



Behavioral Health

Cultural Competency Plan Update Fiscal Year 2018/19

*San Bernardino County Department of Behavioral Health
Office of Cultural Competence and Ethnic Services
Submitted December 2019*

Table of Contents

Cultural Competency Plan Fiscal Year 18/19 Table and Graph List.....	IV
Cultural Competency Plan Update FY18/19 Attachment Cross Reference.....	V
Introduction: San Bernardino County, Department of Behavioral Health	XI
CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE	1
1-I: County Mental Health System Commitment to Cultural Competence.....	1
1-II: The County shall show Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System.....	2
1-III: Each County has a Designated Cultural Competence/Ethnic Services Manager (CC/ESM) Person Responsible for Cultural Competence.....	9
1-IV: Identify Budget Resources Targeted for Culturally Competent Activities.....	12
CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS	16
2-I: General Population.....	16
2-II: Medi-Cal Population Service Needs.....	16
2-III: 200% of Poverty (minus Medi-Cal) Population and Service Needs.....	23
2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.....	26
2-V. Prevention and Early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations	28
CRITERION 3: STRATEGIES AND EFFORTS FOR REDUCING RACIAL, ETHNIC, CULTURAL, AND LINGUISTIC MENTAL HEALTH DISPARITIES	32
3-I: List the Target Populations with Disparities your County Identified in Medi-Cal and all MHSA Components.....	32
3-II: Identified Disparities (Within the Target Populations).....	33
3-III: Identified Strategies/Objectives/Actions/Timelines	35
3-IV: Additional Strategies/Objectives/Actions/Timelines and Lessons Learned.	39
3-V: Planning and Monitoring of Identified Strategies/Objectives/Actions/Timelines to Reduce Mental Health Disparities	45
CRITERION 4: CLIENT/FAMILY MEMBER/COMMUNITY COMMITTEE: INTEGRATION OF THE COMMITTEE WITHIN THE COUNTY MENTAL HEALTH SYSTEM.....	56
4-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.	56
4-II: The Cultural Competence Committee, or Other Group with Responsibility for Cultural Competence, is Integrated within the County Mental Health System.....	60
CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES	66

5-I: The County System shall require all Staff and Stakeholders to receive Annual Cultural Competence Training.....	66
5-II: Annual Cultural Competence Trainings	67
5-III: Relevance and Effectiveness of all Cultural Competence Trainings.	70
5-IV: Counties must have a Process for the Incorporation of Client Culture Training throughout the Mental Health System.	72
CRITERION 6: COUNTY’S COMMITMENT TO GROWING A MULTICULTURAL WORKFORCE: HIRING AND RETAINING CULTURALLY AND LINGUISTICALLY COMPETENT STAFF	74
6-I: Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experienced with, the Identified Unserved and Underserved Populations.....	74
CRITERION 7: LANGUAGE CAPACITY.....	80
7-I: Increase Bilingual Workforce Capacity	80
7-II: Provide Services to Persons who have Limited English Proficiency (LEP) by using Interpreter Services.	81
7-III: Provide Bilingual Staff and/or Interpreters for the Threshold Languages at all Points of Contact.	86
7-IV: Provide Services to all LEP Clients not Meeting the Threshold Language Criteria who Encounter the Mental Health System at all Points of Contact.....	87
CRITERION 8: ADAPTATION OF SERVICES.....	88
8-I: Client-Driven/Operated Recovery and Wellness Programs.....	88
8-II: Responsiveness of Mental Health Services	90
8-III: Quality of Care: Contract Providers	93
8-IV: Quality Assurance Requirement.....	96
Cultural Competency Plan Fiscal Year 18/19 Attachment List	99

Cultural Competency Plan Fiscal Year 18/19 Table and Graph List

	Description	Page
O1	Office of Cultural Competence and Ethnic Services Organizational Structure	10
T1	San Bernardino County General Population Summary 2018	16
T2	Mental Health Program Medi-Cal Indicators for Fiscal Year 2018/2019	18
T3	Substance Use Disorder Medi-Cal Indicators for Fiscal Year 2018/2019	20
T4	Fiscal Year 2018/2019 Population under 200% FPL minus Medi-Cal Eligible Beneficiaries	23
T5	San Bernardino Population under 200% of the Federal Poverty Line, Medi-Cal Beneficiaries, Mental Health Medi-Cal Clients Served and Non-Medi-Cal Clients Served for Fiscal Year 18/19	24
T6	MHSA Community Services and Support (CSS) Information for Fiscal Year 2018/2019	27
C1	Life Functioning Challenges Improved by Discharge	40
C2	Percentage of Youth's Strengths Improved by Discharge	41
C3	Behavioral Health Changes Improved by Discharge	41
T7	PFA's Promoted from FY11/12 to FY18/19	43
T8	Number of Bilingual Interns Fiscal 8/9 to 18/19	44
T9A-P	Identified Strategies/Objectives/Action Timelines	46-54
O2	Cultural Competency Advisory Committee Organizational Structure	59
T10	Live Cultural Competency Trainings Provided in FY18/19	68
T11	Relias Online Trainings that Award Cultural Competency Hours	69
C4	Current DBH Workforce by Ethnicity for Fiscal Year 2018/19	74
T12	Number of DBH Bilingual Staff from FY12/13 to FY18/19	75
T13	Fiscal Year 2018/19 Ethnicity and Gender of DBH Workforce Compared to Populations of Interest	76
T14	DBH Residents/Fellows from FY15/16 to FY18/19	77
T15	Number of Qualified Applications Received for DBH Positions FY17/18 to FY18/19	77
T16	Promoted Peer and Family Advocates from FY07/08 to FY18/19	78
T17	DBH Bilingual Staff by Language and Skill Level for Fiscal Year 18/19	81
T18	Utilization for 24/7 Access Line: Example of NACT Submission	82
T19	Mean Results from Video Translation Pilot Project Customer Survey	83
T20	Customer Perceptions from Video Translation Pilot Project Survey	83

Cultural Competency Plan Update FY18/19 Attachment Cross Reference

	Attachment Description	Page(s)
A1	CUL1002 Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Policy	1
A2	CUL1002-1 Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Procedure	1
A3	CUL1004: Satisfying Clients' Language Needs Policy	1,82,84,87
A4	CUL1005: Consumer Focus Group Policy	1
A5	CUL1005-1: Consumer Focus Group Procedure	1
A6	CUL1006: Cultural Competency Policy	1,58,60,64
A7	CUL1010: Field Testing of Written Materials Policy	1
A8	CUL1010-1: Field Testing of Written Materials Procedure	1
A9	CUL1011: Providing Translation Services Procedure	1,87
A10	CUL1012: Providing Interpretation Services Procedure	1,82,84,87
A11	CUL1013: Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy	1,91
A12	CUL1014: Cultural Competency Training Policy	1,66
A13	TRA8001: Education and Training Policy	1
A14	COM0953: Non-Discrimination-Section 1557 of the Affordable Care Act Policy	2,82,87
A15	COM0953-1: Affordable Care Act (ACA) 1557 Grievance Procedure	2,87
A16	QM6045:24/7 Access Line Requirements Policy	2,82
A17	QM6045-1:24/7 Access Line Requirements Procedure	2
A18	DBH Contract Language Section with Cultural Competency Requirements	2
A19	Published samples from Behavioral Health Commission, Cultural Competency Advisory Committee, District Advisory Committee and the Community Policy Advisory Committee.	3
A21	Hispanic, African American and Native American Flyers, Reports and Agendas	4,14
A22	DDC Flyer and Town Hall Meeting Breakdown	4
A23	Public Relations and Outreach Table of Events for Fiscal Year 18/19	5
A24	MHFA and ASIST trainings in Fiscal Year 18/19	5
A25	Hispanic Heritage Month Event Flyer for 2018	6
A26	LGBTQ Resource Guide	6
A27	CLAS Standards Review Class presentation and sign in from July 10, 2019	8
A28	Cultural Competency Officer Job Description and Requirements	11
A29	FY18/19 Budget Expense Page for OCCES	12
A30	Consumer and Family Members Awareness Subcommittee Agendas	14
A31	Cultural Competency Advisory Committee by laws for FY18/19.	57,58
A32	Cultural Competency Advisory Committee Annual Report FY18/19.	57
A33	List of Cultural Competency Advisory Subcommittees for FY18/19.	3,57
A35	Cultural Competency Advisory Committee Work plan for FY18/19.	57,63

A36	Cultural Competency Advisory Committee Agendas for FY18/19.	57,60,63
A36-1	Cultural Competency Advisory Committee February 2019 Agenda	63
A37	Cultural Competency Advisory Committee Sign In Sheets FY18/19.	60
A38	Mental Health Act Stakeholder Engagement Forums and Webinar Invitations	2,62
A39	CCAC Subcommittee Monthly Updates FY18/19	57,63
A40	Office of Cultural Competency Training Table for Fiscal Year 18/19.	65,67
A41	List of San Bernardino County Client Clubhouses	88
A42	List of San Bernardino County One Stop TAY Centers	88
A43	Consumer and Family Member Committee Agendas July 2016-June 2017	89
A44	TAY Center Calendar of Events -Example	89
A45	Department of Behavioral Health Provider List-Web Example	90
A46	Department of Behavioral Health Fee for Service Provider List-Web Example	90
A48	BOP3031: Guidelines for Promotional, Educational and/or Informational Materials	91
A49	BOP3045: Web Blast Policy and Guidelines	91
A50	BOP3045-1: Web Blast Procedure and Guidelines	91
A51	Mental Health Plan Consumer Perception Survey for Adults and Older Adults	96
A52	Mental Health Plan Consumers Perception Survey for Youth	96
A53	Substance Use Disorders Treatment Perceptions Survey	96
A54	ANSA: Adults Needs and Strengths Assessment San Bernardino	40,96
A55	CANS: Child and Adolescent Needs and Strengths San Bernardino	96
A56E	Department of Behavioral Health Comment Card-English	97
A56S	Department of Behavioral Health Comment Card-Spanish	97
A56V	Department of Behavioral Health Comment Card-Vietnamese	97
A57	QM6029 Grievance and Appeal Policy	98
A58	QM6029-1 Grievance Procedure	98
A59	COM0953 Non-Discrimination-Section 1557 of the Affordable Care Act	98
A60	COM0953-1 Affordable Care Act (ACA) 1557 Grievance Procedure	98
A61	Quality Management Action Committee Grievance & Complaint Summary for FY18/19	98
A62	DBH Master Bilingual Staff List	80,84
A63	NACT Report Sample Language Line Utilization Report March-May 2019	82
A65	Language Reference Poster and World Language Map	84,86
A66	Translation/Interpreter Vendor Services List FY18/19.	84
A67	Outpatient Chart Manual-Pages Related to Language Service and Clinic Interpretation	86
A68	Bilingual Compensation Procedure and Compensation	86
A70	OCCES Training Request Form	70
A71	DBH Health Training Evaluation & Sample with Summary Report	71
A72	Dawnland Screening Evaluation Reports	71
A73	OCFA Training Shaken Tree Sign In Sheets Sample	72
A74	DBH Community Resource Guide	90,91

NONDISCRIMINATION NOTICE

The San Bernardino County Department of Behavioral Health (DBH) complies with Federal and State civil rights laws. DBH does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation or Limited English Proficiency (LEP). DBH provides:

- Free aids and services to people with disabilities to help them communicate effectively with DBH, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact the San Bernardino County Department of Behavioral Health, at 1-888-743-1478, 711 (California State Relay).

LANGUAGE ASSISTANCE TAGLINES

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1 (888) 743-1478 (TTY: 7-1-1).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request.

Call 1 (888) 743-1478 (TTY: 7-1-1).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1 (888) 743-1478 (TTY: 7-1-1).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1 (888) 743-1478 (TTY: 7-1-1).

Tagalog (Tagalog / Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1 (888) 743-1478 (TTY: 7-1-1).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1 (888) 743-1478 (TTY: 7-1-1) 번으로 전화해 주십시오.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1 (888) 743-1478 (TTY: 7-1-1)。

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1 (888) 743-1478 (TTY (հեռատիպ)՝ 7-1-1).

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1 (888) 743-1478 (телетайп: 7-1-1).

Introduction: San Bernardino County, Department of Behavioral Health

The Department of Behavioral Health (DBH) is responsible for providing mental health and substance use disorder services to San Bernardino County residents who are experiencing major mental illness or substance abuse issues. DBH provides mental health/substance use disorder treatment to all age groups, with a primary emphasis placed on treating children/youth who may be seriously emotionally disturbed, adults who are experiencing a serious and persistent mental illness, and individuals who are experiencing substance use disorders. DBH also provides an array of prevention and early intervention services for both mental health and substance abuse.

Note: The term Client and Consumer are used interchangeably throughout the plan. Both terms represent individuals receiving services from the Department of Behavioral Health.

CRITERION 1: COMMITMENT TO CULTURAL COMPETENCE

1-I: County Mental Health System Commitment to Cultural Competence.

The County shall include the following in the Cultural Competence Plan Requirements (CCPR): Policies, procedures, or practices that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the County Mental Health System.

IA. The San Bernardino County Department of Behavioral Health (DBH) continues its strong commitment to cultural competency. Cultural Competence is embedded into our department's values, noting that "Clients and families as central to the purpose of our Vision and Mission. We embrace the following values: sensitivity to and respect for all clients, families, communities, cultures and languages, effective services in the least intrusive and/or restrictive environment, positive and supportive settings with state-of-the-art technologies, open and honest dialogue among all stakeholders, partnerships and collaborations that share leadership, decision-making, ownership and accountability...".

DBH continues to have in place policies and procedures that reflect steps taken to institutionalize the recognition and value of racial, ethnic, and cultural diversity within the county behavioral health system. These policies and procedures apply to all mental health and substance use disorder services rendered within the county behavioral health system. Below are our policies and procedures that are specific to meeting cultural competency that are part of the departments Standard Practice Manual (SPM):

- Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Policy: CUL1002 (Attachment A1)
- Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Procedure: CUL1002-1 (Attachment A2)
- Satisfying Clients' Language Needs Policy: CUL1004 (Attachment A3)
- Consumer Focus Group Policy: CUL1005 (Attachment A4)
- Consumer Focus Group Procedure: CUL1005-1 (Attachment A5)
- Cultural Competency Policy: CUL1006 (Attachment A6)
- Field Testing of Written Materials Policy: CUL1010 (Attachment A7)
- Field Testing of Written Materials Procedure: CUL1010-1 (Attachment A8)
- Providing Translation Services Procedure: CUL1011 (Attachment A9)
- Providing Interpretation Services Procedure: CUL1012 (Attachment A10)
- Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy: CUL1013 (Attachment A11)
- Cultural Competency Training Policy: CUL1014 (Attachment A12)
- Education and Training Policy: TRA8001 (Attachment A13)

- Non-Discrimination-Section 1557 of the Affordable Care Act Policy: COM0953 (Attachment A14)
- Affordable Care Act (ACA) 1557 Grievance Procedure: COM0953-1 (Attachment A15)
- 24/7 Access Line Requirements Policy: QM6045 (Attachment A16)
- 24/7 Access Line Requirements Procedure: QM6045-1 (Attachment A17)

In FY19/20 the Office of Cultural Competence and Ethnic Services (OCCES) will be reviewing and updating the above listed policies and procedures to ensure they are up to date and in compliance with current state and federal policies and procedures.

1-II: The County shall show Recognition, Value, and Inclusion of Racial, Ethnic, Cultural, and Linguistic Diversity within the System.

The Cultural Competency Plan Requirements (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:

1-II-A: A description 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 San Bernardino County Department of Behavioral Health (DBH) is dedicated to including diverse clients, family members, and stakeholders from throughout the county in the planning, implementation, and evaluation of programs and services. DBH encourages community engagement with the goal of empowering the community for the purpose of generating ideas, contributing to decision making and to engender a county/community partnership to improve behavioral health outcomes for diverse San Bernardino County residents. DBH contracted providers participate in the department's efforts to promote the delivery of culturally and linguistically appropriate services. Language on cultural competence is included in all department contracts with providers to ensure contract services are provided in a culturally and linguistically appropriate manner. (Attachment A18) DBH's Office of Cultural Competence and Ethnic Services (OCCES) monitors providers on Cultural Competence requirements in collaboration with DBH's Office of Compliance and provides technical assistance as needed.

DBH coordinates community outreach and collaboration with diverse racial, ethnic, cultural and linguistic communities through the Office of Cultural Competence and Ethnic Services (OCCES) and DBH's Public Relations and Outreach Office (PRO). OCCES is responsible for embedding the tenets of cultural competency throughout all levels of the organization. Services include multicultural education and training, coordination of language services (i.e. translation, as well as in-person, telephonic and video interpretation), development of culture-specific community based programs (i.e. Promotores/community health workers, family resource centers, etc.), and community engagement in program planning and service delivery. OCCES is managed by the

Cultural Competency Officer (CCO). PRO promotes DBH's services, OCCES, and DBH's Mental Health Services Act (MHSA) investment.

DBH's Community Program Planning (CPP) protocol includes a participatory framework of regular, ongoing meetings with diverse stakeholders to discuss topics related to behavioral health policy, pending legislation, program planning, implementation and evaluation, and financial resources associated with behavioral health programs.

This practice has allowed DBH to:

- Be responsive to changes and concerns in the public behavioral health environment.
- Establish and maintain a two-way communication pathway for community-identified areas of improvement, which are introduced into DBH's larger process improvement efforts and report results back to the broader community.
- Encourage community involvement in DBH's planning beyond the typical "advisory" role.
- Educate clients and stakeholders about behavioral health resources and topics and the public behavioral health system as a whole.

DBH ensures diverse attendance by maintaining a published schedule of meetings and advertising these meetings using social media, press releases, other county departments, and an expansive network of known cultural brokers, community partners and contracted vendors. (Attachment A19, A38)

To ensure participation from diverse stakeholders, meetings include interpreter services or, as the occasion dictates, meetings held in languages other than English. Meeting locations are coordinated in every region of San Bernardino County, and web-conference style meetings are available for remote communities or for individuals who are unable to attend an in-person session or prefer the web format. Meetings are documented through agendas and minutes. Stakeholder attendance is recorded through meeting sign-in sheets and feedback forms. These sign-in sheets also document the attendance of underserved, unserved, and inappropriately served populations.

The following are regularly scheduled meetings:

- Behavioral Health Commission (BHC): Twelve annual-monthly meetings
- District Advisory Committee meetings: Five monthly meetings
- Community Policy Advisory Committee (CPAC): Twelve annual meetings-monthly meetings
- Cultural Competency Advisory Committee (CCAC): Twelve annual meetings-monthly meetings
- Association of Community Based Organizations (ACBO): Twelve annual meetings-monthly meetings

OCCES established and manages the DBH Cultural Competency Advisory Committee (CCAC) and thirteen (13) culturally specific subcommittees. (Attachment A33) CCAC is a committee made up of community based providers, organizations, partner agencies, clients, family members, faith based organizations/individuals, representatives from various DBH departments, primary care providers and other interested parties. CCAC has established direct channels of

communication with the staff of the OCCES and the CCO. CCAC interacts closely and advises the CCO on pertinent information and research data regarding the special needs of the target populations in the community. Likewise, information also flows from the CCO and OCCES to the CCAC and the diverse communities the membership represents. The CCAC and its subcommittees meet on a monthly basis.

The Cultural Specific Subcommittees include:

1. African American Awareness Subcommittee
2. Asian/Pacific Islander Awareness Subcommittee
3. Consumer and Family Member Awareness Subcommittee
4. Co-Occurring and Substance Abuse Awareness Subcommittee
5. Disabilities Awareness Subcommittee
6. Latino Awareness Subcommittee
7. LGBTQ Awareness Subcommittee
8. Native American Awareness Subcommittee
9. Older Adult Awareness Subcommittee
10. Spirituality Awareness Subcommittee
11. Transitional Aged Youth Awareness Subcommittee
12. Veterans Awareness Subcommittee
13. Women's Awareness Subcommittee

The OCCES in collaboration with the CCAC and community partners hosts community events focused on outreach to the community, reducing stigma around mental health, increasing access to behavioral health services, and introducing behavioral health services to underserved communities. Some of the community trainings, events, and outreach activities conducted by the OCCES in FY18/19 included: (Attachment A21)

- Native American Event
- African American Heritage Month Celebration
- Hispanic Heritage Month Celebration

The OCCES recognizes and continuously aims to increase racial, ethnic, cultural and linguistic diversity within our system of care. This is accomplished through many strategies, including:

- Department Diversity Committee (DDC) – The DDC exists to create a culturally competent workforce that not only *is* diverse, but also values and respects diversity. The DDC is a collaboration between the OCCES and Workforce Education and Training (WET) that meets to address diversity issues, succession planning, training development, and conflict resolution. The DDC solicits diverse input from all levels of DBH staff and provides recommendations to the executive team on ways to enhance our system of care through diversity (Attachment A22)
- Bilingual Paid Staff – DBH offers a pay differential for staff who are tested and certified as bilingual speaking in one of three categories: Verbal, Written, or Technical. A list of bilingual paid staff is generated every six months and distributed to programs to encourage the use of our own staff for translations and interpretations before using external contracted language service providers. The use of bilingual-pay staff is discussed further in Criterion 7.

- Collaboration with Human Resources (HR) – The OCCES and PRO continue to work closely with the Human Resources (HR) department in ensuring outreach to a diverse pool of applicants. HR representatives have presented on position openings at CCAC and several other community venues. DBH has demonstrated success in our recruitment efforts through the racial/ethnic diversity of our staff which are 37% Latino, 30% Caucasian, 16% African American, 8% Asian, 1% American Indian/Alaska Native, .31% Native Hawaiian/Pacific Islander, 6%, Two or More Races, and 3% not specified as represented in Criterion 6. However, we continue to strive towards building and maintaining diversity within our agency at all levels.

During FY18/19, the Cultural Competency Officer (CCO) also managed the Office of Consumer and Family Affairs (OCFA) and worked collaboratively with the DBH's Public Relations and Outreach (PRO) Office to coordinate and conduct outreach to diverse racial, ethnic, cultural, and linguistic communities with mental health disparities. OCFA provides assistance and support to clients and their families by linking them to appropriate services for treatment. OCFA is comprised of three Peer and Family Advocates (PFA). PFAs enhance family participation in the treatment process and assist clients in learning how to advocate and make choices to determine their path of recovery. OCFA Peer and Family Advocates also serve as members of the Cultural Competency Advisory Committee (CCAC), discussed later in Criterion 4, and facilitate the Consumer and Family Members Awareness Subcommittee which solicits input from clients and their family members on our department's program planning and service delivery. In FY18/19 one PFA position was vacated and will be filled in FY 19/20.

The Public Relations and Outreach (PRO) Office conducts countywide community-based educational activities with cultural and ethnic groups to increase knowledge regarding behavioral health services and access to community resources. Presentations on general mental health services, Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), and several other trainings are provided through venues such as churches and faith-based organizations. Outreach about general behavioral health services is also conducted in underserved communities through K-12 school programs, resource fairs, recovery events, homeless outreach events, and cultural community events. In FY 19/20 PRO will be adding positions to focus on outreach for substance use disorders.

During FY18/19, PRO in collaboration with DBH programs provided outreach and education on Behavioral Health resources to close to 29,000 individuals of diverse racial, ethnic, cultural, and linguistic groups at 128 separate events/venues. For a full list of events see attachment A23. PRO, in collaboration with DBH programs, provided 12 MHFA trainings resulting in 360 individuals trained. PRO also provided 2 ASIST trainings resulting in 60 people trained as well. (Attachment A24)

1-II-B: A narrative description 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.

The OCCES continues to work with both formal and informal diverse community groups to solicit input and feedback on our service delivery and engage them in our planning process for services. OCCES works closely with the Mexican and Guatemalan Consulates to address the behavioral health needs of Latino communities, including new arrivals and their families. An OCCES Mental Health Education Consultant serves as the liaison to the Mexican and Guatemalan Consulates, convening collaborative meetings at the Mexican Consulate in San Bernardino, facilitating MHSA planning meetings, providing DBH informational materials, and hosting mutually supportive events, such as the Hispanic Heritage Month Celebration and the Binational Health Fair. Both the Mexican Consulate and the Guatemalan Consulates actively participate in the CCAC's Latino Awareness Subcommittee. In 2018, the Hispanic Heritage Month Event was a collaborative effort with the Mexican Consulate. This event was hosted at the Mexican Consulate in San Bernardino and included folkloric dance performances, and behavioral health presentations, including a panel presentation on Anxiety Concerns Amongst the Latino Community. Over 40 people were in attendance for this free event. This event helped to reduce stigma and increase access to behavioral health services to the Latino population. (Attachment A25)

OCCES works closely with the LGBTQ Awareness Subcommittee of the CCAC, comprised of several community organizations and stakeholders, to continuously update the LGBTQ Resource Guide and publish it for community distribution. This guide was created out of community feedback regarding the concern of lack of appropriate behavioral health services available to the LGBTQ population. (Attachment A26)

In FY 18/19 OCCES assisted the African American Health Coalition in developing, printing and promoting their 2018 Black History Month Event. This event was designed to educate service providers working with the African American community. Additionally, OCCES coordinated for the DBH Director and Transitional Age Youth (TAY) Program Manager to speak at the event.

OCCES supports the Inland Empire Concerned African American Churches (IECAAC) by consistently attending their monthly meeting, providing information on DBH services, assisting with health fairs, participating in their May is Mental Health Sundays, and their Martin Luther King Celebration.

