reports as part of EQRO and other audit functions. The County is working to construct outcome measurement systems which will better document the experience of consumers, and track the effects of service interventions. Over the next three years, as the County embarks on an electronic health record system, there is an expectation that program outcome measurement will expand to include pre and post testing protocols.

The key strategy the County uses to monitor the reduction or elimination of disparities is a quarterly data review by the Cultural Competence Committee. This review is then reported to the SLOBHD Performance and Quality Improvement (PQI) department. The reduction of disparities is monitored by analyzing penetration rates, service documentation, and measures such as client satisfaction. The Latino Outreach Program regularly assesses its impact on consumers and their families by measuring satisfaction and effects of treatment.

C. SLOBHD has identified the need for technical assistance in the area of evaluation, with the desire for better collection, analyses and reporting. Currently the Department does not employ a data analyst or statistician. Some program leaders have evaluation experience and skills which are often used in grant and report analyses and report writing. However, these responsibilities are often limited to the availability of time. The PEI programs have been launched with an evaluative end in mind, and therefore much data is being collected and reported. The CSS and other Mental Health Services programs have had less evaluative design, so technical assistance in this area would be beneficial.



Example of outreach program sponsored by SLOBHD's MHSA programs.

CRITERION 4

COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

- A. Brief description of the Cultural Competence Committee or other similar group (organizational structure, frequency of meetings, functions, and role).
- B. Policies, procedures, and practices that assure members of the Cultural Competence Committee will be reflective of the community, including county management level and line staff, clients and family members from ethnic, racial, and cultural groups, providers, community partners, contractors, and other members as necessary;
- C. Organizational chart; and
- D. Committee membership roster listing member affiliation if any.

To meet the County Behavioral Health Department's commitment to developing a system of care that serves an increasing, changing and diverse population, a Cultural Competence Committee was formed in 1996 and continues to this day. The Committee consists of staff members from the various programs of the Department, as well as contract agencies and community stakeholders (including consumers). The Committee addresses cultural issues affecting the entire mental health system. The committee members represent diverse cultural backgrounds and other special interests.

A. The Cultural Competence Committee is dedicated to assure that San Luis Obispo County Mental Health Services becomes a culturally competent health system which integrates the concept of cultural, racial and ethnic diversity into the fabric of its operation. The committee creates agency-wide awareness of the issues relevant to cultural diversity and provides recommendations to the County Mental Health Director on issues pertinent to the achievement of these goals.

The Committee operates as an entity of the San Luis Obispo County Behavioral Health Department. The Chairperson is appointed by, and reports to, The County Behavioral Health Director. The Committee members are the decision-making body (and are elected by the Committee) and represent a diverse range of cultural, ethnic, racial and geographic regions of the county. The Committee advises and serves as a resource group to The County Behavioral Health Director, The County Mental Health Training Committee, County Mental Health Staff, Performance Quality Improvement (PQI) team,

and affiliated agencies. General membership is not a requirement for involvement in the Committee.

Meetings are held quarterly. Visitors are welcome to attend committee meetings and provide input.

The goals of the Committee are:

- To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
- To provide recommendations that will increase service delivery to culturally diverse clients.
- To provide recommendations that address the need of continued training on cultural diversity topics.
- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
- To provide recommendations that address the recruitment and retention of bilingual providers.
- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, Native Americans, and transition age youth, and older adults.
- To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.
- To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee.
- To foster a strong network among community agencies that will facilitate an integrated delivery of services.

B. As outlined in the Cultural Competence Committee bylaws (Appendix 14), the Cultural Competence Committee consists of members from County Mental Health, affiliated agencies, network providers, and consumers. The members of the Committee represent a range of cultural and ethnic backgrounds. The Chairperson is a member of the Latino community. Anyone interested in serving on the Committee shall state his/her interest to serve by informing a Committee member. A simple majority is required for the election of Committee members. A vacancy exists when a Committee member misses four consecutive Committee meetings without prior notification to the Chairperson or any other member. A vacancy also exists when a Committee member tenders his/her resignation verbally or in writing to the Chairperson. When a vacancy exists, The Committee shall nominate individuals to serve on the Committee.

No meetings shall be held in a facility that prohibits the admittance of any person based on culture, ethnic background, religious beliefs, sex, sexual orientation, or emotional/physical disabilities. Meetings will convene on the second Monday of each month with a minimum of ten meeting per calendar year. The Chairperson convenes the meetings and the Committee members develop the agenda for the meetings. The Committee will strive to make decisions by consensus. A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by

a quorum to be recommended to the County Behavioral Health Director. A quorum is defined as 50% of the Committee. A motion may be made and seconded by any of the Committee members. Motions require a simple majority to be recommended as action items or task assignments.

C. The Organizational Chart which demonstrates the relationship of the Committee and the Behavioral Health Department is located in the Appendix 15.

D. Please see Appendix 16 for the most recent Cultural Competence Committee Roster and affiliations.

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

The county shall include the following in the CCPR:

- A. Evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's activities including the following:
1. Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;
 2. Provides reports to Quality Assurance/Quality Improvement Program in the county;
 3. Participates in overall planning and implementation of services at the county;
 4. Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;
 5. Participates in and reviews county MHSA planning process;
 6. Participates in and reviews county MHSA stakeholder process;
 7. Participates in and reviews county MHSA plans for all MHSA components;
 8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and
 9. Participates in revised CCPR (2010) development.

A. The following information provides evidence of policies, procedures, and practices that demonstrate the Cultural Competence Committee's (CCC) activities include those listed in Criterion 3, Sec. II of the CCPR:

- ***Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;***
 - As per the Cultural Competence Committee bylaws - Article II: The Purpose of the Committee, Section 1 (Appendix 14): *The Committee is dedicated to assure that San Luis Obispo County Mental Health Services becomes a culturally competent health system which integrates the concept of cultural, racial and ethnic diversity into the fabric of it's operation. The committee will create agency-wide awareness of the issues relevant to cultural diversity.*

- Goals of the Cultural Competence Committee (Appendix 14) include:
 - To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
 - To provide recommendations that will increase service delivery to culturally diverse clients.
 - To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, American Indians, and transition age youth, and older adults.
- **Provides reports to Quality Assurance/Quality Improvement Program in the county;**
 - Goals of the Cultural Competence Committee (Appendix 14) include “To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.” This is done by having Silvia Ortiz, PhD., the Chairperson of the Committee represent the Committee providing quarterly reports to both the County’s Performance and Quality Improvement (PQI) and Quality Management (QMC) committees.
- **Participates in overall planning and implementation of services at the county;**
 - Goals of the Cultural Competence Committee (Appendix 14) include:
 - To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
 - To provide recommendations that will increase service delivery to culturally diverse clients.
 - To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.
- **Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;**
 - As per the Cultural Competence Committee bylaws - Article II: The Purpose of the Committee, Section 2 (Appendix 14): “*The Committee is committed to meeting the goals set forth in this document and will provide recommendations to the County Mental Health Director on issues pertinent to the achievement these goals.*”
- **Participates in and reviews county MHSA planning process;**
 - Silvia Ortiz, PhD., the Chairperson of the Cultural Competence Committee is an original and active member of the County’s MHSA Advisory Committee (MAC). Other members of the Committee have participated on the MAC since the original meetings were held in 2004. The MAC continues to meet bi-annually to review MHSA components, programs, and to guide planning.
- **Participates in and reviews county MHSA stakeholder process;**
 - Cultural Competence Committee members, including Dr. Ortiz, have been

active members of MHSAs stakeholder planning for each component – CSS, PEI, WET, and Innovation. Cultural competence issues were at the forefront of MHSAs planning (including disparities, priority populations, and outreach to consumers and family members) and have been discussed and processed at each level of planning. Committee members have assured that each MHSAs stakeholder process included focus groups and feedback sessions that were held in Spanish, or were provided in settings accessible and comfortable for diverse populations.

- Dr. Ortiz, as a member of the MAC, is responsible for representing the Cultural Competence Committee in reviewing the MHSAs stakeholder process.
- ***Participates in and reviews county MHSAs plans for all MHSAs components;***
 - Dr. Ortiz, as a member of the MAC, is responsible for representing the Cultural Competence Committee in reviewing the MHSAs plans for all components. Other members of the Committee, including the Behavioral Health Director, Dr. Karen Baylor, also participate in this oversight.
- ***Participates in and reviews client developed programs (wellness, recovery, and peer support programs);***
 - The Committee produces a quarterly newsletter (Appendix 4) which addresses issues related to wellness and recovery – and is made available to organizations in the community dedicated to peer support programs.
 - The CCC currently does not have a seat filled by a peer advocate, as it has in the past. The Committee has invited a member of the Peer Advisory and Advocacy Team (PAAT) which is coordinated by TMHA, one of the County’s premier MHSAs partners, to join the CCC. PAAT members are local residents and most have received mental health services in this county. Members enjoy volunteering, whether at community events, on advisory groups and boards; and within the mental health system. Some are also in paid positions within TMHA.
 - In recent months, a Parent Partner, representing one of the County’s contract providers, Family Care Network, Inc. (FCNI) has joined the Committee.
- ***Participates in revised CCPR (2010) development.***
 - Silvia Ortiz, PhD., the Chairperson of the Cultural Competence Committee launched the CCPR preparation sessions and remained on the ad-hoc workgroup charged with preparing the CCPR. Dr. Ortiz has provided content, oversight, and review of each section of the document, while the Committee members representing County staff have taken lead roles in preparing the material included herein (Appendix 21).

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

B. The following documents, included in the Appendix, demonstrate evidence of the Cultural Competency Committee's (CCC) participation in the activities listed in the CCPR:

- **Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county;**
 - Dr. Ortiz, the Chair of the CCC, is contracted with the County to provide a variety of services, including training of Mental Health Services staff in relation to cultural competency issues (Appendix 17). In her role as consultant, Dr. Ortiz also provides review of programs and services by participating in the quarterly Performance Quality Improvement (PQI)/Quality Management team (see next).
- **Provides reports to Quality Assurance/Quality Improvement Program in the county;**
 - An agenda for the PQI/Quality Management team is included in this document (Appendix 18). The group receives regular reports from the CCC quarterly.
- **Participates in overall planning and implementation of services at the county;**
 - As identified in CCC agendas and minutes included herein (Appendices 19 and 20) the County Behavioral Health Director, Dr. Karen Baylor, participates as a member of the Committee and provides monthly reports and discussions of County programs and services.
- **Reporting requirements include directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;**
 - As explained above, CCC agendas and minutes included herein (Appendices 19 and 20) along with PQI agendas and minutes (Appendix 18) demonstrate the interaction and reporting transmittal between the CCC and the County Behavioral (Mental) Health Director, Dr. Karen Baylor.
- **Participates in and reviews county MHPA planning process;**
 - Dr. Ortiz and the Ethnic Services Manager (Nancy Mancha-Whitcomb) are members of the MHPA Advisory Committee (MAC) and take part in all discussions regarding MHPA planning and major decision making. Included in the Appendix is correspondence (Appendix 54) demonstrating this involvement.
- **Participates in and reviews county MHPA stakeholder process;**
 - Dr. Ortiz, along with other members of the CCC, including the Ethnic Services Manager (Nancy Mancha-Whitcomb) are active members of the MHPA stakeholder process, an example of which is demonstrated in the appendix (Appendix 37).
- **Participates in and reviews county MHPA plans for all MHPA components;**
 - Dr. Ortiz, and the Ethnic Services Manager (Nancy Mancha-Whitcomb) are members of the MHPA Advisory Committee (MAC), and take part in reviewing

each of the county's MHSAs plans and reports; as documented in the included example meeting agenda and email announcement (Appendix 54).

- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs); and**
 - The CCC does not currently have a formal objective to review client-developed programs but seeks to increase its engagement with peer advocates and other recovery programs in future years.
- **Participates in revised CCPR (2010) development.**
 - Dr. Ortiz and the membership of the CCC have been integral to the development of this Cultural Competence Plan, as evidenced in the agendas and correspondence herein (Appendix 21).

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

1. Detailed discussion of the goals and objectives of the committee;
 - a. Were the goals and objectives met?
 - If yes, explain why the county considers them successful.
 - If no, what are the next steps?
2. Reviews and recommendations to county programs and services;
3. Goals of cultural competence plans;
4. Human resources report;
5. County organizational assessment;
6. Training plans; and
7. Other county activities, as necessary.

C. The Annual Report of the Cultural Competence Committee is included in the following section. A report to the SLOBHD from the Committee is also included herein Appendix (Appendix 22).

1. The goals and objectives of the Committee, as outlined above, are listed here with details regarding their successes or next steps:
 - To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
 - ❖ The Committee was able to obtain a meeting room within SLOBHD, an improvement from the original meeting location away from the County site.
 - ❖ The Committee was able to obtain an Administrative Assistant to take the Committee minutes and format them for the Committee.
 - ❖ The Committee has increased membership from various sectors of SLOBHD, as well as representation from the community.
 - ❖ The Committee Chairperson, Dr. Silvia Ortiz has begun reporting on the activities of the Committee at monthly PQI meetings.

- To provide recommendations that will increase service delivery to culturally diverse clients.
 - ❖ The Committee has been active in MHSA stakeholder processes, including the Innovation workgroups, in order to keep cultural competence issues at the forefront of service delivery discussions.
- To provide recommendations that address the need of continued training on cultural diversity topics.
 - ❖ The Committee is active in training collaborations countywide, including providing input to the SLOBHD three-year training plan. In recent years the Committee has also informed the WET planning process as well as providing training as outlined in the next Criterion.
- To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
 - ❖ The Committee produces a quarterly newsletter on cultural issues affecting mental health systems and providers. This material is part of the Committee's work to reduce barriers that affect sensitive and competent delivery of service to culturally diverse clients.
- To provide recommendations that address the recruitment and retention of bilingual providers.
 - ❖ The Committee, through its involvement in SLOBHD and MHSA workgroups, has provided strong recommendations for workforce improvements, demonstrated by a 20% increase in bilingual staffing since 2006.
 - ❖ The Latino Outreach Program is an example of this type of service response supported by the Committee.
- To provide recommendations that increase utilization patterns of the unserved and underserved populations such as the Latinos, Native Americans, and transition age youth, and older adults.
 - ❖ The Latino Outreach Program, which has aided a 30% increase in Latino clients since 2006, is an example of this type of service response supported by the Committee.
- To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.
 - ❖ Minutes from the Cultural Competence Committee (example, Appendix 19) are made available to all SLOBHD employees.
 - ❖ The Committee's newsletter is produced quarterly and sent to each SLOBHD staff member.
- To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee.

- ❖ The Committee prides itself on its collaborative spirit and diverse membership. The Committee reflects the vast array of service providers and consumers served by the mental health system.
 - ❖ The Committee has worked within the WET plan to engage other organizations through training collaboratives,
 - ❖ In reporting to the County's PQI team, the Committee is also able to engage providers outside of the SLOBHD system.
- To foster a strong network among community agencies that will facilitate an integrated delivery of services.
 - ❖ The Committee prides itself on its collaborative spirit and diverse membership. The Committee reflects the vast array of service providers and consumers served by the mental health system.

2. The Committee's Annual Report does not currently contain reviews and recommendations to county programs and services. This process is done through Committee meetings (staffed by SLOBHD leadership) and via reports to PQI. Future Annual Reports will include this section.

3. Since the Committee has not adopted a previous Cultural Competence Plan before this current document, the Committee is presenting the goals outlined in the introductory section of this plan.

4. The SLOBHD provides the Committee with its Human Resources information as requested. At this time the Committee does not review the SLOBHD's entire personnel portfolio, but has focused, in recent years, on the increase of bilingual staffing. This is demonstrated by the roster of bilingual staff included in the Appendix (Appendix 31).

5. At this time the Committee does not review the SLOBHD's organizational structure for its Annual Report. A copy of the organization chart outlining the Committee's relationship to the County is included herein (Appendix 15).

6. The Committee does not have its own training plan as it participates and informs the SLOBHD training plan (Appendix 23).

7. The Annual Report (Appendix 22) included features reports on translated and native language material distribution, assessment of organizational cultural competence, and outreach activities.

CRITERION 5

COUNTY MENTAL HEALTH SYSTEM

CULTURALLY COMPETENT TRAINING ACTIVITIES

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

The county shall include the following in the CCPR:

- A. The county shall develop a three year training plan for required cultural competence training that includes the following:
1. The projected number of staff who need the required cultural competence training. This number shall be unduplicated.
 2. Steps the county will take to provide required cultural competence training to 100% of their staff over a three year period.
 3. How cultural competence has been embedded into all trainings.

The San Luis Obispo County Behavioral Health Department (SLOBHD) is committed to provide training and supports which build cultural competence across the mental health system. Staff and stakeholders, including contractual partner providers, are provided with training that meets the goals of the Cultural Competence Committee, outlined in the previous Criterion including the goal “to provide recommendations that address the need of continued training on cultural diversity topics.”

A. SLOBHD, in building upon the strengths of its MHSA Workforce Education and Training (WET) Plan, has developed a three-year training plan (Appendix 23) which includes cultural competence training which is required of all staff and contractual partners. This plan has been developed in partnership with stakeholders and contractual partner providers, although overseen by the Department. A majority of the training is provided by the Department, with community partners offering many opportunities for staff to engage in learning cultural competence strategies outside of the Department. These trainings, offered through the three-year WET Plan, will be coordinated through the Cultural Competence Committee and the Behavioral Health Training Committee.

1. The projected number of County staff that will require training is 186. The projected number of direct services contractual staff is 282. These numbers were identified in Workforce Education and Training Plan that was submitted in May of 2009.

2. SLOBHD, as per its WET training plan, has taken the following steps to provide required cultural competence training to 100% of the staff over the three-year period (2009-2012):

- SLOBHD will liaison with established training partners including local and online Colleges and University and Continuing Education Unit (CEU) providers. These partnerships increase the diversity of training opportunities, as well as increasing the capacity for training larger numbers of staff over time.
- Provide training through an electronic-learning initiative. SLOBHD is embarking on a partnership with an “e-learning” company which will provide core competency and cultural competency training menu which staff and contract partner staff can access at their convenience. This type of expansion will build capacity amongst all staff, and increase training access and delivery to reduce barriers for staff who have limited hours or assignments which preclude attending training events.
- Throughout the year, additional training needs will be identified through surveys, focus groups, and community outreach. It will also cover the cost of refresher courses for interpreters; specialized training focused on the County’s various ethnic populations and attendance at State-wide Cultural Competence trainings.
- A draft policy requiring all county employees to attend at least two identified cultural competence trainings per year (that will be tracked by Workforce Education and Training) has been submitted to SLOBHD Management. It is expected to have this policy ratified in the coming year.

3. The following section will detail the training events held for SLOBHD staff. Cultural Competence is a key component of each training opportunity and at the core of service delivery. Through its membership in the Southern Counties Regional Partnership (WET), SLOBHD will have the opportunity to work with Dr. Steven Lopez, a Professor of Psychology at USC, who will conduct an assessment and subsequent workshops related to the Shifting Cultural Lenses training program. SLOBHD believes this strategy will result in further integration of cultural competence ideals into the training policies and practices of the County.

II. Annual cultural competence trainings

The county shall include the following in the CCPR:

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

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

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

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

The following table (Table 12) provides detail on the cultural competence trainings attended by staff in the past fiscal year. Included in the detail is the name or type of training event, a description of the training, the duration, attendance information, and date of training. In this grid the Attendance by Function lists the identified status of participants. Clients and family members are included in the Community Members/General Public figures. Although, currently the Department does not track registration for training based on client or consumer family status, it is common for each of these workshops and events to be attended by several members of the consumer and recovery community. In future years the SLOBHD training committees will work to improve such tracking.

A. and B.
See **Table 12**

Table 12 – Behavioral Health Training Calendar

2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
PE&I Collaboration Conference	Define prevention and early intervention to motivate partners, stakeholders, and providers to look at PE&I for its role in changing how the community responds to BH issues	7	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	124	3-Sep-09	Maureen Sedonaen from Youth Leadership Institute and Frank Warren from BH
PE&I Collaboration Conference - Cultural Competence Training	Define cultural competence issues in PEI and how to improve service delivery amongst diverse populations and risk factors.	1	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	124	3-Sep-09	C. Rocco Cheng, Ph.D., Pacific Clinics

Table 12 Continued

Table 12 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
Student Assistance Program	A system for pinpointing and intervening in behaviors that interfere with learning and disrupt the classroom. Links with existing programs in the community.	6	Administration/Management, Direct Services, Counties; Direct Services, Contractors; School District Employees	37	4-Sep-09	Bill Spencer
Subpoena Training		2	Medical Records Technicians		8-Sep-09	
Clindox Training		1.5	Interns and Trainees		28-Sep-09	Gerald Clare, LCSW
Documentation training	Intake Assessment and Progress Note Documentation/ Documentation training on Treatment Plans	3	Interns and Trainees		2-Oct-09	Azarm Garehman Ph.D
Documentation Training	Intake Assessment and Progress Note Documentation/ Documentation training on Treatment Plans	3	Interns and Trainees		8-Oct-09	Azarm Garehman Ph.D

Table 12 Continued

Table 12 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
Cultural Clashes in Co-Occurring Disorders: Clinical Dilemmas in Assessment and Treatment	Provides strategies to integrate tx between MH and DAS clinicians and the individual. Identifies and addresses the two systems clashes in treating the co-occurring person	6	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	120	2-Dec-09	Dr. David Mee Lee
Documentation Training					22-Jan-10	Azarm Garehman Ph.D
Beyond Competence: Serving Queer and Trans Youth within a Social Justice Framework Beyond Competence	Address strategies for serving queer and trans youth. Identifying and responding to identity formation, internalized oppression, cultivating a strength based approach	3	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	125	16-Feb-10	Jolie Harris, M.Ed. Director of Thrive Social Justice Consulting and Assistant Director for the Office of Multicultural Affairs, Seattle University And Sarah Tillery, Ph.D.
The Journey of Hope: The Shaken Tree and Kevin Hines-Anti-Suicide Activist. From a consumer's perspective.	Stigma reduction for the family and individual, suicide prevention and education	3	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	240	26-Feb-10	Kevin Hines

Table 12 Continued

Table 12 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
Helping those who Serve: Treating Military Families	To help clinicians to better understand and identify military culture. Looks at different branches, language, rituals, hierarchies, and laws that define the military as its own culture. Special attention was paid to the military family,	6	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	125	8-Mar-10	Kimberely Evans, LMFT Military Therapist
Dr. Mee-Lee - Video #1	Therapeutic Alliance/Co-Occurring Dr. David Mee Lee Video	1	Administration/Management, Direct Services, County	20	9-Mar-10	Linda Baker, LCSW
Smoking Cessation Facilitator Training	Gain Knowledge in smoking cessation issues for pregnant women, people with mental illness and substance use disorders	5	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	75	12-Mar-10	Gary J. Tedeschi, Ph.D. Clinical Director California Smoker's Helpline
Dr. Mee-Lee Video #2	Understanding & Assessing Stages of Change	1	Direct Services, County	21	16-Mar-10	Linda Baker, LCSW
Dr. Mee-Lee - Video #3	Motivational Interviewing and Ambivalence	1	Direct Services, County	17	23-Mar-10	

Table 12 Continued

Table 12 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
Male Sexual Abuse: Helping Clients Emerge from Boyhood Shadows	Providing cultural competent training, skill development, and therapeutic techniques to helping boys, adolescents, and men recover from sexual abuse	6	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	147	16-Apr-10	Stephen Braveman, LMFT and Nickolas McDaniel, LMFT-I
Basic HIPAA FOR New HA Staff		1	Direct Services, County	3	19-Mar-10	Gerald Clare, LCSW; Patient's Rights Advocate
Change Agents Developing Recovery Excellence in Co-occurring	Developing Recovery Excellence in Co-occurring. Consumer and family panel, Consultation with Linda Garret J.D, Assessment and Evidence based practices. Mission Values and vision.	18	Administration/Management; Direct Services, County; Direct Services; Community Members/General Public; Mental Health Board; Agency Board of Directors	40	31-March-2010 1 & 2 April-2010	Star Graber Ph.D, LMFT
Basic HIPAA FOR New HA Staff		1	Direct Services, County	15	2-Apr-10	Gerald Clare, LCSW; Patient's Rights Advocate

Table 12 Continued

Table 12 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
Wellness and Recovery Training Conference	Provides strategies and a framework for the development of a recovery oriented organization that embraces, values and welcomes consumers in the work place	12	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	116	27-April-2010 28-April-2010	Lori Ashcraft, Ph.D
Law and Ethics Training	Update to Law and Ethics for practitioners (LMFT, LCSW, PT, RN, LVN, Ph.D)	6	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	120	7-May-10	Linda J. Garret J.D.
David Mee-Lee, M.D. Part Two of Co-Occurring		6	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	100	3-Jun-10	Dr David Mee Lee
Basic HIPAA FOR New HA Staff		1	Direct Services, County		18-Jun-10	Gerald Clare, LCSW; Patient's Rights Advocate
Basic HIPAA FOR New HA Staff		1	Direct Services, County		17-Dec-10	
TOTAL HOURS:		100.5		1445		

III. Relevance and effectiveness of all cultural competence trainings

The county shall include the following in the CCPR:

- C. Training Report on the relevance and effectiveness of all cultural competence trainings, including the following:
 - 1. Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;
 - 2. Results of pre/post tests (Counties are encouraged to have a pre/post test for all trainings);
 - 3. Summary report of evaluations; and
 - 4. Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.
 - 5. County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.

Cultural Competence trainings are a core element of staff development and the SLOBHD is committed to relevant and effective learning opportunities for all staff and community partners. This section will outline the most recent training conducted by the Department.

C. This section will provide a training report detailing the relevance of all cultural competence trainings. Further detail is provided in the individual training reports contained in the Appendix.

1. All trainings in recent years were identified and developed through key stakeholder input. Three of the trainings, Serving Queer and Transgender Youth within a Social Justice Framework, Treating Military Members and their Families, and Helping Male Sexual Abuse Survivors were identified through the Cultural Competency Committee. The Committee utilized the California Brief Multicultural Competence Scale (CBMCC) to measure clinician level of competence in regards to populations which have disparities in access and treatment. The results indicated a need for further training in the areas of youth and men's issues. Trainings that focused on Co-occurring Disorders were identified through a Workforce Education and Training needs assessment and the SLOBHD Co-Occurring Taskforce. San Luis Obispo County is continuing to further integrate its Drug and Alcohol Services with its Mental Health Services divisions to better serve the need of co-occurring population. Other identified trainings (such as law and ethics) are yearly requirements for licensed clinicians.

2. The County used the CBMCC as a pre-test and created a baseline for cultural competence. Currently, trainings are evaluated in a post-measure construct only, although the results are valuable and by utilizing online survey tools, response rates

have increased. The County will continue to develop strategies to evaluate the level of staff competence through pre and post testing over the next year. The County will access technical assistance in developing standardized measures for pre and post testing of clinical skills.

3. Overall, the clinical trainings provided by the SLBHD in the past year were well received. The majority of the trainings were evaluated using an evaluation form that participants could complete through the SurveyMonkey.com online service. Surveys were made available to participants within a day after completing the training in order to receive Continuing Education Units (CEU). The training evaluation form is a form of post measurement asking demographic information in regards to professional status/licensed held, work location, reasons for choosing the training, rating of the overall value of the training, and three concepts learned from the training. At the current time, the training evaluation form does not measure a level of information or skills learned.

The highest rated training was “Law and Ethics” by Linda Garrett, J.D. Over 114 registered for the training and 80 participants completed the training evaluation form. For those who completed the form, 81% (65 people) rated the training “excellent,” 17% (14) rated the training “good” and 1% (1) rated it “fair.” Concepts that participants learned were information on the Health Information Technology for Economic and Clinical Health Act (HITECH) and how it impacts confidentiality and privacy; updates on the Good Samaritan Law; and confidentiality as it applies to HIPAA and Federal mandates.

Another highly rated training, sponsored by the Cultural Competence Committee, was “Helping Those Who Serve: Treating Military Families” by Kimberly Evans, LFMT. There were 106 participants registered for the training and 48 of them completed the evaluation form. Of those completing the survey, 77% (37) of participants reported that the training was “excellent.” Sixteen percent (16%), or 8 participants rated the training “good” and 6% (3) participants rated the training fair. There was a consumer panel made up of veterans that shared their experiences in attempting to get support and how they had benefited from mental health services. Participants reported that they learned the differences between brain trauma injury vs. PTSD; how serving military personnel includes serving the whole family; effects of deployment on spouses and families; and that embedded therapists exist within the military system. Participants requested that a more in-depth training be offered in the future to better explore best practices for counseling the military and their families. Workforce Education and Training plans to invite this trainer back in 2011 for further training.

The third most successful training, also sponsored by the Cultural Competence Committee, was “Male Sexual Abuse: Helping Clients Emerge from Boyhood Shadows” presented by Stephen Braveman, LMFT and Nickolas McDaniel, MFT-I. This training provided a consumer panel that shared their experiences and recovery. There were 147 individuals registered for the training and 61 individuals completed the evaluation form. Seventy-four percent (74%), or 45 Individuals rated the overall value of the training to be “excellent;” 18% (11) rated the training to be “good” and 6% (4) rated the training to

be “fair.” The concepts individuals reported having learned via the evaluation form included how the survivors of male sexual abuse are an underserved and under-represented portion of our society; there is less than one counseling center per state for male sexual abuse victims; one of six male individuals are a victim of sexual abuse; clinicians need to learn how to ask the right questions when interviewing individuals about sexual abuse; and the false myth of the vampire syndrome - those who are once abused then become an abuser.

The lowest rated training was “Beyond Competence: Serving Queer and Trans Youth within a Social Justice Framework” by Jolie Harris, Assistant Director for the Office of Multicultural Affairs, Seattle University. There were 112 participants and 50 individuals completed the evaluation form. Thirty-two percent (32%), or 16 individuals, rated the training “excellent,” 30% (15) rated the training “good,” 24% (12) rated the training “fair,” and 14% (7) rated the training “poor.” Some of the concepts that participants reported learning included that people who are part of this cultural group have varying ways to identifying themselves; research findings related to gender preference; grounding interventions; boundary interventions; and that “transgender” is an umbrella term. Participants voiced that the grounding exercises were not explained clearly and that they were not linked with the presented training material. Additionally, participants wanted more strategies and therapeutic techniques for working with queer and transgender youth.

Examples of training evaluation reports are included in the Appendix 24.

4. At this time, the County is not currently monitoring the advancement of staff skills learned in trainings. The County will be developing strategies to monitor staff skill by utilizing follow up trainings, post-test, surveys, and employee evaluations.

5. The County will follow the Education and Training Policy (Currently in Draft awaiting ratification, Appendix 25) that identifies the methodology/protocol that supports competency-based trainings, mandatory trainings, and orientation trainings and follows the guidelines put forth in each Mental Health Services Act plan. This policy will assist employees, contracted employees and volunteers to meet training and licensing requirements and to ensure our workforces ability to provide quality of care and culturally and linguistically competent services to the community.

Future plans also include the employment of “e-learning” to allow each staff and community provider access to competency and mandatory trainings through the use of personal computers. This web-based system will include an interface with the County’s human resources management software and it will have the capacity to track individual staff learning. This system and subsequent policies are currently in development and will be implemented within the next year.

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

The county shall include the following in the CCPR:

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

A. The following workshop descriptions provide evidence of a variety of cultural competence trainings provided for the county's mental health system.

Lori Ashcraft, Ph.D. Wellness and Recovery 2 day training

This workshop was led by Ashcraft, a 35-year behavioral health veteran with a strong interest in the therapeutic effects of self-determination, choice, and personal freedom. Ashcraft presented her design of teaching recovery principles and practices to assure people that recovery is possible. She has developed several curricula to help individuals with psychiatric experiences move beyond recovery by finding their purpose, making a unique contribution, and using experiences to help others grow and recover. Ashcraft's passion for recovery stems from personal experience having struggled with severe depression most of her life. This training was able to offer a panel of consumers to share their story and offer support to others who want to enter the mental health workforce.

Jolie Harris M.Ed. and Sarah Tillery, Ph.D. Beyond Competence: Serving Queer and Transgender Youth with a Social Justice Framework.

This interactive day-long workshop addressed strategies for serving queer and trans youth within a social justice framework. Curriculum topics included: identifying and responding to common processes, identify formation, addressing internalized oppression, engaging intersecting identities, cultivating a strengths based approach, and preventing against disproportionate risk. Hands-on exercises throughout the day focused on fostering somatic awareness, resilience, boundary setting, and self-confidence in relationship to sexual orientation and gender identity development.

Kimberly Evans LMFT, Helping Those Who Serve: Treating Military Members and their Families

This all day training was developed to help clinicians better understand and identify military culture. This included a look at the different branches of service, the components that make up the branches, the language, rituals, hierarchies and laws that define the military as its own culture. Special attention was paid to the military family, to include young children, and the affects of deployments on the family and the service member. This training was offered to all members of the community. The workshop connected participants to local and statewide military-specific resources and recommended strategies for creating safe forums for all military members and their families to interact with their local mental health. This training provided panel of military personnel to share their experience and answered questions. Kimberly Evans L.M.F.T is a licensed Marriage and Family Therapist in Ventura County specializing in working with military and their families. She has been working in the military field for the past 8 years. She has been an Embedded Therapist for an Army National Guard Unit for the past three years Ms. Evans has briefed over 5000 service members and their families on mental health issues and is considered an expert on military deployment issues and their affects on families.

Dr. David Mee Lee, Cultural Clashes in Co-Occurring Disorders

This all day training addressed how addiction and mental health treatment fields have arisen from very different roots. Consequently, this has accounted for the ongoing fragmentation that has been aggravated by different training, systems and funding. Clients and clinicians are separated by ideology and treatment orientations that do not serve well the co-occurring disorders client. This workshop reviewed the obstacles to integrated services and offered solutions to these cultural clashes. David Mee-Lee is a leading expert in co-occurring substance use and mental disorders with over 30 years experience in person-centered treatment and program development. Dr. Mee-Lee's past training clients have involved both provider and practitioner groups, as well as managed care organizations. Mee Lee has presented such tools as an instrument he co-authored for individualized treatment planning, the Recovery Attitude and Treatment Evaluator (RAATE).

Kevin Hines: Anti-Suicide Activist from a Consumer Perspective, The Journey of Hope and the Shaken Tree- 3 hour training

This 3 hour training was provided by a consumer and family member to educate about local resources and services available for family members and loved ones of persons with mental illness. Additionally this workshop developed a heightened understanding of

the warning signs leading up to suicidal ideation and behavior. Also it developed an understanding of stigma, how it affects people with mental illness and how it can prevent people from accessing services. The event increased participants' awareness of the concepts of mental health wellness and recovery, including hope, empowerment, spirituality, the importance of developing a support network, and the necessity of having a meaningful role in one's community.

Cultural Competence Newsletters:

San Luis Obispo County Behavioral Health disseminates a Cultural Competence Newsletter on a quarterly basis. This newsletter is a venue to further educate staff to cultural considerations when working with diverse populations. The newsletters have covered topics on the following: Native American, Latino, African American, Veterans, and Gay and Lesbian.

B. The training plan must also include, for children, adolescents, and transition age youth, the parent's and/or caretaker's, personal experiences with the following:

1. Family focused treatment;
2. Navigating multiple agency services; and
3. Resiliency.

Use the following format to report the above requirements:

Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
<i>Example</i>	<i>Overview of cultural competence issues in mental health treatment settings.</i>	<i>Four hours annually</i>	<i>*Direct Services</i>	<i>15</i>	<i>1/24/10</i>	
<i>Cultural Competence Introduction</i>			<i>*Direct Services</i>	<i>20</i>		
			<i>Contractors</i>	<i>4</i>		
			<i>*Administration</i>	<i>2</i>		
			<i>*Interpreters</i>			
				<i>Total: 41</i>		

Table 13

Table 13 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
PE&I Collaboration Conference	Define prevention and early intervention to motivate partners, stakeholders, and providers to look at PE&I for its role in changing how the community responds to BH issues	7	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	124	3-Sep-09	Maureen Sedonaen from Youth Leadership Institute and Frank Warren from BH
PE&I Collaboration Conference – Cultural Competence Training	Define cultural competence issues in PEI and how to improve service delivery amongst diverse populations and risk factors.	1	Administration/Management; Direct Services, Counties; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	124	3-Sep-09	C. Rocco Cheng, Ph.D., Pacific Clinics
Student Assistance Program	A system for pinpointing and intervening in behaviors that interfere with learning and disrupt the classroom. Links with existing programs in the community.	6	Administration/Management, Direct Services, Counties; Direct Services, Contractors; School District Employees	37	4-Sep-09	Bill Spencer

Table 13

Table 13 – Behavioral Health Training Calendar						
2009-2010 FY						
Training Event	Description	Hours	Attendance by Function	# of Attendees	Date	Name of Presenter
The Journey of Hope: The Shaken Tree and Kevin Hines-Anti-Suicide Activist. From a consumer's perspective.	Stigma reduction for the family and individual, suicide prevention and education	3	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	240	26-Feb-10	Kevin Hines
Helping those who Serve: Treating Military Families	To help clinicians to better understand and identify military culture. Looks at different branches, language, rituals, hierarchies, and laws that define the military as its own culture. Special attention was paid to the military family,	6	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	125	8-Mar-10	Kimberely Evans, LMFT Military Therapist

Table 13

Table 13 – Behavioral Health Training Calendar						
2009-2010 FY						
<i>Training Event</i>	<i>Description</i>	<i>Hours</i>	<i>Attendance by Function</i>	<i># of Attendees</i>	<i>Date</i>	<i>Name of Presenter</i>
Beyond Competence: Serving Queer and Trans Youth within a Social Justice Framework Beyond Competence	Address strategies for serving queer and trans youth. Identifying and responding to identity formation, internalized oppression, cultivating a strength based approach	3	Administration/Management; Direct Services, County; Direct Services, Contractors; Community Members/General Public; Mental Health Board; CBO's/Agency Board of Directors	125	16-Feb-10	Jolie Harris, M.Ed. Director of Thrive Social Justice Consulting and Assistant Director for the Office of Multicultural Affairs, Seattle University And Sarah Tillery, Ph.D.

CRITERION 6

COUNTY MENTAL HEALTH SYSTEM

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

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

The county shall include the following in the CCPR:

- A. Extract a copy of the Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component.

SLOBHD is committed to the recruitment, hiring, and retention of a multicultural workforce from, or experienced with, identified unserved and underserved populations.

A. The Mental Health Services Act (MHSA) workforce assessment submitted to DMH for the Workforce Education and Training (WET) component is included herein (Appendix 26).