OCCES attends the Sheriff's Information Exchange meetings that provide the latest updates on highly sensitive interactions, emergency situations and latest law enforcement successes/challenges that are presently affecting the local San Bernardino County Community. OCCES staff provides information on DBH services and reports back to the DBH Director and CCO on issues related to behavioral health needs.

OCCES partners with the San Bernardino County Superintendent of Schools, East Valley Regional Advisory Committee, contributing MHFA, and ASSIST Training, DBH Resources and support.

OCCES continues to collaborate with the Inland Empire Disability Collaborative (IEDC) to address the needs of San Bernardino County residents and DBH clients who are living with mental and physical disabilities.

OCFA staff continue to participate and present at Crisis Intervention Trainings (CIT) for law enforcement to train them on working with families and individuals in accessing appropriate behavioral health services and resources during a mental health crisis.

The CCO and the OCCES staff regularly meet with community leaders, community-based organizations, clients and family members, and behavioral health commission members to address concerns in the community, plan services and programs that are responsive to the needs of the community, collaborate on local events, and remain responsive to our diverse communities.

1-II-C: A narrative discussing how the county is working on skills development and strengthening of community organizations involved in providing essential services.

DBH recognizes the importance of building the capacity of our community partners in order to effectively deliver quality essential services. One of the ways that we increase the quality of services provided by our partner agencies is through cultural competency trainings. Cultural competency trainings enhance the skills of providers and their ability to provide culturally and linguistically appropriate services to our diverse communities. The CCO and OCCES staff provided training on cultural competence and diversity to external partner agencies, community organizations and other county departments. The OCCES reviews trainings provided to the community to determine if they meet the culturally competency training standards for continuing education units, set by the department. The CCO provides subject matter expertise and educates diverse community members to increase their ability to successfully implement DBH culturally funded projects, such as cultural specific community health worker programs and the use of holistic treatment approaches. In FY18/19 OCCES staff provided 30 trainings on cultural competence and diversity to external partner agencies and other county departments including, but not limited to:

- Asian American Resource Center
- Mental Health and SUD contract providers contracted with the county
- Chicano Indigenous Community for Culturally Conscious Advocacy and Action
- Diocese of San Bernardino
- San Bernardino County Superintendent of Schools
- San Bernardino County Community Housing and Development
- West End Family Services
- Various School Districts within the county

The OCCES in collaboration with PRO continues to offer Mental Health First Aid trainings to San Bernardino County community members. Mental Health First Aid (MHFA) is an 8-hour training course designed to give members of the public key skills to help someone who may be developing a mental health concern or experiencing a mental health crisis. MHFA was designed to increase knowledge, reduce stigma, and offer appropriate supports to individuals experiencing a mental health concern. PRO, in collaboration with DBH programs, provided 12 MHFA trainings resulting in 360 individuals trained. Offering MHFA to key community partners aids in the development of informed community members being able to identify when someone is experiencing a mental health crisis. Historically, members of the community and certain cultures

have not been comfortable discussing mental health or mental illness due to several factors. There has been a lack of education and understanding surrounding mental health and mental illness. There have been, and continues to be barriers to treatment, such as lack of trust due to communication difficulties, spiritual beliefs and lack of behavioral health accessibility. The Mental Health First Aid trainings have created a platform to educate, discuss, and provide feedback, with the expectation of allowing the participants to feel more comfortable accessing resources, and further educating the community.

DBH continues to regularly engage in skill-building with our law enforcement partners through Crisis Intervention Trainings (CIT) teaching law enforcement officers how to effectively de-escalate situations, identify mental health issues and how it may impact their encounter with community members, and recognizing the cultural consideration that should be taken in working with our diverse communities. The Peer and Family Advocates of OCFA participate regularly in CIT Trainings for City and County law enforcement lending lived behavioral health experience to the training of law enforcement. This collaborative effort aids in San Bernardino's mentally ill population obtaining the appropriate level of care needed.

In addition, skills development and strengthening is enhanced through the use of outreach engagement activities such as community fairs, community events, and information sessions. Participation in specified activities creates a conduit for information to be shared between community organizations and the department. Information is gathered and presented to the DBH executive management team on the service delivery needs of community organizations.

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

DBH is dedicated to continuous improvement in all areas across the system of care, including outreach and education efforts.

In FY18/19 one of OCCES Mental Health Education Consultants was certified as a LEAP (Listen, Emphasize, Agree and Partner) trainer and will provide LEAP training to community and faith based partners OCCES works closely with as requested in FY19/20. The mission of the LEAP training is to educate the public about the unmet needs of persons with mental illness and anosognosia. The training provides family members, behavioral health providers and criminal justice professionals a skillset to create a therapeutic alliance with persons who have severe mental illness, which can lead to receiving treatment and services.

In FY18/19 DBH's Substance Use Disorder (SUD) providers requested assistance from the DBH's Office of Cultural Competence and Ethnic Services (OCCES) on adopting and reporting their implementation of the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in their agencies. OCCES staff provided an Overview of the CLAS standards to Substance Abuse Provider Network (SAPN) in July of 2019 and will continue to provide technical assistance to providers in FY19/20. (Attachment A27)

In FY 19/20 additional OCCES and OCFA staff will be trained to deliver MHFA trainings to cultural/faith base partnering agencies that OCCES works closely with.

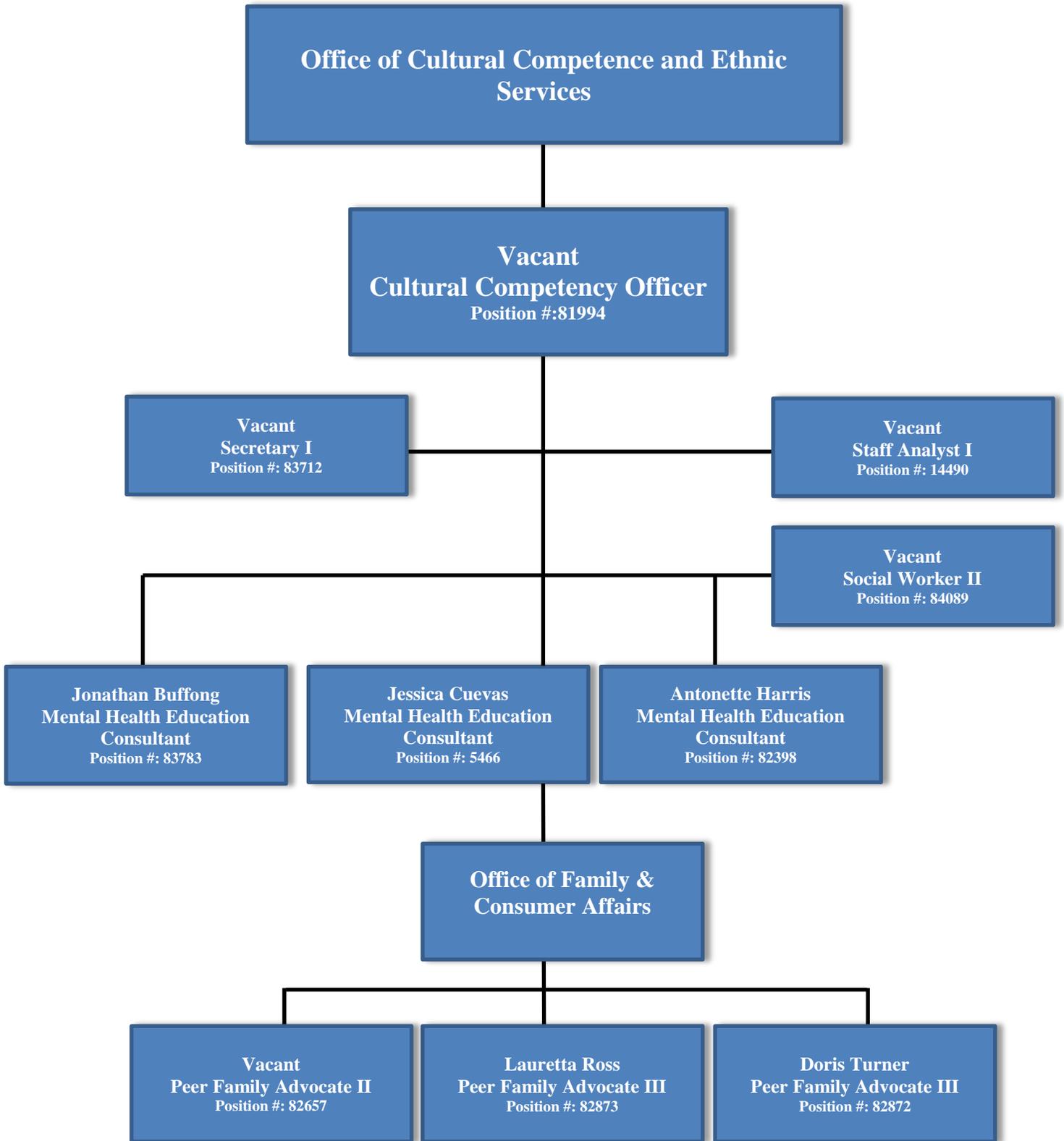
1-II-E: Identify county technical assistance needs.

There are no areas requiring technical assistance at this time.

1-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.

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

The Department of Behavioral Health (DBH) has a designated Cultural Competency Officer (CCO) who is responsible for embedding the tenets of cultural competence throughout the system of care and promotes the development of culturally-appropriate mental health services to meet the diverse needs of our racial, ethnic, cultural and linguistic populations. The CCO is a direct report to the Director of Behavioral Health and is a key figure of San Bernardino County DBH's Executive Management Team. In FY18/19 the CCO position was vacant for half of the year. Recruitment for the position started in January of 2019. During the CCO recruitment process the duties of the CCO were managed by the Department of Behavioral Health's Chief Compliance Officer. The CCO position manages the Office of Cultural Competence and Ethnic Services (OCCES) as well as the Office of Consumer and Family Affairs (OCFA). OCCES is comprised of ten (10) positions indicated in the organizational chart on page 10. The Cultural Competence Officer position was filled in July of 2019.



1-III-B: Written description of the cultural competence responsibilities of the designated CC/ESM.

The following is the description of responsibilities of the Cultural Competency Officer as indicated in the job description. See attachment A28 for more information.

Definition

Under general direction, plan, implement, monitor and evaluate Behavioral Health's cultural and linguistic healthcare and outreach services and programs; coordinate and promote quality and equitable care to racial and ethnic populations; develop, coordinate, and facilitate the implementation of the Cultural Competency Plan including a Training and Education Program; performs related duties as required.

Distinguishing Characteristics

This is a single position classification responsible for administering, implementing, maintaining and evaluating all direct services for the Cultural Competency Program and supervising and training program staff. This position reports to the Director of Behavioral Health.

Examples of Duties:

Duties may include, but are not limited to, the following:

1. Plan, assign, review, and evaluate the work of assigned staff. Prepare and sign performance evaluations; hire staff and recommend and implement disciplinary actions.
2. Plan, develop, implement and monitor a culturally and linguistic healthcare and outreach program; develop and implement translation and interpretation services.
3. Develop and implement strategies to achieve a culturally competent system of care for the implementation of the Mental Health Services Act (MHSA).
4. Develop and manage the implementation of the department's Cultural Competency Plan.
5. Participate in the monitoring of county and service contractors to ensure service delivery complies with local and State mandates as they affect underserved populations.
6. Identify local and regional cultural behavioral health needs of ethnically and culturally diverse populations as they impact county systems of care; make recommendations to department management.
7. Develop budgets for Mental Health Services Act outreach activities such as training, staffing and supplies.
8. Maintain an on-going relationship with community organizations, planning agencies, and the community at large.
9. Provide vacation and temporary relief as required.

1-IV: Identify Budget Resources Targeted for Culturally Competent Activities.

1-IV-A: Evidence of a budget dedicated to cultural competence activities.

In FY18/19, the Office of Cultural Competence and Ethnic Services (OCCES) had an allocated budget of \$742,654 dedicated to cultural competence activities. (Attachment A29)

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

The funding allocations identified in the budget above includes salary and benefits of all OCCES staff and programmatic and operational costs for the office. The staffing of OCCES and staff responsibilities are as follows:

- Cultural Competency Officer (CCO) - Plans, implements, monitors and evaluates Behavioral Health's cultural and linguistically-appropriate healthcare and outreach services and programs; coordinates and promotes quality and equitable care to diverse racial, ethnic, cultural, and linguistic populations; develops, coordinates, and facilitates the implementation of the Cultural Competency Plan including a Training and Education Program.
- Three (3) Mental Health Education Consultants (MHEC) – Facilitate culturally-relevant trainings and staff development, and conduct community outreach and behavioral health education to diverse communities. Mental Health Education Consultants also help to facilitate the 13 subcommittees of the Cultural Competency Advisory Committee and serve as liaisons/cultural brokers between the department and the diverse communities we serve.
- Staff Analyst I – Provides direct monitoring of language services contracts. Reviews and updates Cultural Competency program policies and procedures. Collects and analyzes data. Prepares program reports and documentation for department state reviews and audits. Assists in program monitoring and program development.
- Social Worker II – Assists in program monitoring and program development, community outreach and education, and serves as a liaison/cultural broker between the department and the diverse communities we serve. Supports MHEC in facilitating the 13 subcommittees of the Cultural Competency Advisory Committee.
- Secretary I – Provides clerical support, scheduling, and travel arrangements for OCCES and OCFA staff.
- Three (3) Peer and Family Advocates – With MHEC support, provide culturally-specific, client-focused trainings to department staff and the community. Assists with facilitating cultural events and office support. Serve as liaisons/cultural brokers between the department and the diverse communities we serve.

Interpreter and Translation Services:

A significant budget is allocated for Language and Interpretation Services in DBH's department budget. OCCES staff are responsible for fielding questions, requests and complaints for all translations and interpretations internally and externally, i.e. from DBH staff and contract providers. OCCES staff also monitor all Language Services Contracts, with the goal of ensuring linguistically appropriate services are available for the Limited English Proficiency (LEP) population, hard of hearing, and deaf. For FY18/19, DBH expended \$840,203.00 for language services. The services went well beyond the annual budget amount of \$239,703.

Reduction of racial, ethnic, cultural, and linguistic mental health disparities:

To reduce disparities within our underserved cultural populations, DBH's Prevention and Early Intervention (PEI) program continues to fund the following programs:

- The Resilience Promotion in African American Children (RPIAAC) a program that provides mental health prevention services designed to address the needs of African-American children/youth and their families. Funded in the amount of \$4,862,385 for the period of July 1, 2018 through June 30, 2023.
- The Community Health Workers/Promotores Program a program that deploys trained individuals, who have received behavioral health services, into targeted communities. The purpose of the program is to provide outreach to increase recognition of early signs of mental illness in the African American, Asian/Pacific Islander, Latinos, LGBTQ and Native American communities. Funded for the amount of \$5,750,000 for the period of July 1, 2017 through June 30, 2022.
- The Native American Resource Center (NARC) a program that focuses on reducing stigma and discrimination associated with mental illness, increasing early access and linkage to medically necessary care and treatment, and improving timely access to services for the underserved Native American population. Funded in the amount of \$2,090,000 for the period of July 1, 2015 through June 30, 2019.
- The Military Services and Family Support Program (MSFS) a prevention and early intervention program that provides mental health services to military veterans, active duty and retired military personnel, reservists, and members of the National Guard who served on or after September 11, 2001, and their families, through San Bernardino County. Services address the negative effects of traumatic events and other unique challenges of military life, services are provided in-home and/or in the community. Funded in the amount of \$3,625,000 for the period of July 1, 2017 through June 30, 2022.

Each of the PEI programs mentioned above have their own budget allocation; these allocations are not embedded within the OCCES budget.

Additionally, OCCES staff are committed to supporting the Cultural Competency Advisory Committee (CCAC) and the associated thirteen (13) subcommittees. The subcommittees advocate for the development, implementation and evaluation of high quality,

culturally/linguistically attuned, behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County. The CCAC has direct channels of communication with the staff of DBH OCCES, and the CCO. The CCAC interacts closely with and advises the CCO to share pertinent information and research data regarding the special needs of the target populations in the community. Likewise, information will flow from the CCO to the CCAC to ensure their active participation in the delivery of services, policies and procedures to the diverse communities of San Bernardino County.

OCCES staff, including the Mental Health Education Consultants and Social Worker II, provides technical assistance to DBH programs and contracted providers in regards to: recruitment of participants, culturally attuned program activities, data collection, and report writing.

Outreach to racial and ethnic county-identified target populations:

The San Bernardino County Department of Behavioral Health (DBH) is dedicated to outreaching to diverse clients, family members, and stakeholders from throughout the county. DBH encourages community engagement with the goal of empowering the community for the purpose of generating ideas, contributing to decision making and to engender a county/community partnership to improve behavioral health outcomes for diverse San Bernardino County residents.

The OCCES hosts community events focused on outreach to the community, reducing stigma around mental health, increasing access to behavioral health services, and introducing behavioral health services to underserved communities. Some of the cultural community events conducted in FY18/19 included: (Attachment A21)

- Native American Event
- African American Heritage Month Celebration
- Hispanic Heritage Month Celebration

During FY18/19, the Cultural Competency Officer (CCO) also managed the Office of Consumer and Family Affairs (OCFA) and collaborated with the Office of Public Relations and Outreach (PRO); each of these offices assisted in outreaching to and engaging diverse racial, ethnic, cultural, and linguistic communities with mental health disparities. OCFA provides assistance and support to clients and their families by linking them to appropriate services for treatment. OCFA has three Peer and Family Advocate (PFA) positions. PFA's enhance family participation in the treatment process and assist clients in learning how to advocate and make choices to determine their path of recovery. OCFA Peer and Family Advocates also serve as members of the Cultural Competency Advisory Committee (CCAC), discussed later in Criterion 4, and facilitate the Consumer and Family Members Awareness Subcommittee which solicits input from clients and their family members on our department's program planning and service delivery. (Attachment A30)

The Office of Public Relations and Outreach (PRO) conducts countywide community-based educational activities with cultural and ethnic groups to increase knowledge regarding behavioral health services and access to community resources. Presentations on general mental health services, Mental Health First Aid (MHFA), Applied Suicide Intervention Skills Training (ASIST), and several other trainings, are provided at churches, community and faith-based

organizations. Conducting trainings and presentations in the community, assist in identifying and informing DBH on unserved and underserved communities, as well as detect disparities in services. General behavioral health services outreach is also conducted in underserved communities through K-12 school programs, resource fairs, recovery, homeless outreach, and cultural community events. During FY18/19, close to 29,000 individuals of diverse racial, ethnic, cultural and linguistic groups were provided outreach and education on behavioral health resources through PRO in collaboration with other DBH programs at 128 separate events and venues.

Additionally, DBH supports community-driven activities and practices to outreach and educate by providing resources to community-based organizations for implementation of cultural specific programs for underserved communities in the County.

Culturally appropriate mental health services:

All DBH services are reviewed to be culturally appropriate. Many of the department's programs have components that appropriately address mental health disparities, provide outreach to racial and ethnic target populations, and provide culturally-appropriate mental health services. Some of the most specific examples of programs that achieve these goals are listed below:

- Resilience Promotion in African American Children (RPIAAC)
- Community Health Workers/Promotores Programs
- Native American Resource Center (NARC)
- Military Services and Family Support Program (MSFS)

Descriptions of each of these and many other culturally-specific programs are provided in Criterion 3.

Financial incentives for culturally and linguistically competent providers, non-traditional providers, and/or natural healers:

Bilingual pay differentials/incentives were paid to certified (tested) bilingual employees (Verbal: \$50 per pay period, Written: \$55 per pay period, Technical: \$60 per pay period). \$270,205 was paid in bilingual pay deferential to DBH employees in FY18/19. In FY19/20 DBH, in collaboration with the Human Resources department, will be reviewing and updating the policies and procedures for bilingual compensation.

CRITERION 2: UPDATED ASSESSMENT OF SERVICES NEEDS

2-I: General Population.

2-I-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.

County’s General Population Summary 2018

Table 1: Demographic Characteristics of San Bernardino County

Total Population	2,174,931
Gender	%
Female	50.30%
Male	49.70%
Age	%
0-15 years	25.50%
16 - 25 years	16.70%
25-59 years	44.90%
60 years and up	13.10%
Ethnicity	%
African American	8.50%
Asian/Pacific Islander	6.30%
Caucasian	32.90%
Latino	49.60%
Native American	0.40%
Other/Unknown	2.30%

Data Source: California Department of Finance Demographic Research Unit

2-II: Medi-Cal Population Service Needs

2-II-A: Summarize Medi-Cal population and client utilization data by race, ethnicity, language, age, and gender.

In FY18/19 San Bernardino County had 780,478 Medi-Cal eligible beneficiaries (See Table 2).

Race/Ethnicity

Medi-Cal eligible beneficiaries by race/ethnicity was as follows: 11% were African American, 4.6% were Asian/Pacific Islander, 17.8% were Caucasian, 56.1% were Latino, .2% were Native American, and 10.2% identified as Other.

Language

Medi-Cal eligible beneficiaries language preference was as follows: Cambodian .1%, English 75.7%, Spanish 21.9%, Vietnamese .4% and 1.9% identified as Other.

Age

Medi-Cal eligible beneficiaries by age group was as follows: 33.4% were children (0-15 years), 16.5% were TAY (16-25 years), 38.8% were adults (26-59 years), and 11.2% were older adults (60 years and up).

Gender

Medi-Cal eligible beneficiaries by gender were as follows: 54.4% were female and 45.6% were male.

The Medi-Cal population is geographically distributed throughout the county: 29.6% reside in the Desert/Mountain region, 26.1% reside in the East Valley region, 21.7% in the Central Valley, and 20.4% in the West Valley.

San Bernardino County Department of Behavioral Health (DBH) served 37,804 Medi-Cal Mental Health clients in FY18/19 (Table 2).

Race/Ethnicity

Mental Health Clients race/ethnicity was as follows: 16.4% were African American, 2.3% were Asian/Pacific Islander, 28.8% were Caucasian, 42.7% were Latino, 0.5% were Native American, and 9.2% identified as Other.

Language

Mental Health Clients language preference was as follows: Cambodian .1%, English 90.6%, Spanish 6.7%, Thai .1%, Vietnamese .23%, and 2.3% identified as Other.

Age

Mental Health Clients by age group was as follows: 33.8% were children (0-15 years), 19.1% were TAY (16-25 years), 40.7% were adults (26-59 years), and 6.4% were older adults (60 years and up).

Gender

Mental Health Clients by gender was as follows: 48.2% were female, 51.7% were male and .1% identified as Other.

Table 2: Mental Health Program Medi-Cal Indicators for Fiscal Year 2018/19

	Medi-Cal Beneficiaries		Medi-Cal Clients		Medi-Cal Penetration Rate
	780,478	100.0%	37,804	100.0%	4.8%
Gender					
Female	424,623	54.4%	18,212	48.2%	4.3%
Male	355,855	45.6%	19,541	51.5%	5.5%
Unknown	0	0.0%	51	0.1%	NA
Age					
Children (0-15 y)	260,950	33.4%	12,769	33.8%	4.9%
TAY (16-25 y)	128,869	16.5%	7,229	19.1%	5.6%
Adult (26-59 y)	302,862	38.8%	15,374	40.7%	5.1%
Older Adult (60+ y)	87,797	11.2%	2,432	6.4%	2.8%
Ethnicity					
African American	85,683	11.0%	6,199	16.4%	7.2%
Asian / Pacific Islander	36,012	4.6%	867	2.3%	2.4%
Caucasian	138,955	17.8%	10,894	28.8%	7.8%
Latino	438,106	56.1%	16,152	42.7%	3.7%
Native American	1,897	0.2%	205	0.5%	10.8%
Other	79,825	10.2%	3,487	9.2%	4.4%
Preferred language					
Cambodian	508	0.1%	25	0.1%	4.9%
English	590,706	75.7%	34,263	90.5%	5.8%
Spanish	171,165	21.9%	2,546	6.7%	1.5%
Thai	95	0.0%	47	0.1%	49.5%
Vietnamese	3,074	0.4%	93	0.3%	3.0%
Other	14,930	1.9%	830	2.3%	5.6%
Residence Region					
Central Valley (CV)	169,349	21.7%	7,257	19.2%	4.3%
Desert/Mountain (DM)	231,124	29.6%	13,115	34.7%	5.7%
East Valley (EV)	203,630	26.1%	10,345	27.4%	5.1%
West Valley (WV)	159,544	20.4%	5,416	14.3%	3.4%
Unknown/Out of county	16,831	2.2%	1,671	4.4%	9.9%

Sources: Medi-Cal Eligible Beneficiaries: MMEF file series edited monthly by CA Department of Mental Health, as of 6/1/2019. DBH, R&E Databases, data as of 7/30/2019.

San Bernardino County Department of Behavioral Health (DBH) served 6,035 Medi-Cal Substance Use Disorder clients in FY 18/19 (Table 3 on page 20).

Race/Ethnicity

Substance Use Disorder Clients race/ethnicity was as follows: 10.7% were African American, 1.6% were Asian/Pacific Islander, 44% were Caucasian, 37.6% were Latino, 4.4% were Native American, and 1.8% identified as Other.

Language

Substance Use Disorder Clients language preference was as follows: English 98.7%, Spanish 1.1%, and .2% other.