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

B. Tables and analysis included in the WET Plan's workforce assessment demonstrate full-time staff-to-client ratios by race and ethnicity. An overall shortfall was indicated in the mental health workforce in regards to meeting the prevalence needs within San Luis Obispo County. The County and its providers have indicated that services are only provided to 33% of the consumers who need mental health services. This figure represents all populations, including the Medi-Cal and 200% of poverty populations.

The Plan's assessment also revealed that there remains a need for additional bilingual/bicultural staff in all classifications, especially in the county's threshold language of Spanish. As described in other sections of this document, these practitioners are difficult to recruit.

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.

C. San Luis Obispo County did not receive cultural consultant technical assistance recommendations as part of any review of the WET Plan submission to the State.

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

D. The targets that have been reached based on one year of programming are the following:

- Three Bilingual clinical interns have been hired and placed in the county regionally.
- Over 50 scholarships have been awarded to individuals working in the mental health field or wanting to seek employment in the field;
- Over 100 hours of training reaching out to over 1400 individuals has been provided;
- The Transitions Mental Health Association Peer Advisory Group is meeting weekly and provided stigma reduction education and peer counseling throughout the community;
- The Co-occurring taskforce has been integrating services, providing two full days of trainings hosted by Dr. Mee Lee and the taskforce has shown his 5 part training DVD's to over 50 mental health and drug alcohol staff during their lunch time breaks;
- Crisis Intervention Training has been provided to 20 law enforcement personnel; and,
- The Cultural Competence Committee has provided three trainings to support competence in the mental health field. Additional trainings have been provided to meet licensing and state regulations.

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

E. Several lessons have been learned in implementing county WET planning, including:

- WET funding for a training room equipped with computers and technology training aids was not originally conceived or proposed in the planning process; consequently, Behavioral Health is lacking a designated computer training room for training.
- The development of the Electronic Learning initiative has been a morale boost for staff and will create many opportunities for staff to build capacity and for the Department to enhance its services. The SLOBHD is now working on the challenge of creating policy and procedures so that the product is used to its fullest.
- "Action 5" of the WET plan, Integrating Cultural Competence, has been adapted to provide stakeholders with better monitoring of funds. A need was identified to assure stakeholders that funds were being used efficiently, for instance training or hiring staff that were all ready proficient in Spanish or bicultural instead of trying to train a staff member to learn Spanish.
- Lessons learned regarding training include the need to develop stronger evaluation systems to accurately capture the growth in capacity. This will be

integrated with the three-year training plan, which has been successful for guiding training decisions and developing core competencies.

F. Identify county technical assistance needs.

F. The County has identified the need for further technical assistance in the arena of data collection, evaluation and statistical reporting to further improve SLOBHD's ability to analyze the effectiveness of its WET plan. The County is interested in developing standardized measures to evaluate learning outcomes and best practices in providing training. It will be useful to view standardized models of pre and post tests to evaluate levels of learning in best practices and cultural competence. Additional technical assistance needs include assistance in developing an up-to-date training facility equipped with computers and software. The County is also interested in working with a library or clinical research database that clinicians can access for current research articles to review and gain consultation.

CRITERION 7

COUNTY MENTAL HEALTH SYSTEM

LANGUAGE CAPACITY

I. Increase bilingual workforce capacity

The county shall include the following in the CCPR:

- A. Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:
 1. Evidence in the Workforce Education and Training (WET) Plan on building bilingual staff capacity to address language needs.
 2. Updates from Mental Health Services Act (MHSA), Community Service and Supports (CSS), or WET Plans on bilingual staff members who speak the languages of the target populations.
 3. Total annual dedicated resources for interpreter services.

San Luis Obispo County has made significant strides in improving services to Spanish-speaking clients over the past five years. By increasing the bilingual workforce and the number of bicultural staff, the SLOBHD has reduced barriers, increasing access for many of the county's mentally ill and their families.

A. SLOBHD has committed resources and developed strategies in each of its MHSA plans to grow bilingual staff capacity. In 2005, during the planning process for the first MHSA plan (CSS), a study was done to determine the need for increased staff capacity which would better serve the Latino population in the county. Clearly the most underserved population in need throughout the county; Spanish-speakers were often unable to access services due to limited language proficiency on the part of County and community providers. Since that initial MHSA plan, bilingual staffing has increased 20%; while Latino population client figures have grown 31% since 2006.

MHSA plans and funding have increased the County's staffing of not only Mental Health Therapists, but the County has also increased positions and hours for Spanish-speaking psychiatrists, medication managers, drug and alcohol specialists, and clerical staff.

Another strategy which has emerged from these MHSA discussions and studies has been the need to increase the exposure of position postings. The County's Human Resources Department traditionally only advertises open positions through the county's major newspaper and its own website, neither of which are available in Spanish. Since the launch of MHSA programs the SLOBHD has advertised its bilingual staffing recruitments in a variety of Spanish-language forums. Advertisements have been placed in "Latino Today" a web-based newspaper circulated from Santa Maria, a large

city just south of San Luis Obispo County. Positions have also been advertised through presentations to local cultural organizations, such as the Latino Outreach Council and “Vision Unida.” Both organizations have shared the postings with their constituents through email and mailing lists.

1. The County’s Workforce Education and Training (WET) Plan has specific planks on which to build bilingual staff capacity to address threshold language needs. The **Bilingual Internship Program** strategy provides funding to support three part-time bilingual students to gain experience and knowledge working in the public mental health system within a recovery approach. The Intern Program Supervisor tracks the number of interns obtaining employment with the County and with local community based organizations; and will begin to develop strategies for retaining interns in the behavioral health field.

2. Because cultural competence is a key component of each MHSA plan and its projects, language and cultural appropriateness has expanded throughout the mental health system.

- SLOBHD, partly due to the CSS strategy which created the Latino Outreach Program, has had a 20% increase in bilingual and bicultural staff over the past three years.
- Other CSS programs, including the supports provided by community partner agencies, have increased overall community bilingual capacity. Programs such as TMHA’s peer recovery programs are now available in Spanish.
- Each of the five PEI programs are being implemented in Spanish and English. For instance, the SLOtheStigma campaign and subsequent public presentations are available in Spanish; the school-based wellness programs feature bilingual “Family Advocates;” and all parent education programs and coaches are bilingually offered as well.
- Workforce Education and Training has hired three part-time Spanish speaking Mental Health interns. They have been placed regionally in the county and are serving youth and families. Additionally, two rounds of scholarships have been awarded to individuals who are either working in the mental health workforce or are wanting to enter the workforce. Scholarships have been awarded in the amount of either \$5000 for Bachelors or Masters level candidates and \$1200 for individuals seeking certificates or AA degrees. Positively, over 55 individuals have received an award.

3. The total annual amount of dedicated resources for interpreter services is \$5,686. This is funded by County General Fund Support and Realignment.

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

The county shall include the following in the CCPR:

- A. Evidence of policies, procedures, and practices in place for meeting clients' language needs, including the following:
1. A 24-hour phone line with statewide toll-free access that has linguistic capability, including TDD or California Relay Service, shall be available for all individuals. Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.
 2. Least preferable are language lines. Consider use of new technologies such as video language conferencing. Use new technology capacity to grow language access.
 3. Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access.
 4. Training for staff who may need to access the 24-hour phone line with statewide toll-free access so as to meet the client's linguistic capability.

SLOBHD is committed to providing services to persons having Limited English Proficiency (LEP) by using interpreter services, translated forms, and help lines which are linguistically capable and accessible to those with impairments.

A. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 27): "Mental Health Services is committed to providing multi-lingual and culturally appropriate services to the diverse populations in the County including Telecommunication Device for the Deaf (TDD) and California Relay Services (CRS)."

1. A 24-hour phone line with statewide toll-free access (800-838-1381) that has linguistic capability, including TD, is available for all individuals. We utilize AT&T Language Line for LEP callers and California Relay Services for hearing impaired callers. We utilize bilingual staff for initial contacts when available.

2. SLOBHD is interested in expanding its use of technology to further improve access. Over the next three years the Department will embark on the transition to Electronic Health Records, and "E-Learning" to improve training outcomes. In the Department's desire to move forward with new technology, technical assistance and support from the State will be sought.

3. The Language Line protocol consists of the following steps:

1. Caller requests services in another language.
2. Staff member answering the phone identifies the language and, if Spanish, reads instructions to client in Spanish to hold while the staff member contacts an interpreter.

3. Staff member calls AT&T language Line at 800-523-1786 and asks for an interpreter.
4. Staff Member informs caller through the interpreter in caller's language that interpretation services are free of charge and then ascertains caller's needs through the interpreter. If applicable, services are scheduled with a provider who speaks the caller's language. Language and cultural requests are documented on the Service Request form.

As described in the aforementioned document (Appendix 27) the Department's language line policy consists of the following standards:

- 1. Interventions in alternative languages are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care database.*
- 2. Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.*
- 3. Interventions in alternative, culturally-competent approaches are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care data base.*
- 4. Each clinic site has the capacity to provide services in the County's primary threshold language upon request (i.e. Spanish).*
- 5. All new employees are given a brochure on the use of the AT&T Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure.*
- 6. Linguistic translation and interpretation services are provided in a confidential manner. As a general policy family members will not be relied on as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.*
- 7. When culturally-appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.*
- 8. If there is a need for services not currently available, the following progression of referral is followed:*
 - a. From Therapist or receptionist to Program Supervisor.*
 - b. Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.*

4. All new employees are given a brochure on the use of the AT&T Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure. Additionally, The After-Hours Crisis Worker on the Psychiatric Health Facility (PHF) is currently training all PHF staff 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. Including posting of this right.

B. SLOBHD clients are informed in writing in their primary language, of their rights to language assistance services. Clients are informed of the right to free interpretation services via the Language Line and an option available on the Service Request (Appendix 35). This information is also posted in the Lobby of each SLOBHD center (Appendix 28).

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

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

C. According to SLOBHD's Bilingual Certification Policy (Appendix 29) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services." This is exhibited in the following procedures and practices.

1. Staff at SLOBHD routinely make accommodations to persons who have LEP, getting help for consumers and family members who need bilingual staff or interpreter services. A recent example of this service occurred when police in Paso Robles (a city 30 miles to the north of the County seat, with a diverse population) arrested the proprietor of an assisted living facility due to labor violations. Many of the exploited workers were Filipino, and one in particular had difficulty expressing herself and understanding what was happening. One of the Department's quick thinking program supervisors called Lillian Bucton, LCSW, and a staff member fluent in Tagalog. Lillian responded to the scene and was able to work with the distressed worker, reducing the stress of the situation.

The Department also has staff certified in American Sign Language (ASL). In the past year, accountant Dennis Kemp, fluent in ASL (as well as Russian), has been called into the Psychiatric Health Facility (PHF) to use his signing skills to help a patient communicate with his treatment team. Knowledge of those language and interpretation skills of all members of the organization has increased the Department's capacity to meet the needs of a diverse population.

Lessons have also been learned regarding the Language Line. The tool can sometimes be difficult to use and it is difficult to ask personal-but-necessary screening questions over the phone with an interpreter. Positively, it allows SLOBHD staff to rapidly do the screening needed to enroll clients.

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

D. The greatest challenge in establishing services to persons who have Limited English Proficiency (LEP) using interpreter services is the difficulty the County has in hiring and retaining bilingual staff. Several factors play into this particular challenge. First, the well-established lack of Latino (and other language-capable) health and social service professionals (Institute of Medicine, 2004) is a major roadblock to staffing which accurately reflects the needs of a community in California. Secondly, the cost of living index in the County is higher than the California and U.S. averages, making recruitment of out-of-town professionals difficult – along with the challenge of maintaining a culturally diverse workforce in an expensive market. Advertisements for therapists and other providers who are bilingual get limited responses. Finally, the County faces competition for staff recruitment and salary equity from institutions such as the Atascadero State (Psychiatric) Hospital and the California Men’s Colony, a State prison; both of which pay much higher wages for qualified staff. These issues are at the core of the County’s WET Plan which seeks to improve both intra-county development of diverse providers as well as improve the County’s current cultural and linguistic capacities to serve clients.

E. Identify county technical assistance needs.

E. San Luis Obispo County Behavioral Health would be interested in any developments which may increase the County ability to provide services to persons who have Limited English Proficiency (LEP) using technology. The Department does not have staff capacity to develop computer or telecommunication solutions to this issue, but would welcome technical assistance made to increase the County’s awareness of technological solutions – such as expanded telephone services, video-conferencing, and other web-based language communication technologies.

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

Note: The use of the language line is viewed as acceptable in the provision of services only when other options are unavailable.

The county shall include the following in the CCPR:

A. Evidence of availability of interpreter (e.g. posters/bulletins) and/or bilingual staff for

the languages spoken by community.

- B. Documented evidence that interpreter services are offered and provided to clients and the response to the offer is recorded.
- C. Evidence of providing contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.
- D. Evidence that counties have a process in place to ensure that interpreters are trained and monitored for language competence (e.g., formal testing).

SLOBHD is committed to providing bilingual staff and/or interpreters for the threshold languages at all points of contact. Documents which demonstrate this commitment of practice are described in this section.

A. The flier displayed in each Mental Health center countywide (Appendix 28) demonstrates SLOBHD's availability of interpreter and/or bilingual staff availability for the languages spoken by community. Signs in Spanish and English indicating the availability of free translation services and help with paper work are posted in the lobby/reception area of each County Mental Health Services center.

B. The standard Service Plan (Appendix 35) demonstrates that SLOBHD's interpreter services are offered and provided to clients and the response to the offer is recorded. Once interpretation services are offered the offer/response is documented on the Service Request. Additionally, Care Plans, Master Service Plans and Progress Notes each document whether interpretation services were utilized. These forms are available for review upon State site visit.

C. The included list of bilingual staff (Appendix 31), as well as the Provider List (Appendix 32) demonstrates that SLOBHD provides contract or agency staff that are linguistically proficient in threshold languages during regular day operating hours.

D. According to SLOBHD's Bilingual Certification Policy (Appendix 29) "Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services." The following procedures are in place to monitor and certify bilingual staffing:

Procedure:

1. *The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).*
2. *The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members at least one of whom is a native speaker of the threshold languages in the county.*
3. *The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25*

for each of the areas described below for a total of 100. The checklist will include, but not be limited to:

- a. Fluency, the ability to communicate with ease, verbally and non-verbally.
 - b. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.
 - c. Grammar, appropriate use of tense and grammar.
 - d. Cultural considerations related to potential client.
4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.
5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

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

The county shall include the following in the CCPR:

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

According to SLOBHD's Services for Provider List Availability Policy (Appendix 33), "Mental Health Services provides clients with a list of specialty internal health providers upon first receiving mental health services, upon request, and on an annual basis." The Culturally Competent, Multi-Lingual Services Policy (Appendix 27), adds important procedures which assure clients get the services they seek.

A. These policies outline the procedures for providing clients with updated lists of service providers who are equipped to handle specialty needs – including culturally and linguistically appropriate services. The Department has a Network Provider who speaks German, and a staff member who speaks Tagalog. SLOBHD is prepared to make ASL translation available upon request by way of a contract with Independent Living Resource Center (805-963-0595). Interpretation services are free to the consumer.

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.

B. The following procedure, from Services for Provider List Availability Policy (Appendix 33), outlines how clients, who do not meet the threshold language criteria, are assisted to secure, or linked to culturally and linguistically appropriate services.

Procedure

1. *Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations and telephone numbers of current contracted providers in the beneficiaries' service areas by category.*
2. *Each service site has a list of service providers available and will provide this list to any applicant upon request.*
3. *Upon completion of an application for services at the time of the first specialty mental health service, the applicant is offered a list of service providers.*
4. *The offer of this list is confirmed by the therapist or support staff checking the box labeled "list of service providers available to applicant" on the application form.*
5. *The list of providers is available at any time on request at all service sites and offered on an annual basis. The annual offer of the list is recorded on the Application for Services.*

The Culturally Competent, Multi-Lingual Services Policy (Appendix 27), adds the following procedures which assure clients get the culturally and linguistically-specific services they seek:

- *Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.*
- *When culturally-appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.*
- *If there is a need for services not currently available, the following progression of referral is followed:*
 - a. *From Therapist or receptionist to Program Supervisor.*
 - b. *Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.*

Access

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

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

C. According to SLOBHD's Culturally Competent, Multi-Lingual Services Policy (Appendix 27), the following procedures are in place to assure the Department complies with Title VI of the Civil Rights Act of 1964, including the above-mentioned requirements:

- *Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.*
- *Linguistic translation and interpretation services are provided in a confidential manner. As a general policy family members will not be relied on as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.*
- *When culturally-appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.*

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

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

- A. Culturally and linguistically appropriate written information for threshold languages, including the following, at minimum:
1. Member service handbook or brochure;
 2. General correspondence;
 3. Beneficiary problem, resolution, grievance, and fair hearing materials;
 4. Beneficiary satisfaction surveys;
 5. Informed Consent for Medication form;
 6. Confidentiality and Release of Information form;
 7. Service orientation for clients;
 8. Mental health education materials, and
 9. Evidence of appropriately distributed and utilized translated materials.
- B. Documented evidence in the clinical chart, that 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 (e.g., back translation and culturally appropriate field testing).
- D. Mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing).
- E. Mechanism for ensuring translated materials is at an appropriate reading level (6th grade). Source: Department of Health Services and Managed Risk Medical Insurance Boards.

During the on-site compliance review, the State will be able to review translated documents, forms, signage, and client informing materials, including the following:

A. Examples of culturally and linguistically appropriate written information for threshold languages include the following:

Member service handbook or brochure;

1. The County provides Medi-Cal beneficiaries with a Beneficiary Handbook (Appendix 43) and other informing materials at the time of admission into the system, annually thereafter, and at any time upon request. The Beneficiary Handbook policy specifies that these materials are available in Spanish and for disabled clients. (Appendix 36).
2. An example of general correspondence template is included herein Appendix 34).
3. Beneficiary problem, resolution, grievance, and fair hearing materials are included in the Beneficiary Handbook and the Department's Grievance Process materials (Appendix 50).
4. The Latino Outreach Program has created a satisfaction survey used for both Medi-Cal beneficiaries and community clients. This questionnaire is included (Appendix 13); along with results from the past year (Appendix 38).
5. The Department's Informed Consent for Medication form is included (Appendix 39).
6. The Department's Confidentiality and Release of Information form is included (Appendix 40).
7. Service orientation for clients includes information about specialty services, including the Latino Outreach Program. The brochure provided for consumers and the community is included (Appendix 41)
8. SLOBHD makes several publications and mental health education materials available to the public and the clients visiting each of its centers. An example of materials is included in the Lobby Materials Checklist (Appendix 42).
9. The Lobby Materials Checklist (Appendix 42) and Policy for the Distribution of Translated Materials (Appendix 51) provide further evidence of appropriately distributed and utilized translated materials.

B. The County requires staff to accurately document that clinical findings/reports are communicated in the clients' preferred language. Bilingual staff are required to document key findings and reports for clients using their preferred language within the Master Service Plan (Appendix 35). Elements of the plan which are written in both English and Spanish include desired goals, target symptoms and functions, and objectives. This material is reviewed with the client.

C. As referenced above, the Department's Latino Outreach Program is utilizing a consumer satisfaction survey translated in the threshold language of Spanish (Appendix 13); and results from the past year are provided herein (Appendix 38).

D. As per the County's "Readability of Medi-Cal Informing Materials" Policy (Appendix 52) San Luis Obispo Mental Health Services periodically involves clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level. The Patients Rights Advocate periodically meets face to face with a representative sample of beneficiaries and guides a process for reviewing the Handbook for readability.

SLOBHD does not currently have a further mechanism for ensuring accuracy of translated materials in terms of both language and culture (e.g., back translation and culturally appropriate field testing). Current practice involves consultation with the Department's Ethnic Services Manager to assure necessary documents are made available in Spanish, and that consumers are able to access needed information. This process will be explored by the Cultural Competency Committee over the next year.

E. As per the County's "Readability of Medi-Cal Informing Materials" Policy (Appendix 52) San Luis Obispo Mental Health Services periodically involves clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level. The Patients Rights Advocate periodically meets face to face with a representative sample of beneficiaries and guides a process for reviewing the Handbook for readability.

SLOBHD does not currently have a further mechanism for ensuring translated materials are at an appropriate (6th grade) reading level. Current practice involves consultation with the Department's Ethnic Services Manager to assure necessary documents are made available in Spanish, and that consumers are able to access needed information. This process will be explored by the Cultural Competency Committee over the next year.

CRITERION 8

COUNTY MENTAL HEALTH SYSTEM

ADAPTATION OF SERVICES

I. Client driven/operated recovery and wellness programs

The county shall include the following in the CCPR:

- A. List and describe the county's/agency's client-driven/operated recovery and wellness programs.
 - 1. Evidence the county has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences.
 - 2. Briefly describe, from the list in 'A' above, those client-driven/operated programs that are racially, ethnically, culturally, and linguistically specific.

SLOBHD is committed to providing opportunities which enhance client-driven recovery and wellness programs (Appendix 53). The County has established critical partnerships with community-based recovery and wellness programs to expand the capacity of the mental health system to provide culturally appropriate recovery services.

A. SLOBHD's primary community partner for providing client-driven and operated recovery and wellness programs is Transitions Mental Health Association (TMHA). This established non-profit organization is focused on reducing the stigma of mental illnesses, maximizing personal potential and providing innovative mental health services to individuals and families in need. TMHA offers a full spectrum of programs in both San Luis Obispo and Northern Santa Barbara Counties. THMA includes the National Alliance on Mental Illness (NAMI) as one of its partners in providing culturally appropriate recovery services.

TMHA operates 27 programs at over 35 locations that reach over 2,000 people and 1,500 families in San Luis Obispo and Santa Barbara counties. The emphasis of TMHA's many services is to teach vital independent living skills, and build a framework for community re-entry through personal empowerment and hands on experience. With the County, TMHA is dedicated to providing housing, employment, case management and life-skills support to mentally ill adults, at-risk youth and homeless adults.

TMHA also participates in multi-agency collaboration that provides 24/7 support services where and when they are needed. Staff teams are fully integrated to give each individual a range of choices and help them decide on a recovery process. Services include psychiatric care, housing assistance, substance abuse recovery, health, financial, education, employment and social support options.

SLOBHD's **Full Service Partnership** is a MHA program conducted in partnership with MHA that provides 24/7 intensive community-based wrap around services to help people in recovery live independently. Program participants are assisted in their efforts to gain the skills needed to make choices that reflect their own values, preferences, and goals; supports are developed to meet each person's needs and to empower each individual to attain their highest level of independence possible.

SLOBHD also provides recovery services via its **Behavioral Health Treatment Court (BHTC)**, which operates as an FSP for adults, ages 18 to 60, with a serious and persistent mental illness, on probation, and who have had mental health treatment as part of their probation orders. These individuals have been previously underserved or inappropriately served because of lack of effective engagement or in meeting their needs. They often have a co-occurring disorder, are homeless and have had multiple incarcerations through the criminal justice system.

The County provides funding (via contractual agreements) for TMHA's various recovery and wellness programs and the two organizations work closely to move consumers, families, and supports fluidly between County and community services. TMHA provides the following client-driven/operated recovery and wellness programs:

In Our Own Voice is a NAMI-developed presentation format that equips individuals with mental illness to share their stories with others. This multi-media, interactive, public education program is intended for all audiences, including family members, health providers, law enforcement, faith communities, community or civic organizations and consumer groups.

Stamp Out Stigma (SOS) is a consumer-driven advocacy and educational outreach program designed to make positive changes in the public perception of mental illness and inform the community about the personal, social, economic and political challenges faced by people living with mental illness. SOS presentations consist of 1-6 presenters who share personal experiences of living with mental illness, relating their own experiences of stigma and how they have worked to change the negative societal perceptions. **SLOtheStigma** is a PEI-developed partnership project between the County and TMHA consisting of a documentary and public media campaign utilizing this consumer-led stigma-reduction model.

The Peer Advisory Advocacy Team was created to give consumers the opportunity to participate in committees and workgroups at SLOBHD and other local mental health organizations in order to enhance the mental health system, educate the community and reduce stigma.

TMHA offers **Peer Support Groups** run by and for people with mental illness. The groups provide peer-to-peer interaction, the sharing of stories, education and a sense of community. Currently groups are run in Arroyo Grande, San Luis Obispo, and Atascadero. **Peer-to-Peer** is a formatted peer support group for any person with serious mental illness who is interested in establishing and maintaining wellness. This nine-

week course (two hours per week) developed by NAMI uses a combination of lecture, interactive exercises and structured group processes to explore recovery.

1. The County has alternatives and options available within the above programs that accommodate individual preference and racially, ethnically, culturally, and linguistically diverse differences. As described throughout this Criterion section and subsequent Appendices, the County has policies and practices in place (including those with its community partners) to provide language support along with alternatives which meet a minimum standard of cultural competence.

Examples of community programs which offer alternative supports while meeting specific cultural and diversity needs are also based at TMHA:

Youth Treatment Program (YTP) is a residential treatment program serving young people from San Luis Obispo County who cannot cope with their present living situation and need a different living structure to recover and become stable.

Transitional Housing for Homeless (THH) program serves disabled adult residents of San Luis Obispo County who are currently or potentially homeless. The goal for all program residents is successful independent living within 24 months. At completion of the program, residents may be eligible for Section 8 housing assistance.

Full Service Partnership (FSP) Intensive Residential Program is funded by the Mental Health Services Act (MHSA) and provides 24/7 intensive community-based wrap around services to help people in recovery live independently. Residents are referred to the program through SLOBHD and occupy a variety of community housing and apartment rentals throughout San Luis Obispo, Atascadero and Arroyo Grande.

As described in Criterion Four, it is the intent of the Cultural Competence Committee to continue to develop monitoring strategies and programming options which increase the County's capacity to meet the needs of the diverse citizenry – including the LGBTQ community, veterans and underserved ethnic populations.

2. Of the programs listed in the above section, all strive to meet the needs of participants including racially, ethnically, culturally, and linguistically specific services. Some examples of this effort include:

- SLOtheStigma: Both the documentary film and its website (www.slothestigma.org) are accessible in Spanish. This is critical as the website also serves as a MHSA directory of services including all of the county's support and provider contacts.
- TMHA's Peer Support Groups include specific groups for LGBTQ, older adults, youth, and other diverse populations.
- All FSP and BHTC services are provided in Spanish and other cultural needs are met by the one-on-one support and case management of these specialized programs.

II. Responsiveness of mental health services

The county shall include the following in the CCPR:

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

(Counties may develop a listing of available alternatives and options of cultural/linguistic services that shall be provided to clients upon request. The county may also include evidence that it is making efforts to include additional culture-specific community providers and services in the range of programs offered by the county).

Currently, the County does not have a uniform listing of available alternatives and options of cultural/linguistic services that can be provided to clients upon request. This is an effort which will be undertaken over the next two years to assure that recommended alternative services in the community can meet the County's standards of service.

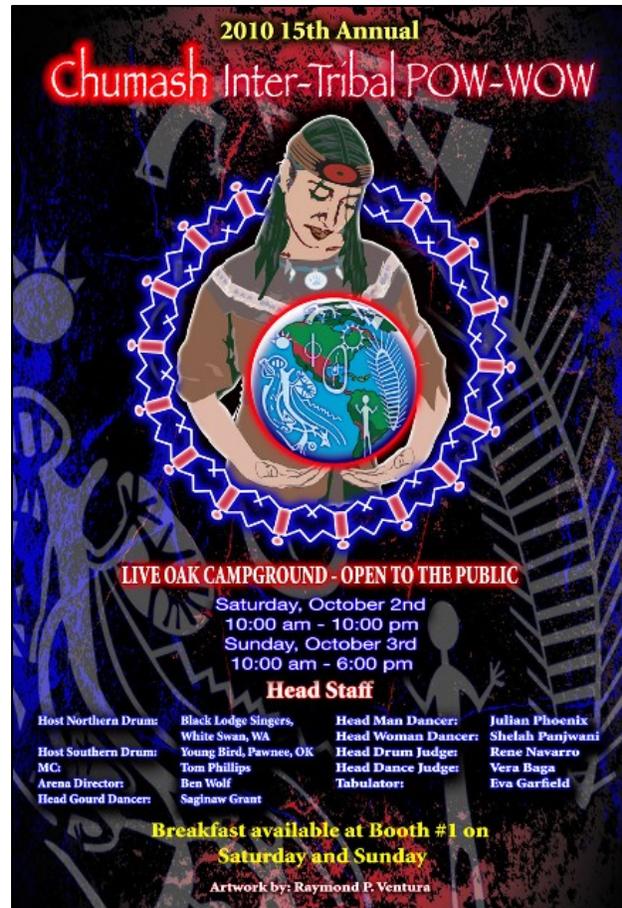
A. The primary resource provided to clients is the Provider List of Behavioral Health Clinics and Contract Providers (Appendix 32). This lists all local programs and services known to meet the mental health and wellness needs of clients within the mental health system. The Provider List includes language and cultural services as well as any other alternative supports available. This list is available to all SLOBHD Mental Health Services clients.

The primary culture-specific program provided by SLOBHD is the **Servicios Sicologicos Para Latinos: A Latino Outreach Program (LOP)** (Appendices 8, 9, 10, 11), described in Criterion 3, Part III, which offers culturally appropriate psychotherapy services to monolingual, low income Spanish speakers and their bilingual children.

SLOBHD staff individually offer clients alternatives and options that accommodate individual preference, or cultural and linguistic preferences, provided by community-based, culturally-appropriate, non-traditional mental health providers. Examples of this include:

- The Human Services and Support Groups Directory published by Hotline/211 (local crisis prevention/intervention phone services, although the publication is no longer in print).
- Contact information for LGBTQ resources including PFLAG (Parents & Friends of Lesbians and Gays) www.pflagcentralcoastchapter.net; GALA (Gay and Lesbian Alliance of the Central Coast) www.ccgala.org; Tranz Central Coast <http://tranzcentralcoast.web.officelive.com>.

- Spiritual resources including all church services found in local directories, drumming circles found in the New Times (popular alternative weekly newspaper), and Native American Resources: www.santaynez.org; see an Annual Pow-Wow flyer that has been distributed to clients.
- Drug and alcohol recovery resources including lists and schedules of all local 12-Step (AA, NA, Al-Anon, etc.) which are available at each SLOBHD site; Christian-based 12-step groups, such as Celebrate Recovery at ABC Church in Atascadero, and specific neighborhood recovery centers such as North County Connection - (Alano club, 12-step & general info.) www.northcountyconnection.com.



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.

B. The County informs clients of the availability of the above mentioned listings primarily via the Beneficiary Handbook and the Provider List of Behavioral Health Clinics and Contract Providers (Appendix 32). The County is currently developing a Member Services Brochure which will include the alternatives and options described in the previous section.

The Beneficiary Handbook is given to MediCal beneficiaries at their intake assessment and subsequently annually thereafter. SLOBHD Policy 2.04 (Appendix 36) outlines the Beneficiary Handbook protocol, which includes the engagement of clients regarding linguistic and cultural treatment options, as described in the Provider List. The Provider List Policy 11.17 (Appendix 33) states that “Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations and telephone numbers of current contracted providers in the beneficiaries’ service areas by category.”

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

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

C. The County conducts several practices to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services. These practices include internal policies which mandate staff to provide information regarding available services under consolidation of specialty mental health services, as described in the previous section. The County informs clients of the availability of the above mentioned listings primarily via the Beneficiary Handbook and the Provider List of Behavioral Health Clinics and Contract Providers (Appendix 43 and 32).

Therapeutic Behavioral Services (TBS) are a specialty mental health service for children and youth under age 21 receiving EPSDT mental health services who are placed in or are being considered for Rate Classification Level 12 or higher, **or** have received psychiatric hospitalization in the past 24 months, **or** are being considered for psychiatric hospitalization. SLOBHD has held forums (Appendix 44) to educate the public and providers as to how these services are engaged. Materials for these forums were distributed in English and Spanish. Reports on the forums were provided to DMH, and an example has been placed in the Appendix (Appendix 45).

Other efforts include outreach services, including those of the **Latino Outreach Program (LOP)**. As described in Criterion 3, the LOP is directed by Dr. Silvia Ortiz. Dr. Ortiz provides many public presentations during the year so that Medi-Cal beneficiaries (including those yet to engage the system) are made aware of the cultural and language capacities of the mental health system locally. In FY 2009-2010 Dr. Ortiz made contact with 1,349 individuals via community presentations and/or forums designed to disseminate information about specialty mental health services.

County partners, such as Transitions Mental Health Association (TMHA) and Family Care Network, Inc. (FCNI) utilize professional web sites which disseminate information regarding specialty mental health services. FCNI's web site provides information regarding its provision of **TBS services** (<http://www.fcni.org/about/services/family-support>). TMHA's web site (http://www.t-mha.org/main/main_ps_hs.html) outlines services including their **Supported Employment Program (SEP)** which provides on-going job support services necessary for individuals with mental illnesses to choose, get and keep competitive employment, while working in jobs and environments they prefer and with the level of professional support they desire. SEP is a growing program serving well over 100 individuals per year and partnering with more than 30 businesses and community agencies throughout San Luis Obispo County.

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

1. Location, transportation, hours of operation, or other relevant areas;
2. Adapting physical facilities to be accessible to disabled persons, while being comfortable and inviting to persons of diverse cultural backgrounds (e.g., posters, magazines, décor, signs); and
3. Locating facilities in settings that are non-threatening and reduce stigma, including co-location of services and /or partnerships, such as primary care and in community settings. (The county may include evidence of a study or analysis of the above factors, or evidence that the county program is adjusted based upon the findings of their study or analysis.)

D. The County continually examines the factors which affect access to its services and develops plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services.

1. The SLOBHD maintains a Provider List of Behavioral Health Clinics and Contract Providers (Appendix 32). This document is available to clients and the public, and includes information about provider services, operating hours and location including access points near public transportation. Each County facility offers the public current and relevant public transportation informational brochures and schedules. Some providers have contracted services with local transportation companies, outside of the scope of County services.

2. The SLOBHD clinics and offices are ADA compliant and accessible to all citizens. The Department maintains a Provider List of Behavioral Health Clinics and Contract Providers (Appendix 32) which includes information about provider services, language capacity, and ADA access.

Department and provider sites are warm, comfortable, and inviting to persons of diverse cultural backgrounds. Photographs have been added to this report to demonstrate examples of County service facilities.

3. The County has been a progressive leader in developing collaborative and integrated services for several years. Systems Affirming Family



Empowerment (SAFE) is the County's foundational integrated services system and continues to offer community members access to integral social and health services in warm, neighborhood settings.

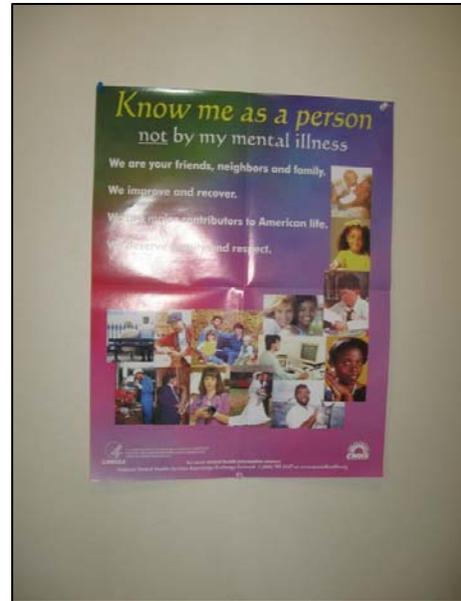
The SAFE Children's System of Care has been evolving since the original Healthy Start Programs. The Substance Abuse and Mental Health Services Administration (SAMHSA) Children's System of Care grant helped establish initial funding for Multiagency Collocated Integrated Children's Systems of Care. The SAFE Program was designed to facilitate the development of a client-family-driven, coordinated treatment planning and implementation system that is strengths driven; community based and demonstrates culturally competent service delivery. The program is made up of a Hub of Service centrally located in the South County. Radiating out from the center are three additional Family Resource Centers (FRCs) that reflect the structure and values inherent in Children's System of Care. Each of the FRCs has bilingual resource specialists and access to bilingual therapists. Agency participants in the SAFE SOC are: Education, Department of Social Services, Probation, Mental Health and other appropriate entities that may be invited to participate when the family believes they are beneficial to the process. The outcomes of the program have been excellent as evidenced by continued reductions in group home placements, reduced hospitalizations, decreased arrests and improved school attendance and performance. (See the Annual Children's System of Care Report to State DMH, Executive Summary Appendix 46)



The County's Mental Health Services and Office of Education have a long history of collaborative programming for Seriously Emotionally Disturbed (SED) children. Mental Health has a contract with many school districts to provide Mental Health services in classes for children designated as SED. The County continues to provide AB3632, Individual Education Plan (IEP) driven services for

children that qualify throughout the SELPA. Collocation allows for coordinated treatment planning. As a Children's System of Care County, the values of family inclusion, strength and needs-driven services provided in the community by culturally competent trained staff permeates the entire system.

Stigma reduction is an outcome that is accomplished by having services available in the community where consumers live and provided by people that are visible and known to the community. SAFE has provided linkage and services that go beyond traditional therapy. FRCs provide linkage to multiple resources such as food, job opportunities, parenting classes, recreational opportunities and linkage to unique services and supports that families identify. The access to bilingual staff has helped reduce the stigma and has made coming to the FRCs safe and comfortable for the diverse population in the South County.



III. Quality of Care: Contract Providers

The county shall include the following in the CCPR:

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

San Luis Obispo County Behavioral Health prides itself on developing strong partnerships with community providers who deliver quality services to the public. SLOBHD requires each community partner receiving funding from the County to demonstrate cultural competence and participate in the development of services which meet the needs of the community's diverse citizenry.

A. Each of the County's MHSA plans has outlined the critical link between community provision of service and the need to improve cultural competence throughout the mental health system. As described in previous sections of this document, the original CSS plan for the County created the Latino Outreach and Engagement Program (LOP) which focused the County's attention on improving services for monolingual and bicultural consumers who made up the county's most significant disparity. This service is provided by a community organization which has a unique capacity to provide quality mental health services in both a linguistic and culturally competent manner. The Scope of Services in the County's contract with Dr. Silvia Ortiz and Associates (Appendix 17) demonstrates the contractor's ability to provide culturally competent mental health services in the CSS, PEI, and WET work plans.

The County's Prevention and Early Intervention plan also outlined specific cultural competence principles within each work plan project. Each of the PEI work plans contained the directive that "Each PEI provider will be required to meet the County's requirements for cultural competence, accessibility, evaluation and innovation." This was followed through by requiring each applicant for PEI contracts to provide the following information as part of the Request for Funding Applications process:

Cultural Competence: Describe your organization's cultural competence in program approach, staffing and organization governance.

A. Describe how services proposed will meet the requirements of cultural competence set forth the County's PEI plan.

Subsequently, contract language for those receiving funding includes the following in the Special Conditions section, Exhibit E (Appendix 47):

Compliance with County Cultural Competence Plan.