Age

Substance Use Disorder Clients by age group was as follows: 0% were children (0-11 years), 1.9% were Youth (12-17 years), and 98.1% were adults and older adults (18+ years).

Gender

Substance Use Disorder Clients by gender was as follows: 44.5% were female, 54.8% were male and .7% identified as Other.

Table 3: Substance Use Disorder Medi-Cal Indicators for Fiscal Year 2018/19

	Medi-Cal Beneficiaries		Medi-Cal Clients		Medi-Cal Penetration Rate
	780,478	100.0%	6,035	100.0%	.8%
Gender					
Female	424,623	54.4%	2,686	44.5%	.6%
Male	355,855	45.6%	3,307	54.8%	.9%
Unknown	0	0.0%	42	0.7%	NA
Age					
Children (0-11 y)	197,237	25.3%	0	0%	0%
TAY (12-17 y)	92,716	11.9%	117	1.9%	.1%
Adult/Older Adult (18+y)	490,525	62.8%	5,918	98.1%	1.2%
Ethnicity					
African American	85,683	11.0%	645	10.7%	.8%
Asian / Pacific Islander	36,012	4.6%	95	1.6%	.3%
Caucasian	138,955	17.8%	2,657	44.0%	1.9%
Latino	438,106	56.1%	2,269	37.6%	.5%
Native American	1,897	0.2%	263	4.4%	13.9%
Other	79,825	10.2%	106	1.8%	.1%
Preferred Language					
English	590,706	75.7%	5,956	98.7%	1.0%
Spanish	171,165	21.9%	69	1.1%	0.0%
Other	18,607	2.4%	10	.2%	.1%
Residence Region					
Central Valley (CV)	169,349	21.7%	1,140	18.9%	.7%
Desert/Mountain (DM)	231,124	29.6%	1,880	31.2%	.8%
East Valley (EV)	203,630	26.1%	1,818	30.1%	.9%
West Valley (WV)	159,544	20.4%	945	15.7%	.6%
Unknown/Out of county	16,831	2.2%	252	4.2%	1.5%

*Includes all clients for DBH, contract agencies, Fee for services (FFS), outpatient, inpatient and residential.
 Medi-Cal Eligible Beneficiaries: MMEF file series edited monthly by CA. Dpt. Of Mental Health, data as of June 1, 2019
 Medi-Cal clients served and clients retained: ADS, R&E SIMON Data Bases. Information as of 8/7/2019
 Medi-Cal clients retained are those who receive 3 or more face to face visits during the fiscal year.*

2-II-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Medi-Cal Eligible to Medi-Cal Mental Health Beneficiaries Served

Several disparities can be identified by comparing the Medi-Cal eligible beneficiaries group to the Mental Health Medi-Cal clients served in FY18/19.

Gender

In reference to Table 2, in terms of gender, fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (48.2% versus 54.4%). In contrast, 51.7% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 45.6%. By gender, the penetration rate was higher for males versus females (4.3% vs. 5.5%).

Age

In terms of age, Transitional Age Youth (TAY) 16-25 years constituted 19.1% of beneficiaries served, compared to 16.5% of Medi-Cal eligible. Adults 26-59 years constituted 40.7% of beneficiaries served, compared to 38.8% of Medi-Cal eligible. Older Adults 60+ years constituted 6.4% of beneficiaries served compared to 11.2% of Medi-Cal eligible. The percentage of Children served was equivalent (33%) to the percentages of the Medi-Cal eligible population. By age group, the lowest penetration rate was for Older Adults (60+) at 2.8%. While the penetration rates for TAY and Adults was over 5%, the rate for children was 4.9%.

Race/Ethnicity

In terms of Race/Ethnicity, although Latinos represented 56.1% of Medi-Cal eligible beneficiaries, they only represented 42.7% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander population. Although 4.6% of Medi-Cal eligible, they represented only 2.3% of the beneficiaries served. In contrast, the opposite trend was noted with the African American and Caucasian populations. The African American group represented 11% of Medi-Cal eligible beneficiaries and 16.4% of beneficiaries served; Caucasians represented 17.8% of Medi-Cal eligible and 28.8% of beneficiaries served.

Although Asian/Pacific Islanders are underrepresented as Medi-Cal clients served they may also be considered as inappropriately served by the system. They have the highest rate of inpatient rate of treatment services (24 hour care) compared to other racial/ethnic groups. In FY18/19, Asian/Pacific Islanders received 9.9 inpatient services per client versus 8.4 for African American clients; 8.6 for Caucasian clients, 7.0 for Latino clients; and 3.6 for Native American clients.

The same holds true when analyzing the Residential Rate per Client as well. Asian/Pacific Islanders had the highest rate at 69.1 of residential treatment per client during FY18/19. Caucasians had a 66.5 average rate, Latino clients a 66.5 rate, Other Ethnicities 59.3 and African American 52.4 rate per client. The lowest rate centered on Native Americans at 41.5 of residential treatment per client during FY18/19.

The percentages of Native American and Other Medi-Cal beneficiaries served were more proportional to the percentages of these groups who were eligible for Medi-Cal. For example,

Native Americans were less than one percent (0.2%) of Medi-Cal eligible, and less than one percent (0.5%) of beneficiaries served in FY18/19. However, this can also be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall. They were a very small percentage of the overall County population, a very small percentage of the Medi-Cal population, but were served at the highest penetration rate (10.8%).

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients (See Table 2), 21.9% of Medi-Cal eligible beneficiaries preferred Spanish, while only 6.7% of Medi-Cal clients served preferred Spanish. The vast majority of Medi-Cal clients preferred English (90.6%). In comparison, 75% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population. The penetration rate for the preferred Spanish language group was 1.5%, the lowest for all the language groups. The second lowest penetration rate was for the preferred Vietnamese language group (3.0%).

Medi-Cal Eligible to Medi-Cal Substance Use Disorder Beneficiaries Served

Several disparities can be identified by comparing the Medi-Cal eligible beneficiaries group to the Substance Use Disorder Medi-Cal clients served in FY18/19.

Gender

In reference to Table 3, in terms of gender, fewer Medi-Cal beneficiaries served were female compared to those who were Medi-Cal eligible (44.5% versus 54.4%). In contrast, 54.8% of Medi-Cal beneficiaries served were male, which was greater than their percentage of the Medi-Cal eligible population of 45.6%. By gender, the penetration rate was higher for males versus females (.6% vs. .9%).

Age

In terms of age, Adults (18+ years) represented 98.1% beneficiaries served compared to 62.8% Medi-Cal eligible. Youth (12-17 years) represented only 1.9% of beneficiaries served, compared to 11.9% of Medi-Cal eligible. The percentages of Children served was Zero (0) compared to the percentages of the Medi-Cal eligible population of 25.3%. The data can be interpreted as Youth and Children being underserved and unserved.

Race/Ethnicity

In terms of Race/Ethnicity, although Latinos represented 56.1% of Medi-Cal eligible beneficiaries, they only represented 37.6% of beneficiaries served. A similar trend was found with the Asian/Pacific Islander population. Although 4.6% of Medi-Cal eligible, they represented only 1.6% of the beneficiaries served. In contrast, the opposite trend was noted with the Caucasian and Native American populations. Caucasians represented 17.8% of Medi-Cal eligible beneficiaries and 44% of beneficiaries served. Native Americans represented 0.2% of Medi-Cal eligible and 4.4% of beneficiaries served. This can be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall. They were a very small percentage of the overall County population, a very small percentage of the Medi-Cal population, but were served at the highest penetration rate (13.9%).

Language

In terms of preferred languages of Medi-Cal eligible beneficiaries and Medi-Cal clients (See Table 3), 21.9% of Medi-Cal eligible beneficiaries preferred Spanish, while only 1.1% of Medi-Cal clients served preferred Spanish. The vast majority of Medi-Cal clients served preferred English (98.7%). In comparison, 75% of Medi-Cal beneficiaries preferred English. The data may suggest that we are underserving the Spanish speaking Medi-Cal population.

2-III: 200% of Poverty (minus Medi-Cal) Population and Service Needs.

2-III-A: Summarize the 200% of poverty (minus Medi-Cal population) and client utilization data by race, ethnicity, language, age, and gender.

The population of San Bernardino County under 200% of the Federal Poverty Line (FPL) in FY 18/19 was 795,540 and 15,062 of those individuals under 200% of FPL were not Medi-Cal Eligible beneficiaries. In FY 18/19 DBH served 5,995 individuals who were not Medi-Cal eligible clients, see table 5.

Table 4: Fiscal Year 2018/19 Population under 200% FPL minus Medi-Cal Eligible Beneficiaries

Population under 200% of Federal Poverty Line:	795,540
Medi-Cal Eligible Beneficiaries:	780,478
Population under 200% FPL minus Medi-Cal Eligible Beneficiaries:	15,062

Sources: California Department of Finance Demographic Research Unit. Medi-Cal Eligible Beneficiaries: MMEF file series edited monthly by CA Dpt. of Mental Health, data as of 5/1/19.

Table 5: San Bernardino Population under 200% of the Federal Poverty Line, Medi-Cal Beneficiaries, and Mental Health Medi-Cal Clients Served and Non-Medi-Cal Clients Served Fiscal Year 18/19

	Population under 200% FPL		Medi-Cal Beneficiaries		Medi-Cal Clients Served		Non Medi-Cal Clients Served	
	795,540	100.0%	780,478	100%	37,804	100.0%	5,995	100.0%
Gender		%				%		%
Female	399,382	50.2%	424,623	54.4%	18,212	48.2%	2,801	46.7%
Male	396,158	49.8%	355,855	45.6%	19,541	51.7%	3,186	53.1%
Other/Unknown	0	0.0%	0	0.0%	51	0.1%	8	0.1%
Age Group		%				%		%
Children(0-15y)	244,477	30.7%	260,950	33.4%	12,769	33.8%	1,697	28.3%
TAY (16-25y)	124,889	15.7%	128,868	16.5%	7,229	19.1%	1,443	24.1%
Adult (26-59y)	347,336	43.7%	302,862	38.8%	15,374	40.7%	2,375	39.6%
Older Adult (60+y)	78,838	9.9%	87,797	11.2%	2,432	6.4%	480	8.0%
Ethnic Group		%				%		%
African American	78,673	9.9%	85,683	11%	6,199	16.4%	764	12.70%
Asian/Pacific Islanders	42,942	5.4%	36,012	4.6%	867	2.3%	185	3.1%
Caucasian	239,094	30.1%	138,955	17.8%	10,894	28.8%	1,783	29.7%
Latino	405,850	51.0%	438,106	56.1%	16,152	42.7%	2,509	41.9%
Native American	5,255	0.7%	1,897	0.2%	205	0.5%	36	0.6%
Other/Unknown	23,726	3.0%	79,825	10.2%	3,487	9.2%	718	12.0%
Region		%				%		%
Central Valley	188,230	23.7%	169,349	21.7%	7,257	19.2%	1,042	17.4%
Desert/Mountain	198,662	25.0%	231,124	29.6%	13,115	34.7%	1,565	26.1%
East Valley	209,919	26.4%	203,630	26.1%	10,345	27.4%	1,204	20.1%
West Valley	197,237	24.8%	159,544	20.4%	5,416	14.3%	1,350	22.5%
Other/Unknown	1,492	0.2%	16,831	2.2%	1,671	4.4%	834	13.9%
Language								
Cambodian			508	0.1%	25	0.1%	1	0.0%
English			590,706	75.7%	34,263	90.6%	5,182	86.4%
Spanish			171,165	21.9%	2,546	6.7%	673	11.2%
Thai			95	0.0%	47	0.1%	7	0.1%
Vietnamese			3,074	0.4%	93	0.2%	4	0.1%
Other			14,930	1.9%	830	2.2%	128	2.1%

2-III-B: Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

Comparison of Medi-Cal Clients Served FY18/19 to County Population under 200% of FPL:

The percentage of Medi-Cal female clients served was 48.2% less than the females under 200% of the federal poverty line (FPL) of 50.2%. The percentage of Medi-Cal male clients served was higher at 51.7% than males under 200% FLP at 49.8%. The percentages of children (0-15 years) was higher in the Medi-Cal clients served group at 33.8% compared to the population in poverty at 30.7%. The percentage of TAY (16-25 years) was higher in the Medi-Cal clients served group at 19.1% compared to the population in poverty at 15.7%. The percentages of adults (26-59 years) and especially older adults (60+ years) were lower in the Medi-Cal client group served compared to the population in poverty. Adults were 40.7% of Medi-Cal clients served compared to the population in poverty at 43.7%. Older adults were 9.9% of the population in poverty, but only 6.4% of Medi-Cal clients served.

The percentages of African Americans and those who identified as Other/Unknown were higher in the Medi-Cal clients served group compared to the population under 200% of FPL. For example, African Americans were 9.9% of the population in poverty, and 16.4% of the Medi-Cal clients served group. In contrast, the percentages of Asian/Pacific Islanders (API) and Latino groups were lower in the Medi-Cal Clients served group compared to the population under 200% of FPL. The percentages of API Medi-Cal clients served was 2.3% compared to 5.4% of the population in poverty. The percentage of Latino Medi-Cal clients served was 42.7% compared to the 51.0% of the population in poverty. The percentages of Caucasians and Native Americans in the Medi-Cal consumers served group were close to the figures in the poverty population.

Comparison of Non Medi-Cal Clients Served in Fiscal Year 18/19 to County Population under 200% of FPL:

Greater percentages of the Non Medi-Cal client group were male than the county population under 200% of the Federal Poverty Line (53.1% vs. 49.8%). Similarly, the only group to have a greater percentage of Non Medi-Cal population than the FPL percentage was the TAY group with 24.1% compared to the 15.7% FPL. In contrast, Children, Adults and Older Adults constituted lower percentages of the Non-Medi-Cal client groups versus the poverty population (See Table 5). The Percentages of African Americans and those who identified as Other/Unknown were higher in the Non Medi-Cal Clients served group versus the population in poverty. The Native American and the Caucasian Non Medi-Cal clients served groups were just under the FPL level by a few tenths of a percent. Lower percentages of Asian/Pacific Islanders and Latino were in the Non Medi-Cal Clients served group versus the population in poverty (See Table 5). For example, Latinos were 51% of the population in poverty yet only 42.9% of the Non Medi-Cal Clients served group.

Comparison of Medi-Cal Clients Served to Non-Medi-Cal Clients Served:

The majority of clients in both groups were male. The two groups varied in their age distribution. While a third of Medi-Cal clients served were children, only 28.3% of Non Medi-Cal consumers were children. The majority of Non Medi-Cal consumers served were adults, 26-59 years old

(39.6%). This majority carried over to the Medi-Cal clients group where 40.7% of the Adults were also the majority.

In terms of ethnicity, the majority of Non Medi-Cal clients served were Latino at 41.9% similar to the Medi-Cal clients served at 42.7%. Greater percentages of Non Medi-Cal clients served were in the Asian/Pacific Islander, Caucasian and Other/Unknown groups compared to Medi-Cal consumers. For example, about 3.1% of Non Medi-Cal consumers were Asian/Pacific Islander versus 2.3% of Medi-Cal consumers. Lower percentages of Non Medi-Cal clients served were in the African American ethnic group at 12.70% compared to 16.4% of Medi-Cal clients served.

2-IV: MHSA Community Services and Supports (CSS) Population Assessment and Service Needs.

2-IV-A: From the CSS component of the county's approved Three-Year Program and Expenditure Plan (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.

See Table 6 on the next page.

Table 6: MHSA Community Services and Support (CSS) Information for Fiscal Year 18/19

	Unduplicated Clients Served		County Population(*)
Total	13,322	100%	100%
Gender		%	%
Female	6,273	47.1%	50.30%
Male	7,029	52.8%	49.70%
Unknown	20	0.2%	0.00%
Age		%	%
Children (0-15 y)	3,149	23.6%	25.5%
Young Adult (16-25y)	3,416	25.6%	16.4%
Adult (26-59y)	5,918	44.4%	44.9%
Older Adult (60+y)	839	6.3%	13.1%
Ethnicity		%	%
African American	2,421	18.2%	8.5%
Asian/Pacific Islander	268	2.0%	6.3%
Caucasian	4,203	31.5%	32.9%
Latino	5,221	39.2%	49.6%
Native American	84	0.6%	0.4%
Other/Unknown	1,125	8.4%	2.3%
Preferred Language**		%	%
Cambodian	2	0.0%	N/A
English	12,406	93.1%	N/A
Spanish	624	4.7%	N/A
Thai	30	0.2%	N/A
Vietnamese	7	0.1%	N/A
Other	253	1.9%	N/A
Residence Region^^		%	%
Central Valley (CV)	2,660	20.0%	20.5%
Desert/Mountain (DM)	3,977	29.9%	23.0%
East Valley (EV)	3,358	25.2%	25.0%
West Valley (WV)	1,960	14.7%	31.5%
Unknown/Out of county	1,367	10.3%	0.0%

Sources: Total Population (*): California Department of Finance and Demographic Research Unit
Unduplicated Clients Served: SIMON database as of 8/14/2019

Table 6 Notes:

MHSA-CSS unduplicated consumers served based on RUs associated to the MHSA program

**County Preferred Language data on preferred language is unavailable.

^^County Residence Region Data from California Department of Finance Demographic Research Unit

In FY18/19, San Bernardino County DBH served 13,322 unduplicated clients through the MHSA Community Services and Support (CSS) Programs. Females represented 47.1% of CSS clients and males represented 52.8%. By age group, the greatest proportions were adults between 26 and 59 years old at 44.4%. Just over a fourth were clients from 16 to 25 years old with 25.6%. The third highest percentage at 23.6% was children up to 15 years old and 6.3% were older adults in the 60+ age range. In terms of ethnicity, the majority of clients identified as either Latino (39.2%) or Caucasian (31.5%); 18.2% identified as African American, 2.0% identified as Asian/Pacific Islander, and 0.6% identified as Native American. The vast majority of CSS consumers' preferred to speak English (93.1%), while 4.7% preferred Spanish. Few clients choose Thai (0.2%) and Vietnamese (0.1%) as their preferred languages.

2-IV-B. Provide an analysis of disparities as identified in the above summary. This can be a narrative discussion of the data. Data must support the analysis.

The proportion of females and males in the MHSA-CSS Unduplicated Clients Served vary from the County population. The County female population is just larger than the male population at 50.3% whereas the female population for the unduplicated clients served comes in at only 47.1% allowing the male unduplicated population the majority at 52.8%. The percentage of children (0-15 years old) in the CSS program (23.6%) is just smaller than its proportion of the County population. (25.5%) The percentage of Transitional Age Youth (16-25 years) in the CSS programs is almost 10% higher compared to the percentage of the County population (25.6 vs. 16.4% respectively). Older adults (60+ years) are underrepresented at 6.3% in the CSS programs compared to their 13.1% proportion of the County population.

The percentage of African Americans in the CSS programs are 10% higher compared to their proportions of the County population. The percentages of Latinos, Caucasians and Asian/Pacific Islanders are slightly lower in the CSS programs compared to their proportions of the County population. Native Americans constitute 0.4% of the County Population and have similar representation, 0.6%, in the CSS program. CSS consumers who identified as Other/Unknown ethnicity were overrepresented (8.4%), compared to their proportion of the County population. (2.3%)

2-V. Prevention and Early Intervention (PEI) Plan: The Process Used to Identify the PEI Priority Populations

2-V-A: Which PEI Priority Population(s) did the county identify in the PEI component of its Plan?

The county could choose from the following seven 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**
- 7. Individuals experiencing co-occurring substance abuse issues**

San Bernardino County utilized an extensive community planning process to select the PEI priority populations that included targeted community forums, as well as a community survey. Sixty-two (62) Targeted community forums were conducted with the general community as well as an extensive listing of Community Based Organizations. Advertisements of the forums were developed with a number of media outlets including; radio (Radio Mexico), internet sites, print (brochures and flyers in English, Spanish, and Vietnamese) and newspapers which included: Black Voice, Big Bear Grizzly, Crestline Chronicles, Daily Bulletin (West Valley), Desert Trails, Fontana Herald Press, Press Enterprise, San Bernardino Sun, Daily Journal, Lucerne Leader, Colton City News, Needles Desert Star, Redlands Daily Facts, Senior Newspaper, and Yucaipa News Mirror.

A Community Service Needs Survey was developed to share ideas, approach strategies, and define priorities related to multiple PEI needs in the communities served. A total of eight hundred and ninety-six (896) were received; three hundred and ninety-seven (397) in Web format and four hundred and ninety-nine (499) in paper design. Additionally demographic data was solicited in English, Spanish and Vietnamese at the targeted forums via a Demographic Data Collection form to ensure an inclusive community process. Eight hundred and ninety-six (896) of these forms were also received. 96% of these forms were completed by English speakers, 3% by Spanish speakers and 1% by Vietnamese speakers. 70% of the respondents identified as female and 30% as male, with the largest age group being adults (70%), followed by older adults (15%), TAY (8%) and children (2%). Ethnicity of respondents included Caucasians (33%), Latinos (30%), African Americans (17%), Native Americans (5%) and Asian/Pacific Islanders (3%). Per the Community Service Needs Survey, and the targeted community forums, community members identified the following as priority PEI populations:

1. Children/Youth at Risk for Juvenile Justice Involvement 51%
2. Early signs of serious Mental Illness (“first break”) 50%
3. Children/Youth at Risk for School Failure 49%
4. Suicide Prevention 49%
5. Children & Youth in Stressed Families 47% %
6. Trauma Exposed Individuals 41%
7. Stigma & Discrimination Related to Mental Illness 41%
8. Underserved Cultural Populations 34%

Based on the overall community input, the targeted PEI populations were identified, understanding that Stigma and Discrimination and Suicide (items #7 and #8 above) would be addressed at the State level via PEI statewide projects.

On October 6, 2015, updated PEI Component Regulations became effective. The updated regulations designed by the Mental Health Oversight and Accountability Commission (MHSOAC) changed the framework and structure of the PEI component as compared to the guidance received vis DMH-IN 07-19.

The majority of the changes related to restructuring IOM Framework principles and concepts. The principles are now parceled out as individual programs. A program is defined in the new regulations as “a stand-alone organized and planned work, action, or approach that evidence indicates is likely to bring about positive mental health outcomes either for individuals and

families with or at-risk of serious mental illness or for the mental health system (WIC §3701 (b)).” Currently, there are six (6) State-Defined Prevention and Early Intervention Programs: Stigma and Discrimination Reduction, Outreach for Increasing Recognitions of Signs of Mental Illness, Access and Linkage to Treatment, Prevention, Early Intervention, and Suicide Prevention. Additionally, all Programs must include the following three (3) strategies as part of their programing: Access and Linkage, Improve Timely Access and Reduce and Circumvent Stigma.

Prior to the finalization of the PEI regulations, DBH conducted a robust community planning process to evaluate the current structure and framework of the PEI component as compared to the new State Program categories. Stakeholders were given the new categories and definitions and asked to determine which new required program reporting category best aligned with the existing PEI program(s) by making their selection on the form. They were also asked to determine if the required strategies were already contained within each program. Stakeholder groups reached a consensus that the existing PEI Component program met the Program and Strategy requirements of the new regulations.

As a result of DBH’s collaboration with stakeholders, implementation of the PEI Component now exists under the reporting construct below:

- Stigma and Discrimination Reduction: Native American Resource Center
- Outreach for Increasing Recognitions of Signs of Mental Illness: Promotores de Salud and Community Health Workers
- Access and Linkage to Treatment: Child and Youth Connection
- Prevention: Student Assistance Program, Preschool PEI Program, Resilience Promotion in African American Children, LIFT, Coalition Against Sexual Exploitation and Older Adult Community Services
- Early Intervention: Family Resource Center, Military Services and Family Support, and Community Wholeness and Enrichment
- Suicide Prevention: DBH continues to participate in the PEI statewide Suicide Prevention project administered by CalMHSA.

In September of 2018, California Senate Assembly Bill 1004 was approved by the Governor. The bill requires the MHSOAC to establish priorities for the use of Mental Health Services Act PEI funds, as specified, and to develop a statewide strategy for monitoring the implementation and effectiveness of PEI program, as specified. The bill will standardize and improve PEI programs ensuring access to effective, quality care in counties across the state.

The bill establishes specific priorities for the use of PEI funds. These priorities include:

- Childhood trauma prevention and early intervention to deal with the early origins of mental health needs.
- Early psychosis and mood disorder detection and intervention, and mood disorder and suicide prevention programming that occurs across the lifespan.
- Youth outreach and engagement strategies that target secondary school and transition age youth, with a priority on partnership with college mental health programs.
- Culturally competent and linguistically appropriate prevention and intervention.
- Strategies targeting the mental health needs of older adults.

- Other programs the commission identifies, with stakeholder participation that are proven effective in achieving, and are reflective of, the goals stated in Section 5840.

The target date for these changes is January 1, 2020. Counties will receive more guidance for implementation from the MHSOAC in the next year.

In response to the updated PEI regulations DBH is looking to update existing PEI programs to meet the new priorities. The Community Wholeness and Enrichment (CWE) program or the Premier program, will be evaluated and could be enhanced to address people having their first episode of psychosis and/or individuals who are identified at a high clinical risk for possibly experiencing psychosis in the future or a new program could be developed to create a comprehensive continuum of services for the identified population. The primary goal will be to assist and direct those to treatment that are identifying with the first initial signs of the onset of a mental illness. Additionally, the Community Wholeness and Enrichment program will be expanded to meet new priorities. To meet the requirement of county mental health programs working closer with colleges this program will be enhanced by piloting co-location of behavioral health services on community college campuses. The primary goal will be to identify, assess, and connect individuals experiencing the onset of a behavioral health issue to the appropriate level of care on campus. The next step for these two proposed updates will be to present them to the community for input and support in FY 19/20.