Contractor will meet cultural, ethnic and linguistic backgrounds of the clients served, in accordance with the County Cultural Competence Plan, including access to services in the appropriate language and/or reflecting the appropriate culture or ethnic group. Contractor will certify, on an annual basis, that it and all of its employees, contractors and agents have read and received a copy of the County Cultural Competence Plan and agree to abide by its provisions.

B. Staff Satisfaction: A description of methods, if any, used to measure staff experience or opinion regarding the organization's ability to value cultural diversity in its workforce and culturally and linguistically competent services; and

B. In 2009 all Mental Health Services staff were asked to participate in the California Brief Multicultural Competence Scale (Appendix 48). The survey was sent to all staff via email and returned surveys were kept confidential. This survey assessed staff comfort and proficiency with handling issues of cultural competence.

In the most recent survey (n = 53) staff reported strengths in assessing and treating the vast diversity of clients with particular confidence surrounding issues of poverty and those affected by disabilities. Staff reported the least amount of confidence and capacity to understand the unique mental health issues of lesbians and males. Data from the survey was provided to the Cultural Competence Committee to assist in developing training to meet the needs of the workforce.

As part of the County's Health Agency, all SLOBHD employees were invited to participate in a 2009 Employee Quality Improvement study (an excerpt shown in Appendix 49) which measured staff satisfaction and workplace environment. This survey yielded important information for managers to assess staff morale and communication issues.

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.

C. The following paragraph from SLOBHD policy 11.07, Grievance Process (Appendix 50), details how the complaints, grievances, and appeals are reviewed and analyzed (See page 2, No. 9.):

"Issues identified as a result of the complaint resolution or Appeal process are presented to the MHP's Performance and Quality Improvement/Quality Management Committee (PQI/QM), as needed and, on a quarterly basis, in summary form. The PQI/QM Committee forwards identified issues to the Behavioral Health Administrator or another appropriate body within the MHP for implementation of needed system changes."

There is not currently any comparison analysis between the general beneficiary population and ethnic beneficiaries with regards to client grievance and complaint data.

The County will address the current policy and its practice to determine if new protocol is necessary to complete this analysis. The Department will consider having the Patients Rights Advocate cross reference the complaint/appeal with the client's Client Service Information (CSI) data to determine the client's ethnicity, for comparison between the general beneficiary population and ethnic beneficiaries. However, a client may choose to not identify their ethnicity, and in this case, no comparison would be made.

References

Atkinson, R. (2003) "Diversity: Not There Yet," Washington Post: Extracted from <http://www.universityofcalifornia.edu/news/article/9806>

Cal Poly (2009) "Cal Poly Ranks in Top 10 Nationally in Degrees to Minority Students". *Cal Poly*. http://calpolynews.calpoly.edu/news_releases/2009/August/diverse.html

California Department of Public Health (CDPH), death statistical master files, 1999-2007; 2010

Casas, J.M., Pavelski, R., Furlong, M., & Zanglis, I. (2001). Advent of systems of care. In Ponterotto, J. Casas, J.M., Suzuki, P & Alexander, C. (EDS.), *Handbook of Multicultural Counseling* (pp. 198-219).

Chung, F.K (1983). The use of mental health services by ethnic minorities. *Minority mental health services*.

Institute of Medicine. (2004). *In the nation's compelling interest: Ensuring diversity in the health care workforce*. Washington, D.C.

Kiselica, M. & Robinson, M. (2001). Bring advocacy counseling to life: the history, issues, and human dramas of social justice working in counseling. *Journal of Counseling and Development*, 79, 387-397.

La Frontera, Inc. "Building Bridges: Tools for Developing an Organization's Cultural Competence" 2nd Edition (2006)

Larson, A. (2000). *Migrant and Seasonal Farmworker Enumeration Profiles Study: California*.

Lehman, E.W., Harrison-Ross, P., & Seigal, K. (1982). Community mental health center's minority group utilization and treatment. (NIMH grant No. Ro1 MH 31034)

Skinner, W.J. (2005) *Treating Concurrent Disorders: A Guide for Counsellors* (Centre for Addiction and Mental Health Publication); Toronto

U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau, Division of State and Community Health (2003). *Maternal and Child Health Services Title V Block Grant Program*, retrieved from <ftp://ftp.hrsa.gov/mchb/blockgrant/bggguideforms.pdf> on July 14, 2010

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Services, retrieved from <http://mentalhealth.samhsa.gov/publications/allpubs/SMA00-3457/ch1.asp> on July 14, 2010



Cultural Competence Plan

**San Luis Obispo County
Behavioral Health
Department
Mental Health Services**

APPENDIX



Mission

The Health Agency's Behavioral Health Department strives to assist individuals of all ages affected by mental illness in their recovery process to achieve the highest quality of life by providing culturally competent, strength-based and client- and family-centered services based on best practices.

Reference:

Welfare and Institutions Code, Section 5600

Departmental Goals

1. To save lives and preserve the safety of individuals with mental illness and the community.
2. To help individuals with mental illness be as functional and productive as possible in the least restrictive and least costly environments.
3. To prevent or reduce the societal problems and high costs to other social services, educational and law enforcement organizations that can result from lack of treatment for the individuals with mental illness.
4. To help clients with emotional trauma and psychological difficulties transform their lives into healthy and contributing citizens.
5. To provide cost effective mental health services to community residents.
6. To ensure equal access and culturally competent services to the diverse populations in the county.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 02/27/2009
Revision dates: 02/27/2009

Mental Health Service's primary goal is to provide the least restrictive treatment and rehabilitation strategies to help the clients with chronic mental illness maintain the highest possible quality of life. For clients with more quickly-remediable disturbances, the Department's basic emphasis is on brief, crisis-oriented treatment. Maximum use of Recovery groups and time-limited Family and Collateral therapy is encouraged.

Client's unique cultural needs and strengths must be a primary factor in treatment formulation and ongoing care. The Recovery Model, based on optimism, wellness and client empowerment, should be used as a guiding principle for treatment.

Mental Health Services understands that clients have the right to be treated with respect and with consideration for their privacy and dignity. They have the right to receive information on alternative treatment options, and choose to refuse treatment if they wish.

Continuity of care for clients is important organizational goal. Within the Mental Health system, this means retaining the same therapist or psychiatrist for a client whenever possible, as well as ensuring a seamless transition of services and transmission of information between programs and clinic sites when clients are transferred. Client's requests for change in Therapist or Psychiatrist will be given fair and open consideration according to the process outlined in standardized Mental Health policies and procedures. If the change in provider is due to a contract termination, reasonable efforts will be made to notify the beneficiary in writing.

When individuals, who have received definitive evaluations and treatment in any of the direct services, are referred to other agencies or facilities, a positive referral should be made, with a clear understanding as to whether responsibility for care is transferred. Treatment summaries and other pertinent information should be promptly disclosed following client's written authorization, whenever needed.

In support of the primary goal of least restrictive treatment measures, every effort should be made to avoid the long-term placement or hospitalization of clients, especially children at risk of placement. This includes minimizing the placement of clients in Institutes of Mental Disorder (IMD), State Hospitals, and Out-of-County facilities by striving to keep them in the community whenever it is therapeutically indicated. Alternatives to inpatient hospitalization should be used whenever possible. Maximum use of community resources and caretakers should be made.

Action #5 – Title: Integrating Cultural Competence in the Public Mental Health System and Increasing Linguistic Competency of Staff

Description:

While cultural competence is embedded in all actions of the WET Plan, this action focuses on specific technical assistance and trainings necessary to achieve Cultural and Linguistic Competency within the public mental health system. We will be coordinating the BHS Cultural Competence Committee comprised of direct care staff from Mental Health Services, Drug and Alcohol Services, Gay and Lesbian Alliance (GALA), Community Based Organizations, consumer and family members. This committee will create the cultural competency plan and develop recommendations for a year round training plan. As this training program is completed, additional training needs will be identified and this action would support such training. It will also cover the cost of a refresher course for interpreters, specialized training focused on the County's various ethnic populations and attendance at State-wide Cultural Competence trainings.

The purpose of cultural competence training is to develop understanding, skills and strategies to assist in embedding cultural competence into the MHSA implementation process and support of cultural competence integration in San Luis Obispo County. Our hope is that the training will provide the tools and skills necessary to increase the County's capacity for the delivery of culturally relevant services therefore resulting in better outcomes for the County's culturally diverse clients. The California Brief Multi-Cultural Competence Scale (CBMCS) and Training Program will be an integral component of the training curriculum for staff. The CBMCS is designed to measure and improve the self-reported multicultural competence of mental health service providers. Training will focus on the disparities identified in the planning process and work with administration and programs to apply the strategies created in the Community Services and Support (CSS) plans. Training will also include continued culturally focused discussions with community based organizations, community agencies, community leaders, clients and family members for their perspectives on the cultural aspects of the organization's MHSA and cultural competence plan. Trainings will be consulting with the Multi-Cultural Services Development Center of the California Institute for Mental Health (CiMH).

Also embedded in this action is the intent to increase the number of staff able to provide services in Spanish or are able to communicate in basic conversational Spanish. This will be accomplished by contracting with San Luis Coastal Adult School to provide a High Intensity Spanish Language training program. The program has a linguistic culture component with an emphasis on workplace communication. Additional specific medical and psychiatric terminology would be covered during the course. Additionally, The Cultural Competency Committee will work to identify consumers, family members, and/or mental health staff who are bilingual and looking to further advance professionally in the mental health field. These identified bilingual individuals will be eligible for grants, stipends, or internships.

Objectives:

1. Utilize the CBMCS Self Assessment Tool to determine a baseline for San Luis Obispo staff and its contractors in the summer of 2009.

Cultural Competency News

San Luis Obispo County
Behavioral Health Services

June 2009

Volume 3, Issue 1

Cultural Competence Committee News Letter

Inside this issue:

Appreciation & Mission	1
Membership and painted Cave	2,3
Names and Tribal Groups	4,5
Featured Article:	6,7
Myths	8



Introduction

Welcome to the third addition of the Cultural Competency News. It is with pleasure that the committee and I release the newsletter on Native Americans. It is our hope that you enjoy and learn from the newsletter. Please feel free to share the newsletter with people on your staff. This Newsletter is intended to be used as an instrument to increase awareness. All Newsletters are done with consultation from experts in the culture group, which is being covered.

Cultural Competence Mission

The mission of the Cultural Competence Committee is to ensure that cultural diversity is incorporated into all levels of San Luis Obispo County Mental Health Services. The committee oversees that the culture of the agency embraces knowledge, attitudes, values, and beliefs of diversity and provides a system of care that respects the diversity of clients it serves, as well as the staff. Given that since the year 2000, ethnic minorities exceed 50% of the population in California, the cultural competence committee is dedicated to eliminating cultural, linguistic, racial and ethnic disparities in the populations served by San Luis Obispo County Behavioral Health Services. It is devoted to ensuring the development of a culturally competent behavioral health system.

The Cultural Competence Newsletter

The Cultural Competence Newsletter is one of the Ways the Cultural Competence Committee provides information on diverse populations. Each Newsletter is based on information obtained from consultation with experts who represent the cultural group being addressed. The Newsletters are intended to provide an insight into the culture group being represented and do not reflect any biases of the committee members. This issue honors the Native American Indians and has particular emphasis on the Chumash tribe whose territory we live on. The upcoming issue will focus on the African American culture. Please address comments to Silvia Ortiz,

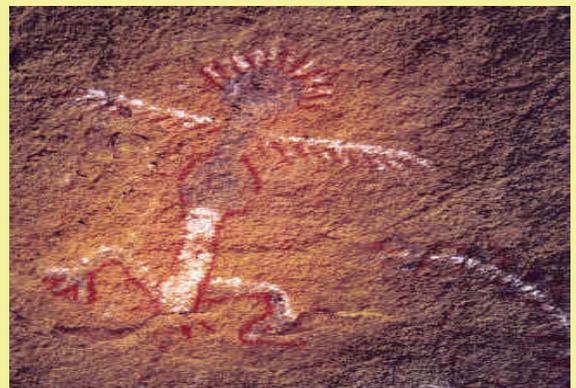
Appreciation

I extend my deep appreciation to Jess Montoya, Executive Director of the Santa Ynez Tribal Health Clinic for providing me the opportunity to meet with his staff and to the Social Services staff of the Clinic for their time, kindness, and teachings of the White Bison Medicine Wheel and 12 Steps Program.

Chumash Indian



Chumash Shaman Painting



Committee Membership

Silvia Ortiz, Ph.D.

Chairperson, Cultural Competence Committee. Director, Servicios Sicologicos Para Latinos: A Latino Outreach Program

Karen Baylor, Ph.D. LMFT

County Behavioral Health Service Department Administrator

Margie Craig, LMFT

Family Care Network

Kris Hiemstra, LMFT

County Behavioral Health Service Mental Health Services

Nancy Mancha-Whitcomb, LMFT

Mental Health Service Act, Division Manager. Ethnic Services Manager

Rolando Rojas

County Behavioral Health Services Drug and Alcohol Services

Casey Roos, LMFT

County Behavioral Health Services Work Education Training Coordinator

Cecilia Sotelo

Family Care Network Parent Partner

Lisa Sweatt, Ph.D.

Associate Professor Psychology and Child Development Cal Poly State University, SLO

Chumash Sun Paintings



Chumash Painted Cave

The Chumash are internationally renowned for their prehistoric rock art. It is believed that the religious leaders took special journeys to the foothills and the mountains during particular times of the year. During these quests they painted empowering and protective symbols on the sandstone cave walls on the rocks and cliffs throughout the mountains in the areas that are known as Ventura, Ojai, Santa Barbara, and San Luis Obispo County.



Names

The Chumash named several hundred places in the 7,000 acres where they lived. Names came from what was in the land and from dreams.

Lompoc: stagnant water

Zach Lake: no bottom, made by thunder

Ojai: moon

Pismo: tar which seals tools

Tomol: canoe

Malibu: where the surf sounds loudly

Saticoy: sheltered from the wind

Mt Pinos: after dusk when the spirits come



California Indian Tribal Groups



California Indian Tribal Groups

A glance at the map shows that a vast number of Native American tribes once resided throughout California. This Newsletter honors all Native American tribes and in particular the Chumash tribe whose land we share. At one time the Chumash tribe encompassed 7,000 square miles that spanned from Malibu to Paso Robles, inland to the western edge of the San Joaquin Valley and west to the Channel Island archipelago. The Chumash were hunters and gatherers. They used the natural environment as their source of food, shelter, clothing, craft materials, tools, dishes, ornaments, even money. The Chumash believed that all beings were able to gain and use power for either good or bad. A person could gain extra power only if they knew the traditions. A person could try to get a dream helper such as a powerful plant (Dantura), an animal (Eagle), natural forces (Wind), and or stars/planets to help gain power. These dream helpers were acquired only through a special ceremony performed by the tribal Shaman wherein the initiator would enter a mythical state through the use of dream inducing plants and would discover their dream helper during this vision quest. As with most Native American tribes, history was passed through stories and legends. Many of these stories were lost in the 1700s and 1800s when the Spanish Mission system was introduced. During this period the Chumash population decreased from approximately 22,000 to 2,788.

White Bison Medicine Wheel and the Twelve Steps

By Silvia Ortiz, PhD

The Medicine Wheel and the 12 Step Program was given to us by the Creator and Elders to make an attempt to over-come our worst enemy ever: Addiction. It is said that those of us who are affected by this disease are the very ones who must carry and nurture this healing process if we are to survive as spiritual people (excerpt from White Bison).

When the simple life was taken away from the Native Americans, they struggled to maintain their language, traditions, ceremonies, and the ability to enact their vision quest, and essentially their sense of self as humans and as a community. Some lost their spirituality and turned to the spirit of drugs and alcohol. Harmony and balance was lost with the abuse of substances and alcohol.

The Medicine Wheel and 12 Steps Program was developed by White Bison to provide a culturally appropriate recovery process for Native American people. The Program was “created as a give away”. No profit can be made from the program. The hope is that it travels to many places and in many directions and is available to the four colors White –Euros; Yellow-Asians; Black-Africans; Red-Natives.

The White Bison Program is designed “to not intrude” on any particular Indian culture. The program acknowledges that “all tribal nations are different from each other” and allows the insertion of each tribal culture in the recovery process. The program draws upon the teachings of the 12 Steps, the Medicine Wheel, the Cycle of Life and the Four Laws of Change. It is designed to bring the natural order back to the lives of Native Americans so that they can embrace their culture with sobriety and assume the Warrior’s path. Through this path a Native American can move from despair to a life steeped with the wisdom of the ancestors, tradition, ceremony, services to other and the discovery of what spirituality means.

Men and women have similar Programs but, travel through them separately. This honors that men and women have different purposes on this earth and that this road of the journey is best traveled within one’s own sex group. Firestarters, who go through the Firestarter Training offered by White Bison, facilitate the teaching of the 12 Steps in an open discussion forum. The videos of White Bison leading these groups reveal the richness of the wisdom of the elders, which is folded into every word, sentence, and Step. There are 9 videos for women and 7 videos for men. Within the context of the Teachings of the Medicine Wheel, the four directions of growth are East- Emotional; South- Mental; West- Physical; North-Spiritual. The 12 Steps follow the circle of the Medicine Wheel in this manner: East- Steps 1,2,3 Finding the Creator; South-Steps 4, 5, 6 Finding Yourself; West- Steps 7,8,9 Finding Your Relationship with Others; North- Steps 10,11,12 Finding the Wisdom of the Elders.

The traditions, ceremonies and wisdom of the elders are an integral part of the White Bison Program: the talking circle, the sweat lodge, the vision quest, healing plants, smudging, the eagle feather, the talking stick, the spirit world, and the Great Spirit. In honor of these traditions and ceremonies, these will be briefly touched upon without elaborate details.

Within the context of the White Bison Program, The talking circle uses smoke, the eagle feather or the talking stick. The smoke and eagle feather are used as a means to open up the communication with the Great Spirit so that the Great Spirit can hear the prayers/ thoughts and provide guidance. The eagle and thus the eagle feather are sacred and hold a special meaning to the Native Americans. When an eagle feather is not available the talking stick, which is prayed on and barrowed from the ground, is used. The White Bison Program has a separate talking circle for men and women. In the circle there is “no cross talk”. Only one person speaks at a time. The person holding the eagle feather or the talking stick is the one speaking. After each person finish speaking, they pass it the eagle feather or the talking stick to the next person. The circle is complete when everyone speaks. The White Bison program uses the Talking Circle at least one time per week. Traditionally, prior to the start of the talking circle and/or the sweat lodge each participant is smudged to draw out the negative spirits and protect them from their reappearance. Smudging utilize the smoke from healing plants. The smoke is guided with the eagle feather over the body with particular emphasis on the head, throat, heart, and abdomen.

The sweat lodge is a healing and cleansing ceremony where communication is opened directly with the Great Spirit. Each Indian

Featured Article

Continued from pg 7.

tribe has a tradition for the manner in which a sweat lodge is convened. Typically, the sweat lodges are done in the dark and use steam that has healing plants in it. Some of the plants used are sage, sweet grass, cedar, and tobacco. Songs, drumming, healing plants, earth, water, wind, animal spirits, and the Great Spirit are part of the ceremony.

The vision quest is a journey to find ones place in this world. Each Indian tribe has their own traditions for the vision quest but all believe that humans have a place in this world. This is the reason we were brought into this life and it is part of the natural order of things.

The importance of spiritual traditions, ceremony, the wisdom of the elders, the teaching of the Great Spirit, and finding ones place on this earth are interwoven in the White Bison Program. Part of the journey is to root back in the ways that were taught by the elders. As White Bison writes, “a long time ago, the Elders tell us, the Great Spirit created a system that runs the Earth and its people. The system he created is based on principles, laws and values. He created a system of harmony, balance, and polarity; it consists of a spiritual world as well as a physical world. It is a value-based system which guarantees love, understanding, trust, forgiveness, acceptance, abundance, empowerment, and solutions.” Within this system healing and wellness can occur. White Bison envisions this system as a healing forest where fear, shame, guilt, anger, alcoholism, codependency, sexual abuse, domestic violence, drug abuse, mental illness, co-occurring disorders, prison, and suicide are replaced with traditional values, spirituality, hope, unity, healing, forgiving the unforgivable, culture, tradition, sober powwows, healthy youth, healthy women, healthy men, healthy elders, sober leaders, traditional families, traditional communities and warriors. As he explains the entire forest with the soil and root system must change into a healing forest because “It is impossible for a well tree to stay well in a sick forest.”



Myths:

Face Painting for Barracuda Dance



Three Worlds

There is this world in which we live, but there is also one above us and one below us. There are two serpents that hold our world up from below. When they are tired they move, and that causes earthquakes. The World above is sustained by the great eagle. He never moves, he is always in the same spot. When he gets tired of sustaining the upper world, he stretches his wings a little, and this causes the phases of the moon. When there is an eclipse of the moon it is because his wings cover it completely. And the water in the springs and streams of this earth is the urine of the many frogs.

Thunder and Lightning

There are two brothers who live in the upper world. They sometimes play the hoop-and pole game. One rolls the hoop and the other runs after it and tries to pierce it with his pole. That is what causes thunder. Also they can throw a light they have to make lightning, and when it hits the ground it makes flint.

Thunder Makes Zaca Lake

Zaca Lake was formed when Thunder sat down there and made a great hole in the earth. There was once a village there, and one day, a man saw Thunder and said insulting things to him. The rest of the people ran away in fear, and when they looked back, the man was gone and there was water where Thunder had sat down.



San Luis Obispo County BHS – CC/Ethnic Service Manager
Areas of Responsibility
FY 2010-2011

The county Cultural competency/Ethnic Services Manager (CC/ESM) reports to and has direct access to, the Mental Health Director regarding issues impacting mental health issues related to the racial and ethnic populations within the county. The CC/ESM promotes and coordinates quality and equitable care as it relates to racial and ethnic populations with both county-operated and contracted mental health programs. The staff position reviews service utilization data and actively participates in local mental health planning and projects that respond to the needs of the county's racial and ethnic population.

The Director recognizes the role and function of the CC/ESM within the organization by allocating sufficient time for the performance of job responsibilities and duties. Additionally, the director promotes the CC/ESM's influence in policy and program change by considering and following the CC/ESM's recommendations for change in human resources, ethnic and culturally specific services and all other related areas. The CC/Ethnic Services Manager:

Takes lead responsibility for the development and implementation of cultural competence planning within the organization.

Identifies local and regional cultural mental health need of ethnically and culturally diverse populations as they impact county systems of care and makes recommendations to local mental health directors, CMHDA, and the State Department of Mental Health.

Participates and advises on planning, policy, compliance, and evaluation components of the county system of care, and makes recommendations to county directors that assure access to services for ethnically and culturally diverse groups.

Promotes the development of appropriate mental health services that will meet the diverse needs of the county's racial and ethnic populations. This includes, but is not limited to, reviewing local proposals to augment or decrease services to the local community, participating in various mental health advisory groups/task forces, facilitating educational training to organizational units within and outside the local mental health department.

Tracks penetration and retention rates of racially and ethnically diverse populations, and develops strategies to eliminate disparities.

Participates in the cultivation of network to promote an array of mental health programs and activities that are specific to underserved populations.

Maintains an active advocacy, consultative, and supportive relationship with consumer and family organizations, local planning boards, advisory groups and task forces, the State and other mental health advocates.

Assists in the development of system-wide training that addresses enhancement of workforce development and addresses the training necessary to improve the quality of care for all communities and reduce mental health disparities.

Attends trainings that inform, educate, and develop the unique skills necessary to enhance the understanding and promotion of cultural competence in the mental health system.

Attends meetings as required by the position including, but not limited to CMHDA Ethnic Services, Full Association and other committee meetings, regional ESM regular meetings, various State meeting, meetings convened by various advisory bodies, and other meetings as appropriate.

Responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC). The BCC Committee shall be made of Ethnic Services Manager and three bilingual staff members at least one of whom will be a native speaker of the threshold languages within the county.

The BCC will be responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-100 for each of the areas described below. The checklist will include, but not be limited to:

1. Fluency, the ability to communicate with ease, verbally and non-verbally.
2. Depth of vocabulary including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.
3. Grammar, appropriate use of tense and grammar.
4. Cultural considerations related to the potential client.

The certification process will be conducted by two bilingual committee members, one of whom will be the committee's identified native speaker. The certification interview will follow a standard initial assessment format. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate will be given an opportunity to make any remarks she or he may wish for clarification.

CPES Estimates of Need for Mental Health Services For California, San Luis Obispo County (079) Chron MH imp7 D120-Agesq (w1xmh2asq_3) for 2007									
	Total Population (HH.,Inst.& Group)			Household Population			Households <200% poverty		
Total Pop	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
All ages	14444	262436	5.50	12015	245952	4.89	6097	74557	8.18
Youth age 0-17									
Youth	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Youth total	3818	52547	7.27	3710	51859	7.15	1487	17003	8.75
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
00-05	1157	15726	7.36	1139	15539	7.33	524	5995	8.74
06-11	1108	15334	7.23	1103	15301	7.21	441	5005	8.80
12-17	1553	21487	7.23	1468	21019	6.99	522	6003	8.70
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	1988	26980	7.37	1899	26487	7.17	776	8877	8.74
Female	1831	25567	7.16	1811	25373	7.14	711	8126	8.76
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.White-NH	2264	33189	6.82	2261	33158	6.82	581	6588	8.82
2.African Am-NH	61	612	9.97	38	487	7.84	20	227	8.99
3.Asian-NH	112	1407	7.93	88	1289	6.84	21	245	8.52
4.Pacific I-NH	3	44	7.36	3	43	7.30	1	16	8.74
5.Native-NH	20	266	7.64	19	258	7.28	6	66	8.51
6.Other-NH	0	0	0.00	0	0	0.00	0	0	0.00
7.Multi-NH	114	1563	7.31	112	1548	7.21	41	462	8.88
8.Hispanic	1243	15466	8.04	1189	15076	7.89	817	9399	8.69
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	637	6374	10.00	634	6343	10.00	634	6343	10.00
2.100%-199%	853	10660	8.00	853	10660	8.00	853	10660	8.00
3.200%-299%	722	10317	7.00	722	10317	7.00	0	0	0.00
4.300%+ pov	1430	23827	6.00	1430	23827	6.00	0	0	0.00
5.Undefined	176	1368	12.87	71	711	10.00	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	3710	51859	7.15	3710	51859	7.15	1487	17003	8.75
Institution	79	396	20.00	0	0	0.00	0	0	0.00
Group	29	292	9.87	0	0	0.00	0	0	0.00
Adults age 18 and older									
Adult total	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Adult total	10626	209889	5.06	8305	194093	4.28	4610	57554	8.01
Age	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
18-20	393	14518	2.70	276	11020	2.50	219	6443	3.39
21-24	1453	23164	6.27	1311	21614	6.07	1104	14238	7.76

25-34	2600	34417	7.56	1902	30842	6.17	1134	10794	10.51
35-44	2572	32024	8.03	1800	28821	6.24	868	6646	13.06
45-54	2117	38941	5.44	1730	37110	4.66	682	5787	11.78
55-64	874	29319	2.98	776	28457	2.73	330	4828	6.83
65+	618	37506	1.65	510	36229	1.41	274	8818	3.11
Gender	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Male	5423	107848	5.03	3308	95072	3.48	1762	26481	6.65
Female	5203	102041	5.10	4997	99021	5.05	2848	31073	9.17
Ethnicity	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.White-NH	7409	159749	4.64	6452	152028	4.24	3301	38031	8.68
2.African Am-NH	676	4430	15.27	99	1864	5.30	74	983	7.55
3.Asian-NH	159	6566	2.42	124	5923	2.10	86	2357	3.66
4.Pacific I-NH	5	239	2.21	4	216	1.94	3	75	3.43
5.Native-NH	95	1426	6.63	70	1326	5.27	37	391	9.42
6.Other-NH	0	0	0.00	0	0	0.00	0	0	0.00
7.Multi-NH	209	3581	5.83	190	3323	5.71	130	1366	9.50
8.Hispanic	2073	33898	6.12	1366	29413	4.65	980	14351	6.83
Marital status	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Married	4598	118297	3.89	2995	107932	2.77	1103	19171	5.76
Sep/Wid/Div	3135	40610	7.72	2590	38510	6.73	1519	13378	11.36
Single	2893	50982	5.67	2720	47652	5.71	1987	25006	7.95
Education	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Grades 00-11	2586	32261	8.02	1411	26317	5.36	1003	13084	7.66
HS graduate	6870	130719	5.26	5749	121446	4.73	3229	38242	8.44
College grad	1170	46909	2.49	1145	46330	2.47	378	6227	6.06
Poverty level	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
1.Below 100%	2411	26340	9.15	2345	25568	9.17	2345	25568	9.17
2.100%-199%	2300	32593	7.06	2265	31986	7.08	2265	31986	7.08
3.200%-299%	1271	29374	4.33	1265	29245	4.33	0	0	0.00
4.300%+ pov	2431	107368	2.26	2430	107294	2.26	0	0	0.00
5.Undefined	2214	14213	15.57	0	0	4.35	0	0	0.00
Residence	Cases	Pop	Percent	Cases	Pop	Percent	Cases	Pop	Percent
Household	8305	194093	4.28	8305	194093	4.28	4610	57554	8.01
Institution	2097	10873	19.29	0	0	0.00	0	0	0.00
Group quarters	224	4922	4.55	0	0	0.00	0	0	0.00

(*) Youth rates based on Serious Emotional Disturbance.

profile07_sas\profile_agesq-dx_htm.sas ----- Updated on 30OCT08 22:05 -ceh(w1xmhm2asq_3)

MEDICAL NECESSITY

California Code of Regulations, Title 9, Chapter 11, Section 1830.205 Medical Necessity Criteria for MHP Reimbursement of Speciality Mental Health Services.

"The beneficiary must meet criteria outlined in (1), (2) and (3) below to be eligible for services:

- (1) Be diagnoses by the MHP with one of the following diagnosis in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:
 - (A) Pervasive Developmental Disorders, except Autistic Disorders
 - (B) Disruptive Behavior and Attention Deficit Disorders
 - (C) Feeding and Eating Disorders of Infancy and Early Childhood
 - (D) Elimination Disorders
 - (E) Other Disorders of Infancy, Childhood, or Adolescence
 - (F) Schizophrenia and Other Psychotic Disorders
 - (G) Mood Disorders
 - (H) Anxiety Disorders
 - (I) Somatoform Disorders
 - (J) Factitious Disorders
 - (K) Dissociative Disorders
 - (L) Paraphilias
 - (M) Gender Identity Disorder
 - (N) Eating Disorder
 - (O) Impulse Control Disorders Not Elsewhere Classified
 - (P) Adjustment Disorders
 - (Q) Personality Disorders, excluding Antisocial Personality Disorder
 - (R) Medication-Induced Movement Disorders related to other included diagnoses

- (2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:
 - (A) A significant impairment in an important area of life functioning.
 - (B) A probability of significant deterioration in an important area of life functioning.
 - (C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

- (3) Must meet each of the intervention criteria listed below:
 - (A) The focus of the proposed intervention is to address the condition identified in (2) above.
 - (B) The expectation is that the proposed intervention will:
 - i. Significantly diminish the impairment, or

- ii. Prevent significant deterioration in an important are of life functioning, or
 - iii. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.
- (C) The condition would not be responsive to physical health care based treatment.”

Section 18310.210 Medical Necessity Criteria for MHP Reimbursement for Speciality Mental Health Services for Eligible Beneficiaries Under 21 Years of Age

- (a) “For beneficiaries under 21 years of age who do not meet the medical necessity requirements of Section 1830.205(b)(2) and (3), medical necessity criteria for speciality mental heath services covered by this chapter shall be met when all of the following exist:
- (1) The beneficiary meets the diagnosis criteria in Section 1830.205(b)(1),
 - (2) The beneficiary has a condition that would not be responsive to physical health care based treatment, and
 - (3) The requirements of Title 22, Section 51340(e)(3) are met; or, for targeted case management services, the service to which access is to be gained through case management is medically necessary for the beneficiary under Section 1830.205 or under Title 22 Section 51340(e)(3) and the requirements of Title 22, Section 51340(f) are met.”

Servicios Psicologicos Para Latinos
A Latino Outreach Program: Addressing Barriers to Mental Health Service

Silvia Ortiz, PhD

The demographic and epidemiological data shows a significant increase in ethnic minorities in the United States. Estimates of the population shifts in California indicate that ethnic minorities will constitute significant pluralities, with the Latino population being the most represented group. With this demographic shift comes an increasing awareness in the mental health community that psychological services need to be responsive to the ethnic minority population. Research, task forces, and committees are tackling the complex issues associated with providing psychological services that are appropriate for ethnic and culturally diverse populations.

In 1988, the APA's Board of Ethnic Minority Affairs (BEMA) established a Task Force on the Delivery of Services to Ethnic Minority Populations. In July 1991 the Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse populations were published (American Psychological Association, 1993). In 1989, the Council for Children with Behavioral Disorders (CCBD) established the Committee on Ethnic and Multicultural Concerns (Bullock, 1999). In January 1999, at the first Multicultural Conference coordinated by the American Psychological Association, the importance of developing cultural competence in mental health services was emphasized.

In February 2010, The California Department of Mental Health (DMH) issued the statewide Cultural Competence Plan Requirements (CCPR) which set new standards for achieving cultural and linguistic competence. In accordance with California Code of Regulations, Title 9, Section 1810.401, each county must develop and submit a Cultural Competence Plan that adheres to the CCPR (2010) by July 2010. The CCPR emphasizes the need to provide culturally and linguistically competent services within the mental health system to the racial, ethnic, and cultural communities which represent California's diversity.

Since 1988, a growing body of research is emerging that help guide the practitioners as they provide therapy to ethnic minorities. The research indicates that the underutilization of mental health services by ethnic minorities is not a reflection of fewer emotional problems, less severe emotional conditions or lack of awareness of these conditions. Minority individuals do recognize the need for services but contextual barriers such as difficulties with language, communication style, and discrepant cultural beliefs affect the utilization of mental health services (Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, 2001).

Cheung (1990) conceptualizes the barriers in terms of institutional, cultural, language and economic. Studies on institutional barriers indicate that minority clients report that they "feel stupid and embarrassed" because they do not fit in with the culture of the agency or understand the procedures of the agency. Other studies indicate that the "red tape" or multiple steps before a person receives the actual help contributes to drop out rates. These studies

explain that clients who are distraught, depressed, and anxious and cannot read or speak the language just give up trying to navigate through the bureaucracy of the agencies that provide mental health services (Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, 2001)..

Even though theories and research provide some guidelines, many of the concepts such as culturally sensitive and culturally appropriate, are very difficult to implement. In their research with Latinos, Casa, Pavelski, Furlong & Zanglis (2001) note the importance of offering services that fit the paradigm of the culture. Since most theories have been developed based on the European culture, which is foreign and difficult for many Latinos to understand, adjusting the paradigm is critical. How to adjust the paradigm or enter into the Latino's world view remains vaguely undefined. The easiest approach is to belong to that world view and share the same values. It has been noted that there is an increase in the use of services and a decrease in dropout rates when there is an ethnic and language match between mental health professional and ethnic minority client (Lehman, E.W., Harrison-Ross, P. & Seigal, K.1982). Given the lack of bicultural/ bilingual mental health professionals, we are faced with the task of finding the way to provide mental health services within a less than ideal situation.

As a bilingual/bicultural Latina psychologist who has provided services to Latinos for about 25 years, I have noted many variables that affect utilization of mental health services as well as retention of clients. These variables are aspects of the Latino culture that need to become part of the therapeutic process.

One variable is that the low acculturated Latinos many not understand how a mental health professional can help. They tend to use family, friends, comadres, priests, and curanderos to help with emotional problems. Somehow we need to fit into this cluster of helpers. A way of fitting in is to be part of the network and work within the network. Lesley & Bestman (1984) and Kiselica & Robinson (2001) stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings". They note that some of these settings can be schools, churches, community centers, and local agencies. I have noticed that in addition to leaving the office, it is helpful to become part of the community by attending community events and becoming acquainted with the members of the community. This enables the mental health professionals to network with potential clients and other respected members of the community.

Another important factor is to have a deep understanding of the context of relationships within the Latino culture. Relationships have a hieratical system, an intense bond of trust that should not be broken, implicit and explicit respect, a strong spiritual connection to God and nature, and a very strong connection to family.

Within the Latino culture trust is critical. Sandoval and La Roza (1986) refer to this as personalism and describe it as a need to relate in personal terms and to trust people. They suspect it could be rooted in the strong family ties that are characteristic of this culture. Personalism provides strong feelings of attachment and commitment to family, friends, and others. It places great

emphasis on interactions with people, which can make life meaningful or empty. In this paradigm people are judged according to their behaviors with their family and friends and not just on public or professional performance. As professionals it is important we extend ourselves in ways that foster interpersonal trust. This comes with knowledge of the cultural values, empathy, practice and exposure to the Latino culture.

Respect is important in the Latino culture. One needs to show respect and be worthy of receiving respect. It is shown in the way one carries oneself, speaks, looks at other, the words that are used, the way one addresses hierarchy, the ability to follow through with ones word, the ability to ask before assuming, the ability to have knowledge without arrogance, the relationships one has with one's own family and the community. The process of gaining respect can be an overwhelming burden. But again, it grows slowly, and is an essential component of the therapeutic process. Many times respect and trust grow simultaneously. At times, respect and trust can be given to a person by the position they hold in the community or through affiliation with a person of respect in the community.

An understanding of the family system and the ability to respect that system is very important. It is a hierarchical close net system based on machismo. Each member has a place in the family and each holds some form of power. The concept of power in the Latino culture differs from that of the majority culture. It is understood as "su position" or "ones position". Every member from the eldest to the youngest has a position. Men and women hold different positions. Providing therapy within the context of the Latino family system can be difficult when the system has been injured through domestic violence, child abuse, sexual abused, and/or substance/alcohol abuse.

The Latino culture is highly spiritual. The spiritual world impacts many aspects of life which at times can only be cured through spirituality. Destiny or "el destine" is closely connected to the spiritual world. Many clients utilize corianders, rely on priests, go on religious missions and use prayer to help deal with emotional problems. As professionals, it is important to have the ability to place one's own religious beliefs aside and work within the spiritual context of the Latino cultural. This culture is highly spiritual and it is an integral part of most clients' sense of self. Being able to therapeutically navigate through the spiritual world is an important role of the bicultural therapist.

The last variable I'll mention which affects the utilization of mental health services, especially those affiliated with the majority culture is the history of racism and oppression. For many Latinos this has become part of their identity. Current issues with the immigration system have given a rise to overt forms of racism. Many Latino clients report feeling the anger, hatred and not being wanted in this country. Although many mental health providers many abhor the oppression and racism that explicitly and implicitly occurred in the past and still exists, they have the burden of gradually proving this to each potential Latino client. Depending on the client's acculturation process and personal history, this may be fairly easy to do or almost impossible.

In 2004, San Luis Obispo County Behavioral Health Services conducted a study to assess the characteristic which influence Latino's underutilization of Mental Health Services. The survey was administered to 200 Spanish speaking low income Latinos who resided in the County. All 200 surveys were completed by those who were Spanish literate and illiterate. The results showed that the following variables affect utilization of mental health services: (a) Latinos did not feel comfortable access services in a government building. They perceive the government as an authoritarian entity and were intimidated by it; (b) Some of the Latinos who had attempted to receive services from The County Behavioral Health Department reported that the experience was confusing and involved telling personal information to various persons prior to being assigned a therapist. Some reported that after sharing personal information they were told that their problem was not serious enough to qualify for services; (c) Latinos reported difficulty trusting someone who was not from their own culture and were concerned they would not be understood because of the differences in life experiences; and (d) Latinos preferred someone who spoke Spanish rather than having an interpreter. They found the interpreter to interfere with the flow of information.

The results of this survey are supported by the previously conducted research. In June of 2006, San Luis Obispo County Behavioral Health Services Via the Mental Health Service Act (MHSA) and Prevention Early Intervention (PEI) provided funding to a program that offers culturally appropriate psychotherapy services to the monolingual low income Spanish speakers and their bilingual children. The program is Servicios Psicologicos Para Latinos: A Latino Outreach Program (LOP) (appendix A, B, C, D). The model for LOP is based on the findings of previous research and the finding of the 2204 SLO County study. The program has been successful in establishing a community base model that provides psychotherapy, medication evaluation, psychotherapy groups, parenting groups for parents whose child is a ward of the court, substance abuse groups, and workshops (table 5 for workshops) to the Spanish speaking community and their bilingual children.

With the utilization of MHSA and PEI funding the program is able to provide services to those who meet medical necessity and those who have a diagnosis outside the realm of medical necessity such as substance abuse, marital problems, parent child relational problems, acculturation issues. The combined funding provides LOP the ability to remove the barrier stated in variable (a) which highlights That County Behavioral Health Services cannot provide psychotherapy to people who do not meet the criteria for medical necessity. LOP is in the unique position that regardless of the diagnosis, cases can be opened under Medical Necessity or under Community Services and no one is turned away based on a diagnosis.

LOP is embed in the community. All workshops, groups, and trainings are provided in community sites. Psychotherapy is offered in Paso Robles, San Luis Obispo, Oceano, Arroyo Grande, and Nipomo at eight community sites (appendix E). The clients who receive services from LOP are able to access therapists, workshops and groups in a familiar community site in their own neighborhood.

This allows the program to break through the barrier stated in variable (a) which addresses the discomfort of receiving psychotherapy in a government agency. The community based model also is consistent with the findings of Cheung's (1990), Lesley & Bestman (1984) and Kiselica & Robinson (2001), which stress the importance of "mental health professionals leaving the comfort of their offices and completing their work in other settings".

The client's access to services is conducted in a manner that minimizes telling the personal story to multiple persons and navigating through a bureaucracy. The clients are referred to the director of LOP, Silvia Ortiz, Ph.D. who directly assigns the client to the therapist that conducts the intake and the therapy. This method of accessing services addresses variable (b) which speaks to the difficulty of telling the personal story to various persons prior to receiving treatment and is respectful of the findings of Casas, J.M., Pavelski, R., Furlong, M. & Zanglis, I, 2001 and Cheung (1990) that indicate clients get lost when they try to navigate through the bureaucracy of the agencies that provide mental health services.

LOP has been fortunate in the hiring process. All therapists are bicultural and bilingual. The director of the program and two of the therapists are immigrants from Colombia and Mexico, respectively. The other two therapists are first generation in the United States (appendix F). The ethnicity of the therapist and their cultural backgrounds address the concerns stated in variable (c), and (d). By being Spanish speaking Latinos/Latinas the therapists can increase the probability of retaining the client because as noted by Lehman, E.W., Harrison-Ross, P. & Seigal, K. (1982) there is a decrease in dropout rates when there is an ethnic and language match between mental health professional and ethnic minority client. This match, as indicated by Casa, Pavelski, Furlong & Zanglis (2001) also facilitates the ability to share world views and enables the therapist to enter the Latino client's paradigm.

Even though the therapists are bicultural and bilingual, the concept of adjusting theories that have been developed on the European culture to the paradigm of the Latino's world view remains vaguely undefined and can be very difficult to implement. Group supervision and individual supervision is conducted in Spanish on a weekly basis to provide a venue for monitoring the delivery of culturally appropriate therapy. The concepts of family, curanderos, spirituality, immigration, acculturation, respect, trust, and working within the Latino paradigm are addressed in supervision. The integration of therapeutic theories and interventions into the Latino worldview is examined in supervision in the hope that the therapists remain true to a culturally sensitive model.

In an effort to educate the community about LOP and to form a stronger partnership with the community, on October 25th 2008 LOP and The County Behavioral Health Department invited specific community members to an event which featured a power point presentation along with dinner, dancing and the opportunity to network (appendix F). It was sponsored via funding from a grant from the Board of Supervisors, The Latino Outreach Council, and MHSA. The event offered a venue for professionals and staff who represent community agencies in SLO county to network and learn about LOP. It drew a group of

approximately 95 persons who represent The Board of Supervisors, the County Behavioral Health Department, The Department of Probation, Latino Outreach Council, Latino Outreach Program, Cal Poly University, Cuesta College, Drug and Alcohol Services, Services, Affirming Family Empowerment, Transitions Mental Health, Vision Unida, Family Care Network, Gay Lesbian and Transgender Alliance, SAFE, and the Public Schools.

This event along with the network system provides the venue for educating the community about LOP. Information on LOP is disseminated via media, workshops, presentations and visits to numerous locations in the community (appendix G). Due to the tremendous amount of requests for LOP services the program has been able to grow from 1 therapist to 3.5 therapist. The statistics reflect the number of persons who have received services in 2008-current (appendix H, I). Client referrals to the program occur through community programs, schools, churches, and the network system. Unfortunately, the program always has a wait list for services and at times referrals have been closed because the wait list is too long. The success of the referral system is a direct reflection of the people and community agencies working together to form a wonderful network that enables the clients to reach LOP directly.

References

- Alderete, E. Vega, W. A., Kolody, B. & Aguilar Gaxiola, S. (1999). Depressive symptomatology: Prevalence and psychosocial risk factors among Mexican migrant farm workers in California. *Journal of community Psychology*, 27, 457-471.
- Aneshensel, C.S., Clark, V.A. & Frerichs, R.R. (1983). Races, ethnicity, and depression. A confirmatory analysis. *Journal of Personality and social Psychology*, 44, 385-398.
- American Psychological Association. (1993). Guidelines for provider of psychological services to ethnic, linguistic, and culturally diverse populations. *American Psychologist*, 48, 45-48.
- Bullock, L. (1999). A historical chronology of the CCBD. Reston, VA: CCBD Min-Library Series.
- Casas, J.M., Pavelski, R., Furlong, M., & Zanglis, I. (2001). Advent of systems of care. In Ponterotto, J. Casas, J.M., Suzuki, P & Alexander, C. (EDS.), *Handbook of Multicultural Counseling* (pp. 198-219).
- Chung, F.K (1983). The use of mental health services by ethnic minorities. *Minority mental health services*.
- Cross-National Collaborative Group. (1992). The changing rate of major depression: Cross-National Comparisons *Journal of the American Medical Association*, 268, 3098-3105.
- Fernandez, P. Blue Stone, H. Morales, G. & Mizudri, M. (1985). Cultural influences and Alcoholism. *Alcohol Clinical Research*. 5, 443-6.
- Keete S..E. & Casas M. (1980) Mexican Americans and Mental Health: A select review and recommendations for mental health services. *American Journal of Community Psychology* 6, 201-220.
- Kiselica, M. & Robinson, M. (2001). Bring advocacy counseling to life: the history, issues, and human dramas of social justice working in counseling. *Journal of Counseling and Development*, 79, 387-397.

Lehman, E.W., Harrison-Ross, P., & Seigal, K. (1982). Community mental health center's minority group utilization and treatment. (NIMH grant No. Ro1 MH 31034) Final Report.

Quintana, M. (2000). Beyond stereotypes: Exploring the complexities of Latino identity. *Family Therapy networker*, 24, 36-66.

Sandavol, M.C. & De La Roza, M.C. (1986). A cultural perspective for serving the Hispanic client. In H.P. Lefley & P.B. Pedersen (Eds.), *Cross-cultural training for mental health professionals* (pp151-181). Springfield, Il: Charles C. Thomas.

Smart, J. F. & Smart, D.W. (1995). Acculturative Stress: The experience of the Hispanic immigrant. *The Counseling Psychologist*, 23, 25-42.

Walsh, F. (ED.). (1999). *Spiritual resources in family therapy*. New York: Guilford press.

Servicios Sicologicos Para Latinos

A Latino Outreach Program

Presentations

The following presentations have been provided in Spanish to the monolingual population:

Outreach Presentations **2008- 2009**

1/24/08	Living in Two Cultures	Pacheco Health Fair
1/25/08	Domestic Violence in Latinos	Oceano Adult Education
2/14/08	Living in Two Cultures	Los Osos Middle School
3/19/08	Latino Leadership	Nipomo Leadership Program
5/23/08	Bicultural Parenting	Cuesta College
6/18/08	Bicultural Parenting	EOC Head start
9/2/08	Leadership Program	Latino Youths
9/19/08	Parent Workshop	Nipomo Parent's Group
9/23/08	Vision Unida	Cuesta College
10/9/08	Parenting Adolescents	Paso Robles High School
10/9/08	Latino Needs	Health Services Advisory Board
11/9/08	Depression and Suicide in Latinos	Cuesta College
11/19/08	Living In Two Cultures	Pacheco School
1/22/09	Bicultural Parenting	Migrant Parents
1/27/09	Bicultural Parenting	Virginia Peterson

1/29/09	Bicultural Parenting	Piefer School
2/12/09	Career Planning	Los Osos Middle School
2/24/09	Bicultural Parenting	S.L.O. High School
3/9/09	Substance Use	Paso Recreation Center
5/5/09	Living in Two Cultures	Cuesta ELAC/Students
5/13/09	Relationships	Probation Adolescents
5/14/09	Career Planning	Nipomo Leadership Group
5/20/09	Relationships	Probation Adolescents
5/27/09	Relationships	Probation Adolescents
6/3/09	Relationships	Probation Adolescents
6/10/09	Bicultural Parenting	Bakari Program
6/17/09	Bicultural Parenting	Bakari Program
6/24/09	Bicultural Parenting	Bakari Program
8/5/09	Substance Abuse	Probation Adolescents
8/19/09	Substance Abuse	Probation Adolescents
9/14/09	Substance Abuse	Probation Adolescents
9/15/09	Bicultural Parenting	Paso Recreation Center
10/8/09	Gang Identity	Paso Recreation Center
10/15/09	Acculturation:Infancy to Adulthood	Paso Recreation Center

The following Presentations have been provided to persons who offer services to the threshold population.

4/2/08	High Risk Adolescents	Morro Bay High School
--------	-----------------------	-----------------------

4/10/08	High Risk Adolescents	Paso Robles High School
4/28/08	Wrap Around Latinos	Safe
5/2/08	Keynote Speech	Cuesta College
9/2/08	Leadership Program	Cuesta College
9/18/08	Cinco Del Mayo	Latino Outreach Council
9/24/08	Counseling Latinos	Social Workers Forum
10/9/08	Latino Needs	Health Service Advisory Board
11/4/08	Therapeutic Issues with Latinos	Cal poly
11/9/08	Elder Latinos	Nipomo Elders Group
11/10/08	Depression and Suicide in Latinos	Cuesta College
6/1/09	Latinos Mental Health	Paso Robles School District
9/24/09	Latinos and Drug Abuse	School Board
10/29/09	Psychotherapy with Latinos	Cal Poly MFT Class
12/9/09	Psychotherapy with Latinos	Morro Bay High School

Servicios Sicologicos Para Latinos A Latino Outreach Program Staff

Silvia Ortiz, Ph.D Silvia.ortiz.phd@gmail.com (805) 788-6652 (805) 448-5006 Cell	Program Director
Francisco Ortiz, MFT portiz@lo.slo.ca.us (805) 540-1769	M.H.T. III
Conrad Mendoza, MFT cmendoza@lo.slo.ca.us (805) 540-9034	M.H.T. III
Lupita Vargas, LMFT vargas@lo.slo.ca.us (805) 458-3177	M.H.T. III
Nancy Withers, LMFT nwithers@lo.slo.ca.us (805) 610-1544	M.H.T. III

Servicios Sicologicos Para Latinos A Latino Outreach Program

Community Sites

Bakari Program

Cal Poly
San Luis Obispo, Ca. 93401
(805) 756-2686 Fax (805) 756-2603

CA Rural Legal Assistance (a.k.a.- Oak Park office)

3350 Park St.
Paso Robles, CA 93446
(805) 239-3708 FAX (805) 239-4912

Mental Health Services Act

2925 McMillan Ave. Suite 124
San Luis Obispo, CA 93401
(805) 781-4850 FAX (805) 781-4866

Nipomo Family Resource Center

920 W. Tefft St.
Nipomo, CA 93444
(805) 473-5560 Fax (805) 473-4373

Oceano Family Resource Center

1511 19th St.
Oceano, CA 93445
(805) 473-4242 FAX (805) 473-4272

Paso Robles Family Resource Center

1802 Chestnut St.
Paso Robles, CA 93446
(805) 237-3196 FAX (805)237-3195

South County SAFE Family Resource Center

1086 Grand Ave.
Arroyo Grande, CA 93420
(805) 474-210 Fax (805) 474-2025

San Luis Obispo High School

1499 San Luis Drive
San Luis Obispo, Ca. 93401

Latino Outreach Program

Safe Site Procedure

Time Away

Normative Time Away

1. Call Frank Warren Division Manager, Mental Health Services Act.
2. Call Silvia Ortiz, PhD, Director, Latino Outreach Program.
3. Inform them how long you will be out.
4. Inform Silvia Ortiz, PhD, if all clients have been reached or messages left. Let her know which clients have not been reached along with phone numbers.
5. Inform Silvia Ortiz, PhD, the sites you will be absent from.
6. Silvia Ortiz, PhD, will e-mail the site/s and inform them of your absence.
7. If a client has been unable to be reached and they show at a site, that client is to be instructed to call Silvia Ortiz, PhD directly on her cell phone.

Emergency Time Away Procedure

1. Call Frank Warren, Division Manager, Mental health Service Act.
2. Call Silvia Ortiz, PhD, Director Latino Outreach Program and provide an estimate of the time you will be away.
3. Silvia Ortiz, PhD will call all your clients and be responsible for them, until you return. This may involve just a phone call, an urgent appointment, or a re- assigning of the case.
4. Silvia Ortiz, PhD will inform the Latino Outreach Therapist of you absence.
5. Silvia Ortiz, PhD will e-mail the sites and inform them of your absence.

Information about Therapists' Schedule

Silvia Ortiz, PhD holds a master of each therapist's schedule and will provide a copy of these to each site via e-mail or at monthly meeting. Each therapist also can provide a copy of their schedule to each site. The schedules will have the location the therapist is working.

New Referrals

1. All new referrals are made through the 788-2136 or the 448-5006 number. Please instruct the potential referral to leave their phone number slowly and clearly. Silvia Ortiz, PhD will return all calls and either assign the client or place them on the wait list. Referrals can check their status on the wait list via the 788-2136 or the 448-5006 number.

2. No cell phone numbers of the individual therapist can be provided to a referral as these persons have not been assigned a therapist. Upon assignment the therapist can provide their cell phone number to their respective clients.

Client Appointments

1. Once a client is assigned to a therapist, that client makes appointments directly with that therapist. There is no need to route an assigned client through Silvia Ortiz, PhD unless it involves the above mentioned procedures.
2. Once a Safe referral is assigned, Silvia Ortiz PhD, will provide the Safe/ LOP referral form to that counselor. The counselor will obtain the clients signature on the County Behavioral Health Services Consent form. This will allow information to be exchanged with the safe staff as needed.
3. The counselor will complete the LOP portion of the Safe Referral form and inform the referring parties that the client has an intake appointment.
4. Upon closure of the case, the therapist will complete the bottom of the safe referral form indicating that the case has been closed and inform the referring parties.

Phone numbers

1. 448-5006 Silvia Ortiz, PhD cell for urgent or emergency calls. Also if a client appears at a site asking questions about their assigned LOP counselor.
2. 788-2136 or 448-5006 Phone numbers to provide clients when they want to make an initial appointment or to call when making a referral.
3. 541-5280 Silvia Ortiz, PhD fax number.
4. If an urgent situation arises and you are unable to locate Silvia within an hour, please use the phone

Services Provided

1. We provide services to mono lingual clients who are low income and to the bilingual children, adolescents of those clients.
2. We open cases under two categories, one is medical necessity and the other is a client that does not meet medical necessity but is in need of services such as domestic violence, substance abuse, oppositional defiant disorder. Please refer clients in need of emotional support and the therapist will decide which category to open the case.
3. We provide groups at the schools and can provide them at a safe site.
4. We provide workshops on topic of interest such as Living in Two Cultures, Domestic Violence, Parenting, Gangs
5. We provide small group discussions on topics of interest.

Draft 11/13/2008

Cuestionario de Satisfacción

Para los Clientes del

Programa:

Latino Outreach

Estimado Cliente,

Como Terapeutas del Programa *Latino Outreach*, nos gustaría agradecerle la oportunidad que nos brinda de servirlo(a) en la comunidad. Por favor tome unos minutos para compartir con nosotros sus opiniones acerca de los servicios que ha recibido. A nosotros nos complace mucho el poderle ayudar y de igual manera queremos estar seguros de que usted esta recibiendo lo que necesita y que nos deje saber si hay alguna manera en la que nosotros podamos servirle aun mejor.

Sinceramente:

Nancy Mancha-Wit com: Supervisora General

Silvia Ortiz: Supervisora Clínica

Susana López: Terapeuta

Ana Fernández: Terapeuta

Francisco Ortiz: Terapeuta

¿Al evaluar su mas reciente visita o contacto con su terapeuta, como describiría la calidad del servicio recibido?

- Excelente *excellent*
- Muy Bueno *very good*
- Bueno *good*
- Algo Malo *someht*
- Muy Malo *very bad*

¿Como calificaría usted el proceso con su terapeuta para trabajar en sus problemas?

- Excelente
- Muy bueno
- Bueno
- Algo Malo
- Muy Malo

¿Su terapeuta ha sido amable y cortés con usted durante las sesiones?

- Siempre
- La mayor parte del tiempo
- Algunas veces
- Casi Nunca
- Nunca

¿Cual de las siguientes cualidades del terapeuta pudo usted observar durante sus sesiones?

- Paciente
- Entusiasta (con energía)
- Escuchaba cuidadosamente
- Amigable
- Sabia dar buenos consejos
- Otra:

X ¿Las cualidades que NO me gustaron de mi terapeuta fueron?

- No tenía paciencia
- No era entusiasta (sin energía)
- No escuchaba cuidadosamente
- No era amigable
- No me daba buenos consejos
- Otra:
- No tengo ninguna queja

¿Mi llamada fue contestada en un tiempo razonable?

- Si
- No
- Tomo algo de tiempo
- Les tomo mucho tiempo hablarme de regreso

X ¿Cuál fue el trato recibido durante su entrevista por teléfono?

- Me pusieron en espera
- Yo tuve que explicar mi situación repetidas veces
- El terapeuta no sabía como lidiar con mi caso
- El terapeuta fue muy cortés y amable
- El terapeuta me escuchó e hizo una cita para platicar en persona
- Otra

Mi terapeuta ...

- Me ha podido entender y ayudar
- No me ha sabido escuchar
- Me ha dado malos consejos
- No me ha podido ayudar a resolver mi problema
- Ha sido desorganizado
- Otra:
- No tengo ninguna queja

¿El tiempo entre sesión y sesión ha sido adecuado (una vez por semana)?

- Totalmente de acuerdo
- De acuerdo
- Me gustaría poder ver a mi terapeuta mas seguido
- Me gustaría tener terapia cada dos semanas
- Otra:

8 ¿Si en los siguientes 6 o 12 meses usted tuviera la necesidad de ver a un terapeuta nuevamente, cuales son las probabilidades de que volviera a utilizar de nuestros servicios?

- Ciertamente volvería a llamarles
- Es muy probable que los volviera a llamar
- Tal vez les hablaría
- Probablemente no les hablaría
- No creo que volviera a hablarles

¿Por cuánto tiempo ha usted recibido nuestros servicios?

- Menos de un mes
- 1 a 3 meses
- 3 a 6 meses
- 6 meses a 1 año
- Mas de 1 año

(2) En General, ¿que tan satisfecho esta usted con los servicios recibidos?

- Muy Satisfecho *very satisfied*
- Satisfecho *satisfied*
- Neutral *neutral*
- Insatisfecho *unsatisfied*
- Muy Insatisfecho *very unsatisfied*

¿Recomendaría usted nuestros servicios a otras personas?

- Definitivamente si
- Probablemente
- Tal vez
- Tal vez no
- Definitivamente no

¿Que tan conveniente es para usted el lugar donde recibe terapia?

- Muy conveniente (cerca de su casa)
- Un tanto conveniente (un tanto lejos de su casa)
- No muy conveniente (Lejos de casa, pero si puede atender)
- Inconveniente (lejos de casa y algunas veces batallo para atender)
- Muy Inconveniente (muy lejos de casa y casi no puedo atender)

¿Que opina usted sobre las sesiones que generalmente duran una hora?

- 1 hora me parece bien
- Me gustaría que las sesiones duraran mas de 1 hora
- Me gustaría que las sesiones duraran menos de 1 hora

Goals

1. To ensure that County Mental Health embraces and implements the behaviors, attitudes, values and policies of cultural diversity.
2. To provide recommendations that will increase service delivery to culturally diverse clients.
3. To provide recommendations that address the need of continued training on cultural diversity topics.
4. To identify and facilitate the removal of barriers that affect sensitive and competent delivery of service to culturally diverse clients.
5. To provide recommendations that address the recruitment and retention of bilingual providers.
6. To provide recommendations that increases utilization patterns of the unserved and underserved populations such as the Latinos, American Indians, and transition age youth, and older adults.
7. To provide County Mental Health employees with the topics and information discussed at the Cultural Competence Committee.
8. To forge alliances with other community agencies and committees who support the mission and goals of the Cultural Competence Committee.
9. To foster a strong networks among community agencies that will facilitate an integrated delivery of services.

BYLAWS

Article I

Name of Committee

Section 1: The Committee is known as the Cultural Competence Committee. The committee operates under the department of San Luis Obispo County Mental health Services.

Article II.

Purpose of the Committee

Section 1: The Committee is dedicated to assure that San Luis Obispo County Mental Health Services becomes a culturally competent health system which integrates the concept of cultural, racial and ethnic diversity into the fabric of it's operation. The committee will create agency-wide awareness of the issues relevant to cultural diversity.

Section 2: The Committee is committed to meeting the goals set forth in this document and will provide recommendations to the County Mental Health Director on issues pertinent to the achievement these goals.

Article III. **Structure of the Committee**

- Section 1: The Committee operates as an entity of the San Luis Obispo County Mental Health Department.
- Section 2: The County Mental Health Director appoints The Chairperson.
- Section 3: The Chairperson reports to The County Mental Health Director.
- Section 4: The Committee members are the decision-making body of the Committee. The members are elected by the Committee and represent a diverse range of cultural, ethnic, racial and geographic regions of the county.
- Section 5: The Committee will advise and serve as a resource group to The County Mental Health Director, The County Mental Health Training Committee, County Mental Health Staff, and affiliated agencies.
- Section 6: General membership is not a requirement for involvement in the Committee. Visitors are welcome to attend committee meetings and provide input.

Article IV. **General Membership**

- Section 1: The Committee consists of approximately six members from County Mental Health, affiliated agencies, network providers, and consumers. The members of the Committee represent a range of cultural and ethnic backgrounds.
- Section 2: The Chairperson is part of the Committee.
- Section 2: Anyone interested in serving on the Committee shall state his/her interest to serve by informing a Committee member.
- Section 3: A simple majority is required for the election of Committee members.
- Section 4: A vacancy exists when a Committee member misses four consecutive Committee meetings without prior notification to the Chairperson or any

other member. A vacancy also exists when a Committee member tenders his/her resignation verbally or in writing to the Chairperson.

Section 5: When a vacancy exists, The Committee shall nominate individuals to serve on the Committee.

Article V. **Meetings**

Section 1: No meetings shall be held in a facility that prohibits the admittance of any person based on culture, ethnic background, religious beliefs, sex, sexual orientation, or emotional/physical disabilities.

Section 2: Meetings will convene on the second Monday of each month with a minimum of ten meeting per calendar year.

Section 3: The Chairperson convenes the meetings

Section 4: The Committee members develop the agenda for the meetings.

Section 5: The Committee will strive to make decisions by consensus.

Section 6: A quorum is necessary to approve Policy and Procedures. All Policy and Procedures require a simple majority by a quorum to be recommended to the County Mental Health Director.

Section 7: A quorum is defined as 50% of the Committee.

Section 8: A motion may be made and seconded by any of the Committee members.

Section 9: Motions require a simple majority to be recommended as action items or task assignments.

Article VI. **Amendments**

Section 1: These Bylaws may only be amended or repealed and new bylaws adopted by the affirmative vote of a majority of a quorum of the Board.

Approved by the Director of Mental Health: _____

Date: _____

Draft 6/14/06

Behavioral Health Administrator

Cultural Competence Committee

Patients Rights Advocate

Mental Health Board

Division Manager Adult

Division Manager Children

Division Manager MHSA

Division Manager Drug & Alcohol

Division Manager PQI

Medical Directory

Committee Membership

Silvia Oritz, Ph.D.
Chairperson, Cultural Competence Committee
Director, Servicios Sicológicos Para Latinos:
A Latino Outreach Program

Karen Baylor, Ph.D., LMFT
County Behavioral Health Service
Department Administrator

Margie Craig, LMFT
Family Care Network

Kris Hiemstra, LMFT
County Behavioral Health Services
Mental Health Services

Cheri Love, MFT Trainee
County behavioral Health Services
Workforce Education and Training Intern

Kari Graton
Trans Central Coast
Steering Committee member

Kaleigh Mancha, MFT Trainee
Cal Poly State University, SLO

Nancy Mancha-Whitcomb, LMFT
Program Supervisor
North County Behavioral Health Services

Lisa Sweatt, Ph.D.
Associate Professor
Psychology and Child Development
Cal Poly State University, SLO

Casey Roos, LMFT
County Behavioral Health Services
Workforce Education and Training

**CONTRACT FOR SPECIAL SERVICE
EXHIBIT A
SCOPE OF SERVICES**

Scope of Services. Pursuant to this Contract, Contractor shall provide to County the following special services under the direction of the Behavioral Health Administrator.

1. Coordinate a Latino Outreach and Services Program to reach unserved and underserved limited English speakers as part of Mental Health Services Act program development.
2. Provide data and outcome measures on number of clients served and efficacy of the program.
3. Provide community-based, culturally appropriate treatment and support services for up to 26 hours per week.
4. Supervise three registered interns to work in the Latino Outreach and Services Program. Coordinate the practicums and provide clinical supervision to bilingual students attending Cal Poly.
5. Chair the Cultural Competence Committee and produce a Cultural Competency newsletter at least three times per year.
6. Provide in-service training to staff regarding mental health cultural competency and treatment with the Latino population.
7. Participate in the planning of other MHSA components such as Prevention and Early Intervention and Innovation.
8. Provide an annual report on the program regarding services delivered by Latino Outreach and Services staff, total number of clients served, and the effect the program is having in reducing disparities.

Cultural Competency Consultant Scope of Work

Silvia Ortiz Benzel, PHD.

July 2009- June 2010

Internal Order: 165R75000

GL: 5050340

Not to Exceed: \$10,000

Hourly Rate: \$100

Maximum Billable Hours: 100

1. Provide training which will enhance supervision and support of culturally specific services (one per fiscal year).
2. Provide training specifically focused on the need of the Latino community as well as the African American, Asian Pacific Islanders communities (one per fiscal year).
3. Provide additional trainings specifically focused on the diverse needs of other alternative life styles or cultures (one per fiscal year).
4. Chairperson of the Cultural Competency Training Development subcommittee, this subcommittee is responsible for the implementation of two all day trainings per year.

Two of the above three mentioned trainings will be all day training events with Behavioral Health Staff and community partners. All trainings will have a minimum of 50 attendees.

Blanket Purchase Order for services on an as-needed basis ending June 30, 2010

Either party may cancel this Agreement on 30 days written notice

San Luis Obispo County MENTAL HEALTH PLAN
PERFORMANCE QUALITY IMPROVEMENT/QUALITY MANAGEMENT

August 20, 2010
8:30 a.m. – 10:00 a.m.

Agenda

1. Review and approval Minutes of July 16, 2010
2. Morbidity and Mortality Committee report
 - a)
3. Risk Management Review (Dr. Ghareman)
 - a) Incident Reports Follow-up:
 - b) Incident Reports-New: #
4. Follow up Old Business
 - a. PHF Discharge FTS Rate (Greg Vickery)
 - b.
5. Other Program Updates or News
6. Monthly Statistics
 - a. Central Access statistics (Greg Vickery)
 - Average days between Central Access and clinic appointments
 - Client referrals
 - After-hours test calls
 - Intake Disposition
 - b. Psychiatrist Wait Times (Dr. Ghareman)
 - c. Jail (Janet Amanzio)
 - d. JSC (Brad Sunseri)
7. PIP Report (Dr. Ghareman)
8. Monthly Audit/Outcome Report: CBO Outcome Measures
9. Consumer/Family Advocate
10. Strategic Initiative / Workplan Item of the month (Dr. Ghareman)
11. Cultural Competence (Dr. Ortiz)

Next meeting will be Friday, September 17, 2010, at 8:30 a.m.

Cultural Competence Committee

2180 Johnson Ave., San Luis Obispo, CA
Health Campus, Conference Room 225

May 10, 2010
10:00am - 11:00am
805-781-4719

1. **CALL TO ORDER**
2. **Introductions and announcements**
3. **Action Item: Reading and discussion of Minutes from April, 2010 meeting.**
4. **Discussion of newsletter and responsibility of distribution of newsletter.**
5. **Discussion of 2010 Cultural Competence Plan Requirements**
6. **Adjournment**

Board Members

Silvia Ortiz (Chair) Latino Outreach Program	Amy Vilanueva, Parent Partner, Family Care Network	Lisa Sweatt, Cal Poly, Associate Professor, Psychology & child Development
Karen Baylor, County Behavioral Health Administrator	Kari Graton, Trans Central Coast	Nancy Mancha-Whitcomb, Program Supervisor, County
Margie Craig, Family Care Network	Casey Roos, County Behavioral Health Services, WET Coordinator	Kris Hiemstra, County Behavioral Health Services
Celia Sotelo, Family Care Network, Parent Partner	Kaleigh Mancha, MFT Trainee, Cal Poly	

**San Luis Obispo County
Cultural Competence Meeting**

May 10, 2010

10:00 a.m. – 11:00 a.m.

Members Present: **Chair:** Silvia Ortiz, Ph.D., Latino Outreach Program
 Karen Baylor, Ph.D, LMFT, County Behavioral Health Administrator
 Lisa Sweatt, Ph.D., Cal Poly, Associate Professor, Psychology & Child Development
 Kris Hiemstra, LMFT, County Behavioral Health Services
 Celia Sotelo, Family Care Network, Parent Partner
 Casey Roos, LMFT, County Behavioral Health Services, WET Coordinator
 Kaleigh Mancha, MFT Trainee, Cal Poly

Members Absent: Nancy Mancha-Whitcomb, LMFT, MHSA – Division Manager
 Margie Craig, LMFT, Family Care Network (FCN)

Secretary: Jane Ahlquist

Topic	Discussion	Recommendations/Actions
Minutes:	<ul style="list-style-type: none"> • April 12, 2010 minutes were reviewed and unanimously approved. 	
Newsletter:	<ul style="list-style-type: none"> • April, 2010, Volume 1, Issue 5 was released; It was a great issue on Veterans, and an incredible poem, titled “Black Shoes,” by Gloria L. Velasquez, Ph.D. • Next newsletter will feature Men’s Issues. • 	<ul style="list-style-type: none"> • Distribution of the newsletter is as follows: <ul style="list-style-type: none"> ○ Casey Roos to distribute to: <ul style="list-style-type: none"> ▪ All of Behavioral Health Dept. ▪ Family Care Network, ▪ Transitions (TMHA) ▪ Biz Steinberg ▪ Cultural Commission ▪ CBO’s (?) ask Kim ▪ Casey to Luise, Luise to Network Providers ○ Jane Ahlquist to distribute to: <ul style="list-style-type: none"> ▪ Mental Health Board ▪ Drug & Alcohol Service Board ▪ Cultural Competence

Topic	Discussion	Recommendations/Actions
<p>Cultural Competence Plan, Criterion 4:</p>	<ul style="list-style-type: none"> • Discussion in how to create the San Luis Obispo Cultural Competence Guiding Principals: Guiding principals, objectives, general guidelines from Mission Statement. Fold Cultural Competence Practice as an ethical practice. Look at CORE Values. • Criterion 4: <ul style="list-style-type: none"> I. <ul style="list-style-type: none"> a. Brief description of the Cultural Competence Committee, ie. Mission Statement. b. Policies and procedures and practices that assure members of the Cultural Competence Committee will be reflective of community, ie. 1 page resume describing our mission. c. Organizational chart: Jane Ahlquist to revised chart. d. Committee membership roster listing member affiliation: i.e.: Mission Statement II. <ul style="list-style-type: none"> a. Evidence of policies, procedures and practices – Frank Warren <ol style="list-style-type: none"> 1. Review of all services - Frank Warren 2. Provides reports to Quality Assurance/Quality Improvement Program in the county: will request PQI minutes from Azarm Ghareman. 3. Participates in overall planning and implementation of services at the county: use MHSA plan as an example. 4. Karen Baylor attends meeting 5. Participates in and reviews county MHSA planning process: Frank Warren 6. Participates in and reviews county MHSA stakeholder process: Frank Warren 7. Participates in and reviews county MHSA plans for all MHSA components: Frank Warren 8. Participates in and reviews client developed programs (wellness, recovery, and peer support programs: TMHA b. Provide evidence that the Cultural Competence Committee participates in the above review process: Minutes 	<p style="text-align: center;">Committee</p> <ul style="list-style-type: none"> • Karen and Silvia will revise the objectives and present a draft for the committee to review at the next meeting.

Topic	Discussion	Recommendations/Actions
<p>Next Meeting, Invite:</p>	<p>c. Annual Report of the Cultural Competence Committee's activities:</p> <p>1. Detailed discussion of the goals and objectives of the committee: included Mission Statement, including data, training, forms, Wellness & Recovery Language.</p> <p>Invite Kathy Peters to discuss how Cultural Competence Language will be integrated into forms in the BHEHR SYSTEM (new computer program system).</p> <ul style="list-style-type: none"> • Thank you Lisa for bringing in the Cultural Competence books to share. • 	

Next meeting: Monday, June 14th, from 10 -11:00am.

2010 Cultural Competency Plan Requirements

Karen Baylor, Ph.D., LMFT, Behavioral Health Administrator; **Janet Amanzio**, M.A., R.N., Division Mgr., Adult Services; **Gerald Clare**, Patients Rights Advocate; **Azarm Ghareman**, Ph.D., MBA, Div. Mrg. Performance & Quality Improvement, Health Agency Compliance Officer; **Barry Johnson**, T-MHA , Division Director, Adult Rehab & Advocacy; **Nancy Mancha-Whitcomb**, MH Program Supervisor, North County; **Mike Taylor**, Accountant; **Kim Miramon**, ASM; **Silvia Ortiz**, PhD, Division Manager, Latino Outreach Program; **Denise Rea**, T-MHA, Division Director; **Casey Roos**, LMFT, WET Coordinator, BHEHR Clinical Project Lead; **Brad Sunseri**, Division Manager, Youth Services; **Greg Vickery**, Program Supervisor; **Frank Warren**, Program Supervisor, SLOBHD

From: Silvia Ortiz, PhD

Date: March 2, 2010

The Californian Department of Mental Health (DMH) has issued the 2010 Cultural Competence Plan Requirements (CCPR). Each County must submit a revised comprehensive CCPR every three years and an annual update in the interim years. The first CCPR is due July 2010. Annual updates are due in 2011, 2012, 2014, and 2015. Comprehensive revised plans are due 2013 and 2016.

On February 23rd 2010 a work group consisting of Silvia Ortiz (chairperson), Karen Baylor, Azarm Ghareman, Frank Warren, and Casey Roos reviewed the requirements and assigned portions of the document to persons whose position with County Behavioral Health provides them the knowledge base to complete that portion of the document. The completed CCPR will be submitted to DMH by Karen Baylor and Silvia Ortiz.

You can obtain a copy of the Cultural Competence Plan Requirements by going to the DMH website www@dmh.ca.gov . DMH Information Notice No. 10-02.

Following is a list of the CCPR sections and the names of the corresponding persons who have been assigned to complete that section. Please start on the sections assigned to each person.

The next meeting is March 23rd from 2:00-4:00 in the Annex (Red Room) at the Health Campus.