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

3-I: List the Target Populations with Disparities your County Identified in Medi-Cal and all MHSA Components (Medi-Cal, CSS, WET, and PEI Priority Populations).

Medi-Cal Target Population with Disparities:

The San Bernardino County Medi-Cal population for FY18/19 includes 780,478 beneficiaries. Of this population, disparities can be seen for the Latino, Asian/Pacific Islanders (API), African American and Native American populations.

CSS Population with Disparities:

The CSS population in FY 18/19 included 13,322 clients. Of this population, disparities can be seen in the older adult (60+ years old), Latinos, African American and Asian/Pacific Islander (API) populations.

WET Population with Disparities:

DBH employed 1,307 employees in FY18/19. Disparities in the workforce exist for the Latino and bilingual workforce. The last WET Ten year plan was developed in June of 2008. In FY18/19 DBH will conduct a workforce analysis and needs assessment to identify workforce patterns and trends to assist in informing the development on a new five year plan that is responsive to the hiring and training needs of Behavioral Health employees in the County.

PEI Population Priority Populations:

1. Children/Youth at Risk for Juvenile Justice Involvement 51%
2. Early signs of serious Mental Illness (“first break”) 50%
3. Children/Youth at Risk for School Failure 49%
4. Suicide Prevention 49%
5. Children & Youth in Stressed Families 47% %
6. Trauma Exposed Individuals 41%
7. Stigma & Discrimination Related to Mental Illness 41%
8. Underserved Cultural Populations 34%

SUD Population with Disparities:

The SUD population in FY 18/19 included 6,035 clients. Of this population, disparities can be seen in the Children and Youth, Asian/Pacific Islander, and Latino populations. Additionally a closer look needs to be placed on the Native American population. They were a very small percentage of the overall County population, a very small percentage of the Medi-Cal population, but were served at the highest penetration rate (13.9%).

3-I-A: 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).

As noted in Criterion 2, the County of San Bernardino (County), Department of Behavioral Health (DBH) and community stakeholders embarked on an extensive community planning process to identify priorities and strategies and to develop concepts to be included in the PEI Component Plan for approval by the State.

3-II: Identified Disparities (Within the Target Populations)

3-II-A: List disparities in each of the populations (Medi-Cal, CSS, WET, and PEI).

Medi-Cal Population:

As previously described in Criterion 2, disparities exist in San Bernardino County for specific populations. For the Medi-Cal population, disparities can be seen in access to services for Latinos, Asian/Pacific Islanders, African Americans and Native Americans. For Latinos, there is a lack of access and service utilization in general, having a penetration rate at 3.7%. The penetration rate for the Asian/Pacific Islander (API) population is the lowest of all ethnic groups at 2.4%. Per consumer, the API population received the lowest number of case management services compared to other ethnic groups at a rate of 5.8 in FY18/19. In comparison, to Native Americans who received services at a rate of 7.2.

Asian/Pacific Islanders (API) are underrepresented in behavioral health services, meaning they are served in DBH at a percentage that is lower than their percentage in the Medi-Cal funded population, 2.3% vs. 4.6%. They receive a higher rate of residential and inpatient (24 hour care) treatment services compared to other racial/ethnic groups. In FY18/19 they had an inpatient rate of services of 9.9 per client and a residential rate of 69.1 per client. In comparison, Native Americans received an inpatient rate of 3.6 per client and a residential rate of 41.5 per client.

Native Americans were less than one percent (0.2%) of Medi-Cal eligible, and less than one percent (0.5%) of beneficiaries served in FY18/19. However, this can also be interpreted as an overrepresentation of Native Americans among beneficiaries served, despite their small numbers overall. They were a very small percentage of the overall County population, a very small percentage of the Medi-Cal population, but were served at the highest penetration rate (10.8%).

Latinos represented 56.1% of Medi-Cal eligible beneficiaries yet they only represented 42.7% of beneficiaries served.

African Americans represented 11% of Medi-Cal eligible and 16.4% of beneficiaries served. While they are overrepresented as beneficiaries served, this group is accessing Mental Health services at lower levels of care when compared to other racial/ethnic groups.

When examining the Medi-Cal population by age, Older Adults have the lowest penetration rate at 2.8%. Children (0-15) follow at a penetration rate of (4.9%). TAY and adults have penetration rates over 5%.

When examining the Medi-Cal population by preferred language, the penetration rate for the preferred Spanish language group was 1.5%, the lowest for all the language groups.

CSS Population:

For the Community Services and Support (CSS) Population, disparities in access to services can be seen among older adults (60+ years old). While older adults constitute 13.1% of the county population, according to the 2017 American Community Survey by the U.S. Census Bureau, they are only 6.3% of CSS clients.

Similarly, the percentages of Caucasians, Latinos and Asian/Pacific Islanders (API) in the county population are greater than their percentages of CSS consumers, pointing to racial/ethnic disparities in access to services. While Latinos constitute 49.6% of the county, they were only 39.2% of CSS clients in FY18/19.

For the API group, they made up 6.3% of the county but only 2.0% of CSS Clients. In contrast the percentages of African Americans served in CSS programs were higher than the general population at 18.2% vs. 8.5%.

The disparities in access to services can be also seen in CSS Full Service Partnership (FSP) programs. Older adults represent 3.4% percent of FSP clients. Latinos represented 44.2% of FSP clients. The API group represented 1.8% of FSP clients served and African Americans served were again higher than the general population at 19.1% FSP clients served.

WET Population:

Latinos, comprise the majority of the San Bernardino County population (49.6%), and the Medi-Cal funded population (56.1%). In FY 18/19 Latinos represented 37% of the DBH workforce and 26% of the licensed workforce. This is an improvement from 2008 when the workforce was 20% Latino, according to the Workforce Education and Training Component Three Year Program and Expenditure Plan of June 30, 2008. However, DBH still aims to further increase the diversity of our workforce.

In regards to language, per the 2007 WET plan, there were approximately one hundred and eighty-two (182) direct service staff who spoke Spanish. In 2010, that number had decreased to sixty-two (62) possibly due to attrition of staff, and the fiscal crisis. In FY 18/19, there were two hundred and seventy-nine (279) bilingual staff members, the majority of whom spoke Spanish (96%). DBH in collaboration with the Human Resources Department continue to actively recruit bilingual staff.

PEI Population:

The following continue to be priority PEI populations in FY18/19:

1. Children/Youth at Risk for Juvenile Justice Involvement 51%
2. Early signs of serious Mental Illness (“first break”) 50%

3. Children/Youth at Risk for School Failure 49%
4. Suicide Prevention 49%
5. Children & Youth in Stressed Families 47% %
6. Trauma Exposed Individuals 41%
7. Stigma & Discrimination Related to Mental Illness 41%
8. Underserved Cultural Populations 34%

Based on the overall community input, the targeted PEI populations were identified, understanding that Stigma and Discrimination and Suicide (items #7 and #8 above) would be addressed at the State level via PEI statewide projects.

3-III: Identified Strategies/Objectives/Actions/Timelines

3-III-A: List the strategies identified for the Medi-Cal population as well as those strategies identified in the MHSA plan for CSS, WET, and PEI components for reducing the disparities identified.

Medi-Cal strategies to address and reduce disparities in service and access include the following programs:

San Bernardino County is the geographically largest county in the contiguous United States. DBH provides access to behavioral health services through an extensive network of County operated clinics, contracted provider agencies, and a fee-for-service network in each region of the County. Addressing disparities in access are addressed on multiple levels. Providers are contractually required to participate in Cultural Competency trainings, provide culturally and linguistically appropriate services, and are subject to secret shoppers that test the effectiveness of their services.

- In the Latino community there is a lack of access and service utilization in general, having one of the lowest penetration rates for a population that is the largest in the County as well as the largest in the Medi-Cal funded population. To address this, DBH has worked with CBOs (community based organizations) to develop a curriculum for use in a Community Health Workers Program (Promotores de Salud). The focus of the program is to train community members intrinsic to the local communities on mental health as well as resources available and how to access them. These same CBOs also provide a continuum of behavioral health services and have requisite knowledge of community resources to support this population. In addition, the Office of Cultural Competency and Ethnic Services (OCCES) partners with the CCAC Latino Awareness subcommittee to develop and implement educational and cultural events throughout the year, assisting in trust building.
- In the African American community DBH has worked with the African American Health Coalition in the development of a Community Health Worker (CHW) Curriculum to address access and utilization of appropriate services. CHWs provide education and outreach and system navigation services for this population. In addition, the Office of Cultural Competency and Ethnic Services (OCCES) partners with the CCAC African American Awareness subcommittee to support symposiums and cultural events throughout the year, assisting in trust building.

- In the Asian/Pacific Islander community DBH has worked with the Asian American Resource Center in the development of a Community Health Worker (CHW) Curriculum to address the lack of access to services and educate on appropriate service utilization. CHWs provide education and outreach and system navigation services for this population. In addition, the Office of Cultural Competency and Ethnic Services (OCCES) partners with the CCAC Asian Pacific Islander Awareness subcommittee to support educational and cultural events throughout the year, assisting in trust building.
- For the Native American community DBH has worked with Riverside San Bernardino Indian Health, Inc. in the development of a Community Health Worker (CHW) Curriculum to address access to services and educate on appropriate service utilization. CHWs provide education and outreach and system navigation services for this population. In addition, the Office of Cultural Competency and Ethnic Services (OCCES) partners with the CCAC Native American Awareness subcommittee to support educational and cultural events throughout the year, assisting in trust building.

CSS strategies to address and reduce disparities in service and access include the following programs:

DBH currently has eight (8) Full Service Partnership (FSP) programs that address the needs of specific populations and age groups. FSP programs are designed for consumers who have been diagnosed with a severe mental illness or serious emotional disturbance and would benefit from an intensive program. FSP services comprehensively address client and family needs and do “whatever it takes” to meet those needs, including supports and strong connections to community resources with a focus on resilience and recovery. FSP programs implement key practices that consistently promote good outcomes for mental health clients and their families that differ from traditional, clinic-based outpatient care due to the 24 hour per day, 7 days per week available support. In FY 18/19 FSP programs served 4,492 unduplicated clients.

FSP programs:

- The Age Wise program provides Full Service Partnership (FSP) services to older adults, age 59 and older, living with a mental health condition or co-occurring disorder. The program works to increase access to services for the older adult population and to decrease the stigma that is associated with behavioral health conditions within the older adult community. In FY17/18 the CCAC established the Older Adult Awareness Subcommittee at the communities request to focus on the unique needs of older adults.
- Three Full Service Partnership programs for children and youth that target uninsured, unserved, underserved and inappropriately served children 0 to 17 are under the CSS Comprehensive Children and Family Support Services program. The three FSP programs are:
 - Children’s Residential Intensive Services (ChRIS) integrates the FSP approach with the residential care of children and youth placed into a group home by either Children and Family Services (CFS) or Probation.
 - Wraparound is a collaborative program between DBH and CFS designed to serve wards and dependents that are at risk of needing group home services. All referrals for Wraparound are made by CFS or Probation.
 - Success First/Early Wrap is a short-term, wrap-informed FSP which serves children and youth who are not eligible for Wraparound services outlined in State

Bill 163 but are having sufficient difficulties that without intervention a higher level of service is likely to be required.

- The Integrated New Family Opportunities (INFO) works with the juvenile justice population, ages 13 to 17, and their families. It uses intensive probation supervision and evidence-based Functional Family Therapy (FFT). The goal of the program is to provide and/or obtain services for children/youth and their families that are unserved or underserved. Services provided by the INFO program increase family stabilization, help families identify community supports, and encourage recovery, wellness, and resiliency.
- Three One Stop Transitional Age Youth (TAY) Centers that provide integrated services to the unserved, underserved, and inappropriately served children and adolescents ages 16 to 25 in the County. These TAY individuals are living with an emotional disturbance and/or severe and persistent mental illness, who may be or are at risk of Homelessness, involuntary or high users of acute care facilities, suffering from co-occurring disorders, experiencing their first episode of serious mental illness, aging-out of the child welfare system or juvenile justice system, and/or involved in the criminal justice system.
- The Adult Criminal Justice Continuum of Care provides FSP services to individuals involved in the criminal justice system (jail population) with co-occurring disorders.
- Members Assertive Positive Solutions (MAPS) and Assertive Community Treatment (ACT) are FSP programs that assist clients in living successfully in the community and support positive progress towards achieving individual personal recovery goals, while avoiding unnecessary psychiatric hospitalization.
- Big Bear Full Service Partnership is an alliance of mental health service providers in the geographically isolated mountain area of Big Bear Lake that provide mental health services to children and adults. The partnership began in May of 2009 to help a traditionally underserved area for mental health services.
- Regional Adult Full Service Partnership (RAFSP) offers FSP programs in the cities of Barstow, San Bernardino, Rialto, Ontario, and Victorville to ensure services throughout the various regions of the County.

WET strategies to address and reduce disparities in service and access include the following programs:

- DBH has in place a Peer and Family Advocate (PFA) workforce support initiative. PFAs are behavioral health clients or family members of behavioral health clients who provide crisis response services, peer counseling, linkages to services, and support for clients of DBH services. The PFA workforce support initiative supports 39 full time PFA positions throughout DBH. This added diversity builds upon the lived experience and adds a greater dimension to service provision. Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification (see Criterion 6).
- DBH works continually with the Human Resources Department to continually recruit bilingual and bicultural staff. As a result there has been an increase in the number of bilingual staff who work for DBH (see Criterion 6). WET also continues to actively recruit bilingual interns to help provide services in other languages.
- DBH continues to have an internship program in place to address the shortage of behavioral health providers. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs: Social Work, Marriage and

Family Therapy (MFT), and Psychology. Depending on their discipline, interns participate in the Internship Program for **12 to 18** months. During that time, they learn to provide clinical services in a public community behavioral health setting. DBH is committed to hiring applicants that were previously interns (see Criterion 6).

- DBH has a Psychiatry Residency Program in place to address the shortage of psychiatrists. The program provides participants an opportunity to experience working in public mental health, and ultimately choosing employment with DBH's system of care (see Criterion 6).
- DBH has a dedicated Volunteer Services Coordinator who conducts focused outreach to high schools, adult education, community colleges, universities, and Regional Occupation Programs (ROP's) to inform audiences on behavioral health career opportunities and offer volunteer opportunities to individuals interested in behavioral health careers (see Criterion 6).
- DBH has in place a Scholarship Program to assist current DBH and contract agency employees in furthering their education to be able to pursue higher level careers in the public mental health system.
- DBH has in place a License Exam Preparation Program (LEPP) for clinicians seeking licensure. The process to get licensure has numerous parts and the license preparation allows for staff to spend the required time on exam preparation in order to improve their chances of successful examination completion.
- The Department Diversity Committee (DDC) exists to create a culturally competent workforce that not only is diverse, but also values and respects diversity. The DDC is a collaboration between the OCCES and Workforce Education and Training (WET) that meets to address diversity issues, succession planning, training development, and conflict resolution. The DDC solicits diverse input from all levels of DBH staff and provides recommendations to the executive team on ways to enhance our system of care through diversity.

PEI strategies to address and reduce disparities in service and access include the following programs:

- **Stigma and Discrimination Reduction:** The Native American Resource Center functions as a one-stop center offering several prevention and early intervention services for the Native American community members of all ages. The center provides services that incorporate traditional and strength-based Native American practices. Services include outreach and education, family support, parenting education, youth empowerment, healthy choice prevention activities, talking circles, drumming circles, employment development, and education assistance. All services and supports are provided to the community in a culturally relevant context.
- **Outreach for Increasing Recognition of Signs of Mental Illness:** The Promotores de Salud/Community Health Workers (PdS/CHW) program is designed to increase awareness of and access to community-based prevention and mental health services in culturally diverse communities. The program promotes mental health awareness, education, and available resources for members of various culturally-specific populations throughout the county. Services are specifically targeted for unserved and underserved populations including Latino; African-American; Native American; Asian/Pacific

Islander; and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ) communities.

- Access and Linkage to Treatment: The Child and Youth Connection (CYC) program address prevention and early intervention in another high disparity population, which are children. The program focuses on PEI for foster children, who are disproportionately of color.
- Prevention: The Student Assistance Program (SAP) minimizes barriers to learning and supports academic success for at risk students/families. This focuses on disparity reduction with the high risk population for school failure, which heavily impacts African American and Latino children at greater proportions.
- Prevention: The Preschool PEI Program provides prevention services to children ages two through five, their parents or caregivers, and teachers.
- Prevention: The Resilience Promotion in African-American Children (RPiAAC) program provides prevention and early intervention services to African American children/youth (ages 5-18) and their families. Resilience Promotion in African-American Children incorporates African American values, beliefs, and traditions into educational mental health programs. This program promotes resilience in African American children in order to reduce the development of mental health and/or substance use disorders. Outreach and education is delivered to diverse student populations, including African-American populations, to generate awareness regarding the importance of mental health and wellness for all students at a specific school site. The program includes curriculum-based education, cultural awareness activities, conflict resolution training, educational workshops, weekly interventions, career-related presentations, parent support/education, individual and family therapy sessions, and linkage to additional resources.
- Prevention: The Lift Program is designed to promote healthy outcomes for at risk mothers and their infants. Nurses provide education and services in participants' homes to promote the physical and emotional care of children by their mothers, family members, and caretakers. Families are linked with needed physical and mental health services. This program is administered by the San Bernardino County Preschool Services Department.
- Prevention: The Coalition against Sexual Exploitation (CASE) is a partnership of public and private entities who have joined together to develop resources in the County to educate, prevent, intervene, and treat victims of commercial sexual exploitation.
- Prevention: The Older Adult Community Services program is a prevention program designed to promote a healthy aging process for older adults (ages 60+).
- Early Intervention: Family Resource Centers provide prevention and early intervention for family systems with regards to all of the PEI target populations.
- Early Intervention: The Military Services and Family Support program addresses all PEI target populations with a focus on military families, who also have a higher disparity in needs and access to services.
- Early Intervention: The Community Wholeness and Enrichment (CWE) program focuses on early intervention for TAY and adult populations and also addresses all of the other PEI components

3-IV: Additional Strategies/Objectives/Actions/Timelines and Lessons Learned.

3-IV-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.

- Recovery Based Engagement Support Teams (RBEST): The RBEST program is a new program under the CSS component effective November 2019. RBEST will provide community (field-based) services in the form of outreach, engagement, case management, family education, support, and therapy for community members who are considered to be chronically mentally ill, are currently inappropriately served, and in some cases, are not served at all. The goal is to “activate” the individual into the mental health system to receive appropriate services. The multi-disciplinary nature of the engagement teams present a holistic approach to address the needs of the individual. The primary purpose of the RBEST program is to increase the quality of services, including better outcomes, along with increasing access to underserved groups.
- Innovative Remote Onsite Assistance Delivery (InnRoads) project: The InnROADs project is a new innovative project that will target individuals living with a serious mental illness who are at-risk of homelessness, chronically homeless, or are homeless, and living in the County’s suburban and urban areas. The focus of the project will be the creation of an intensive, field-based engagement model that supports multidisciplinary/multiagency teams that meet, engage, and provide treatment to youth, adults, and families experiencing homelessness where they live.

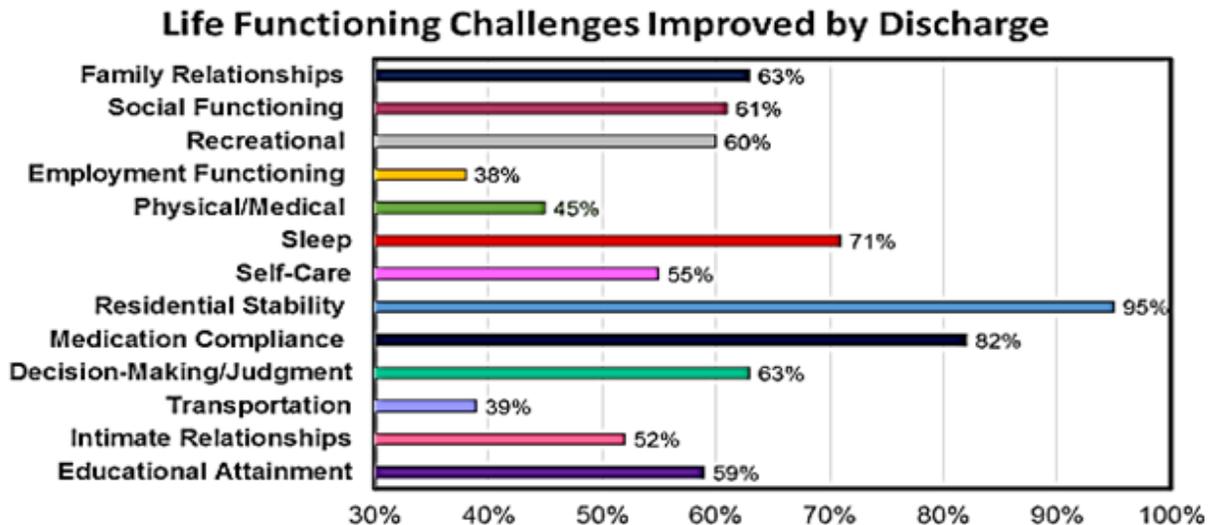
3-IV-A-I: Share what has been working well and lessons learned through the process of the county’s development of strategies, objectives, actions, and timelines that work to reduce disparities in the county’s identified populations within the target populations of Medi-Cal, CSS, WET, and PEI.

CSS: What is working well and lessons learned include:

One Stop TAY Centers

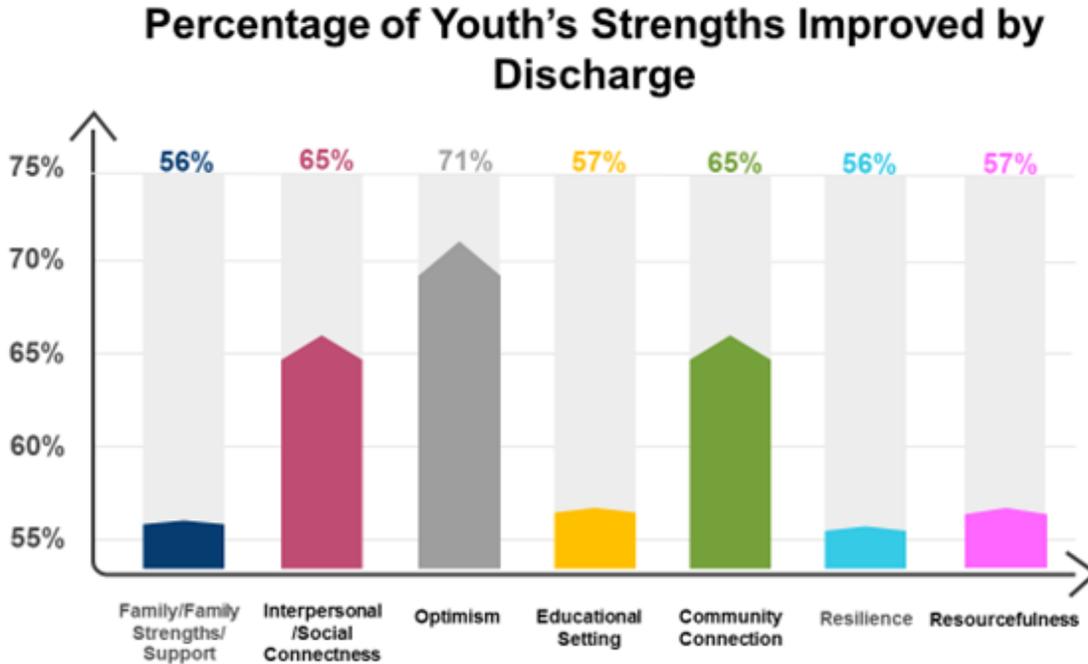
One Stop TAY Centers are an example of an FSP program that is working to reduce disparities and assist youth as they transition into adulthood. DBH uses the Adult Needs and Strengths Assessment (ANSA) tool (Attachment A54) to identify and track participant’s clinical progress.

The data below represents the Percentage of youth who presented with a significant issue on an item within the Life Domain Functioning and had this issue improve by their completion of the program in FY18/19:



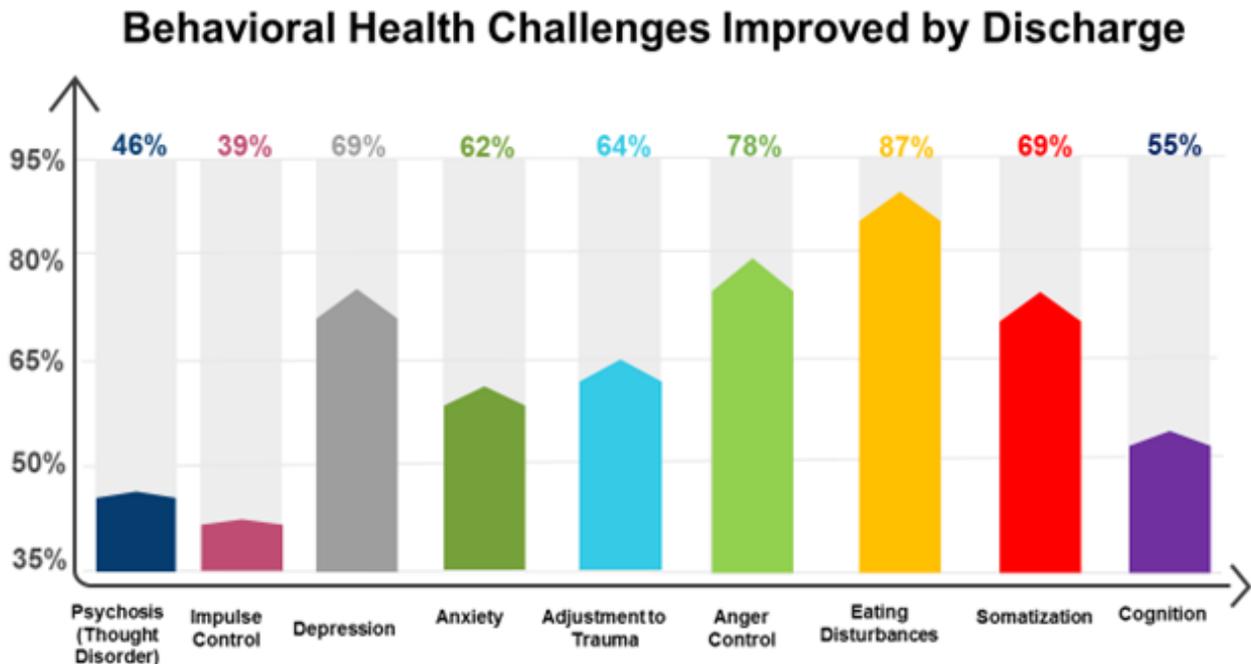
The data below represents the Percentage of youth who presented with a significant issue on an item within the Strength’s domain and had this issue improve by their completion of the program in FY18/19:

Chart 2



The data below represent the of youth who presented with a significant issue on an item within the Behavioral/Emotional Needs and Youth Risk Behavior domains, and had this issue improve by the completion of the program:

Chart 3



Additionally, 95% (41/43) of youth who presented a significant issue in Residential Stability had this issue improve by completion in the program.

CSS: What is working well and lessons learned include: Age Wise Program

The Age Wise Program is another example of an FSP program that is working to reduce disparities for older adults. DBH uses the state Data Collection and Reporting (DCR) system to collect Full Service Partnership data.

According to the DCR 89% of clients have maintained low or reduced risk of subjective suffering as determined by the DCR.

In FY18/19 for the San Bernardino Central Valley Area, one (1) new older adult was placed in safe and permanent subsidized housing, one (1) was placed into a skilled nursing facility due to increased medical issues to provide the necessary services and the remaining 73 maintained safe and permanent subsidized housing.

In FY18/19 for the Hesperia High Desert Area, of the 34 clients, one (1) was placed in License Board and Care, one (1) was placed into low income subsidized housing and the remaining 32 maintained in safe housing.

Therefore, 100% of consumers served by Agewise maintained appropriate stable housing during the FY.

Additionally, for the Hesperia High Desert Area, of the 34 consumers served, 91% of the consumers were able to avoid unnecessary hospitalization.

A pressing concern for the older adult population, as they retire on a limited income, is affordable housing. That issue, coupled with the loss of lifelong support persons through illness and death, as well as managing medical issues of their own, presents great challenges as they address multiple complex issues with case management and a mental health service plan. In addition to providing needed mental health treatment solutions via comprehensive assessments, treatment plans and ongoing services, the Age Wise staff is working diligently to address the housing issue by educating clients on the current availabilities of affordable housing, facilitating housing resolutions by placing clients on wait lists, and continually monitoring and following up for all possible solutions (e.g. MHSA housing availabilities, apartments and rooms for rent, subsidized housing, Section 8 listings, etc.). Once settled in housing, Age Wise staff continues to work with clients to maintain their housing through consumer advocacy and consultation with property managers, landlords and other involved parties.

Reliable transportation to needed resources also remains a challenge, especially in more rural areas, such as the High Desert, where resources tend to be scarce and spread across vast geographic distances. To address transportation issues, Age Wise staff provides education, training and ongoing consultation to link consumers to available resources, in addition to providing themselves the much needed transportation for necessary appointments when other means are not convenient or available.

Another area of concern is the rising tide of financial elder abuse by means of scams perpetrated by increasingly sophisticated, technologically savvy con-artists who utilize fear tactics or lures of significant enrichment to bait vulnerable seniors. Age wise staff provide education to participants to minimize vulnerability to financial scams and other types of elder abuse.

And lastly, the vulnerability of our elders to the dangers of dependence and addiction to substances, whether prescribed, legal or illicit, remains a growing concern, and factors into the necessity and challenge of obtaining clear and accurate diagnoses, in order to properly address the impairing behaviors and issues being manifested. To ensure participants are appropriately served, Age Wise staff takes on a consultative role with physical and psychiatric health care providers, to ensure that they receive accurate and current information, relevant to their treatment provision to mutually shared clients.

**WET: What is working well and lessons learned include:
Peer and Family Advocate (PFA) Workforce Support Initiative program:**

There has been a significant increase in PFAs hired in DBH over the years. This is largely due to increasing knowledge and evidence of the benefits resulting from the inclusion of PFAs in many DBH programs and the positive outcomes it has yielded on the clients served by these programs.

Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The table below shows the number of DBH PFAs promoted since FY 2011/12.

Table 7: PFA’s Promoted

FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
1	1	4	3	4	3	5	6

Internship Program: Bilingual Interns

WET has actively recruited bilingual interns to help provide services in other languages. Since FY 08/09, on average 34% of interns have been bilingual. In FY18/19, 38% of interns were bilingual. Of the bilingual interns, 93% were Spanish speakers. See Table 8 on the next page for more data related to bilingual interns.

Table 8: Number of Bilingual Interns Fiscal Year 08/09 to 18/19

	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	Total
BSW	3	3	2	0	3	3	5	2	2	4	1	28
MSW	5	3	9	5	5	8	6	11	7	4	9	72
MFT	6	3	6	2	5	1	2	8	5	2	3	43
PSY	2	1	1	1	0	2	3	3	2	0	2	17
Total	16	10	18	8	13	14	16	24	16	10	15	160
Total Interns	39	46	41	44	47	51	43	47	39	31	39	467
Percentage	41%	22%	44%	18%	28%	27%	37%	51%	41%	32%	38%	34%

**PEI: What is working well and lessons learned include:
Promotores de Salud/Community Health Workers:**

In FY 18/19 collectively all PdS/CHW providers reached 89,902 unduplicated participants. This is a 61% increase in participation from FY 2017/18.

In FY 18/19 Community Health Workers (CHW) serving the Asian and Pacific Islander populations, have made great progress in penetrating this target population. Historical data, shows that a large quantity of this population immigrated to the United States because of economic or political oppression from their country of origin. This had led to an innate need to be self-sufficient and not very trusting of organizations that offer services that are not familiar.

The provider for this target population has implemented strategies that have been successful in increasing engagement amongst a community that traditionally will not seek information or services, especially for behavioral health concerns. The agency coordinates larger community events and gatherings to attract their target population. They also use the door to door approach to engage community members on an individual level. Similar to the Latino population, faith based organizations play a large role in identifying the needs of this target population. The agency partners with local churches and temples to establish a presence in the community and build trust within the community.

These culturally specific strategies have helped the provider exceed their targeted goal, of 2,400 participants, by 53%.

Military Services and Family Support Project

The MSFS program utilizes the Beck Depression Inventory (BDI) to measure the attitudes and symptoms of depression for its participants. Before receiving treatment, several clients (70%) reported scores that met Severe, Moderate, or Mild Depression criteria. Following early intervention treatment, there was a significant reduction in depressive symptoms reported for all clients, with 97% of clients meeting only *Minimal* or *Mild* Depression criteria, 3% meeting Moderate Depression criteria, and *no* clients (0%) meeting the Severe Depression criteria. In turn, the results indicate that clients significantly reduced their depressive symptoms during their participation in MSFS services.

The MSFS program utilizes Beck's Anxiety Inventory (BAI) to measure the attitudes and symptoms of anxiety for its participants. Before receiving treatment, 69% of clients reported scores that met Mild, Moderate, or Severe Anxiety criteria. However, following Early Intervention treatment, there was a significant reduction in anxiety symptoms reported for all clients, with only 46% falling under the criteria for Mild, Moderate, or Severe Anxiety and more than half of clients (53%) met criteria for only *Minimal* levels of anxiety. In turn, the results indicate that there was a substantial reduction of anxiety symptoms at the conclusion of clients' participation in the MSFS program.

Prior to FY 2019/20, the MSFS program offered services exclusively to service members and their families who served on or after September 11, 2001. As a result of overwhelming stakeholder and community feedback, the MSFS program has been expanded to include all military service members.

3-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.)

3-V-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.).

See the next page for a graphic list of strategies, objectives and timelines related to the planning and reduction of our mental health disparities.

Table 9A

<p>Objective: Reduce Disparities in Access for the following Medi-Cal Populations: Latino and African American</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Partner with CBO's in the development and implementation of cultural specific outreach and education materials.</p> <p>Train members of cultural communities to train members of community on mental health topics and resources</p>	<p>Actions: Release Request for Proposals to solicit qualified vendors for the delivery of Promotores/ community health worker services for Latino, African American, Native American, LGBTQ, and Asian Pacific Islander populations</p> <p>Obtain Board of Supervisors Approval for selected vendors.</p> <p>Recruit Promotores/CHW</p> <p>Develop curriculum and train cultural brokers.</p>	<p>Current Status: Completed</p> <p>Contracts in place for the period of July 1, 2017 through June 30, 2022.</p>

Table 9B

<p>Objective:</p> <p>Reduce Disparities in Access for the following Medi-Cal Populations: Latino and African American</p> <p>TimeFrame: Fiscal Year 2018/2019</p>		
<p>Strategies: Partner with cultural specific organizations to support cultural events and outreach</p>	<p>Actions: Support African American Mental Health Symposium</p> <p>Collaborate with Mexican Consulate</p>	<p>Current Status: Completed:</p> <p>American Mental Health Symposium held February 2019</p> <p>Hispanic Heritage Month Event held October 2018.</p>

Table 9C

Objective: Reduce Disparities in Access for the following CSS Populations: Latino, African American, Criminal Justice and Older Adults TimeFrame: January 2017 to December 2017		
Strategies: Expand Full Service Partnerships to additional populations	Actions: Develop RFP to expand Regional FSP services. Implement new contract with CBO to expand FSP services to diverse populations living in homelessness; conduct bi-weekly support and technical assistance meetings with new contractor Provide mobile services and coordination of transportation supports for older adult population Expand FSP services to additional justice involved populations.	Current Status: Completed Contracts in place for the period of July 1, 2018 through June 30, 2023.

Table 9D

<p>Objective: Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates TimeFrame: Fiscal Year 2018/2019</p>		
<p>Strategies: Peer and Family Workforce Support Initiative</p>	<p>Actions: Recruitment for vacant Peer and Family Member positions (between 150-200 applications for employment received annually)</p> <p>Inclusion of the Peer and Family Member position in as a requirement in applicable MHA funded contracts</p> <p>Continuation of Peer and Family Member support across department through employment of a Liaison position</p>	<p>Current Status: Completed</p> <p>Recruitment occurs once every Fiscal Year</p> <p>MHA funded contracts include PFA positions as appropriate</p> <p>In this Fiscal Year 31 of the 39 PFA positions were filled.</p>

Table 9E

<p>Objective: Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates TimeFrame: Fiscal Year 2018/2019</p>		
<p>Strategies: Build a Culturally Competent Workforce</p>	<p>Actions: Offer trainings to staff and contracted provider staff.</p> <p>Coordination with Office of Cultural Competency to offer Culturally specific trainings.</p>	<p>Current Status: Completed</p> <p>WET provided 80 unique trainings.</p> <p>OCCES and WET provided 87 live unique trainings.</p> <p>Additionally DBH and contract staff have access to online courses through Relias.</p> <p><i>Source: WET Training Annual Update FY18/19</i></p>

Table 9F

<p>Objective: Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates</p> <p>TimeFrame: Fiscal Year 2018/2019</p>		
<p>Strategies: Outreach to high school, adult education, community college and Regional Occupational Program (ROP) to address/educate a future diverse workforce in Behavioral Health</p>	<p>Actions: Participate in 70 school based outreach events Reach 6,900 individuals through outreach</p>	<p>Current Status: Completed WET coordinator visited 63 schools, and reached over 6000 individuals</p>

Table 9G

<p>Objective: Reduce Disparities in Access for the following WET Populations: Latino, Peer and Family Advocates</p> <p>TimeFrame: Fiscal Year 2018/2019</p>		
<p>Strategies: Expand Internship program</p>	<p>Actions: Provide quality internship opportunities for approximately 40 interns across three disciplines (MFT, MSW, and Psychology) Recruit bilingual interns for participation in program</p>	<p>Current Status: Completed 39 interns participated in DBH's Intern program 15 were bilingual interns</p>

Table 9H

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Comprehensive Children’s Services/Student Assistance Program</p>	<p>Actions: Release RFP to solicit vendors for comprehensive service for school-aged children, using a blended funding structure of PEI and Medi-Cal</p> <p>Obtain BOS approval for contracted providers to begin providing services in FY17/18.</p> <p>Train providers in contractual requirements.</p> <p>Support early implementation efforts through technical assistance .</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9I

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Resilience Promotion in African American Children Program</p>	<p>Actions: Release RFP to solicit vendors for RPiAAC program.</p> <p>Obtain BOS approval for contracted providers to begin providing services in FY 17-18</p> <p>Train providers in contractual requirements.</p> <p>Support early implementation efforts through technical assistance.</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9J

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Preschool Prevention and Early Intervention Program</p>	<p>Actions: Continued partnership with the Preschool Services Department Head Start program</p>	<p>Current Status: Completed All contacts are in place and partnerships remain ongoing.</p>

Table 9K

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Family Resource Center</p>	<p>Actions: Release RFP to solicit vendors for comprehensive service Obtain BOS approval for contracted providers to begin providing services in FY17/18 Train providers in contractual requirements Support early implementation efforts through technical assistance</p>	<p>Current Status: Completed All contacts are in place and partnerships remain ongoing.</p>

Table 9L

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Native American Resource Center</p>	<p>Actions: Continue partnership with cultural specific vendor in the delivery of PEI services</p> <p>Support cultural specific outreach events</p> <p>Collaborate through CCAC Native American Subcommittee</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9M

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Promotores de Salud</p>	<p>Actions: Release Request for Proposals to solicit qualified vendors for the delivery of Promotores/ community health worker services for Latino, African American, Native American, LGBTQ, and Asian Pacific Islander populations</p> <p>Obtain Board of Supervisors Approval for selected vendors</p> <p>Recruit Promotores/CHW</p> <p>Develop curriculum and train cultural brokers</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9N

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Military Services and Family Support Program</p>	<p>Actions: Release RFP to procure cultural specific PEI services</p> <p>BOS approval for contracted provider agencies to provide services</p> <p>Coordinate training and support for working with the Military culture</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9O

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: Community Wholeness and Enrichment Program</p>	<p>Actions: Extend current services with CBOs</p> <p>Development of RFP to solicit ongoing provision of early intervention services</p>	<p>Current Status: Completed</p> <p>All contacts are in place and partnerships remain ongoing.</p>

Table 9P

<p>Objective: Reduce Disparities in Access for the following PEI Populations: Latino, African American, Native American, Military Service/Veteran and Child Welfare</p> <p>TimeFrame: January 2017-December 2017</p>		
<p>Strategies: LIFT Program</p>	<p>Actions: Continued partnership with the Preschool Services Department Early Head Start program</p>	<p>Current Status: Completed All contacts are in place and partnerships remain ongoing.</p>

3-V-B: Discuss the mechanism(s) the county will have or has in place to measure and monitor the effect of the identified strategies, objectives, actions, and timelines on reducing disparities identified in Section II of Criterion 3. Discuss what measures and activities the county uses to monitor the reduction or elimination of disparities.

The Research and Evaluation office at DBH produces regular reports on the population served through the MHP and Substance Use Disorder programs through data collected through SIMON, a database used to collect information on clients receiving services. PEI program data not captured through SIMON are compiled and monitored regularly through monthly PEI forms and biannual reports. In particular, program staff report detailed demographic information on participants served on monthly demographic data collection forms. This information allows program and the Office of Cultural Competence and Ethnic Services (OCCES) staff to monitor the effectiveness of programs to reach underserved cultural populations. OCCES provides technical assistance to programs that are having difficulty in reaching their targeted populations.

Not only are strategies for reducing disparities monitored and evaluated internally, all programs provide regular presentations on their services to the public through Behavioral Health Commission, District Advisory Committee, Cultural Competency Advisory Committee and Subcommittees, and Community Policy Action Committee meetings, as well as at other forums as requested. The community provides feedback on programs and identifies gaps in services.

All MHSA programs are analyzed on an annual basis by county staff to assess program outcomes. MHSA staff analyze all data collected by programs to assess the number of unduplicated participants served, demographics of participants, and outcomes data. In annual

reports, MHSA staff share the impact of funded programs, and report progress towards the reduction of disparities among underserved and inappropriately served populations.

Finally, the Cultural Competency Advisory Committee (CCAC) and the associated thirteen (13) subcommittees serve as a mechanism to monitor the effects of DBH's efforts to reduce disparities. The mission of the CCAC is to advocate for the development, implementation and evaluation of high quality, culturally/linguistically competent, behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County. CCAC members and the subcommittees are regularly asked to provide feedback to OCCES staff and the Cultural Competency Officer on how to improve the DBH system of care. Such feedback is shared by the CCO with the Executive Team at DBH and appropriate program staff.

3-V-C: Identify county technical assistance needs.

No technical assistance required.

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

4-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.

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

The Cultural Competency Advisory Committee (CCAC) is a committee of community based providers, organizations, partner agencies, clients, family members, faith based organizations/individuals, representatives from various DBH departments, primary care providers and other interested parties who advocate for the development, implementation and evaluation of high quality, culturally/linguistically competent behavioral health services capable of meeting the diverse needs of all cultural groups in San Bernardino County.

The CCAC meets monthly and has established direct channels of communication with the staff of the Office of Cultural Competence and Ethnic Services (OCCES) and the Cultural Competency Officer (CCO). The CCAC and its subcommittees are community-led and chaired by members of the community. The CCAC interacts closely and advises the CCO on pertinent information and research data regarding the special needs of the target populations in the community. Likewise, information also flows from the CCO and OCCES to the CCAC and the diverse communities the membership represents. The philosophy of the CCAC includes: The belief that persons of all cultural backgrounds have the right to receive quality behavioral health services, regardless of age, creed, gender, sexual orientation, ethnicity, socio-economic status, disability or nationality.

The objectives of the CCAC are:

- Promoting equitable distribution of behavioral health services utilizing multi-lingual, multi-cultural staff,
- Promoting equal access to behavioral health services,
- Advocating for the equitable and efficient use of resources in the behavioral health system,
- Supporting community inclusion and input,
- Promoting community awareness about behavioral health issues,
- Advancing cultural competency through participation in joint efforts to improve the policies and effectiveness of behavioral health services for all cultural groups,
- Promoting research on behavioral health needs and interventions and promising practices with culturally diverse communities,
- To work towards cultural attunement and cultural competency as defined as “a set of congruent practices, skills, attitudes, policies, and structures which come together in a system, agency, or among professionals to work effectively with diverse populations” (Cross et. al, 1989, cited in DMH Information Notice 03-04).

The following are the roles and responsibilities of the members of the DBH Cultural Competency Advisory Committee per Title 9, Chap. 11, Article 4 Section 1810.410 (b):

- Review policies, mission, and program statements to ensure Cultural Competency principles are included,
- Analyze Department services programs, related to county/state demographics, trends, research findings regarding access, retention, and treatment of specific cultural groups by age, gender, language, poverty, and other criteria,
- Hold focus groups to share cultural information, support, resources and receive feedback from the community,
- Review and recommend ways to enhance client/family input,
- Develop opportunities to increase community partnerships and collaboration,
- Review and update DBH's capacity and capability to provide competent cultural and linguistic services,
- Review and update the Cultural Competency Plan annually for submission to the California Department of Health Care Services (DHCS).

The CCAC has developed by-laws (Attachment A31) that address values, objectives, subcommittee structure, membership, composition and commitment. The committee officers include a Chair and Vice Chair, who are elected annually, each on alternating years. The officers are responsible for the initiation of a strategic plan based on the CCAC input and the needs of the community which results in a final report to the CCO. (Attachment A32).

The CCAC meets monthly and the cultural subcommittees hold their own monthly meetings (Attachment A33) addressing more specific disparity issues. Subcommittees report out to the CCAC on their activities at monthly CCAC meetings (Attachment 39). The CCAC Subcommittees maintain a work plan that they review and update annually. (Attachment A35) In addition, the CCAC provides monthly presentations to attendees on various community organizations and programs who serve the diverse groups of San Bernardino County (Attachment A36).

Subcommittees under the CCAC:

1. African American Awareness Subcommittee
2. Asian Pacific Islander Awareness Subcommittee
3. Co-Occurring Substance Abuse Awareness Subcommittee
4. Consumer and Family Members Awareness Subcommittee
5. Disabilities Awareness Subcommittee
6. Latino Awareness Subcommittee
7. LGBTQ Awareness Subcommittee
8. Native American Awareness Subcommittee
9. Older Adults Awareness Subcommittee
10. Spirituality Awareness Subcommittee
11. Transitional Aged Youth (TAY) Awareness Subcommittee
12. Veterans Awareness Subcommittee
13. Women's Awareness Subcommittee

4-I-B: The County shall include the following in the CCPR: 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.

The CCAC has developed by-laws that address values, objectives, subcommittee structure, membership, composition and commitment (Attachment A31). The officers of the CCAC consist of a Chair and a Vice-Chair, who are elected annually, each on alternating years. The Chair shall not be a DBH employee; however, in the event of unprecedented situations where no other non-DBH CCAC members have applied for or shown interest in becoming the Chair, then a DBH employee, by vote can serve as the Chairperson. The Chair shall appoint a nominating committee to present nominations for the election of new officers at the October monthly meeting.

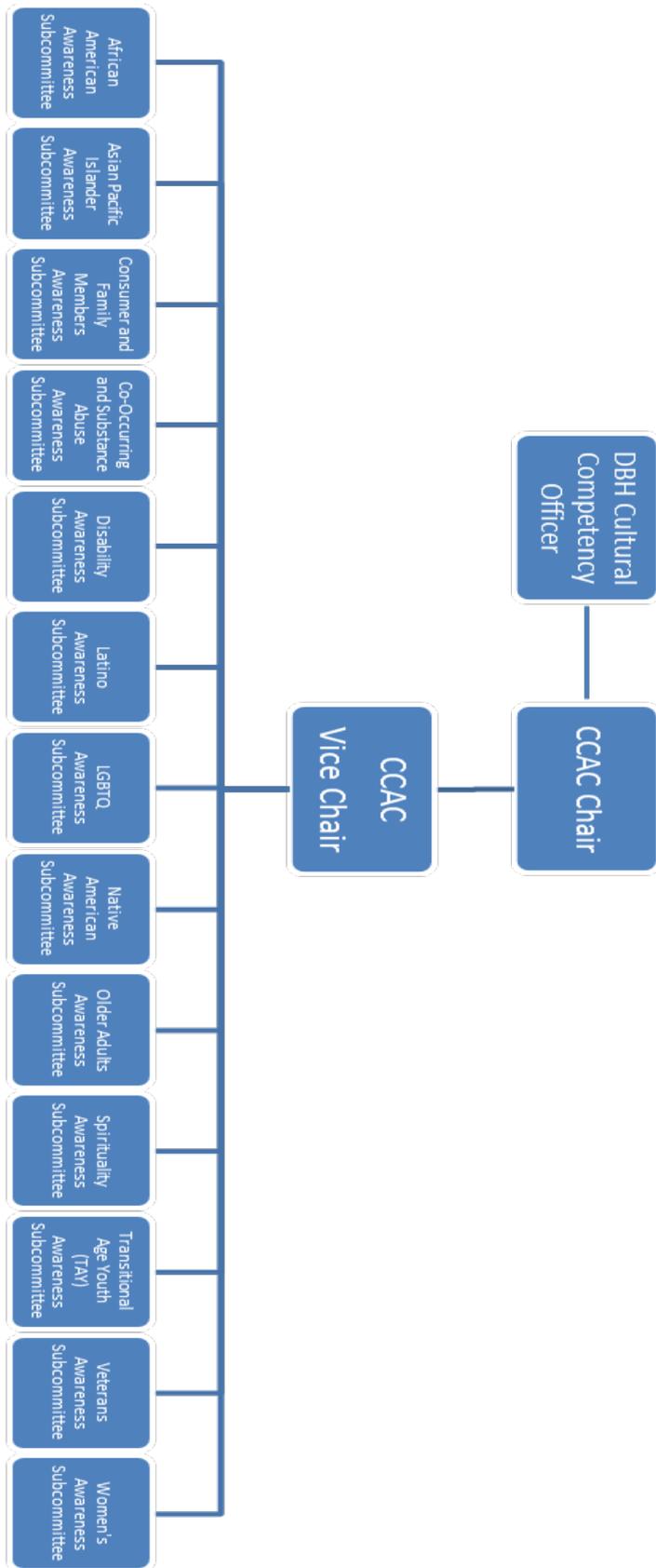
The by-laws of the CCAC also state under Article VI Section I. Participation and Composition:

1. Participation will be open-ended.
2. Participants will include: diversity of community members, consumers, family members, private practice providers, contractors, primary care providers, faith based organizations/individuals, community based agencies, representatives from various Department of Behavioral Health programs, elected members, community leaders, and other interested individuals.
3. The Cultural Competency Advisory Committee will be comprised of sixteen (16) active voting members. Each subcommittee will have a voting member, the CCAC chair and co-chair, and the Cultural Competency Officer.
4. Staff from the Office of Cultural Competence and Ethnic Services (OCCES) will be responsible for the orientation of new members.
5. The CCAC will promote a mission statement letting community members, community based organizations and agencies know the importance of attending CCAC meetings and actively participant in the execution of our objective.