Criterion I - Commitment to Cultural Competence

- I. Karen Baylor/Azarm Ghareman
- II. Casey Roos/Frank Warren
- III. Nancy Mancha-Whitcomb
 - A. Casey Roos/Frank Warren/Mike Taylor
 - B. Karen Baylor/Kimberly Miramon

Criterion 2 - Updated Assessment of Service Needs

- I. Intern supervised by Casey Roos
- II. Intern supervised by Casey Roos
- III. Intern supervised by Casey Roos
- IV. Karen Baylor/Brad Sansei
- V. Frank Warren

2010 Cultural Competency Plan Requirements

Criterion 3 - Strategies and Efforts for Reducing Racial, Ethnic, Cultural, and Linguistic Mental Health Disparities

- I. Karen Baylor/Casey Roos/Frank Warren
- II. Karen Baylor/Nancy Mancha-Whitcomb/Silvia Ortiz
- III. Silvia Ortiz
- IV. Silvia Ortiz
- V. Silvia Ortiz

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

- I. Silvia Ortiz
- II. Silvia Ortiz

Criterion 5 - Culturally Competent Training Activities

- I. Casey Roos
- II. Casey Roos
- III. Casey Roos
- IV. Casey Roos

Criterion 6 - County's Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

- I. Casey Roos

Criterion 7 - Language Capacity

- I. A.1 Casey Roos
A.2 and 3 Karen Baylor
- II. A. Greg Vickery
B. Azarm Ghareman
C. Azarm Ghareman
C.1 Karen Baylor/Silvia Ortiz
D. Karen Baylor/Silvia Ortiz
E. Karen Baylor
- III. Greg Vickery
- IV. Greg Vickery
- V. Gerald Clare

2010 Cultural Competency Plan Requirements

Criterion 8 - Adaptation of Services

- I. Brad Sansei/Janet Amanzio/THMA - Barry Johnson and Denise Rea
- II. A. Karen Baylor
B. Greg Vickery
C. Greg Vickery
D. Greg Vickery
- III. Frank Warren
- IV. Karen Baylor/Silvia Ortiz

**San Luis Obispo County
Mental Health Services
Cultural Competence Committee**

The Cultural Competence Committee has outlined the progress made toward the objectives recommended by La Frontera, Inc. This organization was contracted by San Luis Obispo County Mental Health to develop a "Cultural Competence self assessment manual titled Building Bridges, which has been used by this agency's Cultural Competence Committee". The manual outlined seven objectives which "would help the mental health system in San Luis Obispo county become a more culturally competent organization" The following document address these goals.

Objective

1. Beginning with fiscal year 98-99 and continuing through the 2009 CCP update, the Mental Health system had a goal to disseminate brochures and handouts with Spanish and English translations. These brochures will advise readers of the availability of mental health services. Distribution of these brochures will include locations where there is a high monolingual population... These critical points of contact will include the following:
 - A. Schools with a high percentage of Hispanic students
 - B. Points of entry into medical, mental health, and social service delivery with high concentrations of monolingual Hispanics.
 - C. Spanish speaking media including radio, television, and newspapers.
 - D. Catholic churches in the high monolingual population areas

Current Status:

Brochures and handouts with Spanish and English translations have been distributed to all points of contact A thru D. Churches prove to be a difficult point of entry because they prefer to use their own ministers, priests, and religious leaders to provide faith based counseling. Materials have been distributed to the following locations:

Schools with a high percentage of Hispanic students

C.L.Smith Elementary School, Los Osos
Osos Middle School, Los Osos
Sinshiemer School, SLO
Hawthorne School, SLO
Rural Assistance League, Paso Robles
Del Mar School,
Youth Services, SLO
Baywood Elementary School, Los Osos
Pacheco School, SLO
Nipomo Elementary School, Nipomo
Oceano Elementary School, Oceano
Paso Robles School District
Flanigan middle School

Daniel E. Lewis Middle School
Freedom Phillips School
Cuesta College, SLO
California Polytechnic University, SLO

Points of entry into medical, mental health, and social service delivery in areas with high concentrations of monolingual Hispanics

SHARP Center, SLO
GALA Center, SLO
EOC Oceano and Paso Robles
Paso Robles Community Fair
San Miguel Health Fair
Adelante Mujeres Latinas Convention
PTSD and Latinos Veterans Presentation, SLO
Ocean Family Resource Center,
Paso Robles Family Resource Center
Nipomo Family Resource Center
CA Real Legal Assistance
Vision Unida Organization, SLO
Drug and Alcohol Program, SLO and Ocean
SLCUSD Child Advocacy Board, SLO
San Luis Obispo Law Enforcement, SLO
Emergency Services Network Meetings, SLO
Department of Social Services, SLO and Paso Robles
Department of Social Services Bilingual Networks, Paso Robles, Atascadero, SLO, Oceano,
Grover Beach, Arroyo Grande
Latino Outreach Council, SLO
Transitions Mental Health
Probation
Shelters for Abused Woman
Arroyo Grande Hospital, Board of Director
French Hospital, Board of Directors
Marian Hospital Board of Directors
Bakari Program
ELAC Programs

Catholic churches in the high monolingual population areas

Mission Church, SLO
Paso Robles Iglesias, Paso Robles
San Miguel Mission, San Miguel

Spanish speaking media including radio, television, and newspapers

Aqui Show
Projecto Unido Show
Univision 38
Lazer Broadcasting
Channel 2
Latino Today Newspaper
The Tribune Newspaper

Latino Outreach Council Web Site

Objective

2. This literature distribution will be followed by quarterly telephone contacts with these critical contact points to ensure the efficacy of literature dissemination and to effect provision of information regarding available services.

Current Status

Literature distribution was followed up on a monthly basis to insure the availability of bilingual materials. There has been a break in the quarterly telephone contacts. Points of contact do phone requesting literature, business cards, and brochures when their supplies are depleted. Each call is returned and information is disseminated to the points of contact.

Objective

3. Bilingual mental health professionals from the existing treatment locations in the high-density monolingual population areas will provide outreach presentations two times per year.

Current Status

The following presentations have been provided in Spanish to the monolingual population:

Outreach Presentations 2008- 2009

9/2/08	Leadership Program	Latino Youths
9/18/08	Cinco Del Mayo	Latino outreach Council
9/19/08	Parent Workshop	Nipomo Parent's Group
10/9/08	Bicultural Parenting	Paso Robles High School
11/9/08	Depression and Suicide in Latinos	Latino parents
11/9/08	Elder Latinos	Nipomo Elders Group
11/19/08	Living In Two Cultures	Pacheco School
1/22/09	Bicultural Parenting	Migrant Parents
1/27/09	Bicultural Parenting	Virginia Peterson
1/29/09	Bicultural Parenting	Piefer School
2/12/09	Career Planning	Los Osos Middle School

2/24/09	Bicultural Parenting	S.L.O. High School
3/9/09	Substance Use	Paso Recreation Center
5/5/09	Living in Two Cultures	Cuesta ELAC/Students
5/13/09	Relationships	Probation Adolescents
5/14/09	Career Planning	Nipomo Leadership Group
5/20/09	Relationships	Probation Adolescents
5/27/09	Relationships	Probation Adolescents
6/3/09	Relationships	Probation Adolescents
6/10/09	Bicultural Parenting	Bakari Program
6/17/09	Bicultural Parenting	Bakari Program
6/24/09	Bicultural Parenting	Bakari Program

4. Mental Health staff will develop a resource guide of bilingual service providers both within and without the system to increase awareness of resources and interpreters for Spanish-speaking clients.

Current Status

The resource guide of bilingual service providers has been developed and distributed. A copy is enclosed.

Objective

5. The mental health system will clearly identify the language needs of mental health applicants at points of entry, including the Managed Care Central Access and other system points to entry such as specialized services in the County Jail, Juvenile Service Center and the Mental Health Crisis service.

Current Status

Language needs of mental health applicants are identified at points of entry. The Latino Outreach Program provides therapy to monolingual Spanish speaking clients. The community refers directly to the program and thus the client has a Spanish speaking therapist at the point of entry.

Objective

6. Mental Health will network with other agencies and professionals and nontraditional service providers who serve this population to determine needs and plan service enhancements.

Current Status

Mental Health networks with other agencies, professionals and non-traditional service providers to enhance the delivery of services. The information disseminated to the agencies in objective 1 was provided in person. Participation in various Boards and Committees such as the Latino Outreach Council, the French Hospital Executive Board, Health Services Advisory Committee, Migrant and Seasonal Head Start Programs, Economic Opportunity Commission of San Luis Obispo provides a strong avenue for networking. Via the Latino Outreach Program (LOP), a network system has been established in the six sites and three schools which house the therapists. The Program works closely with Community Health Care, Safe, the schools, the Woman's Shelter, the Rural Assistance League, and English as a Second Language Classes, Mission Church, and The Department of Probation. Networking has occurred via the relationship with the media coverage by The Aqui Show, Projecto Unido Show, Univision 38, and Lazer Broadcasting Channel 2, Latino Today News paper, The Tribune Newspaper.

On October 25th 2008 an event was sponsored via funding from the Mental Health Service Act and a grant from the Board of Supervisors. The event offered a venue for professionals/staff from The Board of Supervisors, County Behavioral Health, The Department of Probation, Latino Outreach Council, Latino Outreach Program, Cal Poly University, Cuesta College, Drug and Alcohol Services, Services Affirming Family Empowerment, Transitions Mental Health, and Vision Unida to network. People represented regions from San Miguel to Nipomo. The event drew a group of approximately 95 persons. It featured a power point presentation along with dinner, dancing and the opportunity to network (appendix A).

Three newsletters covering culturally diverse groups have been distributed to County Behavioral Health staff, Behavioral Health networks providers, Transitions Mental Health, Behavioral Health Advisory Board, Cal Poly M.F.T. Program, and Latino Outreach Council. These Newsletters cover topics on Latino issues, LGBT issues and the Native American culture. The following Newsletter will be distributed October 2009 and will address the African American culture (appendix B, C, and D).

Workshops have been provided to person who provides services to the threshold population.

9/24/08	Counseling Latinos	Social Workers Forum
10/9/08	Latino Needs	Health Service Advisory Board
11/4/08	Therapeutic Issues with Latinos	Cal poly
11/9/08	Depression and Suicide in Latinos	Cuesta College

11/9/08	Elder Latinos	Nipomo Elders Group
6/1/09	Latinos Mental Health	Paso Robles School District

Workshops have been provided by the County Behavioral Health Training Committee to County Behavioral Health staff on Culturally Diverse issues.

3/ 18/09	Cultural Competence	County Behavioral staff
3/25/09	Differential Diagnosis	County Behavioral staff

Objective

- 7. The Mental Health System will make specific efforts to recruit and retain staff that has:
 - A. Training on or demonstration of knowledge about the culture of the consumer services.
 - B. Training on or demonstration of knowledge about how to provide culturally competent mental health services.
 - C. A demonstrated competence with particular cultural groups.

Current Status

The Mental Health System advertises positions as bilingual preferred. Bilingual recruitments have been posted in the Tribune, Latino Today and have been widely announced in the Latino network system. Bilingual network providers are given the incentive of a higher rate than the non bilingual providers. In 2008 The Latino Outreach Program hired two full time bilingual /bicultural therapists. In 2008 they also acquired a bilingual/bicultural doctoral practicum student who was hired on a temporary contract after completion of her practicum. All three are supervised by a bilingual/bicultural psychologist. In addition, The Mental Health System employs two bilingual/ bicultural LMFTs, one Psychological Technician, two Drugs and Alcohol Outreach Specialist, and a contract LMFT Managed Care Provider.

San Luis Obispo County Behavioral Health Services

Training Priorities 2010-2013

FY 2010-2011	Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
	Cultural Competence	Treatment of Trauma	Law and Ethics	CMHACY Conference
	Customer Service and Consumer Oriented Care		Supervision	Trips to Village
	Treatment of Co-Occurring Disorders		CA/LOCUS	In Our Own Voice
	Inspired at Work		Documentation	Stamp Out Stigma
	Leadership training for Consumer and Family Members (emphasis on non-staff consumers)		Grand Rounds	NAMI Provider Training
	Wellness & Recovery		Pro-Social Skills*	
			Functional Family Therapy*	
		Seeking Safety*		
FY 2011-2012	Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
	Cultural Competence	Treatment of Trauma	Law and Ethics	COMACY Conference
	Customer Service and Consumer Oriented Care		Supervision	Trips to Village
	Treatment of Co-Occurring Disorders		CA/LOCUS	In Our Own Voice
	Stigma Reduction		Documentation	Stamp Out Stigma
	Wellness & Recovery		Grand Rounds	NAMI Provider Training
	Inspired at Work		Pro-Social Skills*	
			Functional Family Therapy*	
		Seeking Safety*		
		Clinical Case Management		
FY 2012-2013	Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
	Cultural Competence	Treatment of Psychosis	Law and Ethics	COMACY Conference
	Customer Service and Consumer Oriented Care	Treatment of Depression	Supervision	Trips to Village
	Treatment of Co-Occurring Disorders		CA/LOCUS	In Our Own Voice
	Stigma Reduction		Documentation	Stamp Out Stigma
	Wellness & Recovery		Grand Rounds	NAMI Provider Training
	Inspired at Work		Pro-Social Skills*	
			Functional Family Therapy*	
		Seeking Safety*		

* Evidence Based Practice

San Luis Obispo County Behavioral Health Services

Training Plan FY 2010-2011

Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
Cultural Competence <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 	Treatment of Trauma <ul style="list-style-type: none"> • Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Families • Evidence Based Prac. • Training Modalities 	Law and Ethics	COMACY Conference
Consumer Service and Consumer Oriented Care <ul style="list-style-type: none"> • Developing strategies to improve engagement <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 		Supervision	Trips to Village
Treatment of Co-Occurring Disorders <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 		CA/LOCUS	In Our Own Voice
Leadership training for Consumer & Family Members <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 		Documentation	Stamp Out Stigma
		Grand Rounds	NAMI Provider Training
		Pro-Social Skills*	
		Functional Family Therapy*	
		Seeking Safety*	

San Luis Obispo County Behavioral Health Services

Trainings in Foundational Knowledge FY 2010-2011/2012-2013

Area	Course Content	Educational Objectives	Scheduled Trainings
<p>Cultural Competence</p> <ul style="list-style-type: none"> • Spanish-speaking consultation group • Filipino clinical consultation group • Assessment Using the California Multi-Cultural Scale 	<ul style="list-style-type: none"> • Increase awareness of health disparities in our community • Work with consumers, families, providers, and community partners to reduce health disparities in our community • Focus on trainings to support culturally and linguistically competent services, • Educational and training activities will be available to consumers, family members, providers, and those working and living in the community. <p>(Return to Top)</p>	<ul style="list-style-type: none"> • Improved capacity to utilize interpreters with consumers who are not English-speaking; • Expanded incorporation of a variety of alternative and culturally specific strategies as part of ongoing treatment efforts; • Incorporation of culturally-informed engagement strategies; • Increased satisfaction with services by historically underserved and poorly served cultural populations; • Improved access and service delivery to historically underserved communities. <p>(Return to Top)</p>	<ul style="list-style-type: none"> • California Multi-Cultural Scale • How to Use an Interpreter • Cross Cultural Communication • Multi-cultural Issues in Domestic Violence • Working with Filipino-American Families • Culture as a Worldview • Mental Health 102 • Healthy Living & Chronic Disease Prevention • Pacific Islander Summit • African American Summit • LGBTQQI Focused Training • Convergence of Western & Eastern Medicine • Latino Initiative Summit
<p>Consumer Service and Consumer Oriented Care</p> <ul style="list-style-type: none"> • Developing strategies to improve engagement 	<ul style="list-style-type: none"> • Find out from consumers and family members what helps them to be more engaged • Discussions of specific cases with engagement issues • Discussions of how cultural and linguistic issues affect engagement • Discussions of how welcoming environment fosters engagement, with special focus on clients with co-occurring conditions • Focus on age-specific issues in engagement (e.g., working with youth and seniors) • Focus on clients with major engagement needs, including 	<ul style="list-style-type: none"> • Learn new methods to achieve and sustain consumer and family engagement • Learn to adopt a collaborative style of working with consumers and family members • Improve the ability to identify clients early who are having trouble engaging in services • Learn new methods to ensure the treatment environment is welcoming to clients with diverse cultural backgrounds and expectations <p>(Return to Top)</p>	

San Luis Obispo County Behavioral Health Services

	<ul style="list-style-type: none"> ○ Homeless clients ○ Medically complex, fragile ○ Transition from incarceration ○ Clients with immigration concerns ○ Youth transitioning from placement ● How stigma impacts engagement ● How service provider's attitudes and beliefs may affect their client's engagement ● How stage of change impacts engagement ● Learning new outreach strategies to improve engagement ● How collaboration with other agencies impact engagement ● Learning engagement strategies, skills from consumers and family members <p>(Return to Top)</p>		
<p>Treatment of Co-Occurring Disorders</p>	<ul style="list-style-type: none"> ● Philosophy of best practices for treatment of clients with AOD and MH issues ● Biological issues of COD ● Basic medication case management skills ● Providing brokerage and clinical case management ● Integrating treatment between AOD and MH providers; partnering ● Recognizing street drugs and their impact on health ● Engagement and welcoming skills ● Client retention skills ● Relapse prevention skills 	<ul style="list-style-type: none"> ● Improve engagement and retention of clients with COD. ● Increase collaboration with partners providing care for COD clients, and working together to integrate treatment. ● Learn treatment methods that allow for and encourage client's self-efficacy, including how to collaborate with clients. ● Understand how to apply stage of change model to assess and choose interventions for target behaviors. 	<ul style="list-style-type: none"> ● MI Skills ● Understanding & Working in the Pre-contemplative Stage ● All You Need to Know About Opioid Agonist Therapy ● Opioid Agonist Therapy: Buprenorphine ● Smoking Cessation ● Screening and Assessment for COD ● Motivational Interviewing ● MI Skills Part II ● COD Assessment and Screening TIP 41 ● COD training

San Luis Obispo County Behavioral Health Services

	<ul style="list-style-type: none"> • Stage based assessment and treatment skills • Collaborative, strength-based treatment planning • Determining outcomes of COD interventions • Engagement of family members in treatment • Recognizing and working with cultural and linguistic issues for the COD client <p style="text-align: center;">(Return to Top)</p>	<ul style="list-style-type: none"> • Learn how to address cultural and linguistic issues in engagement and treatment processes. • Learn how to collaborate and communicate with family members and other community supports • Learn the differences between brokerage and clinical case management and how to apply these skills to clients with COD. • Understand how to use information regarding the biology of COD and medications to educate clients regarding these biological brain disorders. <p style="text-align: center;">(Return to Top)</p>	<ul style="list-style-type: none"> • Basic MI Training • Principles and Techniques of Motivational Interviewing • MI Case Application • ACT and Relapse Prevention • MI and COD • MI Skills for Admin Staff <p style="text-align: center;">(Return to Top)</p>
<p>Leadership training for Consumer and Family Members (emphasis on non-staff consumers)</p>	<ul style="list-style-type: none"> • Training in Advocacy • Training in Committee Work • Training in Presentation Skills • Training to be Trainers <p style="text-align: center;">(Return to Top)</p>		<ul style="list-style-type: none"> • Send individuals to State sponsored trainings in this area <p style="text-align: center;">(Return to Top)</p>

San Luis Obispo County Behavioral Health Services

Trainings in Foundational Knowledge FY FY 2010-2011/2012-2013

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Cultural Competence			
Consumer Service and Consumer Oriented Care <ul style="list-style-type: none"> • Developing strategies to improve engagement 	<ul style="list-style-type: none"> • Consumer and family staff will attend all trainings • Consumer led trainings and seminars on engagement and encouraged to discuss their experience • Didactic trainings led by consumers <p>(Return to Top)</p>		<ul style="list-style-type: none"> • Case discussions – identify consultants with special expertise; arrange for consumer and family staff to attend these trainings to share their perspective re: engagement • Didactic trainings led by consumers • Trainings tailored to individual teams as much as possible <p>(Return to Top)</p>
Treatment of Co-Occurring Disorders			
Leadership training for Consumer and Family Members (emphasis on non-staff consumers)			

San Luis Obispo County Behavioral Health Services

Special Annual Training Series FY FY 2010-2011/2012-2013

Area	Course Content	Educational Objectives	Scheduled Trainings
Trauma Training Series	<ul style="list-style-type: none"> • PTSD – Basic level training to understand and assess • Didactic overview of trauma research and assessment • Review of Evidence-Based Practices in the treatment of trauma • Recovery from trauma from the perspective of consumers and family members • The role of trauma in clients with co-occurring conditions • The experience of trauma in culturally diverse communities • Different types of trauma – e.g., Complex vs. simple trauma • The impact of the differential course of trauma and the subsequent developmental process • The effects of trauma on the CNS • Somatic treatment strategies in working with trauma • The impact of forensic interviews on the treatment process and the provider’s role • How to handle informed consent and mandatory reporting laws in the treatment of trauma 	<ul style="list-style-type: none"> • To better understand and treat trauma and trauma-related issues (e.g. PTSD) • To work more effectively with clients who experience trauma and/or have trauma-related diagnoses • To learn about existing EBP in trauma treatment 	<ul style="list-style-type: none"> • Stanford and VA do trainings every year

San Luis Obispo County Behavioral Health Services

Special Annual Training Series FY FY 2010-2011/2012-2013

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Trauma Training Series	<ul style="list-style-type: none"> • Consumer and family staff will attend all trainings • Consumers and family members recovering from trauma will be asked to present their experience in at least one training in the series <ul style="list-style-type: none"> ○ What works from their point of view ○ What they need during treatment • Consumer and family staff will participate in practicum training experiences 	<ul style="list-style-type: none"> • Training series will emphasize current EBP in this field (e.g., Seeking Safety) 	<p>Training will be conducted in a series of trainings over the year</p> <ul style="list-style-type: none"> • Didactic overview including discussants (e.g., consumers and family members) • Case consultation – • Panels comprised by consumers and family members (including consumers with co-occurring conditions) • Seminars/workshops • Identify the depth of the training experience • Develop a practicum for consumer and family staff to observe treatment of clients with trauma

San Luis Obispo County Behavioral Health Services

Scheduled Trainings FY 2010-2011/2012-2013

Cultural Competence

Training	Presenter	Place	Date
California Multi-Cultural Scale	TBD	TBD	TBD
How to Use an Interpreter	TBD	TBD	TBD
Cross Cultural Communication	TBD	TBD	TBD
Multi-cultural Issues in Domestic Violence	TBD	TBD	TBD
Working with Filipino-American Families	TBD	TBD	TBD
Culture as a Worldview	TBD	TBD	TBD
Mental Health 102	TBD	TBD	TBD
Healthy Living & Chronic Disease Prevention	TBD	TBD	TBD
Pacific Islander Summit	TBD	TBD	TBD
African American Summit	TBD	TBD	TBD
LGBTQQI Focused Training	TBD	TBD	TBD
Convergence of Western & Eastern Medicine	TBD	TBD	TBD
Latino Initiative Summit	TBD	TBD	TBD

San Luis Obispo County Behavioral Health Services

Scheduled Trainings FY 2010-2011/2012-2013

Treatment of Co-Occurring Disorders

Training	Presenter	Place	Date
MI Skills		EPA	
Understanding & Working in the Pre-contemplative Stage			
All You Need to Know About Opioid Agonist Therapy			
Opioid Agonist Therapy: Buprenorphine			
Smoking Cessation			
Screening and Assessment for COD			
Motivational Interviewing			
MI Skills Part II			
COD Assessment and Screening TIP 41			
COD training			
Basic MI Training			
Principles and Techniques of Motivational Interviewing			
MI Case Application			
ACT and Relapse Prevention			
MI and COD			
MI Skills			
Understanding & Working in the Pre-contemplative Stage			
All You Need to Know About Opioid Agonist Therapy			
Opioid Agonist Therapy:			

San Luis Obispo County Behavioral Health Services

Buprenorphine			
Smoking Cessation			
Screening and Assessment for COD			
Motivational Interviewing			
MI Skills Part II			
COD Assessment and Screening TIP 41			

Scheduled Trainings FY 2010-2011/2012-2013

Trauma Training Series

Training	Presenter	Place	Date
Working with Youth: Issues of Trauma			

San Luis Obispo County Behavioral Health Services

Training Plan FY 2010-2011

Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
Cultural Competence	Treatment of Depression <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 	Law and Ethics	COMACY Conference
Customer Service and Consumer Oriented Care <ul style="list-style-type: none"> • Increasing Engagement with clients with complicated family situations <ul style="list-style-type: none"> ○ Overview of Proposed Content ○ Educational Objectives ○ Scheduled Trainings ○ Involvement of Consumers & Family Members ○ Evidence Based Practices ○ Training Modalities 		Supervision	Trips to Village
Treatment of Co-Occurring Disorders		CA/LOCUS	In Our Own Voice
Stigma Reduction		Documentation	Stamp Out Stigma
Wellness & Recovery		Grand Rounds	NAMI Provider Training
<ul style="list-style-type: none"> • Developing WRAP plans Inspired at Work		Pro-Social Skills*	
		Functional Family Therapy*	
		Seeking Safety*	

San Luis Obispo County Behavioral Health Services

Trainings in Foundational Knowledge FY 2010-2011

Area	Course Content	Educational Objectives	Scheduled Trainings
Cultural Competence			
Consumer Service and Consumer Oriented Care <ul style="list-style-type: none"> Increasing engagement of clients with complicated family situations 			
Treatment of Co-Occurring Disorders			
Wellness & Recovery <ul style="list-style-type: none"> Developing WRAP plans 			

Trainings in Foundational Knowledge FY 2010-2011

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Cultural Competence			
Consumer Service and Consumer Oriented Care <ul style="list-style-type: none"> Increasing engagement of clients with complicated family situations 	<ul style="list-style-type: none"> Consumer and family staff will attend all trainings Consumer led trainings and seminars on engagement Didactic trainings led by consumers 		<ul style="list-style-type: none"> Case discussions – identify consultants with special expertise; arrange for consumer and family staff to attend these trainings to share their perspective re: engagement Didactic trainings led by consumers
Treatment of Co-Occurring Disorders			
Wellness & Recovery <ul style="list-style-type: none"> Developing WRAP plans 			

San Luis Obispo County Behavioral Health Services

Special Annual Training Series FY 2010-2011

Area	Course Content	Educational Objectives	Scheduled Trainings
Depression Training Series	<ul style="list-style-type: none"> • Didactic overview of recent research and assessment • Review of EBP in the treatment of depression and bi-polar illness • Recovery from depression and bi-polar illness from the perspective of consumers and family members • The role of mood disorder in clients with co-occurring conditions • The experience of mood disorder in culturally diverse communities • Depression in the LGBTQQ community • Depression in seniors • Depression in response to traumatic life events • Depression as a response in family members living with loved with a serious mental illness 	<ul style="list-style-type: none"> • To better understand and treat depression and depression-related issues • To work more effectively with clients who experience depression and/or have depression-related diagnoses 	<ul style="list-style-type: none"> • TBD

Special Annual Training Series FY 2010-2011

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Depression Training Series	<ul style="list-style-type: none"> • Consumer and family staff will attend all trainings • Consumer led trainings reaching out to consumers who are having engagement problems • Didactic trainings led by consumers 	<ul style="list-style-type: none"> • Training series will emphasize current EBP in this field 	<p>Training will be conducted in a series of trainings over the year</p> <ul style="list-style-type: none"> • Didactic overview including consumers and family members • Case consultation – • Panels comprised by consumers & family members • Seminars/workshops

San Luis Obispo County Behavioral Health Services

Training Plan FY 2011-2012

Trainings in Foundational Knowledge	Special Annual Training Series	Trainings in Support of General Clinical Skill	Support for Off-Site Training and Conferences
Cultural Competence	Treatment of Psychosis <ul style="list-style-type: none"> • Overview of Proposed Content • Educational Objectives • Scheduled Trainings • Involvement of Consumers & Family Members • Evidence Based Practices • Training Modalities 	Law and Ethics	COMACY Conference
Consumer Service and Consumer Oriented Care		Supervision	Trips to Village
Treatment of Co-Occurring Disorders		CA/LOCUS	In Our Own Voice
Stigma Reduction		Documentation	Stamp Out Stigma
Wellness & Recovery <ul style="list-style-type: none"> • Use of eCC to promote wellness & recovery 		Grand Rounds	NAMI Provider Training
Inspired at Work		Pro-Social Skills*	
		Functional Family Therapy*	
		Seeking Safety*	

Trainings in Foundational Knowledge FY 2011-2012

San Luis Obispo County Behavioral Health Services

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Cultural Competence			
Consumer Service and Consumer Oriented Care <ul style="list-style-type: none"> Increasing engagement of clients with complicated family situations 	<ul style="list-style-type: none"> Consumer and family staff will attend all trainings Consumer led trainings and seminars on engagement Didactic trainings led by consumers 		
Treatment of Co-Occurring Disorders			

Special Annual Training Series FY 2011-2012

Area	Course Content	Educational Objectives	Scheduled Trainings
Psychosis Training Series			

Special Annual Training Series FY 2011-2012

Area	Involvement of Consumers & Family Members	Evidence Based Practices	Training Modalities
Psychosis Training Series			

Tuesday, February 16, 2010

Beyond Competence: Serving Queer and Trans Youth within a Social Justice Framework

Jolie Harris, Assistant Director for the Office of Multicultural Affairs, Seattle University

8:30 a.m. to 4:30 p.m.

Location: Embassy Suites, 333 Madonna Road, San Luis Obispo

REGISTRATION

Q1. General Information

Answer Options	Response Percent	Response Count
Last Name:	100.00 %	51
First Name:	49.02 %	25
Email Address:	100.00 %	51
Phone Number:	96.08 %	49
	answered question	51
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	1.96 %	1
LPT	0.00 %	0
LVN	0.00 %	0
NP	0.00 %	0
PhD/Psy D	1.96 %	1
LCSW/ASW	1.96 %	1
LMFT	25.49 %	13
INTERNS	19.61 %	10
DRUG & ALCOHOL	9.80 %	5
OTHER,GUESTS,UNLICENSED (CEU'S not available)	43.14 %	22
	answered question	51
	skipped question	0

Total Registered/ Signed In

Total Registered	112
Total Signed In	96

EVALUATION

Q1. General Information

Answer Options	Response Percent	Response Count
Name: First Last	100.00 %	50
License Number:	100.00 %	50
E-mail Address:	98.00 %	49
	answered question	50
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	2.00 %	1
LPT	0.00 %	0
LVN	2.00 %	1
NP	0.00 %	0
PhD/Psy D	0.00 %	0
LCSW/ASW	4.00 %	2
LMFT	70.00 %	35
INTERNS	10.00 %	5
DRUG & ALCOHOL	10.00 %	5
OTHER,GUESTS,UNLICENSED (CEU'S not available)	6.00 %	3
	answered question	50
	skipped question	0

Q3. What is your primary reason for selecting this program?

Answer Options	Response Percent	Response Count
Subject was of interest	75.51 %	37
Reputation of leaders	4.08 %	2
Important to job activities	30.61 %	15
CE credit, degree requirement	20.41 %	10
Other (please explain below)	4.08 %	2
Comments		4
	answered question	49
	skipped question	1

Q5. How would you rate the overall value of this program?

Answer Options	Response Percent	Response Count
Excellent	32.00 %	16
Good	30.00 %	15
Fair	24.00 %	12
Poor	14.00 %	7
	answered question	50
	skipped question	0

Describe three concepts that you learned from the course?

learned new grounding interventions
 learned new boundy intervention
 learned new terminology regarding queer/trans population

existence of school made for queer youth
 Research findings related to gender preference toward opposite sex after sex change
 varied terms provided in handout

Lots of vocabulary
 Transgender is an umbrella term under which much falls (cross dressing, transsexual, etc)
 Asking people how they want to be named is the best policy (gay or queer, for example)

People who are part of this cultural group have varying ways of identifying themselves
 Just because one may be an expert in the subject, doesn't make him/her a good presenter
 Working on one topic of marginalizing may help in other areas of a person's life

February 26, 2010

**The Journey of Hope: The Shaken Tree: From a consumer's perspective.
Kevin Hines-Anti-Suicide Activist.**

Government Center Board Chambers, 1055 Monterey Street, San Luis Obispo
8:30 a.m.-12:30 p.m.

Sponsored by Transitions Mental Health, Peer Advisory and Advocacy Team

REGISTRATION

Q1. General Information

Answer Options	Response Percent	Response Count
Last Name:	100.00 %	23
First Name:	65.22 %	15
Company:	86.96 %	20
Email Address:	95.65 %	22
Phone Number:	95.65 %	22
	answered question	23
	skipped question	0

EVALUATION

Q1. General Information

Answer Options	Response Percent	Response Count
Name: First Last	100.00 %	23
License Number:	100.00 %	23
E-mail Address:	95.65 %	22
	answered question	23
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	4.35 %	1
LPT	8.70 %	2
LVN	4.35 %	1
NP	4.35 %	1
PhD/Psy D	4.35 %	1
LCSW/ASW	4.35 %	1
LMFT	39.13 %	9
INTERNS	4.35 %	1
DRUG & ALCOHOL	21.74 %	5
OTHER, GUESTS, UNLICENSED (CEU'S not available)	17.39 %	4
Comments		16
	answered question	23
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	9.09 %	2
LPT	9.09 %	2
LVN	0.00 %	0
NP	13.64 %	3
PhD/Psy D	0.00 %	0
LCSW/ASW	18.18 %	4
LMFT	36.36 %	8
INTERNS	0.00 %	0
DRUG & ALCOHOL	9.09 %	2
OTHER, GUESTS, UNLICENSED (CEU'S not available)	9.09 %	2
Comments		22
	answered question	22
	skipped question	1

Total Registered/ Signed In

Total Registered	not available
Total Signed In	47

Q3. What is your primary reason for selecting this program?

Answer Options	Response Percent	Response Count
Subject was of interest	65.22 %	15
Reputation of leaders	4.35 %	1
Important to job activities	52.17 %	12
CE credit, degree requirement	21.74 %	5
Other (please explain below)	0.00 %	0
Comments		0
	answered question	23
	skipped question	0

Q5. How would you rate the overall value of this program?

Answer Options	Response Percent	Response Count
Excellent	86.96 %	20
Good	13.04 %	3
Fair	0.00 %	0
Poor	0.00 %	0
	answered question	23
	skipped question	0

Q7. Describe three concepts that you learned from the course?

Responses:

Understanding the stigma of mental illness
How families can help and get help for themselves as well.
Better understanding of why mentally ill people contemplate suicide.

The importance of acknowledging the distress of another person cannot be underrated.
Importance of being sensitive to the distress families of mentally ill experience and importance of finding ways to support them
While mental illness can be devastating, there is hope in proper treatment that can add quality to the lives of those affected.

resources for clients and their families
the client's perspective on what helped him and what could have helped him
One person can make a difference in preventing suicide. People don't always try again.

Encourage clients to stay on medications
Be sensitive to clients who are depressed

March 8, 2010

Helping those who Serve: Treating Military Families

Kimberly Evans, LMFT

Cuesta College Student Center, Cuesta College, Highway 1, San Luis Obispo

8:30 a.m.-4:30 p.m.

REGISTRATION

Q1. General Information		
Answer Options	Response Percent	Response Count
Last Name:	100.00 %	106
First Name:	77.36 %	82
Company:	83.96 %	89
Email Address:	98.11 %	104
Phone Number:	97.17 %	103
	answered question	106
	skipped question	0

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	4.76 %	5
LPT	2.86 %	3
LVN	0.95 %	1
NP	0.00 %	0
PhD/Psy D	0.95 %	1
LCSW/ASW	5.71 %	6
LMFT	45.71 %	48
INTERNS	14.29 %	15
DRUG & ALCOHOL	7.62 %	8
OTHER,GUESTS,UNLICENSED (CEU'S not available)	22.86 %	24
	answered question	105
	skipped question	1

Total Registered/ Signed In	
Registered	103
Signed In	87

EVALUATION

Q1. General Information		
Answer Options	Response Percent	Response Count
NAME: First Last	100.00 %	48
License Number:	100.00 %	48
E-mail Address:	100.00 %	48
	answered question	48
	skipped question	0

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	6.25 %	3
LPT	2.08 %	1
LVN	0.00 %	0
NP	0.00 %	0
PhD/Psy D	0.00 %	0
LCSW/ASW	6.25 %	3
LMFT	68.75 %	33
INTERNS	10.42 %	5
DRUG & ALCOHOL	4.17 %	2
OTHER,GUESTS,UNLICENSED (CEU'S not available)	4.17 %	2
	answered question	48
	skipped question	0

Q3. What is your primary reason for selecting this program?		
Answer Options	Response Percent	Response Count
Subject was of interest	82.98 %	39
Reputation of leaders	6.38 %	3
Important to job activities	27.66 %	13
CE credit, degree requirement	21.28 %	10
Other (please explain below)	2.13 %	1
Comments		6
	answered question	47
	skipped question	1

Q5. How would you rate the overall value of this program?		
Answer Options	Response Percent	Response Count
Excellent	77.08 %	37
Good	16.67 %	8
Fair	6.25 %	3
Poor	0.00 %	0
	answered question	48
	skipped question	0

Describe three concepts that you learned from the course?

Responses:

Examining the difference between brain trauma injury vs ptsd
 Serving military personel includes serving the whole family
 Everyoen who serves in the military is not considered a vet, and may not be elegendible for vet services

The term "veteran" no longer applies to persons out of the military, because they can stiiil be involved in another part of the military.
 Differences between branches
 Effects of deployment on Spouses/Families
 Inspirational Resources available

Issues related to military culture
 That embedded therapists exist
 That active duty and reservists have such differing levels of resources after they come home

Many resources available to support military families that was unaware of previously
 Better understanding of specific sacrifices and difficulties experienced by Guard and Reserve families
 Understanding of the value of embedded therapists within the units

March 12, 2010
Smoking Cessation Facilitator Training

Gary J. Tedeschi, Ph.D.

Sycamore Mineral Springs, 1214 Avila Beach Drive, San Luis Obispo
10:00 a.m. to 4:00 p.m.

REGISTRATION

Q1. General Information

Answer Options	Response Percent	Response Count
NAME: First Last	100.00 %	
License Number:	100.00 %	41
E-mail Address:	97.56 %	
	answered question	41
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.01	1
RN	25.31	20
LPT	8.86	7
LVN	18.98	15
NP	0.00	0
PhD/Psy D	0.00	0
LCSW/ASW	5.06	4
LMFT	16.45	13
INTERNS	13.92	11
DRUG & ALCOHOL	3.79	3
OTHER,GUESTS,UNLICENSED	6.33	5
	answered question	79
	skipped question	0

Total Registered/ Signed In

Registered	81
Signed In	65

EVALUATION

Q1. General Information

Answer Options	Response Percent	Response Count
NAME: First Last	100.00 %	41
License Number:	100.00 %	41
E-mail Address:	97.56 %	40
	answered question	41
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	29.27 %	12
LPT	14.63 %	6
LVN	2.44 %	1
NP	4.88 %	2
PhD/Psy D	0.00 %	0
LCSW/ASW	4.88 %	2
LMFT	17.07 %	7
INTERNS	12.20 %	5
DRUG & ALCOHOL	24.39 %	10
OTHER,GUESTS,UNLICENSED	4.88 %	2
	answered question	41
	skipped question	0

Q4. What is your primary reason for selecting this program?

Answer Options	Response Percent	Response Count
Subject was of interest	68.29 %	28
Reputation of leaders	0.00 %	0
Important to job activities	60.98 %	25
CE credit, degree requirement	41.46 %	17
Other (please explain below)	0.00 %	0
Comments		1
	answered question	41
	skipped question	0

Q6. How would you rate the overall value of this program?

Answer Options	Response Percent	Response Count
Excellent	46.34 %	19
Good	46.34 %	19
Fair	7.32 %	3
Poor	0.00 %	0
	answered question	41
	skipped question	0

Describe three concepts that you learned from the course?