Additionally, DBH's Cultural Competency Policy CUL1006 (Attachment A6) assures members of the Cultural Competence Advisory Committee are reflective of the community, including county management level and line staff, clients and family members, providers, community partners, contractors, and other members as necessary.

4-I-C: Organizational Chart

Please see the next page, for the current orgainzational chart of the Cultural Competency Advisory Committee.



4-I-D: Committee membership roster listing member affiliation if any.

Sign-in sheets from CCAC Meetings are available at attachment A37.

4-II: The Cultural Competence Committee, or Other Group with Responsibility for Cultural Competence, is Integrated within the County Mental Health System.

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

- **Reviews of all services/programs/cultural competence plans with respect to cultural competence issues at the county**
- **Provides reports to Quality Assurance/Quality Improvement Program in the county;**
- **Participates in overall planning and implementation of services at the county;**
- **Reporting requirements including directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director;**
- **Participates in and reviews county MHSA planning process;**
- **Participates in and reviews county MHSA stakeholder process;**
- **Participates in and reviews all components of the county's Plan;**
- **Participates in and reviews client developed programs (wellness, recovery, and peer support programs);**
- **Participates in revised CCPR development.**

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

The Office of Cultural Competence and Ethnic Services (OCCES) is responsible for the integration of cultural competence throughout the entire DBH system of care. Additionally, the Cultural Competency Advisory Committee (CCAC) as stated previously is a community based advisory group that advises the OCCES and the Cultural Competency Officer (CCO) of the needs of the community, as well as provides feedback, review and participates at various levels of program planning and quality assurance. OCCES and CCAC work together to review DBH's services, programs, and cultural competence plan on an ongoing basis. Additionally, the Cultural Competency policy (Attachment A6) clearly states the roles and responsibilities of the CCAC which include the review of DBH services, programs and cultural competency plan.

For evidence of the CCAC's participation in reviews of services, programs, and cultural competence plans with respect to cultural competence issues in the County, see CCAC and Subcommittee meeting agendas (Attachment A36). The CCAC and the Subcommittees are active participants in providing feedback and reviewing DBH's Mental Health Services Act (MHSA) programs.

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

The CCO sits on the Quality Management Advisory Committee (QMAC). In FY19/20 the CCO will Chair the Cultural Competency: Quality Improvement Workgroup. The workgroup is tasked

with monitoring mental health needs in specific cultural and ethnic groups and ensuring services are provided in the counties threshold languages (Spanish) and prevalent non-English languages.

Members from the LGBTQ Awareness subcommittee and OCCES staff in FY18/19 participated in the planning of effective ways to collect data surrounding issues of sexual orientation and gender identity (SOGI). This is an ongoing collaborative effort with several DBH departments, including Quality Management, Compliance, and IT. New information will be collected in response to new legislation and as a way to improve service delivery. OCCES and the LGBTQ Awareness subcommittee in FY19/20 will begin developing and providing trainings on effective and appropriate ways to collect SOGI data.

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

The CCAC, CCO and OCCES are actively involved in MHSA's stakeholder engaged community planning process. The CCAC and Subcommittees annually invite MHSA staff to provide updates to their meeting participants creating opportunities for community stakeholders to provide input and feedback on the DBH system of care. Additionally, stakeholder Comment Forms are included in every CCAC and Subcommittee meeting for input on program development, implementation, evaluation, and policy of MHSA funded programs. The values of cultural competence are written throughout the MHSA Plan to provide services that emphasize recovery, wellness, and resiliency. OCCES continues to strive to meet the priority needs identified by local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act (MHSA).

As a result of the stakeholder planning process OCCES has been involved in the development of culturally specific programs for the County through MHSA. Specific programs include Native American Resource Center, Promotores de Salud/Community Health Workers, and Resilience Promotion in African-American Children. The programs contained in the Plan are designed to develop a continuum of services in which clients, family members, providers, County agencies (including law enforcement and staff), and faith-based and community based organizations can work together to systematically improve the public behavioral health system in a culturally and linguistically competent way.

The Cultural Competence Plan (CCP) is continually used for the development and improvement of outreach efforts and programs for underserved groups. DBH in collaboration with the CCAC continues to coordinate ongoing educational forums to increase mental health and substance use disorder awareness and provide informational materials in preferred languages spoken in specific communities. The CCP helps guide the work of the CCAC.

Reporting requirements including directly transmitting recommendations to executive level and transmitting concerns to the Mental Health Director.

The CCO is a direct report of the Director and an integral piece of the executive management team. As such, the CCO meets on a weekly basis with the executive team regarding concerns and needs of the community and county staff. The CCO also has weekly supervision with the Director.

Participates in and reviews county MHSA planning process.

In 2019, during the months of February and March, the Mental Health Services Act (MHSA) Stakeholder Engagement Forums for the MHSA Annual Update took place. The Department of Behavioral Health conducted 31 MHSA Stakeholder Engagement Forums in all the districts, including at the DAC, CCAC and all CCAC sub-committees which included a Spanish presentation at the Mexican Consulate, during the Community Policy Advisory Committee meeting, as well as two online webinar sessions for after hour stakeholders in order to accommodate varying schedules (Attachment A38). The MHSA updates served as an opportunity to discuss any updates made to the plan reflect on what has transpired over the past year, discuss current services offered by the department, and most importantly gave stakeholders and community members the chance to offer feedback to the department.

Participates in and reviews county MHSA stakeholder process.

The CCAC is continually invited to review and enhance DBH's stakeholder process and as result each of the subcommittees has held MHSA stakeholder meetings, assisted in the recruitment of community members, and have provide community based facilities for stakeholder/community forums.

Participates in and reviews all components of the county's Plan.

The CCO and OCCES are actively involved in MHSA's stakeholder engaged community planning process. Stakeholder Comment Forms are included in every CCAC and Subcommittee meeting for input on program development, implementation, evaluation, and policy of MHSA funded programs. The values of cultural competence are written throughout the MHSA Plan to provide services that emphasize recovery, wellness, and resiliency. OCCES continues to strive to meet the priority needs identified by local diverse community stakeholders, meet the key community and priority population needs outlined in the Mental Health Services Act (MHSA). The CCO and OCCES are responsible for presenting all components of the county's MHSA plan, Cultural Competency Plan (CCP) and Quality Improvement Performance Plan to the CCAC and associated subcommittees for review and comment.

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

The CCAC, and specifically the Consumer and Family Members Awareness Subcommittee, participates in the review of client-developed programs such as our Clubhouse program (described further in Criterion 8). The Consumer and Family Members Subcommittee takes place at the Pathways to Recovery Clubhouse to make it most accessible for a large group of our clients to attend. Members of this subcommittee are vocal about issues in service delivery, and also have direct access to Clubhouse staff and/or the program manager who regularly attends the meeting to share their concerns.

Participates in Revised CCPR Development.

It is a primary function of the CCO and OCCES to develop the revised CCP. This includes engaging all levels of leadership from across DBH to participate in the process. This also includes regular communication with and buy-in from the CCAC and the associated subcommittees in the development of the plan.

4-II-C: Annual Report of the Cultural Competence Committee's Activities including:

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

Attached is the CCAC Work Plan for FY18/19 (see Attachment A35). Goals and objectives are ongoing and completed by Fiscal Year. Work plans are reviewed and updated in January of every calendar year or as requested by the subcommittee members. Attachment A35 provides the detailed monthly updates from each of the subcommittees on their activities, recommendations and progress in meeting their respective goals.

Reviews and recommendations to county programs and services:

The CCAC and its subcommittees review and makes recommendations to DBHs programs and services annually through MHSA annual update stakeholder meetings or as requested by DBH and its partners. (Attachment A36-1)

Goals of Cultural Competence Plans:

The following are the goals and requirements of the CCP:

- Commitment to Cultural Competence
- Updated assessment of service needs
- Cultural Competency Advisory Committee
- Strategies and efforts for reducing racial, ethnic, cultural and linguistic mental health disparities
- Client/Family/Family member/Community Committee: Integration of the Committee within the County mental health System
- Culturally competent training activities
- County's commitment to growing a multicultural workforce: Hiring and retaining culturally and linguistically competent staff
- Language capacity
- Adaptation of services

No updates or changes to the cultural competency plan goals have been recommended or made by the CCAC.

Human Resource Report:

No report for FY18/19. In FY19/20 the CCAC will review demographic and linguistic capabilities data of the DBH workforce and provide recommendations on addressing challenges to growing a diverse workforce for the development of the departments new five year workforce plan.

County Organizational Assessment:

In the fall of 2016, the Department Diversity Committee administered an organization survey to DBH staff. The purpose was to collect feedback to assist the department's effort around cultural competency, diversity and inclusion. A total of eight hundred and thirty-five (835) employees completed the survey. Highlights of the results included:

- 76% of those surveyed agreed or strongly agreed that the organization addresses cultural factors such as language, race, ethnicity, sexual orientation, and customs when interacting with clients.
- 71% of those surveyed agreed or strongly agreed that our organization supports and understands values from all ethnic/age and cultural groups sensitively and competently.
- 70% of those surveyed agreed or strongly agreed that staff, program materials, brochures, and policies and procedures manuals are culturally and linguistically oriented to the diverse populations we serve.
- 69% of those surveyed agreed or strongly agreed that the organization uses interpreters who understand the cultures as well as language of our clients and families.
- 69% of those surveyed agreed or strongly agreed that our organization has service hours and sites which are accessible to the consumers we serve.
- 66% of those surveyed agreed or strongly agreed that our organization has administrative staff that proportionately reflect the ethnic, gender, age and other cultural differences of the population we serve.
- 66% of those surveyed agreed or strongly agreed that the organizations seeks and incorporates current and relevant information about all diverse groups served.
- 52% of those surveyed agreed or strongly agreed that our organization has recruitment efforts that seek individuals from culturally diverse groups and advertise position vacancies in culturally diverse print and broadcast media.
- 54% of those surveyed agreed or strongly agreed our organization is able to retain a diverse staff at all levels.
- 51% of those surveyed agreed or strongly agreed that consumers are involved in the planning, designing, outreach and delivery of services.

In FY19/20 OCCES, CCAC and the DDC will review the results of survey administered in 2016 and identify areas for improvement.

Training plans:

Training plans are developed in collaboration with DBHs Workforce Education and Training (WET) program. (See attachment A40)

CRITERION 5: CULTURALLY COMPETENT TRAINING ACTIVITIES

5-I: The County System shall require all Staff and Stakeholders to receive Annual Cultural Competence Training.

5-I-A: The County shall develop a three year training plan for required cultural competence training that includes the following:

- **The projected number of staff who needs the required cultural competence training. This number should be unduplicated;**
- **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.**

DBH policy CUL 1014 (Attachment A12) requires that all DBH staff and contract provider staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery. The policy indicates that staff who do not have direct contact providing services to clients shall complete a minimum of two (2) hours of cultural competency training, and direct service clinical staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Certain cultural competency trainings are mandated either as an incorporated part of New Employee Orientation (NEO) or as a requirement by the respective Deputy Director, Manager, or Supervisor to ensure that staff are most effectively serving the respective populations that the program reaches.

DBH staff and contracted provider staff have access to live and web-based trainings to meet cultural competency training requirements. In FY18/19 OCCES staff provided 30 live trainings to DBH staff, contract provider staff, and community stakeholders (Table 10). DBH's online training system Relias offers 54 courses that qualify for Cultural Competency hours. Additionally, staff who attend community-based trainings and/or out of county trainings are able to submit a request to OCCES to have the training they attended reviewed and qualified to meet DBH cultural competency training hour requirements.

DBH staff compliance with training is monitored annually and verified by staff supervisors during annual work performance evaluations. Statistics gathered through DBH's online training system Relias are also available to show the number of staff who completed cultural competency training requirements in Relias. In FY 18/19 Relias reported over 5000 cultural competency training hours granted to DBH and contract provider staff. Of the hours granted to DBH staff 30% were granted to DBH licensed and pre-licensed Clinical Therapists. Compliance with cultural competence is verified for contracted provider's staff during program reviews and site visits by DBH contract monitoring staff. In FY19/20, OCCES and the Cultural Competency: Quality Improvement Workgroup will be reviewing Relias training reports on a bi-monthly basis to monitor completion of cultural competency trainings by DBH staff.

OCCES works collaboratively with DBHs Workforce Education and Training (WET) program to embed cultural competence into all trainings throughout the department by reviewing trainings submitted for content that addresses cultural competence, diversity, equity, implicit bias, customer service, and cultural considerations with underserved populations. Training content that

meets these criteria is reviewed and awarded Cultural Competency hours by the Cultural Competency Officer (Table 11).

OCCES and WET set an annual cultural competency training plan and meet frequently to ensure DBH continues to provide quality, relevant trainings, presentations, and events to increase the awareness of cultural diversity, knowledge of strategies to engage diverse communities in culturally and linguistically appropriate services. Some ongoing training topics include:

- General Cultural Competence and CLAS standards Trainings
- Deaf Sensitivity
- Historical Trauma in Underserved Communities (such as the African American, Latino and Native American communities)
- Trainings to effectively engage LGBTQ clients
- Effective Use of Interpreters
- Developing and Maintaining Cultural Competency Across Human Services Agencies

5-II: Annual Cultural Competence Trainings

5-II-A: Please report on the cultural competence trainings for staff. Please list training, staff, and stakeholder attendance by function:

Live cultural competence trainings completed by staff for FY18/19 (Attachment A40).
List of Relias cultural competence trainings completed by staff and contract providers for FY18/19 (See Table 11).

5-II-B: The County shall include the following in the CCPR: Annual cultural competence trainings topics shall include, but not be limited to the following:

- **Cultural Formulation**
- **Multicultural Knowledge**
- **Cultural Sensitivity**
- **Cultural Awareness**
- **Social/Cultural Diversity (Diverse groups, LGBTQ, SES Elderly, Disabilities, etc.)**
- **Mental Health Interpreter Training**
- **Training staff in the use of mental health interpreters**
- **Training in the use of Interpreters in the mental health setting**

The following is a list of live cultural competency trainings provide in FY 18/19:

Table 10: Live Cultural Competency Trainings Provided in FY18/19:

	<u>Training Name</u>
7/11/2018	Diversity Film Series: The Wellbriety Journey to Forgiveness
8/03/2018	Diversity Film Series Training
8/09/2018	Deaf Sensitivity Training
8/20/2018	Un Momento/One Moment
10/09/2018	National Day of Prayer
10/11/2018	Un Momento/One Moment
10/13/2018	Hispanic Heritage Month
11/13/2018	Safe Talk Trainng
11/19/2018	Historical Trauma in Native American Communities
12/03/2018	Safe Space Training
1/22/2019	Cultural Competency Training
1/30/2019	Un Momento/One Moment
2/08/2019	Breath...Together We Can Handle Anxiety-EVENT
2/20/2019	Un Momento/One Moment
2/22/2019	Love Is Love-Event
3/05/2019	Un Momento/One Moment
3/14/2019	Deaf Sensitivity Training
3/26/2019	New Employee Orientation and Un Momento Por Favor
4/02/2019	Un Momento/One Moment
4/22/2019	Cultural Sensitivity Support Staff
4/30/2019	New Employee Orientation and Un Momento Por Favor
5/21/2019	Critical Conversations: Asian American and Pacific Islander Mental Health and Addiction
5/28/2019	New Employee Orientation and Un Momento Por Favor
5/28/2019	Diversity Film Series: Misunderstood Cultures
5/30/2019	Un Momento/One Moment
6/18/2019	New Employee Orientation and Un Momento Por Favor
6/19/2019	Diversity Film Series: Dawnland
6/19/2019	Cultural Competency Presentation

See Attachment A40 for more detail.

The following is the list of trainings that award cultural competence hours available to DBH and contracted provider staff online year round:

Table 11: Relias Online Trainings Awarding Cultural Competency Hours

<u>Course Name</u>	<u>Credit Hours</u>	<u>Number of Participants</u>
10 Steps to Fully Integrating Peers into your Workforce	1.0	36
A Culture-Centered Approach to Recovery	1.0	140
Abuse and Neglect of Individuals with I/DD	2.5	16
Abuse, Neglect and Exploitation of Older Adults	1.5	0*
Addressing Substance Use in Military and Veteran Populations	1.5	23
Adolescent Substance Use Disorder Clinical Pathways	1.75	23
Advanced Co-Occurring Disorders	1.75	42
Advocacy and Multicultural Care	1.5	101
Affirmative Action	0.5	4
An Overview of Cognitive Behavioral Therapy	1.5	45
Barriers to Recovery	1.0	36
Behavioral Health Issues in Older Adults for Paraprofessionals	1.5	9
Choice Making for People with Intellectual and Developmental Disabilities	1.0	7
Cultural Competence	0.5	105
Cultural Issues in Treatment for Paraprofessionals	2.25	69
Customer Service in a Behavioral Health Environment 2240	2	213
Dialectical Behavioral Therapy: Advanced Techniques	1.25	23
Dialectical Behavioral Therapy: An Introduction	1.5	21
Domestic and Intimate Partner Violence	1.0	34
Employee Wellness - Emotional Intelligence: Awareness	0.25	23
Epidemiology of PTSD in Military Personnel and Veterans	1.5	6
Family Assessment and Intervention	1.75	11
Family Psychoeducation: Introduction to Evidence Based Practices	1.25	11
Film Screening and Panel Discussion-“The Anonymous People”	2.0	61
Goals, Values and Guiding Principles of Psychosocial Rehabilitation	1.0	6
Identifying and Preventing Child Abuse and Neglect	1.5	89
Identifying and Preventing Dependent Adult Abuse and Neglect	1.0	8
Illness Management and Recovery Model	1.0	2
Integrated Treatment for Co-Occurring Disorders Part 2--EBP	1	6
Legal Procedures and Client Rights for Behavioral Health Interpreters	0.5	13
Meeting the Behavioral Health Needs of Returning Veterans	1.5	6
Military Cultural Competence	1.25	40
Overview of Assertive Community Treatment: Evidence-Based Practices	1.5	5
Overview of Cognitive Processing Therapy for PTSD in Veterans and Military Personnel	2.0	9

Overview of Substance Use Disorders: Part 1	1.25	8
Overview of Substance Use Disorders: Part 2	1.5	5
Overview of the Behavioral Health System for Behavioral Health Interpreters	1	8
People with Disabilities: Building Relationships and Community Membership	1	2
Person-Centered Planning in Behavioral Health	1	19
Prolonged Exposure Therapy for Service Members and Veterans with PTSD	1	5
Promoting Treatment Engagement with Behavioral Health Disorders	1.5	2
Recovery of Persons with Severe and Persistent Mental Illness	1.75	7
Recovery Promoting Relationships	1	10
Respecting Cultural Diversity in Persons with IDD	1	30
Solution-Focused Therapy	1.25	14
Strengths Based Approach in Working with At-Risk Youth	1.25	14
Substance Use Disorder Treatment and the LGBTQ Community	1.75	14
The Impact of Deployment and Combat Stress on Families and Children, Part I: Families and Deployment	2.75	4
The Impact of Deployment and Combat Stress on Families and Children, Part II: Enhancing Resilience	1.75	2
The Role of the Behavioral Health Interpreter	1	12
The Twelve Steps	1	0*
Treating Gambling Problems	2.25	0*
Understanding Recovery	1	0*
WRAP One on One	1.5	0*

*Course to be offered in FY19/20

Source: DBH Relias Cultural Competency Course Completions FY18/19

5-III: Relevance and Effectiveness of all Cultural Competence Trainings.

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

- **Rationale and need for the trainings: Describe how the training is relevant in addressing identified disparities;**
- **Results of pre/post-tests (Counties are encouraged to have a pre/posttest for all trainings);**
- **Summary report of evaluations; and**
- **Provide a narrative of current efforts that the county is taking to monitor advancing staff skills/post skills learned in trainings.**
- **County methodology/protocol for following up and ensuring staff, over time and well after they complete the training, are utilizing the skills learned.**

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

Trainings are requested to the office of OCCES, (Attachment A70) either by DBH Staff, contract providers, community stakeholder or CCAC subcommittees. For example, OCCES offers trainings such as Deaf Sensitivity each fiscal year due to the high percentage of deaf and hard of hearing population within the community we serve. In conducting these trainings we increase the Cultural Competence level of our staff when serving this cultural population. The objectives of this training are to demonstrate strategies to improve communication with the hard of hearing clients, identify barriers and eliminate obstacles, eliminate misconceptions about the hard of hearing community and discuss the Americans with Disabilities Act, and model policies and practices for the county behavioral health system of care.

Results of pre/posttest:

In order to test participants' knowledge prior to and after a training is received OCCES, in collaboration with WET and DBH Research and Evaluation team, started meeting in FY18/19 to further develop pre and post surveys to capture staff skills learned in trainings. OCCES plans to implement Pre and Post Surveys in FY19/20.

Summary report or evaluations:

After training has been concluded, an evaluation/satisfaction survey is given to all participants, to express their satisfaction with the trainer, overall content, relevance. That information is used to inform and develop/update future trainings. All DBH training evaluations include the following questions to ensure cultural competence is addressed in the training.

- Content of the Training: The training addressed cultural issues and issues of diversity.
- Trainer(s): The trainer(s) promoted and facilitated discussions of cultural sensitivity.

See Attachment A71 to view one a sample evaluation form and training evaluation report.

In FY18/19 the CCAC Native American Awareness Subcommittee in collaboration with OCCES and DBH Research and Evaluation developed and implemented a new separate survey evaluation for the film screening of "Dawnland". The rationale for developing a separate survey evaluation for this training came from the subcommittee. The subcommittee hosting the screening was interested in capturing the impact of viewing the film, measuring not only new knowledge gained, but also the participant experience as a result of attending the screening and participating in both the viewing and discussion of the film and content. The existing surveys we currently have for events are fairly general and lack an experiential component. The subcommittee was interested in education gained around the specific content of the film and the nuanced ways in which this may or may not apply/be utilized within their occupational fields. The subcommittee also wanted to capture what it was like for the participants to view this film. To capture this, an experiential component was included in the survey, where participants were asked to share what the experience of engaging with the content of the film was like for them. This could be done using images, words, pictures, whatever way they wanted to share their experience. The subcommittee was pleased with the results of the survey evaluating and has requested to continue this practice for future cultural competency trainings, when appropriate. See attachment A72 for the survey evaluation results/report.

Customization of survey evaluations to assess education gained, impact, and experience will continue in an effort to ensure cultural competency in all of our data collection forms. For certain cultures and/or settings, it makes more sense to communicate with words instead of boxes, images instead of words, conversations instead of forms. In addition, the results from customized surveys that are created in an effort to better capture specific information can be utilized to address state-level questions about the influence that these events are having for DBH staff, community partners, and the community-at-large. OCCES will work with DBH Research and Evaluation and continue to develop separate survey evaluations for Cultural Competency trainings.

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

In FY19/20 OCCES will continue to work with WET and DBH Research and Evaluation team to develop post surveys to capture staff skills learned in trainings. OCCES plans to implement Post surveys next FY.

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

OCCES in collaboration with WET and DBH Research and Evaluation is currently in the process of developing post training surveys to capture if staff is utilizing the skills learned 30 or 60 days after they received training.

Sample questions for a post survey may include:

- Are you utilizing the skills/information you gained from the training?
- How are you utilizing the skills/information you gained from the training?
- What are your challenges in utilizing the skills/information you learned in the training?
- Do you need a refresher or additional training in utilizing the skills/information you learned in the training?

5-IV: Counties must have a Process for the Incorporation of Client Culture Training throughout the Mental Health System.

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

The Office of Consumer and Family Affairs (OCFA) provides ongoing trainings on Client Culture using the video "The Shaken Tree", a 30 minute documentary that depicts through a collection of stories the journey families experience when one of its members has chronic, persistent mental illness. After the film, two (2) of the Peer and Family Advocates (PFAs) from OCFA facilitate a discussion, sharing personal stories of lived experience with mental illness and of being a family member of someone with lived experience. This presentation is given regularly as a part of New Employee Orientation for new DBH staff, as well as to Crisis Intervention Team (CIT) law enforcement partners, medical students, nursing students, and other outside agencies. In FY18/19 OCFA provided "Shaken Tree" training to **216** individuals, sample sign in sheets are attached as attachment A73.