Reiterated stages of change
Some replacement treatments that are effective
Confirmed knowledge of co occurring

Shared Responsibility Model
Single counseling sessions may be as effective as multiple sessions
Using the concept of "developing discrepancy" in motivational interviewing

People who quit smoking cold turkey can be just as successful as those who use NRT.
The action of smoking itself, not the nicotine, can cause medication to be metabolized differently.
Phone follow-up in the first 3 days after quitting can be as effective as a face to face encounter.

Making frequent phone calls/meetings/contacts in the first week of session
Hotlines available that I didn't know where available
medications used for smoking cessation

April 16, 2010

Male Sexual Abuse: Helping Clients Emerge from Boyhood Shadows
Stephen Braveman, LMFT and Nickolas McDaniel, LMFT-I
 Embassy Suites, 333 Madonna Road, San Luis Obispo
 8:30 a.m.-4:30 p.m.
 Sponsored by the Multicultural Competence Committee

REGISTRATION

Q1. General Information		
Answer Options	Response Percent	Response Count
Last Name:	100.00 %	147
First Name:	89.12 %	131
Company:	84.35 %	124
Email Address:	99.32 %	146
Phone Number:	94.56 %	139
	answered question	147
	skipped question	0
Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	0.00 %	0
LPT	1.45 %	2
LVN	0.72 %	1
NP	0.72 %	1
PhD/Psy D	1.45 %	2
LCSW/ASW	7.97 %	11
LMFT	31.88 %	44
INTERNS	14.49 %	20
DRUG & ALCOHOL	5.80 %	8
OTHER,GUESTS,UNLICENSED (CEU'S not available)	39.13 %	54
Comments		68
	answered question	138
	skipped question	9

Total Registered/ Signed In	
Registered	141
Signed In	119

EVALUATION

Q1. General Information		
Answer Options	Response Percent	Response Count
Professional Status: (e.g. LMFT, LCSW)	83.87 %	52
License Number:	70.97 %	44
E-mail Address:	100.00 %	62
	answered question	62
	skipped question	0
Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	1.04 %	1
LPT	1.04 %	1
LVN	0.00 %	0
NP	0.00 %	0
PhD/Psy D	0.00 %	1
LCSW/ASW	18.72 %	9
LMFT	47.84 %	24
INTERNS	18.72 %	9
DRUG & ALCOHOL	8.48 %	5
OTHER,GUESTS,UNLICENSED (CEU'S not available)	4.16 %	2
	answered question	52
	skipped question	10

Q3. What is your primary reason for selecting this program?		
Answer Options	Response Percent	Response Count
Subject was of interest	66.13 %	41
Reputation of leaders	4.84 %	3
Important to job activities	48.39 %	30
CE credit, degree requirement	22.58 %	14
Other (please explain below)	3.23 %	2
Comments		3
	answered question	62
	skipped question	0

Q5. How would you rate the overall value of this program?		
Answer Options	Response Percent	Response Count
Excellent	73.77 %	45
Good	18.03 %	11
Fair	6.56 %	4
Poor	1.64 %	1
	answered question	61
	skipped question	1

Describe three concepts that you learned from the course?

The damage caused by abuse extends far beyond the victim.
 In many states there is a 10 year statute of limitations on prosecution of sexual abuse of children.
 There is less than one counseling center per state for male sexual abuse victims.

Reasons for silence
 Asking the right questions to learn about sexual abuse history
 safe touch

Survivors of male sexual abuse are an under served and under represented portion of our society.
 It is important that clinicians and the public at large become familiar with the concept/term/myth, "Vampire Syndrome" meaning that once a victim is abused they
 Grp therapy seems to be even more effective then ind. therapy for helping survivors move through their trauma.

It might sound like abuse survivors are lying, but that could be due to their having a hazy memory of the event
 It is not uncommon for survivors to either immerse themselves in work or participate in addictive behaviors later in life

April 27 and 28, 2010
WELLNESS AND RECOVERY TRAINING CONFERENCE IN SLO WITH
Lori Ashcraft, Ph.D., CPRP
Executive Director, Recovery Opportunity Center, LLC.
(Sponsored by TMHA)

REGISTRATION		
Q1. General Information		
Answer Options	Response Percent	Response Count
Last Name:	100.00 %	134
First Name:	100.00 %	134
Email Address:	100.00 %	134
Phone Number:	98.51 %	132
	answered question	134
	skipped question	0

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	1.54 %	2
LPT	4.62 %	6
LVN	0.00 %	0
NP	2.31 %	3
PhD/Psy D	0.00 %	0
LCSW/ASW	3.85 %	5
LMFT	6.92 %	9
INTERNS	3.85 %	5
DRUG & ALCOHOL	6.15 %	8
OTHER,GUESTS,UNLICENSED	73.08 %	95
Comments		26
	answered question	130
	skipped question	4

Total Registered/ Signed In		
	Day 1	Day 2
Registered	134	67
Signed In	104	59

EVALUATION		
Q1. General Information		
Answer Options	Response Percent	Response Count
Last:	100.00 %	25
First:	100.00 %	25
Professional Status (e.g. LCSW, LMFT)	84.00 %	21
License Number	76.00 %	19
E-mail Address:	96.00 %	24
	answered question	25
	skipped question	0

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	0.04	1
LPT	0.04	1
LVN	0.00 %	0
NP	0.00 %	0
PhD/Psy D	0.00 %	0
LCSW/ASW	2.00	5
LMFT	2.40	6
INTERNS	1.20	3
DRUG & ALCOHOL	1.20	3
OTHER,GUESTS,UNLICENSED	1.20	3
Comments		
	answered question	22
	skipped question	3

Q3. What is your primary reason for selecting this program?		
Answer Options	Response Percent	Response Count
Subject was of interest	36.00 %	9
Reputation of leaders	8.00 %	2
Important to job activities	56.00 %	14
CE credit, degree requirement	28.00 %	7
Other (please explain below)	4.00 %	1
Comments		1
	answered question	25
	skipped question	0

Q5. How would you rate the overall value of this program?		
Answer Options	Response Percent	Response Count
Excellent	52.00 %	13
Good	36.00 %	9
Fair	12.00 %	3
Poor	0.00 %	0
	answered question	25
	skipped question	0

Describe three concepts that you learned from the course?

Stigma's in relation to Mentally Ill as cases to be managed
 Importance of empowerment
 How peers can be vital in recovery

Focus on strengths
 Let client be part of progress
 Take out outdated words like "compliance" "triggers" and "what is wrong" Focus on person, not problems

Keeping participants active in their recovery
 solution planning sheet
 8 Strategies to empowering clients and the development of a tx plan/WRAP plan

Venting about clients holds them in a one down position
 Solution planning form / strength based questioning and plan for treatment
 Having client write progress note, holds them responsible (we will do and staple to our form)

May 7, 2010
Law and Ethics
Linda Garrett, J.D.
 SLO County Library
 8:30 a.m.-4:30 p.m.

REGISTRATION

Q1. General Information		
Answer Options	Response Percent	Response Count
Last Name:	100.00 %	114
First Name:	74.56 %	85
Company:	91.23 %	104
Email Address:	100.00 %	114
Phone Number:	96.49 %	110
	answered question	114
	skipped question	0

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.00 %	0
RN	2.75 %	3
LPT	2.75 %	3
LVN	0.92 %	1
NP	1.83 %	2
PhD/Psy D	2.75 %	3
LCSW/ASW	11.01 %	12
LMFT	42.20 %	46
INTERNS	15.60 %	17
DRUG & ALCOHOL	11.93 %	13
OTHER,GUESTS,UNLICENSED (CEU'S not available)	14.68 %	16
Comments		68
	answered question	109
	skipped question	5

Total Registered/ Signed In		
Registered		114
Signed In		101

EVALUATION

Q1. General Information		
Answer Options	Response Percent	Response Count
Professional Status: (e.g. LMFT, LCSW)	100.0%	80
License Number:	100.0%	80
E-mail Address:	100.0%	80
	answered question	
	skipped question	

Q2. What is your current professional status:		
Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.0%	0
RN	3.8%	3
LPT	2.5%	2
LVN	0.0%	0
NP	2.5%	2
PhD/Psy D	2.5%	2
LCSW/ASW	11.3%	9
LMFT	55.0%	44
INTERNS	13.8%	11
DRUG & ALCOHOL	15.0%	12
OTHER,GUESTS,UNLICENSED (CEU'S not available)	2.5%	2
	answered question	80
	skipped question	0

Q3. What is your primary reason for selecting this program?		
Answer Options	Response Percent	Response Count
Subject was of interest	27.8%	22
Reputation of leaders	17.7%	14
Important to job activities	50.6%	40
CE credit, degree requirement	64.6%	51
Other (please explain below)	1.3%	1
Comments		1
	answered question	79
	skipped question	1

Q5. How would you rate the overall value of this program?		
Answer Options	Response Percent	Response Count
Excellent	81.3%	65
Good	17.5%	14
Fair	1.3%	1
Poor	0.0%	0
	answered question	80
	skipped question	0

Describe three concepts that you learned from the course?

Information on the HITECH Act and how it impacts confidentiality and privacy.
 Update on the Good Samaritan Law.
 Information on requirements for reporting breaches of confidentiality.

Confidentiality as it applies to HIPAA is less strict than State
 Good Samaritan Act applies to Mental Health workers
 Keep process notes only until you can input into case notes then shred

New Laws: SB 788, AB 1142, SB 296, AB 91
 Duty to Mitigate Harm and HIPAA, Also the Health Information Technology for Economic and Clinical Health Act (HITECH)
 AOD Treatment Programs and Subpoena's

Children over 12 do not have to sign releases.
 Stepparents cannot sign for treatment.
 new BBS designation "Licensed Professional Clinical Counselors" per SB 788

June 03, 2010
David Mee-Lee, M.D. Part Two of Co-Occurring
 8:30 a.m. to 4:30 p.m.
 Location: Embassy Suites, 333 Madonna Road, San Luis Obispo

REGISTRATION

Q1. General Information

Answer Options	Response Percent	Response Count
Last Name:	100.0%	121
First Name:	82.6%	100
Email Address:	98.3%	119
Phone Number:	96.7%	117
	answered question	51
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.9%	1
RN	2.6%	3
LPT	4.4%	5
LVN	0.0%	0
NP	1.8%	2
PhD/Psy D	0.0%	0
LCSW/ASW	9.6%	11
LMFT	31.6%	36
INTERNS	15.8%	18
DRUG & ALCOHOL	14.0%	16
OTHER,GUESTS,UNLICENSED	22.8%	26
Comments		63
	answered question	114
	skipped question	7

Total Registered/ Signed In

Total Registered	121
Total Signed In	101

EVALUATION

Q1. General Information

Answer Options	Response Percent	Response Count
First Name:	100.0%	59
Last Name:	100.0%	59
License Number: (please includ	100.0%	59
E-mail Address:	100.0%	59
	answered question	59
	skipped question	0

Q2. What is your current professional status:

Answer Options	Response Percent	Response Count
MD (CEUs not available)	0.0%	0
RN	5.1%	3
LPT	6.8%	4
LVN	0.0%	0
NP	1.7%	1
PhD/Psy D	0.0%	0
LCSW	15.3%	9
LMFT	32.2%	19
ASW	0.0%	0
INTERNS	11.9%	7
DRUG & ALCOHOL	16.9%	10
OTHER,GUESTS,UNLICENSED	11.9%	7
	answered question	59
	skipped question	0

Q3. What is your primary reason for selecting this program?

Answer Options	Response Percent	Response Count
Subject was of interest	57.6%	34
Reputation of leaders	20.3%	12
Important to job activities	64.4%	38
CE credit, degree requirement	20.3%	12
Other (please explain below)	3.4%	2
Comments		3
	answered question	59
	skipped question	0

Q5. How would you rate the overall value of this program?

Answer Options	Response Percent	Response Count
Excellent	72.9%	43
Good	22.0%	13
Fair	5.1%	3
Poor	0.0%	0
	answered question	59
	skipped question	0

Describe three concepts that you learned from the course?

Principles for Integrated Treatment, Co morbidity is n expectation, not an exception, etc.
 To not make the treatment fit criminal justice's mission of consequences, compliance and control.
 Use of the Multidimensional Assessment to organize and look at immediate needs.

If you can answer "what made me say that" you can do better treatment planning
 Getting clarity about what the client wants and clients basic needs
 Make paperwork "people work"

States of change - doing time vs. participating in the change process
 Recovery Environment and Aftercare (after professional care)
 ASAM Levels of Care/service to match severity of problems and assigning treatment levels of service

The 3 Cs that drive the criminal justice system - Consequences, Compliance, and Control - and although necessary in the CJ system do not work with in the therapeutic realm.
 Assessment Dimensions - key areas that need to be addressed in order to meet the client's needs.
 The importance of knowing "what the client wants" and starting from there. If there is resistance then the plan needs to be changed so the client is in agreement and motivated.

Policy:

It is the policy of the Behavioral Health Department to provide education and training to employees, contracted employees, and volunteers that is in accordance with State requirements and Departments goals.

Purpose:

To assist employees, contracted employees and volunteers to meet training and licensing requirements and to ensure our workforces ability to provide quality of care and culturally and linguistically competent services to the community.

Definitions:**Competency Based Training:**

Trainings/classes within a group of trainings/classes deemed a “competency”, for a specific job classification to be completed in order to meet the Department’s training requirements and or attain job related knowledge.

Mandatory Training:

Training required by BH, the supervisor or training necessary to maintain licensing and certification requirements for job classifications or job related duties.

Orientation Training:

Training provided by the Department during a new employee’s orientation process.

Training Types:

Training may be delivered by any of the following sources:

- * Online/Web – Essential Learning (E-Learning)
- * County – BH or another County department
- * Private – Contracted consultant or organization

Mental Health Services Act:

As part of the Mental Health Services Act (MHSA) Workforce Education and Training Component, the Departments education and training program is dedicated to:

- * Maintaining a curriculum to train and retrain staff to provide services that are in accordance with provision under Act
- * Establishing partnerships among the behavioral health system and educational system to expand outreach to multicultural communities
- * Increasing the diversity of the behavioral health workforce to reduce the stigma associated with mental illness, co-occurring illness, and addiction
- * Promoting the use of web-based technologies and distance learning techniques.
- * Promoting the inclusion of behavioral health consumers and family members’ viewpoints and experiences in the training and education program.
- * Promoting the inclusion of the cultural competency in the training and education programs.

Cultural Competence:

As defined by the California Code of Regulations (CCR) Title 9 § 3200, 100, cultural competence means incorporating and working to achieve the items listed below, into all aspects of policy-making, program design, administration and service delivery.

Goals of cultural competence:

- * Equal access to services
- * Treatment interventions and outreach
- * Reduction of disparities in services
- * Understanding of the diverse belief system concerning behavioral illness
- * Understanding the impact of historical bias, racism, and other discriminations have on behavioral health.
- * Improvement of services and support unique to individuals racial/ethnic, cultural and linguistic populations.
- * Development and implementation of strategies to promote equal opportunities for administrators, service providers and others involved in service delivery who share the diverse racial/ethnic and linguistic characteristics of individuals being served

Cultural Competency Training:

In accordance with the Cultural Competency Plan, it is required that all new employees attend the mandatory cultural competency training that the Department offers. In addition, administrative and management employees, as well as direct service providers are required to attend more extensive cultural competency trainings.

On a continuous basis, all BH employees are required to take cultural competency training annually.

Continuing Education (CE) Credit Training:

The Department will offer several training opportunities to obtain CE credits to meet licensing and certification requirements as needed.

Other Trainings:

Trainings related to the Departments rules, regulations, goals, as well competency based trainings, and those required under CCR, Title 9 §1922, will also be offered through the Department.

References:

- * California Code of Regulations, Title 9, Division 1, Chapter 11 §1810.410, Chapter 12, § 1922, and Chapter 14, §3200.100
- * Behavioral Health Department, (2010) Cultural Competency Plan
- * Welfare and Institution Code, Division 5, Chapter 4 §5820 - §5822

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+(7)+(8)+(9)+(10) (11)
A. Unlicensed Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	0	0	0							
Case Manager/Service Coordinator	2.0	0	4.0							
Employment Services Staff	0	0	0							
Housing Services Staff	0	0	0							
Consumer Support Staff	1.0	0	2.0							
Family Member Support Staff	0	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other <i>Unlicensed</i> MH Direct Service Staff	1.0	0	2.0							
<i>Sub-total, A (County)</i>				(Unlicensed Mental Health Direct Service Staff; Sub-Totals Only) ↓						
	4.0	0	8.0	3.0	1.0	0	0	0	0	4.0
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	60.4	1.0	120.8							
Case Manager/Service Coordinator	29.5	0	59.0							
Employment Services Staff	5.5	0	11.0							
Housing Services Staff	19.3	1	38.6							
Consumer Support Staff	16.0	0	32.0							
Family Member Support Staff	6.0	1.0	12.0							
Benefits/Eligibility Specialist	0	0	0							
Other <i>Unlicensed</i> MH Direct Service Staff	22.0	1.0	44.0							
<i>Sub-total, A (All Other)</i>				(Unlicensed Mental Health Direct Service Staff; Sub-Totals and Total Only) ↓						
	158.7	4.0	317.4	115	31.7	7	2	1	2	158.7
Total, A (County & All Other):	162.7	4.0	325.4	118	32.7	7	2	1	2	162.7

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+(7)+(8)+(9)+(10) (11)
B. Licensed Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general.....	10.0	1.0	20.0							
Psychiatrist, child/adolescent.....	1.0	1.0	2.0							
Psychiatrist, geriatric.....	0	0	0							
Psychiatric or Family Nurse Practitioner.....	4.0	1.0	8.0							
Clinical Nurse Specialist.....	0	0	0							
Licensed Psychiatric Technician.....	34.0	0	68.0							
Licensed Clinical Psychologist.....	3.0	0	6.0							
Psychologist, registered intern (or waived).....	0	0	0							
Licensed Clinical Social Worker (LCSW).....	11.0	1.0	22.0							
MSW, registered intern (or waived).....	2.0	1.0	4.0							
Marriage and Family Therapist (MFT).....	35.0	0	70.0							
MFT registered intern (or waived).....	12.0	0	24.0							
Other Licensed MH Staff (direct service).....	1.0	0	2.0							
<i>Sub-total, B (County)</i>	113.0	5.0	226	86	7	1	2	0	2	98
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general.....	0	0	0							
Psychiatrist, child/adolescent.....	0	0	0							
Psychiatrist, geriatric.....	0	0	0							
Psychiatric or Family Nurse Practitioner.....	0	0	0							
Clinical Nurse Specialist.....	0	0	0							
Licensed Psychiatric Technician.....	5.5	0	0							
Licensed Clinical Psychologist.....	3.0	0	6							
Psychologist, registered intern (or waived).....	0	0	0							
Licensed Clinical Social Worker (LCSW).....	2.5	0	4							
MSW, registered intern (or waived).....	2.0	0	0							
Marriage and Family Therapist (MFT).....	18.4	0	22							
MFT registered intern (or waived).....	12.8	0	2							
Other Licensed MH Staff (direct service).....	0	0	0							
<i>Sub-total, B (All Other)</i>	44.2	3.0	88.2	38.2	4.5	1.5	0	0	0	44.2
Total, B (County & All Other):	157.2	8.0	314.2	124.2	11.5	2.5	2.0	0	2.0	142.2

(Licensed Mental Health Direct Service Staff; Sub-Totals Only)



(Licensed Mental Health Direct Service Staff; Sub-Totals and Total Only)



EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions (1)	Estimated # FTE authorized (2)	Position hard to fill? 1=Yes' 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)							# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)		
				White/Caucasian (5)	Hispanic/Latino (6)	African-American/Black (7)	Asian/Pacific Islander (8)	Native American (9)	Multi Race or Other (10)				
C. Other Health Care Staff (direct service):													
County (employees, independent contractors, volunteers):													
Physician	1.0	0	2.0										
Registered Nurse	8.0	1.0	16.0										
Licensed Vocational Nurse	0	0	0										
Physician Assistant	0	0	0										
Occupational Therapist	0	0	0										
Other Therapist (e.g., physical, recreation, art, dance).....	0	0	0										
Other Health Care Staff (direct service, to include traditional cultural healers).....	0	0	0										
<i>Sub-total, C (County)</i>				9.0	1.0	18.0	9.0	0	0	0	0	0	9.0
All Other (CBOs, CBO sub-contractors, network providers and volunteers):													
Physician	0	0	0										
Registered Nurse	1.5	1.0	3.0										
Licensed Vocational Nurse	0	0	0										
Physician Assistant	0	0	0										
Occupational Therapist	0	0	0										
Other Therapist (e.g., physical, recreation, art, dance).....	0	0	0										
Other Health Care Staff (direct service, to include traditional cultural healers).....	0	0	0										
<i>Sub-total, C (All Other)</i>				1.5	1.0	3.0	1.5	0	0	0	0	0	1.5
Total, C (County & All Other):				10.5	2	21.0	10.5	0	0	0	0	10.5	

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions (1)	Esti- mated # FTE author- ized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						
				White/ Cau- casian (5)	Hispanic/ Latino (6)	African- Ameri- can/ Black (7)	Asian/ Pacific Islander (8)	Native Ameri- can (9)	Multi Race or Other (10)	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
D. Managerial and Supervisory:				(Managerial and Supervisory; Sub-Totals Only) ↓						
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	7.0	0	14.0							
Supervising psychiatrist (or other physician)	1.0	0	2.0							
Licensed supervising clinician.....	7.0	0	14.0							
Other managers and supervisors.....	2.0	1	4.0							
<i>Sub-total, D (County)</i>	17.0	1	34.0	15.0	1.0	0	0	0	1.0	17.0
All Other (CBOs, CBO sub-contractors, network providers and volunteers):				(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
CEO or manager above direct supervisor.....	11.0	1.0	14.0							
Supervising psychiatrist (or other physician)	0.5	1.0	1.0							
Licensed supervising clinician.....	7.5	1.0	4.0							
Other managers and supervisors.....	22.0	2.0	14.0							
<i>Sub-total, D (All Other)</i>	41.0	5.0	33.0							
Total, D (County & All Other):	58.0	6.0	67.0	55.5	1.0	0	0	0	1.5	58.0
E. Support Staff (non-direct service):				(Support Staff; Sub-Totals Only) ↓						
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	3.0	0	6.0							
Education, training, research	1.0	1.0	2.0							
Clerical, secretary, administrative assistants	28.0	0	56.0							
Other support staff (non-direct services).....	11.0	0	22.0							
<i>Sub-total, E (County)</i>	43.0	1.0	86.0	37.0	6.0	0	0	0	0	43.0
All Other (CBOs, CBO sub-contractors, network providers and volunteers):				(Support Staff; Sub-Totals and Total Only) ↓						
Analysts, tech support, quality assurance.....	10.5	0	4.0							
Education, training, research	4.0	0	2.0							
Clerical, secretary, administrative assistants	13.8	0	4.0							
Other support staff (non-direct services).....	8.8	0	1.0							
<i>Sub-total, E (All Other)</i>	37.2	0	11.0							
Total, E (County & All Other):	80.1	1.0	97.0	67.4	12	0	0.8	0	0	80.2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

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

Major Group and Positions (1)	Esti- mated # FTE author- ized (2)	Position hard to fill? 1=Yes; 0=No (3)	# FTE estimated to meet need in addition to # FTE authorized (4)	Race/ethnicity of FTEs currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10) (11)
				White/ Cau- casian (5)	Hispanic/ Latino (6)	African- Ameri- can/ Black (7)	Asian/ Pacific Islander (8)	Native Ameri- can (9)	Multi Race or Other (10)	
County (employees, independent contractors, volunteers) (A+B+C+D+E)	186.0	8.0	372.0	150.	15.0	1.0	2.0	0	3.0	171.0
All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)	282.5	13	452.6	225.6	42.2	8.5	2.8	1.0	2.5	282.5
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	468.5	21	824.6	375.6	57.2	9.5	4.8	1.0	5.5	453.5

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

(1)	(2)	(3)	(4)	Race/ethnicity of individuals planned to be served -- Col. (11)						All individuals (5)+(6)+ (7)+(8)+ (9)+(10) (11)
				White/ Cau- casian (5)	Hispanic/ Latino (6)	African- Ameri- can/ Black (7)	Asian/ Pacific Islander (8)	Native Ameri- can (9)	Multi Race or Other (10)	
F. TOTAL PUBLIC MH POPULATION	Leave Col. 2, 3, & 4 blank			3382	684	131	50	49	113	4409
G. TOTAL % PUBLIC MH POPULATION	Leave Col. 2, 3, & 4 blank			77.%	16%	3.0%	1.0%	1.0%	2.0%	100%

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Major Group and Positions (1)	Estimated # FTE authorized and to be filled by clients or family members (2)	Position hard to fill with clients or family members? (1=Yes; 0=No) (3)	# additional client or family member FTEs estimated to meet need (4)
A. Unlicensed Mental Health Direct Service Staff:			
Consumer Support Staff.....	7.0	0	7.0
Family Member Support Staff	6.0	1.0	6.0
Other <i>Unlicensed</i> MH Direct Service Staff	4.0	0	0
Sub-Total, A:	17.0	1.0	13
B. Licensed Mental Health Staff (direct service)	16.2	0	0
C. Other Health Care Staff (direct service)	0	0	0
D. Managerial and Supervisory	10.5	1.0	2.0
E. Support Staff (non-direct services).....	25.3	0	0
GRAND TOTAL (A+B+C+D+E)	69.0	2.0	15.0

III. LANGUAGE PROFICIENCY

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

Language, other than English (1)	Number who are proficient (2)	Additional number who need to be proficient (3)	TOTAL (2)+(3) (4)
1. <u>SPANISH</u>	Direct Service Staff <u>44.0</u> Others <u>10.0</u>	Direct Service Staff <u>88.0</u> Others <u>20.0</u>	Direct Service Staff <u>132.0</u> Others <u>30.0</u>
2. <u>VIETNAMESE</u>	Direct Service Staff <u>0</u> Others <u>0</u>	Direct Service Staff <u>2.0</u> Others <u>1.0</u>	Direct Service Staff <u>2.0</u> Others <u>1.0</u>
3. <u>CANTONESE</u>	Direct Service Staff <u>0</u> Others <u>0</u>	Direct Service Staff <u>1.0</u> Others <u>1.0</u>	Direct Service Staff <u>1.0</u> Others <u>1.0</u>
4. <u>HMONG</u>	Direct Service Staff <u>1.0</u> Others <u>0</u>	Direct Service Staff <u>1.0</u> Others <u>0</u>	Direct Service Staff <u>1.0</u> Others <u>0</u>
5. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Methodology: The projections of estimated need for staff were based on a comparison of the overall prevalence of mental illness in San Luis Obispo County with the proportion of that prevalent need currently being met by existing providers. In general, San Luis Obispo County needs to increase its current providers by three times the current level. This Needs Assessment attempted to capture the current workforce within the San Luis Obispo County Public Mental Health Service System. Accurate data was obtained from the San Luis Obispo County Human Resources data system (from FY2007-08) and directly from each Community Based Organization (CBO). Language proficiency data was obtained by survey of staff or from current, existing human resources data. Data was obtained from Behavioral Health Services (BHS) and all of its organizational and network providers including those organizations serving diverse unserved, underserved and inappropriately served communities. San Luis Obispo County conducted a Workforce Needs Assessment Survey of all BHS Staff and all Network Providers in December of 2008. Through vigorous follow up, San Luis Obispo County was able to achieve a 100% response rate. The information was analyzed to prepare these remarks.

A. Shortages by occupational category:

- There is a need for additional bilingual/bicultural staff in all classifications, especially in our threshold language of Spanish, which we have found to be hard to recruit.
- Psychiatrist and Registered Nurses that work at the Psychiatric Health Facility (PHF) are very hard to recruit.
- Other employers in the county, such as the State University, California Men's Colony and Atascadero State Hospital pays higher wages draws on the limited resources of the mental health workforce.
- Most of our positions are impacted greatly by the county's cost of living that limits the qualified pool of applicants.
- There is a small pool of graduate students looking for work, however the pay is minimal.

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

- The table below displays FTE-to-client ratios by race and ethnicity for total and direct service staff. There is an overall shortfall in the mental health workforce in regards to meeting the prevalence needs within San Luis Obispo County. The county and its providers have indicated that it only provides services to 33% of the consumers who need mental health services.
- As indicated in the chart below, direct service providers for the County of San Luis Obispo do not represent target population in race/ethnicity and there is a specific shortage in bilingual staff.
- Contract providers and Behavioral Health Services need to hire more bilingual Spanish speaking employees as indicated below.
- It has been very difficult to find, hire, and train bilingual therapists skilled at working with individuals, families, and children.

	Number of Consumers who Identify as:	Direct Service Staff		Total Staff	
		Who Identify as	Ratio	Who Identify as	Ratio
White/Caucasian	3382 (77%)	108	31:1	280	12:1
Hispanic/Latino	684 (16%)	9	76:1	48	14:1
African-American	131 (3%)	2.5	52:1	9.5	14:1
Asian/Pacific Islander	50 (1%)	2	25:1	4	12:1
Native American	49 (1%)	0	0:1	1	49:1
Multi/Other	113 (2%)	2	56:1	5	23:1

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

- There is a significant shortfall in the mental health workforce in regard to the employment of consumer and family staff throughout the system though some CBO contractors have been more successful than others in recruiting consumer staff.
- There is a need to employ consumer staff in regular benefited positions vs. relying on volunteers, stipends, personal service contracts, ect.
- We need a significant increase in bilingual Spanish-speaking direct service consumer and family member staff in order to meet service demands.

D. Language proficiency:

- There is a great demand for bilingual (English/Spanish) clinicians.
- There is a strong need to improve the training and recruitment of language proficient and bicultural individuals.
- There is a need for bilingual (English/Spanish) consumer and family member staff.

E. Other, miscellaneous:

The geographic size and rural location of San Luis Obispo County makes the provision of services to all those in need of mental health services a challenge. For those individuals that do enter the mental health field, they seek higher paying positions with the State Hospital, Men's Colony Prison, or Cal Poly State University. Due to a high cost of living, it is particularly challenging to recruit professional staff into relocating to this area.

Policy

Mental Health Services is committed to providing multi-lingual and culturally appropriate services to the diverse populations in the County including Telecommunication Device for the Deaf (TDD) and California Relay Services (CRS).

Procedure

1. Interventions in alternative languages are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care database.
2. Individuals with limited English proficiency are informed, in a language they understand, that they have a right to free language assistance. This is documented on the Service Request Form and logged in the Managed Care data base.
3. Interventions in alternative, culturally-competent approaches are offered to all applicants upon request. This information is documented on the Service Request Form and logged in the Managed Care data base.
4. Each clinic site has the capacity to provide services in the County's primary threshold language upon request (i.e. Spanish).
5. All new employees are given a brochure on the use of the AT&T Language Line Service. They receive further mandatory training at their site as a part of Human Resources' new employee orientation procedure.
6. Linguistic translation and interpretation services are provided in a confidential manner. As a general policy family members will not be relied on as interpreters. However, upon request of the Beneficiary, a family member may provide interpretation.
7. When culturally-appropriate services are unavailable at the clinic site, or upon request of the beneficiary, referrals for such services will be made within the community.
8. If there is a need for services not currently available, the following progression of referral is followed:
 - a. From Therapist or receptionist to Program Supervisor.
 - b. Program Supervisor will facilitate language access through Central Access or AT&T Language Line Services.

Dear Consumers,

Informational materials are available in alternative formats. Please ask the receptionist for assistance.

Estimado Consumidores,
Informar materias estan
disponible en formatos
alternativos. Pregunte por favor
al recepcionista para la ayuda.

Gracias.

Dear Consumers,

Free language assistance services are available upon request.

Please ask the receptionist or any staff person for assistance.

Si usted busca servicio de salud mentales y necesita ayuda en Espanol por favor de informarle a la recepcionista.

Gracias

Free language
assistance available
upon request.

Asistencia gratuita
disponible en español
si la requiere.

Policy

Provision of bilingual treatment services or facilitation of treatment services by means of bilingual interpretation services, are evaluated and certified by Mental Health Services.

Procedure:

1. The Ethnic Services Manager will be responsible for the establishment and continued operation of a Bilingual Certification Committee (BCC).
2. The BCC Committee is comprised of the Ethnic Services Manager and three bilingual staff members at least one of whom is a native speaker of the threshold languages in the county.
3. The committee is responsible for developing a minimum of four clinical scenarios in each threshold language when evaluating candidates for certification. The committee will develop an evaluation checklist which will require a score from 0-25 for each of the areas described below for a total of 100. The checklist will include, but not be limited to:
 - a. Fluency, the ability to communicate with ease, verbally and non-verbally.
 - b. Depth of Vocabulary, including the ability to communicate complex psychiatric/psychological concepts which may or may not have direct corollaries in the language in question.
 - c. Grammar, appropriate use of tense and grammar.
 - d. Cultural considerations related to potential client.
4. The certification process is conducted by two bilingual committee members, one of whom is the committee's identified native speaker. The native speaker assumes the role of the client as described in one of the four clinical scenarios presenting for an initial Assessment. The certification interview will follow a standard initial Assessment format.
5. The certification interview should take approximately 30 minutes. The BCC members may ask follow-up questions for clarification. The candidate is given an opportunity to make any remarks she or he may wish for clarification.

6. Following the departure of the candidate the BCC members separately score their evaluation of the candidate's performance. The evaluators' score is then averaged. A passing score will be 60 or greater. The candidate is notified by a memo issued from the committee as to the outcome of the evaluation, with copy given to Mental Health Human Resources.

7. A candidate who has failed to be certified may appeal to the Bilingual Certification Committee and request to be retested by two other committee members who will repeat the process.

**HEALTH AGENCY'S BEHAVIORAL HEALTH
MENTAL HEALTH SERVICES ACT – FULL SERVICE PARTNERSHIP
PROGRAM DESCRIPTION**

Four, Full Service Partnerships (FSP) will provide “whatever it takes”, wraparound-like, intensive, community based mental health services and supports to a focal population of individuals with mental illness. This program is founded on a strength-based, solution focused, culturally-competent, client/family- model to help individuals accomplish wellness, recovery, and resiliency in their lives and remain in their community.

Target Populations:

A) **Children and Youth**, 0-17 years old, that have one or more of the following characteristics:

- “High Utilizers” of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Foster Youth with multiple placements
- Risk of out-of-home placement
- In juvenile justice system

B) **Transitional Age Youth (TAY)**, 16-21 years old, that have one or more of the following characteristics:

- “High Utilizers” of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Co-Occurring substance abuse issues.
- Foster Youth with multiple placements, or aging out/have aged out.
- Recently diagnosed with a mental illness

C) **Adults**, 18-59 years old, that have one or more of the following characteristics:

- At risk for involuntary institutionalization
- “High Utilizers” of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Co-Occurring substance abuse issues.
- Homeless or at risk of becoming homeless

D) **Older Adults**, ages 60+, that have one or more of the following characteristics:

- “High Utilizers” of the system including, but not limited to, chronic history of 5150, psychiatric hospitalizations, emergency room visits, law enforcement involvement.
- Homebound – unserved
- Homeless or at risk of becoming homeless
- Co-Occurring substance abuse issues.
- Presenting with mental issues at their primary care provider’s office

Location: 2925 McMillan Ste. # 124, San Luis Obispo, CA 93401, (805) 781-4850
Services will also be provided in the community, home, and school, as needed, throughout the County.

Hours of Operation: Services are available 24 hours a day. 7days/week, 355 days/year

Services:

Children and Youth FSP (10 participants): Assessment, individual and family therapy, rehabilitation services focusing on activities of daily living, social skill development and vocational/job skills, case management, crisis services, medication evaluation and ongoing medication support.

TAY FSP (20 participants): Assessment, individual, group and family therapy, vocational supports including skill building and job readiness, housing supports, financial and legal counseling, integrated co-occurring drug and alcohol services, case management, crisis services, medication evaluation and ongoing medication supports.

Adult FSP (24 participants): Assessment, individual and group therapy, housing supports, integrated vocational services, peer supports, integrated co-occurring drug and alcohol services, case management, crisis services, medication evaluation and ongoing medication supports.

Older Adult FSP (12 participants): Assessment, individual and group therapy, integrated vocational supports, integrated co-occurring drug and alcohol services, case management, housing supports, medication evaluation and ongoing medication supports.

Referral Process: Referrals will be generated from multiple sources including Department of Social Services, Juvenile Justice System, mental health providers and case managers, Homeless Outreach Staff, Jail Staff, emergency room physicians, primary care providers, teachers and schools, family members, and the Psychiatric Health Facility (PHF).

Staffing Levels:

Children and Youth FSP: 1 FTE Mental Health Therapist/Case Manager; 1 FTE Resource and Support Specialist; .12 FTE Psychiatrist; .25 FTE Program Supervisor

TAY FSP: 2 FTE Mental Health Therapist/Case Manager; 2 FTE Resources and Support Specialists; .23 FTE Vocational Specialist; .30 FTE Co-Occurring Disorders Specialists; .26 FTE Psychiatrist; .33 FTE Program Supervisor.

Adult FSP: 2 FTE Personal Service Coordinators; 2 FTE Resources and Support Specialists; .23 FTE Vocational Specialist; .30 FTE Co-Occurring Disorders Specialist; .26 FTE Psychiatrist; .33 FTE Program Supervisor.

Older Adult FSP: 1 FTE Personal Service Coordinators; 1 FTE Resource and Support Specialist; .05 FTE Vocational Specialist; .15 FTE Co-Occurring Disorders Specialist; .12 FTE Psychiatrist; .17 FTE Program Supervisor.

Funding: Mental Health Services Act, EPSDT, and Medi-Cal

SLOBHD Bilingual Staff 2010-2011

First Name	Last Name
Thomas	Comar
Elaine	Palacios
Olivia	Azevedo
Maria	Troy
Lupe	Sixto
Augustine	Rodriguez
Marina	Garza
James	Pearce
Rita	Jordison
Dianne	Anderson
M	Vargas
Francisco	Ortiz
Nancy	Mancha-Whitcomb
Lauren	McCracken
Nickole	Moore
Patricia	Angulo
Cindy	Stricklen
Conrad	Mendoza
Kirclin	Guadalupe
Withers	Nancy

SAN LUIS OBISPO COUNTY HEALTH AGENCY



BEHAVIORAL HEALTH
2180 Johnson Avenue
SLO, California 93401
Central Access
800-838-1381

Provider List of Behavioral Health Clinics and Contract Providers

How to Use this List	Page 2
Emergency or Crisis Services	Page 2
Psychiatric Health Facility	Page 2
Outpatient Mental Health Clinics	Page 3
Specialty Programs	Page 3
Organizational Providers	Page 4
Network Providers	Page 5-8

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

How to use this list:

This is a list of names, locations, and phone numbers of our clinics and contract providers, and languages spoken there. It explains how to get different types of services and which services may be available to you. Some types of services have limited numbers of sessions available.

Can I call these Providers directly?

No! All initial appointments must be pre-authorized by calling our toll free Central Access line **1-800-838-1381** during regular business hours.

For more information about our services or your rights, please read the Guide to Medi-Cal Mental Health Services, which is available at any clinic location or can be obtained by calling **1-800-838-1381**. The Guide is available in English, Spanish, in large print version and in a CD format.

Emergency or Crisis Services

Emergency assistance can be obtained by calling 911. Mental Health emergency calls can also be made to our toll free number, **1-800-838-1381**, which is available 24 hours per day/seven days per week. In some situations, our Mobile Crisis response team may be sent to evaluate emergency situations.

Psychiatric Health Facility

Facility Name:	Address:	Phone:	Other Language or Cultural Services:	Services Provided:
Psychiatric Health Facility	2178 Johnson Av. SLO	781-4700	Spanish	Inpatient psychiatric care for youth and adults

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Outpatient Mental Health Clinics and Programs

Outpatient clinics provide a range of services, including medication management, crisis intervention, case management, therapy, and individual/group rehabilitation. All clinic locations are handicap accessible. Other accommodations, including ASL translation, can be arranged by request. All clinics are accepting new referrals.

Facility Name:	Address:	Phone:	Other Language or Cultural Services:	Ages Served:
South County Mental Health Clinic	1106 Grand Av. Arroyo Grande	473-7060	Spanish	Youth and Adult
South County SAFE	1104 Grand Av. Arroyo Grande	474-7017	Spanish	Youth
SLO Mental Health Clinic	2178 Johnson Av. SLO	781-4700	Spanish	Adults
Youth Services	1989 Vicente Dr. SLO	781-4179	Spanish	Youth
North County Mental Health Clinic	5575 Hospital Way Atascadero	461-6060	Spanish	Youth and Adult

Specialty Programs

Facility Name:	Address:	Phone:	Other Language or Cultural Services:	Population served/ Specialty:
Martha's Place Children's Assessment Center	2945 McMillan Av. SLO	547-1650		Assessment and early intervention with substance exposed youth aged 0-5.
Youth Day Treatment	1989 Vicente Dr. SLO	781-4179	Spanish	Day Treatment, youth
Mental Health Services Act (MHSA)*	2945 McMillan Av. SLO	781-4874	Spanish	Youth and Adult

*Full Service Partnership, Latino Outreach Program, Behavioral Health Treatment Court, Forensic Release Program, Mobile Crisis, Early Intervention Programs and Workforce Education Training are all MHSA programs.

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Organizational Providers

Organizational providers are larger agencies which work closely with Behavioral Health to provide a range of services to consumers. Call for more information regarding programs and availability.

Facility Name	Address	Phone	Other Language/ Cultural Services:	Population Served/ Specialty:
Transitions Mental Health Association	PO Box 15408 SLO Group Locations in Atascadero, SLO and Arroyo Grande	541-5144	Spanish	Peer support and advocacy for adults and families. <u>Programs include:</u> <ul style="list-style-type: none"> • WRAP (Wellness Recovery Action Plan) • Peer Support Groups • Advocacy Team • PEP Drop in Center (Atascadero) • Dual Recovery Anonymous • Stamp Out Stigma • Growing Grounds • Vocational Support • Hope House
Child Development Center	1720 Bishop St. SLO	544-0801	Spanish	Preschool and school aged children. Childcare and abuse prevention program. Parenting education and counseling.
Family Care Network	508 S. Higuera St. SLO	781-3535	Spanish	WRAP, TBS, therapy for youth and families.
Kinship Center	71 Main St.	434-3839	Spanish	Youth with issues related to adoption, attachment or loss. Provides services much like those available at a MH Clinic location.

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Network Providers

Network Providers are individual therapists in private practice who contract with Behavioral Health. Network Providers conduct brief individual and family therapy sessions (up to 18 sessions) for Medi-Cal beneficiaries only.

Referrals to Network Providers come from Mental Health clinics only. **Please do not call providers directly to begin treatment.** To access a Network Provider, you must first call Central Access at 1-800-838-1381 to schedule an intake assessment at a clinic. You may discuss all your treatment options with the therapist who conducts your assessment. The clinic's Site Authorization Team (SAT) makes decisions about Network Provider referrals, with your input. If the SAT recommends therapy with a Network Provider, the Central Access team calls providers whose expertise matches your treatment, language and cultural needs. We want to refer you to a therapist who can work well with you and has current openings.

All initial appointments must be pre-authorized by calling our toll free Central Access line 1-800-838-1381 during regular business hours.

The list is arranged by city within three regions – South County, SLO/Central and North County.

Network Providers	Address	Phone	Population Served
South County			
Gerald Arseneau, LMFT	215 S. Mason, Arroyo Grande	489-3870	Adolescents, adults, older adults.
Deana Huddleston, LMFT	126 W. Branch #7, Arroyo Grande	473-1687	Children, adults
Joan McKenna, LCSW	411 Traffic Way, # A, Arroyo Grande	801-0536	Adults, older adults
Elaina Schenberg, LCSW	1303 E. Grand Av., # 215, Arroyo Grande	441-2768	Adults, older adults
Clay Watkins, LMFT	129 E. Branch St., # A, Arroyo Grande	546-2656	Age 5 through adult
Jane Hill, LCSW	150 South 6th St., C-1, Grover Beach	481-8534	Late adolescent through older adult
Robert McAfee, LMFT	150 South 6th St., Grover Beach	801-1163	Children, adults
Michelle Ogle, LMFT	910 Ramona Av., #H, Grover Beach	260-5710	Children, adults
Sandra Thomas, PhD, LCSW	160 N. 7th St., Ste. A, Grover Beach	473-1543	Age 4 through older adult

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Network Providers South County Continued	Address	Phone	Population Served
Teresa Pardini, LMFT	151 W. Dana, Ste. 200, Nipomo	260-4833	Age 3 through adult
Laurie Reifsnnyder, PhD	848 Rosana Place, Nipomo	929-6241	Age 12 through older adult
Christopher Howard, LMFT <i>Spanish speaking</i>	855 4th St., Pismo Beach	674-2252	Children, adults
Lisa Finn, LCSW	301 E. Cook, Ste. B-2, Santa Maria	720-3039	Children, adults
Skip Purper, LMFT	2880 Santa Maria Way, Ste. D4, Santa Maria	938-5801	Children, adults
Zac Siegler, LMFT <i>Spanish speaking</i>	150 D South 6th St., Grover Beach	544-9129	Adolescents, adults

Network Providers SLO/Central County	Address	Phone	Population Served
Michele Simone, LMFT	900 Los Osos Valley Rd., Ste. C, Los Osos	534-9373	Age 5 through adult
Ruth Lapp, LMFT	895 Napa Av., Ste. B6, Morro Bay	771-9867	Age 5 through adult
Margaret Lindt, LMFT	645 Mani St., Ste. A, Morro Bay	534-9031	Adolescents, adults
Peggy Atwill, LMFT	1437 Higuera St., SLO	234-6435	Children, adults
Douglas Bing, LMFT	1264 Higuera St., Ste. 200, SLO	546-0902	Adults, older adults
Catherine Currie, LCSW	684 Higuera St., Ste. 200, SLO	542-9024	Adults, older adults
Rive Douglass, LMFT	641 Higuera St., Ste. 218, SLO	441-3330	Adults, older adults
Matthews Elijah, LMFT <i>Spanish speaking</i>	1160 Marsh, Ste. 221, SLO	748-9090	Age 3 through adult
Charles Golodner, LMFT	1264 Higuera St., Ste. 200, SLO	543-7211	Adults, older adults

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Network Providers SLO/Central County Continued	Address	Phone	Population Served
Marjorie “June” Henry, LMFT	1129 Marsh St., SLO	801-0399	Children, adults
Brian Landis, LMFT	11545 Los Osos Valley Rd., Ste. A-3 SLO	489-9043	Age 4 through adult
Ami Grace Magnani, LCSW	1411 Marsh St., Ste. 104, SLO	234-2573	Children, adults
Kim Miller, LMFT	3220 S. Higuera St., #306, SLO	235-1585	Age 4 through adult
Desda Morris, LMFT	1190 Marsh St., Ste. G, SLO	545-8892	Age 3 through adult
Victor Silva-Palacios, PhD <i>Spanish speaking</i>	11573 Los Osos Valley Rd., Ste. H, SLO	801-7590	Adolescents, adults, older adults
Nancy Walsh, LMFT	1190 Marsh St., Ste. C, SLO	781-9530	Age 3 through adult
Robert Weber, PhD	1329 Chorro St., SLO	541-1964	Adolescents, adults
Thomas Wylie, PhD	11573 Los Osos Valley Rd., Ste. C, SLO	545-8951	Neuropsychological testing, adolescents, adults

Network Providers North County	Address:	Phone:	Population Served
Susanne Haas-Clark, LMFT <i>German speaking</i>	7350 El Camino Real #104, Atascadero	712-2828	Age 4 through adult
Kristi Ross, LCSW	5805 Capistrano, Ste. D, Atascadero	466-3856	Age 10 through adult
Cynthia Smith, LMFT	7350 El Camino Real #104; Atascadero	462-1503	Age 4 through adult

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Network Providers North County Continued	Address:	Phone:	Population Served
Marne Trevisiano, PhD	7730 Morro Rd., Ste. 101, Atascadero	462-8025	Age 5 through adult
Catherine Cascadden, LCSW	5805 Capistrano, Ste. D, Atascadero 2216 Alban Place, Cambria	466-3150	Adolescents, adults
Marlene Gilbert, LMFT	1104 Vine St., Paso Robles	462-4626	Age 5 through older adult
Denise Mock, PhD	1244 Pine St., Ste. 208, Paso Robles	237-0058	Age 13 through adult
Diane Rhodes, LMFT	1104 Vine St., Ste. A, Paso Robles	610-2069	Age 3 through adult
Al Santos, LMFT	731 21 st St., Ste. C, Paso Robles	239-2886	Age 5 through older adult
Julie Seden-Hansen, LMFT	819 12 th St., #209, Paso Robles	423-4028	Age 5 through adult
Elise Tobin, LMFT	835 12 th St., #201, Paso Robles	237-4462	Children, adults

All non-emergency services must be pre-authorized by calling 1-800-838-1381 (toll free) during regular business hours. Emergency services do not require pre-authorization.

Policy

Mental Health Services provides clients with a list of specialty internal health providers upon first receiving mental health services, upon request, and on an annual basis.

Reference

CFR, Title 42, Sections 438.10(f)(3)(6)(i); MHP Contract, Exhibit A, Attachment 1, V; CCR, Title 9, Chapter 11, Sections 1810.360(d) and 1810.110

Procedure

1. Upon initial contact with Mental Health Managed Care, an applicant may request a list of service providers. This list contains the names, locations and telephone numbers of current contracted providers in the beneficiaries' service areas by category.
2. Each service site has a list of service providers available and will provide this list to any applicant upon request.
3. Upon completion of an application for services at the time of the first specialty mental health service, the applicant is offered a list of service providers.
4. The offer of this list is confirmed by the therapist or support staff checking the box labeled "list of service providers available to applicant" on the application form.
5. The list of providers is available at any time on request at all service sites and offered on an annual basis. The annual offer of the list is recorded on the Application for Services.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, MFT Date:
Review dates:

BEHAVIORAL HEALTH SERVICES

COUNTY OF SAN LUIS OBISPO



COMMUNITY MENTAL HEALTH SERVICES
2178 JOHNSON AVENUE
SAN LUIS OBISPO, CA 93401-4535
(800) 838-1381
(805) 781-4176 (FAX)

August 26, 2010

Client name and address

Respecto a Sus Servicios Psicoterapia:

Dear Senor:

Servicios psicoterapia an a sido arriglado para usted con el concejeros:

Network Provider Name, Office Address, and phone number

Por favor ponerse en contacto con el concejero para a ser una cita para servicios.

Gracias,

Lynette Kirkpatrick, RHIT
Medical Records Technician
Managed Care

UR Status/Annual Dates	<input type="checkbox"/> Annual Review	<input type="checkbox"/> Six Month Review
Reporting Unit: _____	Start Date: ____/____/____	Provider: _____
Target Symptom / Functional Impairment:		
Interventions:		
Frequency / Duration:		
Objectives:		Date Objectives Met: ____/____/____
1. _____		Date Objectives Met: ____/____/____
2. _____		Date Objectives Met: ____/____/____
3. _____		Date Objectives Met: ____/____/____
Reporting Unit: _____	Start Date: ____/____/____	Provider: _____
Target Symptom / Functional Impairment:		
Interventions:		
Frequency / Duration:		
Objectives:		Date Objectives Met: ____/____/____
1. _____		Date Objectives Met: ____/____/____
2. _____		Date Objectives Met: ____/____/____
3. _____		Date Objectives Met: ____/____/____
Reporting Unit: _____	Start Date: ____/____/____	Provider: _____
Target Symptom / Functional Impairment:		
Interventions:		
Frequency / Duration:		
Objectives:		Date Objectives Met: ____/____/____
1. _____		Date Objectives Met: ____/____/____
2. _____		Date Objectives Met: ____/____/____
3. _____		Date Objectives Met: ____/____/____
Reporting Unit: _____	Start Date: ____/____/____	Provider: _____
Target Symptom / Functional Impairment:		
Interventions:		
Frequency / Duration:		
Objectives:		Date Objectives Met: ____/____/____
1. _____		Date Objectives Met: ____/____/____
2. _____		Date Objectives Met: ____/____/____
3. _____		Date Objectives Met: ____/____/____
Authorization Date: From: ____/____/____ To: ____/____/____		
Client Signature: _____ Date: ____/____/____		
Parent / Guardian Signature: _____ Date: ____/____/____		
Lead Coordinator / Therapist _____	Date: ____/____/____	Co-Signature (When Required) _____ Date: ____/____/____
Program Supervisor/Approval/Authorization _____	Date: ____/____/____	
Interpretation Service Utilized in (Language) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No Culture Specific Service Utilized (Culture) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No		

Policy

The Mental Health Plan will provide Medi-Cal beneficiaries with a Beneficiary Handbook and other informing materials at the time of admission into the system, annually thereafter, and at any time upon request.

Reference

CFR, Title 42, Section 438.10(f)(3); CCR, Title 9, Chapter 11, Section 1810.360(d); MHP Contract, Exhibit A, Attachment 1, V

Procedure

1. As part of the assessment process, Mental Health staff gives Medi-Cal beneficiaries a copy of the Beneficiary Handbook.
2. Mental Health staff documents this on the intake progress note to ensure that step one has taken place.
3. Thereafter, on an annual basis, when the fee sheet is completed, Mental Health staff gives Medi-Cal beneficiaries a copy of the Beneficiary Handbook and other informing materials.
4. This is documented at the bottom of the fee sheet.
5. Medi-Cal beneficiaries may receive a copy of the Beneficiary Handbook any time upon request.
6. The Beneficiary Handbook is available in a Spanish language version at all Mental Health Service sites.
7. Visually impaired clients, or others who request it, may request assistance from the Patients' Rights Advocate or site support staff to access the Beneficiary Handbook or other informing materials in English or Spanish.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 02/27/2009
Revision dates: 02/27/2009

County: San Luis Obispo (SLO County)
November 17, 2008

Date:

1. The county shall ensure that the Community Program Planning Process is adequately staffed. Describe which positions and/or units assumed the following responsibilities:

a. The overall Community Program Planning Process

The San Luis Obispo County Behavioral Health Department Administrator, Karen Baylor, Ph.D, MFT in conjunction with Nancy Mancha-Whitcomb, Mental Health Services Act Division Manager, had the overall responsibility for ensuring that the Community Program Planning Process was carried out as required by statute.

Ms. Mancha-Whitcomb was responsible for participating in statewide discussions and ensuring that DMH Notices and communications were followed, and that a compliant, feasible proposed PEI plan was submitted to DMH for approval.

A County Mental Health Services Accountant II, Lisa Anderson, is dedicated to MHSA and had the overall fiscal responsibility during the planning process.

Frank Warren, Program Supervisor within Drug and Alcohol Services, was the lead for writing the plan document, and will work with the MHSA Oversight and Accountably Commission to obtain approval of the plan. Mr. Warren will be responsible for PEI program implementation.

A 34-member Community Planning Team of diverse public and private stakeholders was responsible for guiding the planning process, analyzing community input, and selecting projects in accordance with community priorities. That membership is described further in Section 1c below.

An independent planning consultant, Dale Magee, was contracted to design and manage the planning process resulting in project selection and assist Mr. Warren in writing the plan document. Ms. Magee was also responsible for the 2005 CSS Community Program Planning Process.

b. Coordination and management of the Community Program Planning Process

From January through October 2008, the planning consultant coordinated and managed all components necessary to conduct a comprehensive community input and program planning process, including: the recruitment and coordination of the Community Planning Team and age-specific workgroups; a publicity campaign; develop and distribute surveys, create informational materials; conduct focus groups and stakeholder interviews; synthesize and analyze input data; create data reports; identify community priorities; research program options and details, and facilitate the Planning Team's project selection process.

A mental health therapist experienced in community partnerships and integrated systems of care was dedicated half time from February through June 2008, to assist with outreach and input efforts, especially to reach underserved rural communities, age groups, and cultural populations.

From March through May 2008, the bilingual/bicultural psychologist who directs the CSS Latino Services Program and chairs County Mental Health's Cultural Competency Committee conducted extensive outreach to low-aculturated Latino communities and other Latino groups, and conducted focus groups, interviews and PEI presentations. She also served an advisory role to the planning consultant.

An internal SLOBHD work team met at least monthly beginning September 2007 to review the PEI Guidelines, formulate the overall planning process, refine survey and input instruments, track the state and local planning process, and develop program and projects details. Those members included:

- Karen Baylor, Ph.D, MFT Behavioral Health Administrator
- Nancy Mancha-Whitcomb, MHSA Division Manager (joined January 2008)
- Frank Warren, Drug and Alcohol Services (DAS) Program Supervisor
- Lisa Anderson, MHSA Accountant
- Rhea Liamaa, Systems Affirming Family Empowerment (SAFE) Coordinator (January - June 2008)
- Brad Sunseri, Youth Services Division Manager (September - December 2007)
- Janet Amanzio, Adult Services Division Manager (September - December 2007)
- Dale Magee, planning consultant

c. Ensuring that stakeholders have the opportunity to participate in the Community Program Planning Process

The comprehensive Community Program Planning Process began in August 2007 and consisted of four phases:

1. "Plan to Plan." August 2007 through January 2008.
2. Community Outreach and Input. February through April 2008.
3. Data Analysis; Priorities and Strategy Identification. May through August 2008.
4. Project Selection and Design. August 2008 through October 2008.

More than 3,000 individuals were involved in the Community Program Planning Process throughout the phases. Stakeholders were involved from the beginning and will continue once PEI projects are operating.

Phase I: Plan to Plan (August 2007 - January 2008)

This phase was for educating the work team on the PEI guidelines and DMH's approach, for strategy development for the community input process, and to gather resources to ensure a successful Community Program Planning Process. This was primarily an internal effort yet key stakeholders provided valuable input and guidance.

The existing MHSA CSS Community Planning Team, whose membership includes most of the representatives required for the PEI planning process, was consulted in December 2007 to

provide recommendations on outreach strategies and stakeholder groups to include during the forthcoming PEI community input process. More than 25 people, including consumers, family members and Latino community representatives, contributed.

Recruitment for the PEI Community Planning Team began during this phase. Both “required” and “recommended” stakeholders were enlisted.

The 34-member PEI Community Planning Team first convened in January 2008 for a PEI component orientation and training. The Planning Team represents most of the required and recommended PEI groups, and serves as the oversight body for the Community Program Planning Process, and ensured a comprehensive and inclusive input process and that the resulting proposed PEI Plan reflected the spirit of the community’s wishes.

The **Community Planning Team** membership includes representatives from the following groups (some members represent more than one group):

- Individuals with mental illness (at least 4)
- Consumers (at least 2)
- Family members (at least 7)
- Family Advocates
- Behavioral Health Department Administrator
- California Polytechnic University (Cal Poly), Counseling Services
- Community Members at Large
- County Jail / Custody
- County Office of Education
- Department of Social Services
- Drug and Alcohol Services
- Economic Opportunity Commission
- Family Care Network
- Law Enforcement
- Mental Health Board
- Mental Health Adult and Youth Services (MHS)
- Mental Health Services Cultural Competency Committee
- MHSA Administrative Staff
- MHSA Latino Outreach and Services
- National Alliance on Mental Illness (NAMI)
- Older Adult Full Service Partnership (FSP)
- Probation Department
- Psychotherapists, private practice (active and retired)
- Public Health Department
- SAFE System of Care
- Family Resource Centers
- San Luis Obispo County Community Foundation
- Special Education Local Plan Area
- Transitions-Mental Health Association (T-HMA)
- Tri-Counties Regional Center

Cuestionario de Satisfacción

Para los Clientes del programa:

Latino Outreach

Estimado Cliente,

Como terapeutas del Programa Latino Outreach, nos gustaría pedirle que se tome unos minutos para compartir con nosotros sus opiniones acerca de los servicios que ha recibido. Para nosotros es de mucha importancia el saber de que modo podemos mejorar aun más los servicios que ofrecemos a la comunidad.

Sinceramente:

Silvia Ortiz	PhD	Supervisora Clínica
Paco Ortiz	MFT-I	
Lupita Vargas	LMFT	
Conrad Mendoza	MFT-I	
Nancy Withers	LMFT	

Las siguientes preguntas son para la persona que es atendida por alguno de los terapeutas: (si el cliente es un menor, el padre o la madre puede llenar este formulario).

Edad:	Youth 0-15	12%
	TAY 16-25	26%
	Adult 25-59	60%
	Older Adult 60+	2%

Sexo:	Masculino	44%
	Femenino	40%
	Otro	0%
	No Se	16%

Nacionalidad:		
	Mexican	79%
	Mex/Amer	7%
	American	5%
	Otro	7%
	No Se	2%

Lugar de Residencia:

San Luis Obispo	33%
Nipomo	12%
Oceano	26%
Arroyo Grande	4%
Grover Beach	4%
Otro	12%

Tiempo que permaneció en la lista de espera:

menos de 1 mes	51%
1 a 2 meses	21%
2 a 3 meses	14%
3 meses o mas	2%
No Se	12%

Grado Escolar:

0 to 8th	23%
9 to 12th	40%
13	2%
No Se	35%

Si es adulto, hasta que grado estudio:

6	16%
12	7%
Otro	16%
No Se	60%

Ingresos Anuales De la familia:

\$0 a \$10,000	23%
\$10,000 a \$15,000	12%
\$15,000 a \$20,000	16%
\$20,000 a \$25,000	23%
\$25,000 a \$30,000	14%
\$30,000 o mas	7%
No Se	5%

Favor de contestar las siguientes preguntas de acuerdo a la escala que a continuación se presenta:

5: Excelente **4:** Muy Bueno **3:** Neutral **2:** Pobre **1:** Muy Pobre

1. La calidad de los servicios que he recibido de mi terapeuta es:

4.7 94%

2. El trato que recibo de mi terapeuta es:

4.7 94%

3. Mi nivel de satisfacción con los servicios que he recibido es:

4.6 92%

4. Considero que el lugar donde recibo la terapia es:

4.3 86%

5. La confianza que tengo para recomendar estos servicios a otras personas es:

4.8 96%

6. Mi primer contacto telefónico con mi terapeuta fue:

4.5 90%

7. Mi terapeuta me ha sabido escuchar y entender de una manera:

4.8 96%

8. Dentro de la terapia yo he sentido que puedo expresarme de una manera:

4.6 92%

9. En terapia, mi terapeuta ha podido ayudarme a entender/resolver mi problema de una manera:

4.7 94%

10. La amabilidad y cortesía que mi terapeuta me ha demostrado es:

4.8 96%

11. Siento que mi terapeuta comprende y entiende mi cultura de una manera:

4.7 94%

12. La calidad del idioma español que mi terapeuta utiliza es:

4.8 96%

13. El valor que yo le doy a los servicios de Latino Outreach en mi comunidad es:

4.8 96%

PLEASE READ THIS FORM CAREFULLY. IF YOU HAVE PROBLEMS READING IT, ASK TO HAVE IT READ TO YOU.

Dr. _____ has met with me and we talked about the following items.

- 1) We discussed my illness or condition for which my doctor is recommending medication.
- 2) The doctor told me of medications, and other reasonable alternatives, if any, which are known to be of help in treating problems such as mine.
- 3) The doctor also informed me why such medications are important or necessary in the treatment of my illness or condition and discussed with me the likelihood of my improving or not improving without such medication(s). I understand the medication will be from the group that follows:

MEDICATIONS AND DOSAGE/RANGE

**Neuroleptic/
Major Tranquilizer** _____

Mood Stabilizer _____

Antidepressant _____

**Hypnotics/
Antianxiety** _____

Stimulants _____

Other _____

We also discussed:

- a) the type, frequency, and amount of each medication, as well as the method (by mouth, injection, etc.), and how long I will need to take them.
- b) the side effects of these medications which commonly occur and ones which may particularly affect me.

I understand that I have the right to accept, to refuse, or to discontinue medication(s) ordered for me by telling my physician or a member of the treatment staff at any time.

I understand that if I have any further questions or want to know more about my medications I can ask for further information.

I HAVE READ THIS FORM, I UNDERSTAND IT, AND I CONSENT TO TAKE THE MEDICATION(S) PRESCRIBED BY THE DOCTOR. I HAVE RECEIVED EDUCATIONAL MATERIAL(S) WHICH DISCUSSES THE ABOVE MEDICATIONS AND POSSIBLE SIDE EFFECTS.

Patient's Signature: _____ Date / /

Physician's Signature: _____ Date / /

CLIENT NAME: _____
Original: Client Record
Copy: Client

RECORD NUMBER: _____

POR FAVOR, LEA ESTE DOCUMENTO CUIDADOSAMENTE. SI TIENE ALGUNA DIFICULTAD PARA LEER LO, PIDA QUE ALGUIEN LE AYUDE.

El Doctor _____ me ha comunicado personalmente lo siguiente:

- 1) Hemos hablado de mi condición o enfermedad por lo cual el me ha recomendado medicamento(s).
- 2) El doctor me ha explicado acerca de los medicamentos y otras alternativas razonables conocidas, si las hay, efectivas en el tratamiento de problemas como el mío.
- 3) También el doctor me ha informado acerca de la importancia o necesidad de este(os) medicamentos en el tratamiento de mi enfermedad o condición. Además, el doctor me explicó acerca de las posibilidades de mejorar, o no mejorar, sin tomar este(os) medicamentos. Yo entiendo que los medicamentos serán de las siguientes categorías:

MEDICAMENTOS Y SU DOSIS/AMPLITUD

**Neurólépticos/
Tranquilizante Mayor** _____

**Hipnóticos/
Anti-Ansiedad** _____

Estabilizante de Humor _____

Estimulantes _____

Anti-Depresivo _____

Otro _____

Nosotros también placticamos de lo siguiente:

- a) el tipo, la frecuencia, y la cantidad de cada medicamento y el método de tomarlo (por la boca, por inyección) y por cuanto tiempo necesitaré tomarlo(s).
- b) las contraindicaciones de este(os) medicamento(s) que son comunes, y los que me pueden afectar a mí en particular.

En cualquier momento, retengo el derecho de aceptar, rechazar, o discontinuar este(os) medicamento(s) ordenados para mi solamente con decirle a mi médico o uno de los trabajadores de tratamiento.

Yo entiendo que si tengo más preguntas o quiero saber más acerca de mis medicamentos, puedo pedir más información.

DESPUES DE HABER LEIDO Y ENTENDIDO ESTE DOCUMENTO, DOY MI CONSENTIMIENTO PARA TOMAREL (LOS) MEDICAMENTO(S) QUE HAN SIDO RECETADOS POR EL DOCTOR. TAMBIEN HE RECIBIDO MATERIALES EDUCATIVOS QUE INFORMAN SOBRE LOS MEDICAMIENTOS MENCIONADOS Y LOS EFECTOS NEGATIVOS POSIBLES DE ELLOS.

Firma del paciente: _____

Fecha: _____

Firma del doctor: _____

Fecha: _____

CLIENT NAME: _____

RECORD NUMBER: _____

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Last Name	First	Middle	AKA:	
Street Number/Name		City	State	Zip Code
Home Telephone: ()	DOB:	Last four digits of SSN#: XXX - XX - _____		
San Luis Obispo County Behavioral Health Services is authorized to:				
<input type="checkbox"/> Receive/Obtain information from AND/OR <input type="checkbox"/> Release information to:				
Contact Person Name/Organization:				
Street Address:				
City/State/Zip Code				
Telephone: ()			Fax:()	

_____ I authorize the use and/or disclosure of the entire behavioral health record.
 (Initials)

OR*

I only authorize the use and/or disclosure of the following (initial):

- _____ Mental Health Diagnosis/Diagnostic Information
- _____ Initial Evaluation/Assessment
- _____ Psychiatric Evaluation
- _____ Medication History _____ Discharge Summary _____ Transfer Summary
- _____ Labs _____ Nursing Assessment _____ Treatment Summary
- _____ Other: _____

*Psychotherapy notes require a separate authorization

I additionally specifically authorize the use and/or disclosure of the following health information (initial):

- _____ Alcohol and/or Drug Abuse Treatment Program
- _____ HIV/AIDS Testing, Diagnosis and/or Treatment

PURPOSE: I authorize San Luis Obispo County Behavioral Health Services to use or disclose my health information, during the term of this authorization for the following specific purpose:

- Evaluation Treatment Planning/Course/Delivery
- Other (Specify): _____

Client Name: _____ **Record Number:** _____

I understand the following about this authorization:

- I can revoke this authorization in writing. Requests to revoke authorizations must be made in writing at the Medical Records Office where this form originated. For additional information see our Notice of Privacy Practices. Revocation is effective upon receipt, except to the extent that others have previously acted in reliance upon this authorization
- Treatment cannot be denied to you if you refuse to sign this authorization. However, outside agencies, that require protected health information to provide various services to, or for, you may not be able to do so.
- If the recipient of this information is subject to California or federal confidentiality laws, it is possible that it may be redisclosed.
- This authorization includes written, electronic, and/or verbal disclosure.
- I have a right to receive and I will be offered a copy of this authorization. _____
Please Initial Received Offered copy
- A copy of this authorization is as valid as an original.

I may contact San Luis Obispo County Behavioral Health Services Privacy Officer by mail at: 2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, or by calling (805) 781-4700.

TERM: This authorization will remain in effect from the date of this authorization until the _____ day of _____, 20 _____ .

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and/or disclosure of my health information. By my signature below, I hereby, knowingly and voluntarily, authorize San Luis Obispo County Behavioral Health Services to use and/or disclose my health information in the manner described above.

Client Signature : _____ Date: _____

A minor client's signature (12-17) is required in order to release information concerning care for mental health conditions and/or alcohol drug abuse issues.

Signature of Parent/Guardian/Conservator and Authorized Representative and Description of Authority**

_____ Date: _____

** (with copy of court papers/letters of conservatorship)

Signature of Staff: _____ Date: _____

(MD, PhD, LCSW, LMFT)

Client Name: _____ Record Number: _____

AUTORIZACIÓN PARA USAR Y/O REVELAR INFORMACIÓN SANITARIA PROTEGIDA
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

Apellido	Primer nombre	Segundo nombre	También conocido como:
Calle/Número	Ciudad	Estado	Código postal
Teléfono particular: ()	Fecha nac.:	Últimos cuatro dígitos del Nro. de seguro social: XXX - XX - _____	
El servicio de salud conductual del condado de San Luis Obispo está autorizado a:			
<input type="checkbox"/> Recibir / Obtener información de Y/O <input type="checkbox"/> Brindar información a:			
Nombre de la persona/organización de contacto:			
Domicilio:			
Ciudad/Estado/Código postal			
Teléfono: ()		Fax:()	

_____ Autorizo el uso y/o la publicación de toda la historia clínica conductual.
(Firmas)

O *

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):

_____ Diagnóstico de enfermedad mental/Información del diagnóstico
_____ Evaluación inicial/Diagnóstico
_____ Evaluación psiquiátrica
_____ Historial de medicación _____ Resumen del alta médica _____ Resumen para transferencia
_____ Laboratorio _____ Evaluación de las enfermeras _____ Resumen del tratamiento
_____ Otros: _____

*Las anotaciones de psicoterapia requieren una autorización por separado.

Sólo autorizo el uso y/o la publicación de lo siguiente (firma):

_____ Programa de tratamiento para el abuso de alcohol /drogas
_____ Pruebas para VIH, su diagnóstico y/o tratamiento

PROPÓSITO: Autorizo al Servicio de salud conductual del condado de San Luis Obispo a usar y publicar información sobre mi salud durante el término de esta autorización para los siguientes propósitos específicos:

Evaluación Planificación del tratamiento/Curso/Entrega
 Otro (especificar) _____

Client Name: _____

Client Number: _____

Entiendo lo siguiente acerca de esta autorización:

- Puedo revocar esta autorización por escrito. Las solicitudes para revocar autorizaciones pueden hacerse por escrito en la oficina de registros médicos donde se emitió este formulario. Para más información, vea nuestra notificación sobre prácticas de privacidad. La revocación tiene vigencia a partir de su recepción, excepto en la medida en que otros hayan actuado en base a la autorización.
- No se le pueden negar tratamientos sobre la base de haberse negado a firmar esta autorización. Sin embargo, es probable que agencias externas, que requieran información protegida de salud para brindarle varios servicios, no estén en condiciones de brindarle el tratamiento.
- Si quien recibe esta información está sujeto a las leyes de California o a las federales de confidencialidad, es posible que la pueda volver a publicar.
- Esta autorización incluye la revelación por escrito, en forma electrónica y/o oral.
- Tengo derecho a recibir y se me debe ofrecer una copia de esta autorización. _____
Firme Recibido Copia ofrecida
- La copia de esta autorización es tan válida como el original.

Puedo ponerme en contacto con la oficina de privacidad del Servicio de salud conductual del condado de San Luis Obispo por correo escribiendo a:
2178 Johnson Avenue, San Luis Obispo, CA 93401-4535, o llamando por teléfono al (805) 781-4700.

PLAZO: La presente autorización tendrá vigencia a partir de la fecha de la presente autorización hasta el _____ día de _____ de 20 _____.

He leído y entiendo los términos de la presente Autorización y he tenido la oportunidad de hacer preguntas acerca del uso y/o la publicación de información relativa a mi salud. Por medio de mi firma, que aparece más abajo, en forma voluntaria y con conocimiento, autorizo por la presente al Servicio de salud conductual del condado de San Luis Obispo a usar y/o revelar la información sobre mi salud en la forma descrita más arriba.

Firma del paciente: _____ Fecha: _____

En caso de un paciente menor de edad (12-17 años), se requiere su firma para revelar información relativa a su estado de salud mental y/o temas relacionados con el abuso de drogas y alcohol.

Firma del padre/tutor/protector, representante autorizado y descripción de autoridad**

Fecha: _____

** (con copia de documentos del tribunal/documentos de tutela o curaduría)

Signature of Staff

Firma del personal: _____ Fecha(Date): _____

(Doctor en medicina, PhD., asistente social clínico matriculado, terapeuta familiar matriculado)
(MD, PhD, LCSW, LMFT)

Client Name: _____

Client Number: _____

Silvia Ortiz, Ph.D.

(805) 788-2136

Licensed Psychologist

Psy11656

Directora del Programa

Correo

2178 Johnson Avenue

San Luis Obispo, CA

93401-4535

Citas Disponible en:

Paso Robles, Atascadero,

San Luis Obispo y Oceano

Mental Health Service Act

La aprobación de la **Proposición 63** en **Noviembre 2004** generó **dinero** para crear cambios en los servicios públicos de salud mental. La **Mental Health Service Act (MHSA)** se convirtió en ley el **1 de enero del 2005**. Esta ley requiere que los condados crean e implementen un **plan de tres años** que logre las metas y objetivos de la MHSA. Algunos de los conceptos del plan se enfocan en las necesidad de convertirnos en un sistema de servicios competente culturalmente.

**Servicios Sicologicos
para Latinos**

A Latino Outreach Program



**San Luis Obispo County
Behavioral Health Services**

MHSA Program

Le podemos ayudar si está experimentando:

Gran dificultad ajustando a vivir en la cultura Americana

Sentimientos y comportamientos que no sabe por qué le ocurren

Coraje que no puede controlar

Tiene dolor de cuerpo no relacionados con enfermedades físicas.

Llanto incontrolable

Recuerdos dolorosos y temerosos que le causan angustia

Funcionamiento disminuido en la escuela, trabajo

Oye voces o tiene visiones

Ideas irracionales

Temporadas de mucha energía con poco dormir

Estrés extremo

Dificultad extrema en crear a sus hijos

Servicios Ofrecidos:

Terapia para adultos, adolescentes, niños, parejas y familias

Evaluación para medicamentos y manejo de medicamentos

Grupos de apoyo que se unen semanalmente por seis a ocho semanas

Platicas de grupos pequeños sobre temas de interés para la comunidad Latina

Talleres

Información Sobre Nuestros Servicios

La terapia, evaluación para medicamentos, grupos de apoyo, y las platicas son ofrecidas en español para Latinos de bajos ingresos que no tienen aseguransa de salud mental.

Nosotros proveemos servicios a los Latinos que son cubiertos por Medical o Medicare. Cuando apropiado la agencia de Salud Mental del Condado de San Luis Obispo le cobrara a Medicare y Medical.

Los talleres son ofrecidas en español y ingles. Los consejeros son bilingües y biculturales.

Por favor llame al número detrás de este folleto si le gustaría recibir nuestros servicios. Estableceremos una cita y determinaremos como le podemos ayudar.