In FY18/19 OCFA started preparing the “Recovery, Resilience, Wellness” training. This training focuses on educating staff and contract agencies about the culture of people receiving behavioral health services in San Bernardino County. “Recovery, Resilience, Wellness” helps participants define and understand recovery, resilience and transformation through role play, personal stories, and discussion of the “Medical Model” and “Recovery Model”. OCFA will facilitate this training in with participation from Clubhouse and One Stop TAY Center members in FY19/20

5-IV-B: The training plan must also include, for children, adolescents, and transition age youth, the parent’s and/or caretakers’, personal experiences with the following:

- ✓ **Family focused treatment;**
- ✓ **Navigating multiple agency services; and**
- ✓ **Resiliency.**

Family Focused Treatment:

- Maternal Mental Health
- Safe Place

Navigating Multiple Agency Services:

- Un Momento Por favor – One Moment Please
- Trans Awareness
- Deaf Sensitivity

Resiliency:

- National Day of Prayer
- Diversity Film Series: The Wellbriety Journey to Forgiveness, Dawnland, Misunderstood Cultures
- Historical Trauma in Native American Communities
- Love is Love Event
- Hispanic Heritage Event

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

6-I: Recruitment, Hiring, and Retention of a Multicultural Workforce from, or Experienced with, the Identified Unserved and Underserved Populations.

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

Rationale: Will ensure continuity across the County Mental Health System.

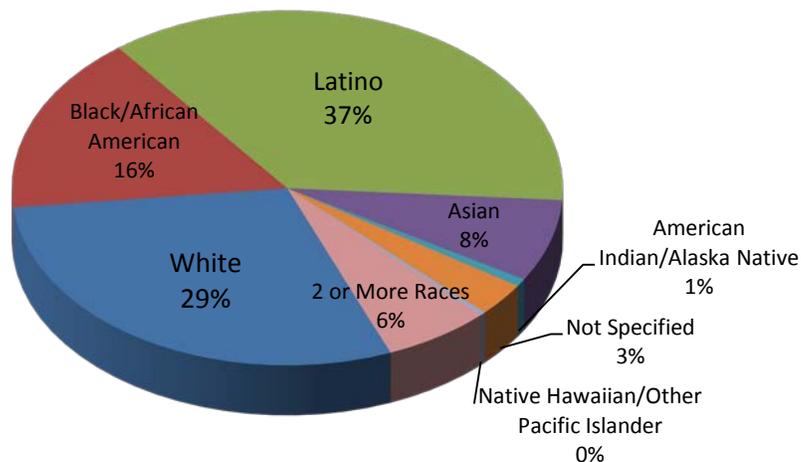
The County of San Bernardino’s Workforce Education and Training (WET) component of the Three-Year (3) Program and Expenditure Plan addresses the shortage of qualified individuals who provide services in San Bernardino County’s Public Mental Health System. This includes community based organizations and individual or small group practices that contract with DBH to provide behavioral health services. This WET 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 (5) Strategic Plan (Five-Year Plan), and San Bernardino County’s current MHSA Community Services and Supports component.

The following excerpt was extracted from the San Bernardino County Department of Behavioral Health Mental Health Services Act Three Year Integrated Plan Fiscal Years 2017/18-2019/20:

“To help provide culturally and linguistically competent services to consumers, DBH actively recruits applicants who are bilingual and bicultural.”

Chart 4

Current Workforce by Ethnicity Fiscal Year 2018/19



Source: DBH Human Resources

As can be seen below, there is an increase in the number of bilingual staff who worked at DBH in FY18/19. However, it remains a top priority of the department to continue to recruit and retain bilingual staff. Bilingual staff accounted for 21% of the workforce in FY18/19.

Table 12: Number of Bilingual Staff

FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
150	165	162	171	171	170	279

The majority of bilingual staff speak Spanish (96%), but other languages spoken by staff include:

- Arabic
- ASL
- Farsi
- Tagalog
- Mandarin
- Vietnamese

WET continues to actively recruit bilingual interns to help provide services in other languages. Since FY08/09, on average 34% of interns have been bilingual. In FY18/19, 38% of interns were bilingual. Of the bilingual interns, 93% were Spanish speakers.

In FY19/20 the county will be conducting a new workforce needs assessment and developing an updated WET Plan to support the recruitment, development, and retention of its workforce.

6-I-B: Compare the Workforce Needs Assessment data for the WET component of the Plan with the general population, Medi-Cal population, and 200% of poverty data.

Rationale: Will give ability to improve penetration rates and eliminate disparities.

The Department of Behavioral Health (DBH) workforce for FY18/19 was as follows by race/ethnicity 16% African America, 8% Asian/Pacific Islander, 29% Caucasian, 37% Latino, 0.69% Native American, and 9% Other/Unknown.

Latinos had a high level of disparity as evident by the comparison of DBH workforce to the general population (36.6%), population under 200% poverty level (51.0%), and Medi-Cal Consumers (42.6%). When looking at DBH staffing needs, it is clear that the Latino population is underrepresented; however DBH has made efforts to address the population disparities through its recruitment and hiring practices. To address some of the potential language disparities DBH has made efforts to improve the number of bilingual staff, which has increased by 53% from FY12/13 (150) to FY18/19 (279). Additionally, DBH is attempting to address the potential language disparities through its internship program by recruiting bilingual and bicultural interns. The bilingual program often acts as a pipeline to the DBH workforce by training future clinicians to work in the public mental health field. In FY18/19, 38% of DBH interns were bilingual and of those 93% are Spanish speakers.

By comparison, there is a large disparity in the gender makeup of DBH workforce, with male staff being underrepresented. The DBH workforce is 22.7% male, as compared to the general

population (49.7%), population under 200% poverty level (49.8%), and Medi-Cal Consumers (51.7%). Recruitment efforts for FY18/19 resulted in 34% of the DBH staff hired being male.

Table 13: FY18/19 Ethnicity and Gender of DBH Workforce Compared to Populations of Interest

	Total Population		Population under 200% FPL		Medi-Cal Beneficiaries		Medi-Cal Consumers		DBH Workforce	
	2,192,203		795,540		780,478		37,804		1,307	
Female	1,102,645		389,382		424,623		18,212		1,010	
Percentage of Females	50.3%		50.2%		54.4%		48.2%		77.28%	
Male	1,089,558		396,158		355,855		19,541		297	
Percentage of Males	49.7%		49.8%		45.6%		51.7%		22.7%	
Other/Unknown	0	0%	0	0.0%	0	.0%	33	0.1%	0	0
Ethnic Group	Total Population		Population under 200% FPL		Medi-Cal Beneficiaries		Medi-Cal Consumers		DBH Workforce	
African American	185,919	8.5%	78,673	9.9%	85,683	11.1%	6,199	16.4%	212	16.22%
API	138,952	6.3%	41,942	5.4%	36,012	4.6%	867	2.3%	102^	7.81%
Caucasian	720,664	32.9%	239,094	30.1%	138,955	17.8%	10,894	28.8%	384	29.38%
Latino	1,086,865	49.6%	405,850	51.0%	438,106	56.1%	16,152	42.7%	478	36.57%
Native American	9,167	0.4%	5,255	0.7%	1,897	0.2%	205	0.5%	9	0.69%
Other/ Unknown	50,636	2.3%	23,726	3.0%	79,825	10.2%	3,487	9.2%	82^^	6.27%

^Includes Asian and Native Hawaiian or other Pacific Islander categories of employees

^^Includes Two or more races and Not Applicable categories of employees

Sources:

() California Department of Finance Demographic Research Unit*

Report E-4 Population Estimates for cities, counties and the State 2011-2019 with 2010 Benchmark

Estimated as of January 1st, 2019 Released May 1, 2019

Total Population, Poverty Population, Persons in Need are estimated based on different sources like: US Census Bureau, American Community Survey

California Department of Finance Demographic Research Unit, California Health Interview Survey (provided for UCLA Center for Health Policy Research) etc.

Medi-Cal Eligible Beneficiaries: Medical Monthly Eligibility Files (MMEF) provided by CA Department of Health Care Services. Monthly average for the FY18/19

Unduplicated Clients: DBH-SIMON database and Data Warehouse as of 7/30/2019

6-I-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 Department’s review of the WET component of its Plan.

Not applicable

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

Targets reached to grow a multicultural workforce in rolling out the WET planning and implementations include the expansion of the Psychiatry Residency Program. The expansion of the Psychiatry Residency Program, which included the addition of Fellows to the program, has been an effort to address the severe shortage of psychiatrists by providing an opportunity for the participating Residents and Fellows to experience working in public mental health, and ultimately choosing employment with DBH’s system of care. The result of this program allowed DBH to hire 6 Fellows into permanent positions within our system of care.

Table 14: Number of Participants in the DBH Residency Program

FY2015/16	FY2016/17	FY2017/18	FY2018/19	FY18/19 Hires
6	8	11	12	6

To address the shortage of licensed clinical positions WET continues to work with the human resource department to recruit for these positions year round. As a result of the year round recruitment there was an increase in qualified applications received for licensed positions in FY 18/19 from FY17/18. The result of this program allowed DBH to hire 47 licensed and pre-licensed clinicians into permanent positions within our system of care.

Table 15: Number of Qualified Applications Received for DBH Positions per Fiscal Year and Hires in Fiscal Year 18/19

Job Title	FY 17/18	FY 18/19	FY18/19 Hires
Clinical Therapist, LCSW	7	11	1
Clinical Therapist, MFT	16	25	2
Clinical Therapist, Psychology	0	1	1
Clinical Therapist II	35	58	10
Pre-Licensed Clinical Therapist, LCSW	152	164	11
Pre-Licensed Clinical Therapist, MFT	201	235	11
Pre-Licensed Clinical Therapist, LPCC	39	44	11
Psychiatric Technician I	24	56	1

DBH’s Internship Program is also in place to address the shortage of behavioral health providers. Currently, the Internship Program trains students who are enrolled in the following bachelor and graduate programs: Social Work, Marriage and Family Therapy (MFT), and Psychology. Depending on their discipline, interns participate in the Internship Program for 12 to 18 months. During that time, they learn to provide clinical services in a public community behavioral health setting. In FY18/19, there were a total of 38 interns in the intern program across the three disciplines. Also, the MFT program expanded to include one doctoral MFT Graduate Student intern.

The program continues to grow and receive positive feedback from participants who report that they received comprehensive training and a valuable experience during their time at DBH. It is hoped that integrating psychiatric residents into the clinical staff and supporting their understanding of the therapeutic process, as well as increasing their clinical skills, will lead to an increase in the retention and hiring of psychiatrists who complete their residency at DBH. DBH is committed to hiring applicants that were previously interns. In FY18/19, 33% of clinical hires were DBH interns.

DBH has a dedicated Volunteer Services Coordinator who conducts focused outreach to high schools, adult education, community colleges, universities, and Regional Occupation Programs (ROP’s) to inform audiences on behavioral health career opportunities, offer volunteer opportunities to individuals interested in behavioral health careers and coordinate outreach to the monolingual Spanish speaking community members. The coordinator has partnered with a bilingual co-presenter and translated presentations and handouts into Spanish. The co-presenter also helps to explain behavioral health career opportunities to monolingual parents that may not have a full understanding of what kind of career options are available for their children. The coordinators outreach efforts have resulted in increased internships for diverse psychologists, social workers and marriage family counselors and volunteer opportunities to enter the public mental health field. Working with ROP has also initiated interest in a Mental Health professional focus for ROP. In FY 18/19 DBH’s Volunteer Services and Outreach program visited 63 schools and reached 6,377 students and, 204 volunteers donated their time to DBH.

The Peer and Family Advocate (PFA) workforce support initiative supports 39 full time PFA positons throughout DBH. This added diversity builds upon the lived experience and adds a greater dimension to service provision. Once a PFA starts working for DBH, they are encouraged to develop professionally and promote to a higher classification. The following table shows the number of PFAs promoted since 2008.

Table 16: Promoted Peer and Family Advocates from FY07/08 to FY18/19

FY 07/08	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
3	1	1	4	3	4	3	5	6

6-I-E: Share lessons learned on efforts in rolling out county WET planning and implementation efforts.

One of the biggest lessons learned is that even if an agency has a solid plan of action for workforce development, unplanned or uncontrolled conditions can make it difficult to carry out even the best of plans. The fiscal crisis of 2010 drastically altered the implementation of the Departments plan, and led to a hard hiring freeze in San Bernardino County. To mitigate these negative aspects of the fiscal crisis, the WET Plan allowed for a more extensive use of WET Plan initiatives such as License Exam Preparation Program (LEPP) courses for clinicians seeking licensure. The process to get licensure has numerous parts and the license preparation allows for staff to spend the required time on exam preparation in order to improve their chances of successful examination completion. DBH continues to offer LEPP, to date there has been, on average, an approximately 67% licensure rate among 401 participants.

DBH continues to have difficulty retaining licensed clinical staff due to challenges presented by the Memorandum of Understanding (MOU) for the Professional bargaining unit. Although the new MOU has increased compensation for clinical staff, one of the challenges remains other employers that can offer higher wages and/or better benefits. Additionally, the Department has encountered the following challenges:

- High vacancy rate of hard to fill positions like AOD counselor,
- Lack of clinical supervisors for all three internship programs,
- Unclear line of succession for the PFA position, and
- Lack of DBH volunteer sites.

To address these challenges DBH continues to work closely with County Human Resources to develop creative solutions to address the issue of retaining qualified licensed clinicians. DBH is working to continue implementing creative strategies to retain staff in clinical positions, and is working diligently through outreach efforts to increase the interest of students and community members in behavioral health careers. Additionally, DBH has taken the following actions to address the challenges:

- Held a hiring fair to address the AOD counselor which is a hard to fill position,
- Developed a plan to implement Incentives for clinical supervisors,
- Updated the succession plan for PFA positions,
- Increased capacity building efforts of potential DBH sites for volunteers.

6-I-F: Identify county technical assistance needs.

There are no identified technical assistance needs at this time.

CRITERION 7: LANGUAGE CAPACITY

7-I: Increase Bilingual Workforce Capacity

7-I-A-1: Evidence of dedicated resources and strategies counties are undertaking to grow bilingual staff capacity, including the following:

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

To help provide culturally and linguistically competent services to clients, DBH continues actively recruit applicants who are bilingual and bicultural. Updates on the counties efforts are included in the San Bernardino County Department of Behavioral Health Mental Health Services Act Annual Updates.

In FY18/19, DBH employed 279 bilingual employees and interns accounting for 21% of the workforce.

The majority of bilingual staff speak Spanish (96%), but other languages spoken by staff include:

- Arabic
- ASL
- Farsi
- Tagalog
- Mandarin
- Vietnamese

WET has actively recruited bilingual interns to help provide services in other languages. Since FY08/09, on average 34% of interns have been bilingual. In FY18/19, 38% of interns were bilingual. Of the bilingual interns, 93% were Spanish speakers.

7-I-A-2: Updates from the CSS or WET component of the county's Plan on bilingual staff members who speak the languages of the target populations.

The DBH Bilingual Staff List is updated on a quarterly basis (Attachment A62); please see below for a breakdown of bi-lingual staff by language and skill level for this fiscal year.

Table 17: DBH Bilingual Staff by Language and Skill Level for FY18/19

	Proficiency			Total
	Verbal	Written	Technical	
Spanish	126	45	97	268
ASL	1	0	0	1
Arabic	0	0	1	1
Farsi	0	0	1	1
Mandarin	3	0	1	4
Tagalog	0	0	1	1
Vietnamese	0	0	3	3

**As of August 2019, DBH HR*

7-I-A-3: Total annual dedicated resources for interpreter services in addition to bilingual staff.

In addition to hiring bilingual staff, DBH continued to contract with five (5) vendors to provide translation and interpretation services for the contract period of September 1, 2015 to August 31, 2019. The total budgeted amount for the contract was \$1,752,835. This allocation of resources does not include the bilingual pay differential paid to certified (tested) bilingual employees (Verbal: \$50 per pay period, Written: \$55 per pay period, Technical: \$60 per pay period) which totaled \$270,205 for FY18/19.

7-II: Provide Services to Persons who have Limited English Proficiency (LEP) by using Interpreter Services.

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

- **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.**
- **Consider use of new technologies such as video language conferencing. Use new technology capacity.**
- **Description of protocol used for implementing language access through the county’s 24-hour phone line with statewide toll-free access.**
- **Training for staff that may need to access the 24-hour phone line with statewide toll-free access so as to meet the client’s linguistic capability.**

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:

DBH provides a 24-hour Access & Referral Line which links callers to access to mental health services, responds to urgent conditions, and provides beneficiary problem resolution through grievances and appeals. Access & Referral is available 24 hours a day, 7 days a week and can be reached by calling (888) 743-1478 or 711 for TTY users. DBH’s Access & Referral Line is

equipped, and required to, provide language services and interpretation for all individuals through bilingual staff or through one of the five (5) contracted language services providers. It is the department’s policy to ensure beneficiaries have access to appropriate linguistic services and ensure beneficiaries are made aware of these services offered. (Attachments A16, A3, A14 & A10). Below is a data sample of Language Line Utilization for the 24/7 Access Line from March to May 2019. However, Language Line utilization extends beyond our 24/7 Access Line, across our system of care.

Table 18: 24/7 NACT Language Line Submission Example

Utilization for 24/7 Access Line (See Attachment A63 for More Detail)			
Exhibit Name:	Language Line Utilization		
Plan Name:	Contract Languages Services		
Reporting Period :	March 2019	April 2019	May 2019
Total # of encounters requiring language line services:	490	494	462

Consider use of new technologies such as video language conferencing. Use new technology capacity:

In June 2016, DBH partnered with Health Care Interpreter Network (HCIN) to pilot the use of a video interpretation system to provide interpreter accessibility promptly, on demand, and in real time. Given our threshold language of Spanish, the feature of having 24/7 Spanish, Portuguese and American Sign Language by video is tremendously valuable. Staff has access to interpreters via phone (voice only) and video (image and voice). The benefits of the video interpretation services have included reduced cost, added convenience, reliability, increased productivity, and increased quality of care.

Feedback from staff has been positive. Over a 1.5 year period (2016-2017), 70 staff surveys were collected from two clinics. The vast majority of staff who completed surveys at the Crisis Walk-In Clinic (CWIC) and Mesa Clinic, both in Rialto, CA, strongly agreed or agreed (87%) that they have a positive outlook to the use of the video interpretation device. In addition, a majority of staff at both clinics strongly agreed or agreed that they considered the device user friendly (83%), and that it was viewed favorably by clients (90% of staff at Mesa and 71.4% of staff at CWIC).

Results of the consumer surveys (n=65) also showed a positive outlook. On average, consumers agreed or strongly agreed that: they felt comfortable communicating with the interpreter, it was easy communicating with the video interpreter, they were satisfied with the quality, and they would be comfortable using the unit during the next visit. See table below for details.

Table 19	2016-2017	2017
	<u>Mesa</u> (N=45)	<u>CWIC</u> (N=20)
1. I felt very comfortable communicating with the interpreter.	4.16	4.32
2. It was easy communicating with the video interpreter.	4.43	4.37
3. I was satisfied with the quality of the video/audio interpretation.	4.29	4.26
4. I would be comfortable using the video interpretation unit during my next visit.	4.38	4.32

Response Options: Strongly Disagree = 1; Disagree = 2; Neutral = 3; Agree = 4; Strongly Agree = 5

51% of consumers at the Mesa clinic indicated that they preferred having an in-person interpreter. In contrast, only 20% of consumers at CWIC felt this way. See details below.

Table 20	2016-2017	2017
	<u>Mesa</u> (N=45)	<u>CWIC</u> (N=20)
5. How does this video unit compare to an in-person interpreter?		
I prefer the video unit	20% (n=9)	15% (n=3)
This is about the same for me as an in-person interpreter	29% (n=13)	65% (n=13)
I prefer an in-person interpreter	51% (n=23)	20% (n=4)

The reasons that 51% of consumers surveyed at Mesa Clinic in Rialto might have stated they prefer the in-person interpreter are unclear. Consumers were given the opportunity to provide comments on the survey, but most consumers did not leave comments, or noted it was a positive experience. Only two consumers from Mesa provided comments reflecting a negative view of the device. They are listed below:

- “I was communicating with the interpreter when the call was cut short and I had to call once more and with an interpreter in person this does not happen.”
- “It was a bad connection.”

Usage:

Based on invoices received from HCIN for June 2016 through Sept 2017, a total of 256 calls were placed to the Video Interpretation devices across all clinics (129 from CWIC, 102 calls from Mesa Clinic, and 24 from Mariposa). In terms of languages utilized, two hundred and twenty-two (222) of the two hundred and fifty-six (256) calls were for Spanish interpreters, twenty-two (22) for ASL, four for Vietnamese, three for Arabic, two (2) for Cambodian, two (2) for Mandarin, and one (1) for Farsi.

Future Plans:

The pilot project with HCIN ended in June of 2019. Due to the success of the pilot project DBH included video interpreting into the Request for Proposals for future language services contacts

to begin in September of 2019. Four of the six the language service vendors DBH entered into contracts with for FY19/20 have the ability to provide video (image and voice) interpretation services. DBH is currently in the process of providing these services at two DBH clinics ensuring that the department has the infrastructure and capacity to provide quality interpretation services within a clinic setting and field based before starting the services in all regions of the county.

Description of protocol used for implementing language access through the county's 24-hour phone line with statewide toll-free access including staff training protocol:

In FY18/19 when a speaker with Limited English Proficiency called the County's statewide toll free number during business hours (7:30am-5:00pm) the call went to the DBH Access Unit. They were staffed with Spanish speakers. If a call was received from a caller who spoke another language, they utilized the Language Line for interpretation. If the call came in after hours (5:00pm-8:00am), the call went to the County's 211 hotline. They were also staffed with Spanish speakers, as well as a number of additional languages and also utilize telephonic interpreters for languages not spoken by staff. In FY19/20 DBH is no longer utilizing the county's 211 hotline. All calls now are handled by DBH Access Unit staff, which is staffed by bilingual staff and staff who have been trained to utilize the Language Line for interpretation when needed.

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.

DBH provides live training to all staff on how to interact and connect non-English speaking clients either at the clinic or on the phone to appropriate language services. This training, Un Momento Por Favor, focuses on the Spanish language, and the process is to ensure appropriate language linkage when clients/family members are present in person or on the telephone. The training includes the distribution of a Quick Reference Guide for Translation/Interpretation (Attachment A64) which includes how to access language services both during day time hours as well as after hours.

7-II-B. Evidence that clients are informed in writing in their primary language, of their rights to language assistance services.

Clients are informed at all points of access about their language rights. A language rights poster and a language identification poster are posted in all clinic and County sites. Additional flyers are posted in multiple locations at the clinic sites to ensure that clients/family members see them. (Attachment A65) In FY19/20 the Office of Cultural Competence and Ethnic Services will be visiting all DBH sites to update and replace posted language rights posters.

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

The Department of Behavioral Health (DBH) has the full capacity to accommodate Limited English Proficient (LEP) clients, see policy CUL1004. (Attachment A3) Procedure CUL 1012 (Attachment A10) outlines steps to access an interpreter, including bilingual staff as well as contracted language service providers. (Attachment A66) A list of bilingual-paid staff is generated quarterly and made available for staff's reference. (Attachment A62)

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

No lessons learned in FY18/19. In FY19/20 OCCES will be developing a survey to request feedback on language services delivered from staff who frequently access these services to ensure they are satisfied with the quality of service provided from DBH vendors. The results will also allow us to identify future training opportunities.

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

Challenges and Efforts (A):

- Video interpretation services- LEP clients prefer services in person in their language of choice. A video interpreter is less preferred.
- There is no established centralized tracking system to monitor or track usage of the Video interpretation devices throughout our system of care.
- Ongoing language services training is needed for all county staff on the use and advantages of video interpretation. Clinics were not open to utilizing the technology.
- Some clients did not feel comfortable using video services.

Lessons learned (A):

- Unable to monitor usage of Video interpretation machines.
- Need a standardized reporting process.
- Training and education needed on the use of services for staff and clients.

Challenges and Efforts (C):

- Clinic staff is unaware of the availability of access to language services or when services are updated.
- Short appointment time frames.
- Staff and clients are unaware of how to access or explain language services.

Lessons learned (C):

- Frequent and ongoing language services training for staff and contact services providers.
- Notifying staff and removing old information when services are updated. Updating policies and staff reference sheets.

In FY19/20 OCCES will survey DBH staff to identify any current challenges in providing language services.

7-II-E: Identify county technical assistance needs.

There are no current areas of technical assistance needed.

7-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.

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

Bilingual staff and interpreter vendors are available in languages spoken by the community. Staff who receive bilingual pay are kept on a Bilingual Staff master list that is updated and kept on the County Intranet DBH site. This list is utilized first when a non-English speaking clients/family member accesses services. Every effort is made by staff to accommodate need to the point of traveling between sites to provide language services, if needed. The next level of language service delivery is via a vendor. In FY18/19, DBH contacted with five (5) vendors for translation and interpretation services. Language posters are present at all clinic sites and state that language services are free and available. (Attachment A65)

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

Interpreter services are offered to clients/family members and their response to the offer is recorded in their chart. The Outpatient Chart Manual describes the exact process of documenting interpreter services offer and requests. Additionally, the Outpatient Chart Manual also provides the procedure for inclusion of translated forms in charts. (Attachment A67)

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

DBH bilingual and contacted language services vendors are available during business hours in the counties threshold language (Spanish). DBH bilingual staff proficiency is tested by the counties Human Resources Department. Contact vendors provide evidence of their staff's proficiency in threshold languages in their proposals to provide services and as requested by the county.

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

To ensure that DBH bilingual staff is linguistically proficient, they must pass a written and verbal exam. This process is initiated through the County Human Resources (HR) Department, as opposed to DBH Human Resources Department. There are two (2) stages of bilingual testing. Written testing is multiple choice-booklet format and tests comprehension, grammar and idiomatic expression in a multiple choice format. A second tier of examination tests the user's ability to translate expressions frequently found in a clinical or judicial environment. The user must be able to translate efficiently and think in a quick manner in order to be successful. The level a staff member is tested for depends on their job classification and job duties. (Attachment A68)

7-IV: Provide Services to all LEP Clients not Meeting the Threshold Language Criteria who Encounter the Mental Health System at all Points of Contact.

7-IV-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.

The Department of Behavioral Health (DBH) has policies and procedures in place that address service delivery for LEP consumers/family members who may not meet the threshold language criteria. Please see policies CUL 1004 and COM0953 (Attachment A3, A14) and procedures CUL 1011 (Attachment A9) and CUL 1012. (Attachment A10)

7-IV-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.

Clients who do not meet the threshold language criteria (identified as only English and Spanish in San Bernardino County) are appropriately linked to bilingual certified staff, if there is no staff available DBH staff will utilize a vendor to provide appropriate language services. For the specific process for engaging an interpreter, please refer to procedure CUL 1012 (Attachment A10).

7-IV-C: Policies, procedures, and practices that comply with the following Title VI of the Civil Rights Act of 1964 requirements:

- **Prohibiting the expectation that family members provide interpreter services;**
- **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**
- **Minor children should not be used as interpreters.**

The aforementioned requirements are addressed in DBH policy COM0953 and DBH procedure COM0953-1 (Attachments A14 and A15 respectively).

CRITERION 8: ADAPTATION OF SERVICES

8-I: Client-Driven/Operated Recovery and Wellness Programs.

8-I-A: List client-driven/operated recovery and wellness programs.

San Bernardino County Department of Behavioral Health (DBH) has an extensive client driven/operated recovery and wellness program.

DBH has nine (9) client Clubhouses (Attachment A41) and four (4) One Stop TAY Centers (Attachment A42) which are primarily staffed by Peer and Family Advocates (PFA's) who are culturally and linguistically representative of the clients served throughout the DBH system of care.

DBH and Contracted Providers currently operate nine (9) clubhouses in the following areas:

- Desert Stars – Barstow
- Our Place –Loma Linda
- TEAM House – San Bernardino
- A Place to Go Clubhouse – Lucerne Valley
- Central Valley FUN Clubhouse – Rialto
- Amazing Place – Ontario
- Santa Fe Social Club – Yucca Valley
- Pathways to Recovery – Fontana
- Serenity Clubhouse – Victorville

DBH and Contracted Providers operate four (4) One Stop TAY Centers in the following areas:

- Ontario
- San Bernardino
- Victorville
- Yucca Valley

DBH has a Peer and Family Advocate (PFA) program with the goal of increasing the number of clients and family members of clients employed in the public mental health system. PFA's are individuals with the lived experience of being behavioral health clients or family members of behavioral health clients. PFAs provide crisis response services, peer counseling, linkages to services, and support for clients of DBH services. In FY18/19, DBH had thirty nine (39) PFA positions within DBH.

DBH has the Office of Consumer and Family Affairs (OCFA) which is comprised of three (3) PFA's. OCFA provide assistance and support to clients and their families by linking them to appropriate services for treatment. OCFA also facilitate the CCAC Consumer and Family Members Awareness Subcommittee.

All of these programs use the Recovery, Wellness, and Resilience model in a stigma free environment.

8-I-A-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.

Clubhouses and One Stop TAY Centers provide recovery oriented programs using a Recovery, Wellness, and Resiliency model in stigma free environments for adult clients living with serious mental illness. The main objective of Clubhouse programs is to assist clients of diverse racial, ethnic, cultural, and linguistic backgrounds in making their own choices and integrating into the community as contributing members, thereby achieving optimum wellness. In FY18/19 Clubhouses served 10,252 unduplicated individuals. The demographic breakdown of the Clubhouse clients shows they serve diverse populations: 28% of clients were African American, 28% Latino, 32% Caucasian, 5% Asian, 3% American Indian or Alaskan Native, and 4% Other.

The main objective of the One Stop TAY Centers is to provide San Bernardino County residents ages 16 to 26th birthday (youth) with outpatient mental health, case-management and placement services. TAY Centers coordinate the transition of youth from child to adult services and assist youth in adjusting to the new, adult environment. One Stop TAY Centers served 346 unduplicated individuals in FY18/19. The demographic breakdown for One Stop TAY Centers is as follows: 11% of clients were African American, 25% Latino, 54% Caucasian, 3% Asian, 1% American Indian or Alaskan Native, and 6% Other.

The Consumer and Family Members Awareness subcommittee meets on a monthly basis, with participants from a diverse array of cultural backgrounds. The purpose of the subcommittee is to bring forward issues faced by clients and their family members to the Office of Cultural Competence and Ethnic Services and the Cultural Competency Officer, who in turn brings such ideas to the executive team to address within the system of care. The Chair also participates at our monthly CCAC meeting and events. (**Attachment A43**)

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

All nine (9) Clubhouses and four (4) One Stop TAY centers have culturally diverse staff. Client programs are primarily run by the adult clients and have minimal support from department staff. In an effort to increase overall functioning and community integration, members are encouraged to provide input related to program and activity choices. Members often take ownership of the clubhouses and TAY centers and demonstrate an eagerness to participate in the various opportunities and activities.

The various growth opportunities and activities available to the diverse clubhouse and TAY members aid in increasing members’ ability to integrate and cope within the community. Clubhouses and TAY Centers also sponsor regularly scheduled social and recreational activities, both in the community and on-site, which increases the members’ ability to interact and develop skills that improve their ability to function in the community. These activities are mostly decided on by the clubhouse and TAY center members, and so they take into consideration options that accommodate individual preference and cultural/linguistic differences. (**Attachment A44**) Clubhouses and TAY Centers provide growth opportunities and activities for members, such as:

- Living skills
- Volunteerism
- Job skills
- Community integration excursions
- Canteen and clothing closet operations
- Nutrition and cooking
- Physical health

8-II: Responsiveness of Mental Health Services

8-II-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.

A Provider Directory and Resource Guide are provided to clients for their personal accommodation of preference, cultural/linguistic needs. The directory provides options for clients/family members.

Department of Behavioral Health Provider Directory: (Attachment A45)
<http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/10/mhp-provider-directory.pdf>

Department of Behavioral Health Fee for Service Provider Directory: (Attachment A46)
http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/11/ffs-provider-list_october_2019_english.pdf

DBH Program and Community Resource Guide (Attachment A74)

Furthermore, the Department of Behavioral Health provides several culturally-specific programs, both County-operated and through contract agencies, including but not limited to:

- Resilience Promotion in African American Children: Provides prevention and early intervention services to African American children/youth (ages 5-18) and their families.
- Culture-Specific Community Health Worker/Promotores de Salud Programs: A prevention program designed to address the needs of San Bernardino County's culturally diverse communities. The program increases community awareness and connection to community-based prevention and behavioral health services without fear of discrimination or stigma. Services are specifically targeted at underserved and unserved groups, including Spanish speaking communities, African American communities, Asian/Pacific Islander communities, and Lesbian, Gay, Bisexual, Transgender and Questioning (LGBTQ) communities.
- Native American Resource Center: A one-stop center offering several prevention and early intervention services for Native American community members of all ages. The center provides services that incorporate traditional, strength based, Native American practices.

- One Stop TAY Centers: Provide integrated behavioral health services to individuals age 16 to 25 with behavioral and/or emotional problems.
- Age Wise Program: Provides intensive case management services for older adults.
- The Military Services and Family Support Program (MSFS) a prevention and early intervention program that provides mental health services to military veterans, active duty and retired military personnel, reservists, and members of the National Guard who served on or after September 11, 2001, and their families, through San Bernardino County. Services address the negative effects of traumatic events and other unique challenges of military life, services are provided in-home and/or in the community.

8-II-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.

DBH's Program and Community Resource Guide (Attachment A74) contains the information on the availability and location of alternative providers.

8-II-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):

DBH's Public Relations and Outreach (PRO) Office works in conjunction with OCCES to outreach to diverse communities of San Bernardino County. DBH has developed the following policies and procedures on the development of materials to inform all Medi-Cal beneficiaries of available services under consolidation of specialty mental health services.

- Guidelines for Promotional, Educational and/or Informational Materials: BOP3031 (Attachment A48)
- Web Blast Policy: BOP3045 (Attachment A49)
- Web Blast Procedure and Guidelines: BOP3045-1 (Attachment A50)
- Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy: CUL1013 (Attachment A11)

Please refer to **Criterion 1** for a list of all outreach conducted by PRO and OCCES.

8-II-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:

- **Location, transportation, hours of operation, or other relevant areas;**
- **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**
- **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.)

OCCES conducts Mystery Shopper site visits and calls to DBH and Contact Provider facilities. The purpose of the mystery shopper process is to ensure timely access to services and access to appropriate language services. Mystery shoppers not only test the services, but also ensure appropriate signage; forms and posted materials are available to clients and San Bernardino County residents in both English and Spanish (threshold languages) and prevalent non-English languages in facility lobbies. During site visits DBH staff also document if people are greeted with a welcoming environment within the clinic and by staff and that facilities are accessible to individuals with disabilities.

In FY19/20 OCCES will be conducting Mystery Caller studies for the Department's Substance Use Disorder and Recovery Services program. Calls will be made to DBH's after-hours' access line and contracted providers to assess for linguistic capabilities, ADA accessibility and alternative Medication Assisted Treatment (MAT) services.

Another way the county assesses the ease with which culturally and linguistically diverse populations can obtain services is through annual program reviews. When county staff conducts annual program reviews, they assess the cultural competency of the contractors' services and sites.

DBH contracted providers are contractually required to satisfy the following Cultural Competency requirements:

- Contractors shall participate in the County's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.
- To ensure equal access to quality care for diverse populations, contractors shall adopt the federal Office of Minority Health Cultural and Linguistically Appropriate Service (CLAS) national standards.
- Contractors shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.
- Upon request, provide DBH with cultural specific service options available to be provided by the contractor.
- Contractors shall have the capacity or ability to provide interpretation and translation services in threshold and prevalent non-English languages, free of charge to beneficiaries.
- Contractors shall provide written informing materials in alternate formats and in threshold and prevalent non-English languages.
- Contractors shall have in place strategies to recruit, promote, and support a culturally and linguistically diverse workforce that is representative of the demographic characteristics of to the population in the service area.

- Contractor shall have in place procedures to determine if their staff is multilingual/bilingual and their competency level.
- Contractors shall have in place procedures notifying beneficiaries of interpretation services, auxiliary aids and services, which must be available to them free of charge.

The items above are in the program review tools and assessed for each contractor. DBH staff must assess whether the contractor has implemented the item, if the item needs improvement, or if immediate action is required. When contractors are found to need improvement or immediate action on specific cultural competency items, county staff includes the findings in a Corrective Action Plan, which contractors must address within a specific time frame.

Another way the county assesses factors and develops plans to facilitate the ease with which culturally and linguistically diverse populations can obtain services is during the annual MHSA update process. OCCES staff carves out a specific time during each of the subcommittee meetings to elicit feedback on challenges in relation to clinic or service providers' locations, hours of operation, and other access issues. This information is then provided to MHSA staff, and utilized to improve MHSA services in the future.

8-III: Quality of Care: Contract Providers

8-III-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.

As part the procurement or formal bid process, DBH maintains cultural competence requirements and guidelines. DBH defines Cultural Competency or Cultural Relevance as the acceptance and understanding of cultural mores, history, language, race, ethnicity, and culture and their possible influence on the client's issues and/or behavior, that is, using the understanding of the differences between the prevailing social culture and that of the client and their family to aid in developing individualized supports and services.

Submitted proposals by mental health providers are evaluated on the following items specific to cultural competence:

- The agency's ability to understand the population they are proposing to serve and how to best meet their needs.
- A detailed description in the form of an implementation plan as to how the agency will provide services in culturally competent manner by recruiting, hiring, and maintaining staff member who can provide services to a diverse population. This includes ensuring that the agency's staff completes training in cultural competency annually. Administrative staff that does not provide direct services to clients shall complete two hours of cultural competency training annually. Direct service and clinical staff shall complete a minimum of four hours of cultural competency training annually.
- Each agency must describe how they will provide services in the appropriate language and in a culturally competent manner. This aids in establishing community-wide collaboration in service design and system evolution, include clients, formal and informal

supports, mental health, criminal justice system, education, social welfare, and cultural stakeholders in the community. The provision of culturally competent services by tailoring responses to family culture, values, norms strengths, and preferences. Services are culturally competent and respectful of the cultural of participants and their families.

- Cultural values and norms should be included in assessments for the analysis of relevant cultural issues and history and in the Individualized Service Plan as the plan should reflect the best possible fit with the culture, value and beliefs of the client.
- Agencies goals include providing services appropriate to need based on functioning and cultural background.
- Agencies will make an effort to gather demographic information on its service for service planning.
- The number of required staff fluent in other languages is dependent upon the community being served; however, it must be sufficient to accomplish services.
- Inclusion of the above-mentioned items will help to ensure program services are culturally competent and inclusive of individual values and norms.

All DBH contracts have the following standard language:

A. *Cultural Competency*

The State mandates counties to develop and implement a Cultural Competency Plan (CCP). This Plan applies to all DBH services. Policies and procedures and all services must be culturally and linguistically appropriate. Contract agencies are included in the implementation process of the most recent State approved CCP for the County of San Bernardino and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the County's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.

1. *Cultural and Linguistic Competency*

Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.

- To ensure equal access to quality care for diverse populations, Contractor shall adopt the federal Office of Minority Health Cultural and Linguistically Appropriate Service (CLAS) national standards.*
- Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.*

- c. *Upon request provide DBH with cultural specific service options available to be provided by Contractor.*
- d. *DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing medically necessary specialty mental health and substance use disorder treatment services in a culturally appropriate and responsive manner is fundamental in any effort to ensure success of high quality and cost-effective behavioral health services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers does not reflect high quality of care and is not cost-effective.*
- e. *To assist the Contractor's efforts towards cultural and linguistic competency, DBH shall provide the following:*
 - i. *Technical assistance to the Contractor regarding cultural competency implementation.*
 - ii. *Demographic information to the Contractor on service area for service(s) planning.*
 - iii. *Cultural competency training for DBH and Contractor personnel.*

NOTE: Contractor staff is required to attend cultural competency trainings. Staff who do not have direct contact providing services to clients/consumers shall complete a minimum of two (2) hours of cultural competency training, and direct service clinical staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Contractor shall upon request from the County, provide information and/or reports as to whether its provider staff completed cultural competency training.
 - iv. *Interpreter training for DBH and Contractor personnel, when available.*
 - v. *Technical assistance for the Contractor in translating mental health and substance use disorder services information to DBH's threshold language (Spanish). Technical assistance will consist of final review and field testing of all translated materials as needed.*
 - vi. *Monitoring activities administered by DBH to demonstrate documented capacity to offer services in threshold language or contracted interpretation and translation.*

- vii. *Contractor's written organizational procedures must be in place to determine multilingual and competency level(s).*
- viii. *The Office of Cultural Competence and Ethnic Services (OCCES) may be contacted for technical assistance and training offerings at cultural_competency@dbh.sbcounty.gov or by phone at (909) 386-8223*
- f. *Contractor agrees to provide culturally competent services. Contractor shall ensure its policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Contractor shall ensure translation services are available for beneficiaries, as needed.*

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

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

Client outcomes are collected by various survey tools as well as focus group projects.

The following tools are utilized to address cultural/linguistic issues in addition to other items:

- Mental Health Plan Consumer Perception Survey: Surveys are facilitated two (2) times per year in May and November. Three (3) specific questions are used to measure customer satisfaction in regards to culturally appropriate customer service and written information for Adults, including Older Adults. (Attachment 51)
- Five (5) specific questions are used to measure customer satisfaction in regards to culturally appropriate services customer service and written information for youth.
- (Attachment 52)
- Substance Use Disorders Treatment Perceptions Survey: Surveys are facilitated once a year in October. One (1) question is used to measure culturally appropriate customer service. (Attachment 53)
- Transformation Collaborative Outcomes Management (TCOM): DBH utilizes the following TCOM assessment tools which include items to measure client's strengths and needs in relation to the culture.
 - ANSA: Adults Needs and Strengths – San Bernardino (ANSA-SB) (Attachment 54)
 - CANS: Child and Adolescent Needs and Strengths – San Bernardino (CANS). (Attachment 55)
- DBH uses the Consumer Comment Card (see attached A56E, A56S and A56V) to collect data from individuals who utilize interpreter services.
- Additionally, in FY18/19 the Clubhouse Expansion Program, in partnership with DBH Research and Evaluation, started the process of supporting the newly formed Consumer

Evaluation Counsel in selecting new and appropriate measurement tools for clubhouse outcomes. The Consumer Evaluation Counsel is currently piloting several evaluation methods including surveys, emergent methodologies and focus groups as a means of more effectively evaluating the outcomes of the program. The Consumer Evaluation Counsel is comprised of clubhouse consumers and peers from all regions.

8-IV-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 its culturally and linguistically competent services

In the fall of 2016, the Department Diversity Committee (DDC) administered an organization survey to DBH staff. The purpose was to collect feedback to assist the department's effort around cultural competency, diversity and inclusion. A total of eight hundred and thirty-five (835) employees completed the survey. Highlights of the results included:

- 76% of those surveyed agreed or strongly agreed that the organization addresses cultural factors such as language, race, ethnicity, sexual orientation, and customs when interacting with clients.
- 71% of those surveyed agreed or strongly agreed that our organization supports and understands values from all ethnic/age and cultural groups sensitively and competently.
- 70% of those surveyed agreed or strongly agreed that staff, program materials, brochures, and policies and procedures manuals are culturally and linguistically oriented to the diverse populations we serve.
- 69% of those surveyed agreed or strongly agreed that the organization uses interpreters who understand the cultures as well as language of our clients and families.
- 69% of those surveyed agreed or strongly agreed that our organization has service hours and sites which are accessible to the consumers we serve.
- 66% of those surveyed agreed or strongly agreed that our organization has administrative staff that proportionately reflects the ethnic, gender, age and other cultural differences of the population we serve.
- 66% of those surveyed agreed or strongly agreed that the organizations seeks and incorporates current and relevant information about all diverse groups served.
- 52% of those surveyed agreed or strongly agreed that our organization has recruitment efforts that seek individuals from culturally diverse groups and advertise position vacancies in culturally diverse print and broadcast media.
- 54% of those surveyed agreed or strongly agreed our organization is able to retain a diverse staff at all levels.
- 51% of those surveyed agreed or strongly agreed that consumers are involved in the planning, designing, outreach and delivery of services.

In FY19/20 OCCES, DDC and the Cultural Competence Advisory Committee (CCAC) will review the results of survey administered in 2016 and identify areas for improvement.

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

The DBH Grievance and Complaint process is twofold. Complaints and Grievances come through the DBH's ACCESS unit for outpatient services. This data is then recorded in a log and analyzed between departments. Grievances can also come through the Patients' Rights Office for issues related more directly to Patients' Rights, as well as Inpatient Hospitalization issues. Patients' Rights currently collect data regarding the nature of the grievance and the facility/program involved. The Access Unit receives logs, analyzes, and creates and maintains summary reports of all mental health and substance use disorder grievances received. Summaries of the grievances are reviewed during the monthly Quality Management Action Committee (QMAC) meetings. (Attachment A61) Grievance and Appeal Policy and Procedure see attachment A57 and A58.

Additionally, DBH has a separate process for grievances related to Non-Discrimination-Section 1557 of the Affordable Care Act. (Attachment A59 & A60) Grievances are submitted to the ACA 1557 Coordinator who oversees the grievance process, including due process and prompt and equitable resolution of complaints and grievances from clients. Appeals of the decision made by the ACA 1557 Coordinator would be reviewed by the Cultural Competency Officer (CCO), and appeals of the decision made by the Cultural Competency Officer would be reviewed by the DBH Director. In FY18/19 no grievances were received. In FY19/20 any grievances that are received will be reviewed during the bi-monthly Cultural Competency Quality Improvement Workgroup.

Cultural Competency Plan Fiscal Year 18/19 Attachment List

	Attachment Description	Page
A1	CUL1002 Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Policy	102
A2	CUL1002-1 Behavioral Health Services for Clients/Family Members Who are Deaf or Hard of Hearing Procedure	104
A3	CUL1004: Satisfying Clients' Language Needs Policy	106
A4	CUL1005: Consumer Focus Group Policy	108
A5	CUL1005-1: Consumer Focus Group Procedure	109
A6	CUL1006: Cultural Competency Policy	112
A7	CUL1010: Field Testing of Written Materials Policy	114
A8	CUL1010-1: Field Testing of Written Materials Procedure	116
A9	CUL1011: Providing Translation Services Procedure	119
A10	CUL1012: Providing Interpretation Services Procedure	122
A11	CUL1013:Providing Written Communications in Threshold/Primary Languages for Consumer/Family Members Policy	126
A12	CUL1014: Cultural Competency Training Policy	128
A13	TRA8001: Education and Training Policy	130
A14	COM0953: Non-Discrimination-Section 1557 of the Affordable Care Act Policy	138
A15	COM0953-1:Affordable Care Act (ACA) 1557 Grievance Procedure	143
A16	QM6045:24/7 Access Line Requirements Policy	145
A17	QM6045-1:24/7 Access Line Requirements Procedure	147
A18	DBH Contract Language Section with Cultural Competency Requirements	154
A19	Published samples from Behavioral Health Commission, Cultural Competency Advisory Committee, District Advisory Committee and the Community Policy Advisory Committee.	157
A21	Hispanic, African American and Native American Flyers, Reports and Agendas	164
A22	DDC Flyer and Town Hall Meeting Breakdown	175
A23	Public Relations and Outreach Table of Events for Fiscal Year 18/19	179
A24	MHFA and ASIST trainings in Fiscal Year 18/19	181
A25	Hispanic Heritage Month Event Flyer for 2018	182
A26	LGBTQ Resource Guide	184
A27	CLAS Standards Review Class presentation and sign in from July 10, 2019	203
A28	Cultural Competency Officer Job Description and Requirements	261
A29	FY18/19 Budget Expense Page for OCCES	263
A30	Consumer and Family Members Awareness Subcommittee Agendas	264
A31	Cultural Competency Advisory Committee by laws for FY18/19.	269
A32	Cultural Competency Advisory Committee Annual Report FY18/19.	273
A33	List of Cultural Competency Advisory Subcommittees for FY18/19.	282
A35	Cultural Competency Advisory Committee Work plan for FY18/19.	284
A36-1	Cultural Competency Advisory Committee February 2019 Agenda.	288
A36	Cultural Competency Advisory Committee Agendas for FY18/19.	289
A37	Cultural Competency Advisory Committee Sign In Sheets FY18/19.	310
A38	Mental Health Act Stakeholder Engagement Forums and Webinar Invitations	334
A39	CCAC Subcommittee Monthly Updates FY18/19	352
A40	Office of Cultural Competency Training Table for Fiscal Year 18/19.	385

Cultural Competency Plan Update Fiscal Year 18/19

A41	List of San Bernardino County Client Clubhouses	386
A42	List of San Bernardino County One Stop TAY Centers	387
A43	Consumer and Family Member Committee Agendas July 2016-June 2017	388
A44	TAY Center Calendar of Events -Example	400
A45	Department of Behavioral Health Provider List-Web Example	401
A46	Department of Behavioral Health Fee for Service Provider List-Web Example	402
A48	BOP3031: Guidelines for Promotional, Educational and/or Informational Materials	403
A49	BOP3045: Web Blast Policy and Guidelines	407
A50	BOP3045-1: Web Blast Procedure and Guidelines	408
A51	Mental Health Plan Consumer Perception Survey for Adults and Older Adults	412
A52	Mental Health Plan Consumers Perception Survey for Youth	417
A53	Substance Use Disorders Treatment Perceptions Survey	421
A54	ANSA: Adults Needs and Strengths Assessment San Bernardino	422
A55	CANS: Child and Adolescent Needs and Strengths San Bernardino	425
A56E	Department of Behavioral Health Comment Card-English	428
A56S	Department of Behavioral Health Comment Card-Spanish	430
A56V	Department of Behavioral Health Comment Card-Vietnamese	432
A57	QM6029 Grievance and Appeal Policy	434
A58	QM6029-1 Grievance Procedure	442
A59	COM0953 Non-Discrimination-Section 1557 of the Affordable Care Act	448
A60	COM0953-1 Affordable Care Act (ACA) 1557 Grievance Procedure	453
A61	Quality Management Action Committee Grievance & Complaint Summary for FY18/19	455
A62	DBH Master Bilingual Staff List	456
A63	NACT Report Sample Language Line Utilization Report March-May 2019	463
A65	Language Reference Poster and World Language Map	465
A66	Translation/Interpreter Vendor Services List FY18/19.	468
A67	Outpatient Chart Manual-Pages Related to Language Service and Clinic Interpretation	470
A68	Bilingual Compensation Procedure and Compensation	478
A70	OCCES Training Request Form	482
A71	DBH Health Training Evaluation & Sample with Summary Report	484
A72	Dawnland Screening Evaluation Reports	491
A73	OCFA Training Shaken Tree Sign In Sheets Sample	516
A74	DBH Community Resource Guide	519