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH LOBBIES:

North County MH Clinic/Atascadero, Kinship Center, SLO Adult MH Clinic (CON REP), SLO Youth Services, MHSA, Martha's Place, Family Care Network, Juvenile Services Center, Transitions Mental Health Admin Office, South County Clinic/Arroyo Grande, SAFE Family Resource Center - South County

LOCATION: _____ **AUDIT DATE:** _____

- ___ Consumer Request Form **ENGLISH**, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)
- ___ Consumer Request Form **SPANISH**, w/addressed stamped envelope
(Tri-fold double-sided: Addresses complaints, 2nd opinion, grievances, appeals)
- ___ GUIDE TO Medi-Cal Mental Health Services, **ENGLISH** booklet
(beneficiary handbook)
- ___ GUIDE TO Medi-Cal Mental Health Services, **SPANISH** booklet
(beneficiary handbook)
- ___ Notice of Privacy Practices (May 10, 2010) **ENGLISH** (HIPAA)
- ___ Notice of Privacy Practices (10/1/2009) **SPANISH** (HIPAA)
- ___ Medi-Cal Ombudsman Services (tri-fold brochure), **ENGLISH**
- ___ Medi-Cal Ombudsman Services (tri-fold brochure), **SPANISH**
- ___ SIGN (font 48): "Dear Consumers, **Informational materials are available in alternative formats.** Please ask the receptionist for assistance."
- ___ SIGN (font 48): "Dear Consumers, **Free language assistance services** are available upon request. Please ask the receptionist for assistance."
- ___ SIGN (font 48): "Estimado Consumidores, **Informar materias estan disponible en formatos alternativos.** Pregunte por favor al recepcionista para la ayuda."
- ___ SIGN (font 48): "**Si usted busca servicio de salud mentales y necesita ayuda en espanol** por favor de informarle a la recepcionista. Gracias."
- ___ SIGN (font 72): "**Free language assistance available upon request.**"
- ___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO **ENGLISH**
- ___ YOUR RIGHTS poster (8 ½ X 14), HEALTH AGENCY, County of SLO **SPANISH**
- ___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided) On M-Drive, each Program Supervisor has access/copy

LOBBY MATERIALS CHECKLIST

FOR THE FOLLOWING SLO COUNTY MENTAL HEALTH FACILITIES:

- **PSYCHIATRIC HEALTH FACILITY (PHF), SLO COUNTY MENTAL HEALTH**
- **YOUTH TREATMENT PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA)**
- **SOCIALIZATION PROGRAM, TRANSITIONS MENTAL HEALTH ASSOCIATION (TMA)**
- **AMERICAN CARE HOME, ATASCADERO**

LOCATION: _____ **AUDIT DATE:** _____

___ MENTAL HEALTH PATIENTS RIGHTS poster (CA Dept M Health, 1999)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. **HANDBOOK ENGLISH:** (CA Dept of Mental Health)

___ Rights for Individuals in Mental Health Facilities - Admitted under the Lanter-man-Petris-Short Act. **HANDBOOK/MANUAL SPANISH:** (CA Dept of M. Health)

___ Consumer Request Form **ENGLISH**, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ Consumer Request Form **SPANISH**, w/addressed stamped envelopes
(Tri-fold double-sided) Addresses complaints, 2nd opinion, grievances, appeals

___ **GUIDE TO Medi-Cal Mental Health Services ENGLISH** booklet
(beneficiary handbook)

___ **GUIDE TO Medi-Cal Mental Health Services SPANISH** booklet
(beneficiary handbook)

___ Notice of Privacy Practices (May 10, 2010) **ENGLISH**

___ Notice of Privacy Practices (10/1/2009) **SPANISH**

___ Medi-Cal Ombudsman Services (tri-fold brochure) **ENGLISH**

___ Medi-Cal Ombudsman Services (tri-fold brochure) **SPANISH**

___ **SIGN (font 48): "Dear Consumers, Informational materials are available in alternative formats. Please ask the receptionist for assistance."**

___ **SIGN (font 48): "Dear Consumers, Free language assistance services are available upon request. Please ask the receptionist for assistance."**

___ **SIGN (font 48): "Estimado Consumidores, Informar materias estan disponible en formatos alternativos. Pregunte por favor al recepcionista para la ayuda."**

___ **SIGN (font 48): "Si usted busca servicio de salud mentales y necesita ayuda en espanol por favor de informarle a la recepcionista. Gracias."**

___ **SIGN (font 72): "Free language assistance available upon request."**

___ Provider List of Behavioral Health Clinics and Contract Providers
7 pages (print double sided) This document is on the SLO County M-Drive



GUÍA PARA

Servicios de Salud Mental de Medi-Cal





Si tiene una emergencia, llame al 9-1-1 o visite la sala de emergencias del hospital más cercano.

Si desea información adicional que lo ayude a decidir si se trata de una emergencia, consulte la información sobre el Estado de California en la página 6 de este folleto.



Números Telefónicos Importantes

Emergencia911
San Luis Obispo(800) 838-1381 *las 24 horas*
Servicios de Salud Mental
Coordinador de Quejas(805) 781-4700
Oficina de Derechos del Paciente: ..(909) 358-4600
Defensor del Pueblo de
Medi-Cal en el Estado(916) 653-9194



Cómo Conseguir un Directorio de Proveedores:

Usted puede pedir, y su Plan de Salud Mental (MHP) le debería entregar, un directorio de personas, clínicas y hospitales donde puede recibir servicios de salud mental en su área. Éste se llama una “lista de proveedores” y contiene nombres, números telefónicos y direcciones de doctores, terapeutas, hospitales y otros lugares donde puede obtener ayuda. Quizás necesite contactar a su MHP primero, antes de buscar ayuda. Llame las 24 horas al número gratuito de su MHP antes mencionado, para pedir un directorio de proveedores y preguntar si necesita contactar al MHP antes de ir al consultorio, clínica u hospital de un proveedor de servicio, para solicitar ayuda..



¿En Qué Otros Idiomas y Formatos están Disponibles Estos Materiales?

Este folleto (o información) **esta disponible en Español.** Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.



GUIDE TO Medi-Cal Mental Health Services





If you are having an emergency, please call 9-1-1 or visit the nearest hospital emergency room.

If you would like additional information to help you decide if this is an emergency, please see the information on State of California page 6 in this booklet.



Important Telephone Numbers

Emergency 911
 San Luis Obispo(800) 838-1381 *24-hours*
 Mental Health Services
 Grievance Coordinator..... (805) 781-4700
 State Patient’s Rights Office(909) 358-4600
 Medi-Cal State Ombudsman(800) 896-4042
(916) 653-9194



How to Get a Provider List:

You may ask for, and your Mental Health Plan (MHP) should give to you, a directory of people, clinics and hospitals where you can get mental health services in your area. This is called a ‘provider list’ and contains names, phone numbers and addresses of doctors, therapists, hospitals and other places where you may be able to get help. You may need to contact your MHP first, before you go to seek help. Call your MHP’s 24-hour toll-free number above to request a provider directory and to ask if you need to contact the MHP before going to a service provider’s office, clinic or hospital for help.



In What Other Languages And Formats Are These Materials Available?

Este folleto (o información) **esta disponible en Español.** Usted puede solicitarlo llamando al número de teléfono gratuito mencionado anteriormente.

SAN LUIS OBISPO BEHAVIORAL HEALTH

You are Cordially Invited to
Participate in a Discussion about
Therapeutic Behavioral Services (TBS)
In San Luis Obispo County

Who: County of San Luis Obispo Mental Health; Public Defenders; CASA; Family Court Judge; San Luis Obispo Probation; San Luis Obispo Child Welfare Services; Foster Family Agencies; THMA; Mr. Baily; CAP SLO; Child Development Center; County Office of Education; SELPA;

Who is eligible for TBS under the Emily Q settlement?

Children and youth under age 21 receiving EPSDT mental health services who:

- are placed in or are being considered for RCL 12 or higher, **or**
- have received psychiatric hospitalization in the past 24 months, **or**
- are being considered for psychiatric hospitalization.

Agenda Topics

Introduction – Welcome and Purpose of the Meeting

TBS Overview

TBS – A Case Presentation

Discussion regarding the following questions:

- Are the children and youth in your county who are Emily Q class members and who benefit for TBS, getting TBS?
- Are the children and youth who get TBS experiencing the intended benefits?
- What alternatives to TBS are being provided in your county?
- What can be done to improve the use of TBS and/or alternative behavioral support services in your county?
- What are the other issues or concerns do you have?

When: October 30, 2009 from 10-12 noon

Where: San Luis Obispo County Library

Why: Assure that TBS services are accessible to those that need

RSVP

Patty Ford, LMFT at pford@co.slo.ca.us

Phone: 805-781-4209



Therapeutic Behavioral Services Accountability Structure Report to the Department of Mental Health

Purpose: The goal of the Therapeutic Behavioral Services (TBS) Accountability Structure is to identify and develop a statewide practice and performance improvement structure. This structure will include outcome and utilization measures and a continuous quality improvement process that will allow the California State Department of Mental Health (CDMH) to effectively ensure that TBS are accessible, effective, and sustained for the Emily Q class members as outlined in the Court-approved TBS Plan.

The accountability structure, to be implemented by CDMH, will be accomplished through annual reports submitted by the county Mental Health Plans (MHPs). This new report utilizes a quality improvement process based on principles and accountability activities that focus on practice and service coordination, rather than compliance and disallowances. The report is designed to increase Emily Q class access to appropriate TBS services. This approach requires an interagency review of relevant data in response to four questions, utilizing a standard report format.

--Nine Point Plan, Appendix C

Directions: Please provide a brief summary of the answers to the following four questions as discussed in your local learning conversation (both Level I and Level II counties). Per the Nine Point Plan, it is the Mental Health Director's responsibility to submit the completed form. Please save this form to your computer then submit, along with a list of attendees, to TBS@dmh.ca.gov.

County MHP: San Luis Obispo

Date of Meeting: Dec 4, 2009

MHP Contact Information

Name: Brad Sunseri Phone Number: (805) 781-4179

Email: bsunseri@co.slo.ca.us

Was this a: Stakeholder or a Decision-Maker meeting?

1. Are the children and youth in the county who are Emily Q class members and who would benefit from TBS, getting TBS?

Representatives from one of local elementary schools, including the principal and counselor indicated that students that meet class eligibility were receiving TBS services. They do not feel that parents are aware "enough" of TBS and expressed they do not feel comfortable suggesting TBS when they are not sure if the child meets eligibility criteria. Schools were well represented and many expressed concern that TBS is not available to non Medi-Cal students who might meet the criteria otherwise. The school representatives felt that lack of public information and strict criteria for TBS was a barrier to children in general to not receive TBS. We spent a good deal of time differentiating TBS from school's academic support responsibility. The Head Start representative felt like TBS is well known within the Community Action Partnership circle and that children that meet criteria were accessing TBS. Our CBOs shared stories of preschoolers and elementary age children that have accessed TBS. The representatives did not feel that age or gender was a barrier. Some suggested more meeting like this to inform more consumers, educators, physicians, and agency personnel. All expressed positive regard for the individuals providing TBS. Another CBO expressed that the TAY youth are resistant to TBS. One CBO shared a success story of a Transitional Aged Youth who had received TBS. Responders agreed that we need to do a better job of keeping TAY engaged by meeting their specific needs.

2. Are the children and youth who get TBS experiencing the intended benefits?

School representatives stated that the students who have received TBS have improved and avoided placement. The schools learned of the efforts to transfer skills to caretakers and the challenges of engaging teachers and school aides in the learning process. All agency representatives expressed awareness of the TBS referral process and did not express discrepancies in access to any geographical area, age, gender or culture. The responders were pleased to hear that we have bilingual and bicultural TBS workers. We had a grandmother living with her daughter and grand daughter share her experience with TBS at the forum. Her story was a successful avoidance of group home care that generated a lot of good questions, which she handled very well. TBS was seen as preventing a number of placements by education and group home providers. Transitioning youth from high to lower levels of care was valued by our group home provider and SB163 Wrap around providers.

3. What alternatives to TBS are being provided in the county?

The answer to this question was very similar to the answers provided by the decision maker group. The schools enthusiastically shared the positive aspects of specialized mental health services in most ED classes via contract. The program in some school ED classes includes a .5 FTE therapist and 1.0 personal service specialist. This amounts to a quasi DT level of care. CAPSLO, CBO and Education each spoke to the MHSA Full Service Partnership teams, who perform a significant amount of rehabilitation service for their customers. SB163 also performs rehabilitation services often providing one to one work on specific behaviors.

4. What can be done to improve the use of TBS and/or alternative behavioral support services in the county?

The theme regarding this question was the suggestion to increase community awareness by presenting TBS as an in-service training to Superintendents of schools, school psychologists, physicians, and public agencies. We have presented to probation and DSS a few times. Schools offered to be the conduit for community training for parents. We agreed to follow up with schools when they provide some possible formats and times. Representatives from schools and CBOs finished by saying they felt that TBS awareness in the community was good among professionals, but that they sensed that parents were not aware of the service. They reinforced the idea of more community forums.

Additional Comments:

The Grandparent who presented her experience with TBS was the highlight of the meeting. She was articulate and inspirational. We provided handouts that included TBS notices, Emily Q fact sheet, TBS descriptor, TBS Data Dashboard, Agency TBS Referral Form and the 24 hour MH managed care number.

20 stakeholders attended

4 panelists

1 facilitator

1 consumer

The participants included School personnel, group home provider, Foster Family Agencies, Child Development Center, CAPSLO (EOC), family advocates and staff from a FRC.

The following signed our sign in sheet: Vicky Jarvis, CAPSLO; Tania Resendiz, Link (family advocate); Dot Stauble, CAPSLO 0-5 program; Bonnie Parsons, SLO HS counselor; Danielle Martinez, Family Care Network; Lisa Gibson, Link (family advocate); Allison Keller, CAPSLO Head Start; Daniel Carlisle, FCN; Carol Birch, FCN TBS Supervisor; Mirissa Lomeli, CAPSLO; Sharon Corcoran, San Luis Coastal Unified School District (SLCUSD); Joyce Hunter, Principal SLCUSD; Dana Francis, School Counselor SLCUSD; Chelse Starr, Child Development Center; Angela Barakat, CDC; Lilita Thomas, SLCUSD; Patty Ramirez, Transition Mental Health Association; Rosalina Rodriguez, Aspira; Patty Ford, MFT MH Youth Supervisor; Jon Nibbio, MFT FCN Clinical Director; Brad Sunseri, MFT MH Youth Services Division Manager.

**Executive Summary/Accomplishments
For
San Luis Obispo County
Children's System of Care-Interagency Enrollee Based Program
2008-2009**

The San Luis Obispo County Children's System of Care continues to demonstrate successes in spite of a hiring freeze that was imposed in each of the last 5 years. Some essential staff were hired in between hiring freezes, which required the County Administrator's approval. *Although San Luis Obispo County Mental Health has benefited from significant County budget overmatch for a number of years, the discrepancy between county costs and declining revenues continues to result in the BOS edict that county funds will no longer be available to fund budget shortfalls.* The consequences to County departments for the *third* year in a row are cuts in services. In order to prepare for the projected shortfalls in *FY 2010/11*, service level reductions are being scheduled for *January of 2010*. MHSA programs and SAMHSA supports for CSOC will continue. The Multi-agency's commitment to the mission, vision and goals set forth by the Children's Services Network remained strong. The Children's Services Network continues to meet monthly with the full membership of public and private agency representatives. The Executive Committee of the CSN continued to meet monthly to guide the countywide committee structure to advance the multi-agency Children's Systems of Care. The Mental Health Services Act activities and the DSS redesign are braided together to further enhance services for children and families.

The State hospitalization rate has remained at zero throughout this year and group home placements have remained steady as compared to last year, with the length of stay reduced for group home placed children. Under the direction of the CSN and the Management Support Team, the South County SAFE SOC team continues to provide services to those children at risk of home, school, and/or community failure. School linked services continue to demonstrate excellent success. Therapists are assigned to all children in countywide designated Emotionally Disturbed classes. The Vicente Intensive Day Treatment program continues to be 85% effective in preventing out of county group home placements. This program has continued to be very effective as a step down program for children returning from out of county placements and is an excellent adjunct to the SB163 Wrap-Around Program and the Mental Health Service Act funded Full Service Partnership Program for Children and Transitional Aged Youth. Mental Health and the County Office of Education's collaborative programs in 4 E.D. classes continue to demonstrate excellent outcomes.

(SAMHSA funds will support non-reimbursable activities that support the multi-agency co-located South County SAFE SOC).

The most significant change in CSOC/IEBP was the discontinuation of the North County SAFE Program in 2008. Although this program was not funded by SAMHSA, the intensive services that were provided by the multiagency collocated team were cut due to severe fiscal shortfalls. Some of these youth are receiving traditional out patient service and some have gone on to SB163 or the Full Service Partnership Program. The SAFE system continues to offer multiagency coordinating committees in all regions of the county. These teams continue to link youth to appropriate levels of service. The South County SAFE Team continues to enroll youth into CSOC/IEBP.

Mental Health and the Probation Department continue to offer collaborative programming. Cultural competence has been improved at the juvenile hall by requiring a minimum of 1.0FTE bilingual therapists. Mental Health will be reducing therapist staff at the Juvenile Hall by .5FTE leaving 2.0FTE licensed therapists and 4 hours of psychiatrist time at the juvenile hall.

Additional therapist time will no longer be authorized when necessary due to budget cuts in both the Probation Department and Mental Health. The addition of 2 staff via the Mental Health Service Act has continued to improve mobile crises response times, crises intervention in the field, and resulted in fewer acute hospitalizations. MHSA has also allowed the creation of an addition Children's FSP team and expansion of Latino outreach services

San Luis Obispo County has completed nearly 3 years of providing for 30 youth in the SB163 Wrap-Around Program. SB163 Wrap Around slots increased to 40 last year and 44 this year. 36 of these slots are for regular Wrap around programming, including the provision of Wrap Around in foster homes. Eight of the 44 slots are operated under the principles of Multi-dimensional Treatment Foster Care replicating the Oregon Model for MTFC. TBS services continue to ramp up and have proven successful in preventing readmissions to the hospital and maintaining children in less restrictive settings. Mental Health Services for children in the foster care system continues to improve. Only 4% of the children in San Luis Obispo County are considered unserved. Mental Health therapists are out-stationed at the Department of Social Services to consult and provide intake and referral for dependents of the court. Mental Health participates in DSS' differential response programs.

Mental Health continues to contract with Child Development Center as an organizational provider to serve SED children 3-5 years old in a preschool setting. In addition MH and the DSS partnered with EOC to create a Home Parenting Intervention Program for children referred to DSS. Mental Health and our partner agencies continue to work with Dr. Ira Chasnoff to staff and support a diagnostic and treatment center for children with Fetal Alcohol Syndrome, developmental problems and serious emotional disturbance. Mental Health maintains a contract with Transition Mental Health Association, which includes services to youth placed in the Youth Treatment Program, which is an RCL12 group home. THMA also hired 2 Family Partners via MHSA. They are integrated into CSOC.

The MHSA process has been very successful in generating a tremendous amount of valuable feedback from partner agencies, consumers, family members, advocates etc. The values and concepts of strength based/solution focused, client/family centered, community-based services, as well as wellness, recovery and resiliency are firmly rooted in the CSOC. The community embraces wrap around concepts, intensive services, expansion of the mobile crises service and inclusion of consumers in all aspects of program development and service delivery. The Full Service Partnership Program for children and TAY are established, as well as other MHSA programs, including the dual diagnosis component of FSP. These programs are built upon years of collaboration and evolution so they easily integrate and dovetail into Children's SOC. SLO County continues to work with the Department of Social Services and CIMH in the development of our Trauma Focused Cognitive Behavioral Program to assure integration with DSS, clinical integrity and fidelity to the model.

Despite the loss of State CSOC funding and serious anticipated funding shortfalls this year and into the foreseeable future, the commitment to multi-agency collaboration and coordination of services remains strong. There is great interest in the community to develop regionally based Community Resource Centers. The implementation process for PEI is well underway. SLO County has initiated the Workforce, Education and Training component of the MHSA. This will be an eventful year that will include major challenges to programs within core services, as well as transformation opportunities.

EXHIBIT E
CONTRACT FOR BEHAVIORAL HEALTH SERVICES

SPECIAL CONDITIONS

1. Compliance with Health Care Laws.

Contractor agrees to abide by all applicable local, State and Federal laws, rules, regulations, guidelines, and directives for the provision of services hereunder, including without limitation, the applicable provisions of the Civil Code, Welfare and Institutions Code, the Health and Safety Code, the Family Code, the California Code of Regulations, the Code of Federal Regulations, and the Health Insurance Portability and Accountability Act. This obligation includes, without limitation, meeting delivery of service requirements, guaranteeing all client's rights provisions are satisfied, and maintaining the confidentiality of patient records.

2. No Discrimination In Level Of Services.

As a condition for reimbursement, Contractor shall provide to and ensure that clients served under this Contract receive the same level of services as provided to all other clients served regardless of status or source of funding.

3. Nondiscrimination.

Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended pertaining to the prohibition of discrimination against qualified handicapped persons in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of Health and Human services, effective June 2, 1977, and found in the Federal Register, Volume 42, No.86 dated May 4, 1977.

Contractor shall comply with the provisions of the Americans with Disabilities Act of 1990, the Fair Employment and Housing Act (Government Code section 12900 et seq.) and the applicable regulation promulgated thereunder (Title 2 Section 7285 et seq.) The Contractor shall give written notice of its obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical handicap.

4. Quality Assurance.

Contractor agrees to conduct a program of quality assurance and program review that meets all requirements of the State Department of Mental Health. Contractor agrees to cooperate fully with program monitoring or other programs that may be established by County to promote high standards of mental health care to clients at economical costs.

5. Compliance Plan.

Contractor and its employees, contractors and agents shall read, acknowledge receipt, and comply with all provisions of the latest edition of the County Mental Health Compliance Plan and Code of Ethics ("Compliance Plan"). The Compliance Plan

includes policies and procedures that are designed to prevent and detect fraud, waste and abuse in federal health care programs, as required by Section 6032 of the Deficit Reduction Act (“DRA”). Failure to comply with any Compliance Plan provision, including without limitation, DRA compliance provisions is a material breach of this Contract and grounds for termination for cause.

Contractor will certify, on an annual basis, that it and all of its employees, contractors and agents have read and received a copy of the Compliance Plan and agree to abide by its provisions. In addition, at the time Contractor hires a new employee, contractor or agent, Contractor will certify that the individual has read and received a copy of the Compliance Plan and agrees to abide by its provisions.

6. Compliance with County Cultural Competence Plan.

Contractor will meet cultural, ethnic and linguistic backgrounds of the clients served, in accordance with the County Cultural Competence Plan, including access to services in the appropriate language and/or reflecting the appropriate culture or ethnic group. Contractor will certify, on an annual basis, that it and all of its employees, contractors and agents have read and received a copy of the County Cultural Competence Plan and agree to abide by its provisions.

7. Training Program.

Contractor will participate in training programs as provided in Title 22 of the California Code of Regulations, Health Information Portability and Accountability Act, and other appropriate regulations, and as required by County.

8. Record keeping and reporting of services.

Contractor shall:

- a. Keep complete and accurate records for each client treated pursuant to this Contract, which shall include, but not be limited to, diagnostic and evaluation studies, treatment plans, progress notes, program compliance, outcome measurement and records of services provided in sufficient detail to permit an evaluation of services without prior notice. Such records shall comply with all applicable Federal, State, and County record maintenance requirements.
- b. Submit informational reports as required by County on forms provided by or acceptable to County with respect to Contractor's program, major incidents, and fiscal activities of the program.
- c. Collect and provide County with all data and information County deems necessary for County to satisfy State reporting requirements, which shall include, without limitation, Medi-Cal Cost reports in accordance with Welfare and Institutions Code 5651(a)(4), 5664(a) and (b), 5705(b)(3), 5718(c) and guidelines established by DMH.

9. State Audits.

Pursuant to California Code of Regulations section 1810.380, Contractor shall be subject to State oversight, including site visits and monitoring of data reports and claims processing; and reviews of program and fiscal operations to verify that medically necessary services are provide in compliance with said code and the contract between the State and County. If the Contractor is determined to be out of compliance with State or

California Brief Multicultural Competence Scale

Below is a list of statements dealing with multicultural issues within a mental health context.

Please indicate the degree to which you agree with each statement choosing from the drop down list.

1.	I am aware that being born a minority in this society brings with it certain challenges that White people do not have to face.	1.	1 Strongly Disagree
2.	I am aware of how my own values might affect my client.	2.	1 Strongly Disagree
3.	I have an excellent ability to assess, accurately, the mental health needs of persons with disabilities.	3.	1 Strongly Disagree
4.	I am aware of institutional barriers that affect the client.	4.	1 Strongly Disagree
5.	I have an excellent ability to assess, accurately, the mental health needs of lesbians.	5.	1 Strongly Disagree
6.	I have an excellent ability to assess, accurately, the mental health needs of older adults.	6.	1 Strongly Disagree
7.	I have an excellent ability to identify the strengths and weaknesses of psychological tests in terms of their use with persons from different cultural, racial and/or ethnic backgrounds.	7.	1 Strongly Disagree
8.	I am aware that counselors frequently impose their own cultural values upon minority clients.	8.	1 Strongly Disagree
9.	My communication skills are appropriate for my clients.	9.	1 Strongly Disagree
10.	I am aware that being born a White person in this society carries with it certain advantages.	10.	1 Strongly Disagree
11.	I am aware of how my cultural background and experiences have influenced my attitudes about psychological processes.	11.	1 Strongly Disagree
12.	I have an excellent ability to critique multicultural research.	12.	1 Strongly Disagree
13.	I have an excellent ability to assess, accurately, the mental health needs of men.	13.	1 Strongly Disagree
14.	I am aware of institutional barriers that may inhibit minorities from using mental health services.	14.	1 Strongly Disagree
15.	I can discuss, within a group, the differences among ethnic groups socioeconomic status (SES), Puerto Rican client vs. high SES Puerto Rican client).	15.	1 Strongly Disagree
16.	I can identify my reactions that are based on stereotypical beliefs about different ethnic groups.	16.	1 Strongly Disagree
17.	I can discuss research regarding mental health issues and culturally different populations.	17.	1 Strongly Disagree
18.	I have an excellent ability to assess, accurately, the mental health needs of gay men.	18.	1 Strongly Disagree
19.	I am knowledgeable of acculturation models for various ethnic minority groups.	19.	1 Strongly Disagree
20.	I have an excellent ability to assess, accurately, the mental health needs of women.	20.	1 Strongly Disagree
21.	I have an excellent ability to assess, accurately, the mental health needs of persons who come from very poor socioeconomic backgrounds.	21.	1 Strongly Disagree

Employee Q.I. Survey

1. Directions: Choose how much you agree or disagree with each statement.									
	Strongly Agree	Agree	Somewhat Agree	Somewhat Disagree	Disagree	Strongly Disagree	N/A	Rating Average	Response Count
I would recommend the services at the Health Agency to the public.	38.6% (98)	43.7% (111)	13.8% (35)	1.6% (4)	1.2% (3)	0.4% (1)	0.8% (2)	1.83	254
I think the Department is following it's vision and mission.	17.6% (44)	51.6% (129)	20.4% (51)	4.8% (12)	3.6% (9)	1.2% (3)	0.8% (2)	2.28	250
I feel I have Health Agency employment stability.	18.1% (46)	44.1% (112)	23.6% (60)	8.3% (21)	5.1% (13)	0.8% (2)	0.0% (0)	2.41	254
I trust the COWORKERS with whom I work.	27.0% (69)	37.5% (96)	25.0% (64)	5.9% (15)	3.5% (9)	1.2% (3)	0.0% (0)	2.25	256
I trust the SUPERVISORS with whom I work.	28.2% (72)	36.9% (94)	17.6% (45)	4.7% (12)	5.5% (14)	6.3% (16)	0.8% (2)	2.41	255
I trust the MANAGERS with whom I work.	22.7% (58)	37.6% (96)	18.4% (47)	8.2% (21)	4.3% (11)	5.9% (15)	2.7% (7)	2.50	255
I trust the ADMINISTRATORS with whom I work.	13.0% (33)	39.1% (99)	25.3% (64)	9.9% (25)	4.7% (12)	4.7% (12)	3.2% (8)	2.67	253
The Health Agencies leadership has a clear vision of the future.	6.7% (17)	31.7% (80)	38.5% (97)	10.7% (27)	6.3% (16)	3.2% (8)	2.8% (7)	2.87	252
Health Agency leadership is setting a clear direction for agency growth.	6.0% (15)	27.0% (68)	35.3% (89)	15.1% (38)	9.5% (24)	4.8% (12)	2.4% (6)	3.10	252
I am kept informed by Health Agency leaders.	11.1% (28)	36.9% (93)	31.0% (78)	9.5% (24)	6.0% (15)	5.2% (13)	0.4% (1)	2.78	252
Health Agency leaders are									

Policy

San Luis Obispo Community Mental Health has a system to enable beneficiaries to resolve concerns or grievances about any specialty mental health services-related issue they have received.

Mental Health Plan (MHP) trains staff in annual documentation trainings that beneficiaries may not be subjected to discrimination or any other penalty for filing a grievance or appeal.

Reference

CFR, Title 42, Section 438.408 (a)(b)(1); CCR, Title 9, Chapter 11, Section 1850.206
MHP Contract, Exhibit A, Attachment 1, H

Procedure

If any beneficiary is dissatisfied about any of the services received, the beneficiary may file a grievance with the Mental Health Plan.

1. Beneficiary or designee files a grievance with the Grievance Coordinator (i.e. Patient's Rights Advocate), either orally or in writing, by completing a Consumer Request Form (See Attachment A)
2. Within (1) working day, the Grievance Coordinator logs the grievance into the Consumer Request Log and acknowledges receipt in writing to the Beneficiary (See Attachment B).
3. The Grievance Coordinator or designee has not been involved in any previous level of review or decision making regarding the subject of the grievance at hand.
4. The Grievance Coordinator or designee resolves the matter within 60 calendar days from the date the Grievance is filed. There may be a 14-day extension given if the Beneficiary requests it or if the Mental Health Plan determines that there is a need for additional information and that the delay is in the Beneficiary's interest. The beneficiary is informed in writing of any extensions.
5. If the grievance regards a clinical issue, the decision maker must also be a healthcare professional with the appropriate clinical expertise in treating the Beneficiary's condition. If the

grievance is not a clinical issue, the Grievance Coordinator or designee renders a decision on the grievance.

6. In either case, the Mental Health Plan notifies the Beneficiary and the provider in writing of the decision. This notification ends the Grievance Process.
7. If the Beneficiary is not satisfied with the Grievance decision, he/she may apply for a Standard Appeal or an Expedited Appeal if appropriate.
8. A beneficiary may authorize another person to act on the beneficiary's behalf, including the Mental Health care provider. A beneficiary may authorize his/her representative in the grievance process. This representative can be authorized to provide information regarding the status of a beneficiary's grievance.
9. Issues identified as a result of the complaint resolution or Appeal process are presented to the MHP's Performance and Quality Improvement/Quality Management Committee (PQI/QM), as needed and , on a quarterly basis, in summary form. The PQI/QM Committee forwards identified issues to the Behavioral Health Administrator or another appropriate body within the MHP for implementation of needed system changes.

See Attachments A and B.

Behavioral Health Services

County of San Luis Obispo



Behavioral Health Services
2178 Johnson Avenue
San Luis Obispo CA 93401
805-781-4738
805-781-1232

Grievance Confirmation

John Doe
34 Springbok Lane
Arroyo Grande CA 93420

This notice confirms that on Monday, May 4, 2009 I have initiated an investigation of your grievance which I have summarized as follows:

"Transcript of client's grievance or appeal from the appropriate form"

Your grievance will be reviewed by the appropriate MH staff. They will investigate the details of the case. I will send you a letter describing the conclusions and actions taken within 60 days of the receipt of your grievance.

If staff acted incorrectly in this matter corrective or disciplinary measures will be taken, however due civil service regulations those measures are strictly confidential. However I want to assure you that we are committed to providing services with the highest clinical and ethical standards. That is our professional mission and is demanded by the laws of the state of California Welfare and Institutions Code. I also want to assure you that filing a grievance itself may not and will not result in any reduction in the level or quality of care from Mental Health.

You have the right to request that a friend or family member represent you in this matter. A provider or a staff member from Behavioral Health may also represent you if you wish.

If you choose to have someone other than yourself represent you please complete and sign the enclosed Authorization to Disclose Protected Health Information. Return it in the enclosed business reply envelope as soon as possible. Mental Health Services cannot speak with your representative until you have properly completed both sides, signed, and returned the Authorization form.

Please feel free to call me at 805-781-4738 with any questions, comments or additional information relevant to the matter under consideration. You are entitled to review all pertinent documents and present your views by phone, in writing or in person. If the conclusions of the grievance are not satisfactory to you, you will be able to request an **Appeal**. Details of that process will be provided to you at that time.

Yours truly,

Gerald Clare, LCSW
Patient's Rights Advocate

)

Policy

Bilingual materials are distributed to all treatment sites.

Procedure

1. Mental Health Services maintains a list of bilingual materials including, but not limited to:
 - a) Outpatient medical records materials on the list called Bilingual Forms.
 - b) Patient's Rights poster as contained in the medical records Forms Managed Care file
 - c) Medi-Cal Beneficiary Member Handbook
 - d) County of San Luis Obispo Health Agency Grievance Form
 - e) Department of Mental Health Medi-Cal Ombudsman Services Brochure
 - f) Consumer Satisfaction Survey
2. Bi-Lingual materials are distributed on an as-needed basis by the Central Medical Records to sites.
3. Program Supervisors and Contract Provider Supervisors designate a contact employee for the inventory and distribution of bi-lingual materials at each service site.
4. The designated contact person replenishes the displayed bilingual materials from Patient's Rights Advocate and Medical Records.

Policy

San Luis Obispo Mental Health Services periodically involves clients of the mental health plan in determining the readability of the Medi-Cal Beneficiary Handbook for literacy level.

Reference

CFR, Title 42, Section 438.10(d)(1)(i)

CCR, Title 9, Chapter 11, Section 1810.110(a)

Procedure

1. The following is the standardized review protocol is followed to assess the readability of the Beneficiary Handbook as well as other informing handouts.
2. The Patients Rights Advocate periodically meets face to face with a representative sample of beneficiaries and follows these steps:
3. The presenter introduces the process to a group of clients using wording such as the following: We need your assistance in reviewing our Beneficiary Handbook and other informing materials. If you wish to participate you may do so voluntarily, you are not required to participate in this focus group. Each client of mental health should get a Beneficiary Handbook when he/she signs up for service and at the time of the review their client care plan, at least annually. We want to make sure the handbook is understandable to our clients. Clients also receive other informing materials and we want to know whether these materials are easy to understand.
4. The presenter distributes the handbook and materials to the clients and reads selected portions of them as clients follow by reading their own copy.
5. The presenter queries for questions or comments and records the responses.
6. The presenter presents a summary of the clients' responses to the Performance and Quality Improvement/Quality Management Committee.
7. Test of readability must happen with each significant revision of the Handbook or informing materials.

Policy:

The Mental Health Services Act (MHSA) of County of San Luis Obispo establishes Peer support and family education support services and expand these services to meet the needs and preferences of clients and/or family members.

Reference

Title 9, Chapter 14, Section 3610(b)

Procedure

A. Transitions Mental Health Association (T-MHA) is the leading local Community-Based Organization (CBO) responsible for consumer based activities in San Luis Obispo County. MHSA funds the following consumer-based activities run by T-MHA which aims at providing a forum for advocacy, education, promotion of Wellness and Recovery, and striving to eliminate stigma:

1. **Supportive employment and vocational training** is provided through employment readiness classes and job placement.
2. **Client and family-run support**, mentoring and educational groups is conducted through the following programs overseen by a community-based organization.
3. **Peer to Peer** is a 9-week experiential education course on recovery that is free to any person with a mental illness. It is taught by a team of 3 to 4 peer teachers who are experienced at living well with mental illness.
4. **Family to Family** is a 12-week educational course for families of individuals with severe mental illness. It provides up to date information on the diseases, causes and treatments, as well as coping tools for family members who are also caregivers. A team of 2 family members teach the class.
5. The **Peers Empowering Peers (PEP) Center** is a consumer driven Wellness Center in the northern region of the county. Support groups and socialization activities as well as NAMI –sponsored educational activities are conducted here.
6. **Client & Family Partners act as advocates**, to provide day-to-day, hands on assistance, link people to resources, provide support and help to “navigate the system.” This strategy will also include a flexible fund that can be utilized for individual and family needs such as uncovered health care, food, short-term housing, transportation, education, and support services.

Approved by Behavioral Health Administrator: Karen Baylor, PhD, LMFT Date: 05/30/2009
Review dates: 05/30/2009

7. **Peer Advisory/Advocacy Team (PAAT)**, Advocates and educates the community about mental health and recovery. Goals include: Eliminate the stigma attached to mental illness. Advocate and educate the mental health system about the valuable workforce contributions to be made by the individuals it serves. Educate individuals served and family members about their rights and responsibilities in the mental health system. Provide support to peer employees and other leaders of the peer movement to ensure that they have the tools they need to achieve and maintain success and job satisfaction. Promote the concept of wellness versus illness and focus attention on personal responsibility and a balanced life, grounded in wholeness.
- B.** Evidence that the County, in collaboration with T-MHA, has established ongoing peer support and family education support services, as well as expanded these services will be provided in the form of:
- i. Announcements and flyers of the aforementioned programs.
 - ii. Agendas and sign-in sheets
 - iii. Brochures and newsletters
 - iv. Meeting minutes
 - v. Curricula or similar documents that reflect that peer support services and family education support services are available or offered.
 - vi. Records of statistics for required DMH reports will also be available.



Reminder: MHSA Update Meeting

Nancy Mancha-Whitcomb to
 : Holmes, Janice, bjohnson,
 bsteinberg, Brad Sunseri, Casey
 Roos, dune92004, dlinden, Frank
 Warren, jbw, jnibbio, jroberts, Janet
 Amanzio, Jeanne Dukes, Jim Salio,
 joyceh7, Karen Baylor, Kim Barrett,
 Laurie Morgan Laurie Morgan, 07/27/2009 12:09 PM
 : Norma Hoffman, Pam Dudley, Patty
 Ford, rgambs, silviaortizphd, Star
 Graber, Tracy Buckingham, Elisa
 Leigan, Kimberly Miramon, Mike
 Taylor

From: Nancy Mancha-Whitcomb/MHS/COSLO
 To: "Holmes, Janice" <jholmes@t-mha.org>, bjohnson@t-mha.org, bsteinberg@eocslo.org, Brad
 Sunseri <bsunseri@co.slo.ca.us>, Casey Roos/MHS/COSLO@Wings,
 dune92004@yahoo.com: mcamusso@sbcglobal.net, dlinden@slocity.org, Frank

History: This message has been replied to.

Good Morning,

I would like to remind everyone of the MHSA Update Update Meeting this Wednesday July 29, from 2:30 to 4:30 at the Large Conference room on the second floor of the Health Campus on Johnson St.

Please send me a decline, confirm, or will send a representative, if you had not had a chance to do so at this time.

In addition to important program and budget information, we will be discussing the newest component, *Innovation*, and creating the process to get this component off the ground.

See you there,
Nancy.

Nancy Mancha-Whitcomb, LMFT
 County of San Luis Obispo
 MHSA - Division Manager
 Phone (805) 781-4868
 Fax (805) 781-4866